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GLOBAL SMOKELESS TOBACCO CONTROL POLICIES AND THEIR IMPLEMENTATION

GLOBAL

SMOKELESS TOBACCO CONTROL POLICIES AND THEIR IMPLEMENTATION

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*Indicative depiction of the countries where SLT is used globally.

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ABBREVIATIONS

AFR	African Region
AMR	American Region
CDTL	Central Drug Testing Laboratory
CoP	Conference of Parties
EMR	Eastern Mediterranean Region
EU	European Union
EUR	European Region
FCTC	Framework Convention on Tobacco Control
FY	Financial Year
GATS	Global Adult Tobacco Survey
GDP	Gross Domestic Product
GHPSS	Global Health Professions Student Survey
GSPS	Global School Personnel Survey
GST	Goods and Service Tax
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
HIC	High Income Country
HRIDAY	Health Related Information Dissemination Amongst Youth
HW	Health Warnings
IHD	Ischemic Heart Disease
INR	Indian National Rupee
ITCP	International Tobacco Control Project
KH-SLT	WHO FCTC Global Knowledge Hub on Smokeless Tobacco
LIC	Low Income Country
LMIC	Lower Middle Income Country
MYTRI	Mobilizing Youth for Tobacco-Related Initiatives.
NCD	Non-Communicable Disease
NCCD	National Calamity Contingent Duty
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NICPR	National Institute of Cancer Prevention & Research
NIH	National Health Institute
NNK	Nicotine-derived Nitrosamine Ketone
NNN	N-Nitrosornicotine
NQL	National Quit Lines

NRT	Nicotine Replacement Therapy
NSSO	National Sample Survey Organization
NTTL	National Tobacco Testing Laboratory
OPMD	Oral Potentially Malignant Disorders
pH	Power of Hydrogen
PHFI	Public Health Foundation of India
PHW	Pictorial Health Warnings
RDTL	Regional Drug Testing Laboratory
RIP	Relative Income Price
SDG	Sustainable Developmental Goal
SEAR	South East Asian Region
SLT	Smokeless Tobacco
ST	State Tax
STEPS	STEP wise approach to Surveillance
TAPS	Tobacco Advertising, Promotion and Sponsorship
TB	Tuberculosis
TFI	Tobacco Free Initiative
TobLabNet	Tobacco Laboratory Network
TobReg	Tobacco Product Regulation
TPD	Tobacco Products Directive
TSNAs	Tobacco-specific Nitrosamines
TV	Television
UADT	Upper Aero Digestive Tract
UMIC	Upper Middle Income Country
USA	United States of America
VAT	Value Added Tax
VoTV	Voice of Tobacco Victims
WHO	World Health Organization
WPR	Western Pacific Region

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Supporting background documents are available online at:
<http://untobaccocontrol.org/kh/smokeless-tobacco/supporting-background-documents/>

EXECUTIVE SUMMARY 2017

A. INTRODUCTION

The present report is prepared in accordance with the decisions taken by the Conference of the Parties (COP) at its sixth session in October 2014 (FCTC/COP/6/9). It provides an overview of the status of smokeless tobacco (SLT) control policy and its implementation by the Parties to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). Besides facilitating an exclusive discussion on SLT policy related matters in an Inter-Party Meeting cum Global Expert Consultation, it also provides a comparative progress with progress indicators with cigarettes, some key observations on the progress made in SLT control policy by Parties. It further explores opportunities and challenges related to the specific articles under the convention along with proposed recommendations.

B. METHODOLOGY

The report is based on systematic compilation of standard data that is validated by numerous cross-checks by team of experts at the WHO FCTC Global Knowledge Hub on Smokeless Tobacco (KH-SLT) at ICMR-National Institute of Cancer Prevention and Research (ICMR-NICPR), Noida, Uttar Pradesh, India.

Information for the study is sourced from WHO FCTC reporting instruments, WHO global tobacco epidemic report 2013, 2015 and 2017, WHO smokeless tobacco survey report, tobacco control legislation, regulation, decree of individual countries and published articles in peer reviewed journals and validated by at least one additional document. For regional analysis, parties were categorized into two major groups – High-Resource Parties by combining High Income (HIC) and Upper Middle Income (UMIC) Parties; and Low-Resource Parties by combining Lower Middle Income (LMIC) and Low Income (LIC) Parties. In addition, another criterion for consideration was Parties having more than one million SLT users or prevalence of greater than or equal to 10% in males or females as high SLT burden Parties.

This report presents policy progress of the convention with analysis at the following levels:

1. Number and percentage of Parties, policy progress on Articles 1(f), 6, 9, 10, 11, 12, 13, 14, 16, and 20 and in addition, some other relevant issues pertinent to SLT are also included.
2. Annual Policy progress has been mapped.
3. Examples of recent and innovative activities, legislative processes and other actions have been presented as case studies.
4. It does not always include the enforcement and compliance aspects unless some outcome or process indicators are cited in some reports at national level.

The report presents overall recommendations for inclusion of SLT in the legislative and regulatory framework of a Party as considered in line with Article 1(f) of the Treaty, which mentions that “Tobacco products means products entirely or partly made of the leaf tobacco as raw material which are manufactured to be used for smoking, sucking, chewing or snuffing.”

Out of 179 Parties, 135 Parties have included SLT under tobacco products definition in their laws. Of the 135 Parties, 112 have expressly and 23 defined SLT either in a general or in an obscure way. Forty-four Parties have either not included SLT or their laws were not available in English language.

C. FINDINGS

1. Article 6: Price and Tax Measures on SLT

Since Smokeless tobacco consists of a wide range of heterogeneous products which are manufactured and sold in a variety of forms, it is difficult to establish a standardized unit for the purposes of pricing or taxing. Price and tax measures on these products are often confusing and require more clarity to have an effective tax policy on SLT products.

EXECUTIVE SUMMARY 2017

Taxes on SLT products are imposed either as *ad valorem* or specific. In several Parties, there is a federal level excise tax and a state level sale or value added tax. Tax on SLT products varies considerably across Parties, from 0% in 7 Parties (i.e. no tax of any kind) to 72.4% in Sudan. Only 4 Parties had SLT tax incidence of 70% and above. Similarly, there is also larger variation in prices of SLT products across Parties and within the Party, across products. Although there is no discernible pattern in tax incidence across income groups the retail prices (PPP dollars) were on average lower for SLT products in low-resource Parties and higher in high-resource Parties. This could explain the relatively high prevalence of SLT use in low-resource Parties. Nineteen out of 32 Parties had unit price of SLT products at least two PPP \$ lower than that of cigarettes. Available estimates show that the price elasticities for various SLT products are largely negative and less than one. Based on the findings, taxation can be used as an effective tool not only to decrease consumption of SLT products, but also to increase tax revenue. Empirical evidence from India and Bangladesh suggest that high taxation has reduced SLT use in the general adult population. Available estimates on affordability of SLT products indicate that these products have become more affordable in India while the affordability has remained the same in Bangladesh over the years. The compounded levy system followed in India, to tax SLT products has been found quite effective after incorporating 'speed of packing machines' (used to pack SLT products) into the 'deemed production' (as declared by the manufacturer). This could be emulated in similar settings elsewhere in the world.

Taxation on SLT products should be such that it keeps up with inflation whilst simultaneously ensuring their prices sufficiently increase with the objective of making SLT products more unaffordable. Tax rates should be standardized across the SLT products and in a manner that discourages substitution with other tobacco products. It is important to set a minimum floor price on all tobacco products, including SLT, that are sold in a country. The minimum floor price per the lowest unit of the tobacco product sold should be equalized across all tobacco product categories. Governments, India in particular, should be able to exercise excise taxation option on SLT products to adequately raise their tax burden consistently.

2. Article 9 & 10: Regulation of SLT Contents and its Disclosures

Article 9 deals with testing, measuring and regulating of the contents as well as emissions of tobacco products. Article 10 deals with disclosure by manufacturers and importers about the contents and emissions of tobacco products to governmental authorities and the public. As Article 9 & 10 are closely related guidelines for their implementation have been developed together. Effective regulation of tobacco products, in line with Articles 9 and 10 will act as a milestone. If the long-term objective of reducing the danger of SLT products is to be achieved by the Parties.

According to the FCTC reporting instruments, the average implementation rate for Articles 9 and 10, was nearly 50% during 2012–16, but this was mainly related to cigarettes. Forty-one and 31 Parties have laws banning the display of quantitative information on emission yields (such as nicotine) on cigarettes and SLT packaging respectively. The majority of them were high-resource Parties. Sixty-four and 22 parties have laws that mandates the display of qualitative information on relevant constituents and emissions of cigarettes and SLT products respectively.

Thirteen percent (n=24) of Parties have done the analysis of the chemical composition of SLT on an ad hoc basis. Not all SLT products available with these Parties had been analyzed, nor were they analyzed on a periodic basis.

It was further noted that levels of NNK, NNN, B[a]P, heavy metals, pH and nicotine content showed wide variation in various analysis. The estimated levels were inconsistent among various SLT products, individual brands of the same product and also within the brand in that Party.

Moreover, the establishment of a tobacco testing laboratory network across the globe is limited, with minimal focus on SLT.

For effective regulation of SLT products, Parties should encourage and invest in further research on SLT products, their ingredients and emissions. Major initiatives are required to promote collaborations between academia, researchers, scientists and governments to ensure that reports from the testing laboratory are quickly interpreted and efficiently translated for implementation.

Detailed guidelines on Articles 9 and 10 including information on SLT should be developed. Parties should contribute towards development of comprehensive guidelines for Articles 9 and 10 as well as support their adoption.

3. Article 11: Packaging and Labeling of SLT

Article 11 pertains to effective packaging and labeling of tobacco products. The impact of this has proven outstanding for smoked products especially cigarettes. The emphasis on implementing the Health Warnings (HWs) has always been on cigarettes, with minimal focus on other tobacco products. This is despite the fact that effectiveness of Hws applies to SLT as well. There has been rapid progress in HW (30% size) since adoption of the FCTC. However, this is disproportionately focused on cigarettes as compared to SLT. By 2016, nearly half of the Parties (51%) had notified HWs on SLT, whereas three-quarter of Parties (77%) had HWs on cigarettes. Large HWs (50% size) were notified by one-quarter of Parties (27%) on SLT packages, as compared to more than half the Parties (56%) for cigarettes packages. Pictorial Health Warnings were notified by one-fifth of Parties (20%) for SLT and more than half the Parties (56%) for cigarettes. Similarly, multiple HWs (2 specific warnings) were notified by one-quarter of the Parties (27%) for SLT and two-thirds of the Parties (66%) for cigarettes. Thus, for cigarettes, all the above provisions were notified by higher proportion of high-resource Parties as compared to low-resource Parties. On the other hand, for SLT, low-resource Parties showed better compliance. Overall, SEAR recorded best compliance in accordance with provisions of Article 11 for SLT.

Among high-burden Parties for SLT, India, Nepal, Philippines, Egypt, Kenya, Uruguay and Kyrgyzstan have complete policies and their implementation on SLT products. Bangladesh, Myanmar, Colombia, Cambodia and Burkina Faso have complete law in place, but not fully implemented. Globally, only 16% (n=28) Parties have complete policies for SLT.

The current findings emphasize the need for comprehensive policy formulation and total implementation of Article 11 for all tobacco products. Parties need to implement large warnings with pictorial representations and multiple messages on various diseases caused by all tobacco products.

4. Article 12: Education, Communication, Training and Public Awareness on SLT

Article 12 creates an obligation for the Parties to *"promote and strengthen public awareness of tobacco control issues, using all available communications tools, as appropriate."*

Global FCTC Implementation Progress Report 2016 indicates that 70% of the reporting Parties have implemented Article 12 in their jurisdictions. The WHO Global Tobacco Epidemic reports (2015 and 2017) indicate that nearly 39% Parties in 2014 and 36% Parties in 2016 had conducted at least one anti-tobacco national mass media campaign. Neither report provides any specific information on implementation of Article 12 with respect to SLT.

High-resource Parties include SLT in their campaign wherever required. Some of the low-resource Parties (India, Bangladesh, Nepal, Pakistan etc.) and several high-resource Parties, including one non-Party (United States), have implemented some form of national and sub-national mass media campaign on SLT prevention and control. Parties have also gained media coverage from various events and activities highlighting the hazards of SLT products. Among high SLT burden Parties, only India has implemented a dedicated national mass media on anti-SLT awareness.

Global School Personnel Survey (GSPS) undertaken by several Parties indicated that curricular and co-curricular activities on tobacco are almost negligible. School personnel who wish to have training on youth tobacco prevention and cessation do not have access to teaching and learning material and have not been formally trained on tobacco cessation.

Several national and local surveys have indicated that people are unaware about the harmful effects of SLT use, instead subscribing to myths regarding its use.

There is an urgent need to implement dedicated national mass media and social media campaigns focused on reducing SLT use.

5. Article 13: Ban on SLT Advertisement, Promotion and Sponsorship (TAPS)

Article 13 provides guidelines to Parties for a comprehensive ban on TAPS. Evidence suggests that TAPS bans reduce tobacco use, especially among young people. However, partial advertising bans provide tobacco companies opportunities to find new ways to market their products.

According to the WHO Global Tobacco Epidemic Report 2017, $\geq 65\%$ of the Parties have banned SLT advertisement in 'national TV and radio', 'national print media' and 'billboards'. More than half of the Parties (59%) have banned SLT 'advertisement on international TV and radio'. However, majority of the Parties have not banned 'advertisement at point of sale' (58%) and in 'international print media' (47%). Half of the Parties (50%) have banned SLT promotions and sponsorship. Only 8% Parties (n=15) have framed comprehensive policies for SLT TAPS ban. Implementation status over high SLT burden Parties such as in India, is poor and exposure to SLT advertisements and promotion among adults is higher as compared to smoked products.

A distinct gap is noticed among cigarettes and SLT products for all provisions under Article 13, with 'advertisement at point of sale' and 'international print media' being the least notified regulations. A comprehensive ban on TAPS should be affected towards implementation of Article 13 for all tobacco products by all Parties.

6. Article 14: Demand Reduction Measures Concerning SLT Dependence and Cessation

Article 14 of WHO FCTC deals with demand reduction measures concerning tobacco dependence and cessation. Tobacco cessation support and national toll-free quit lines are available in very few Parties ($\geq 20\%$ and 31% respectively), mostly in high-resource Parties and those of the European region. Nicotine Replacement Therapy (NRT) is legally available in the jurisdiction of almost three-quarters of the Parties (70%). Very few Parties (12%) have reported full coverage of the costs of tobacco cessation treatment or available pharmaceutical products, in at least one of their tobacco cessation support facilities.

Findings from the Global Adult Tobacco Survey (GATS) reports from various Parties show that health care professionals advise at least 50% smokers to quit while they advise the same to only 25% of SLT users.

Global Health Professions Students Survey indicates that medical, dentistry, pharmacy and nursing students have agreed that tobacco cessation is the primary function of health care providers. They also wish to have training on tobacco cessation but have not been formally trained.

A literature search shows that only 5 Parties (3%) have experience in SLT cessation. Meta-analysis has shown that behavioral intervention alone has 60% more chance of quitting and is the most effective way of intervention both for low- and high-resource settings. Tobacco cessation with behavioral intervention in low-resource and high SLT burden Parties is the most suitable solution and thus recommended. Health care providers need to be sensitized to provide equal care to both smokers as well as to SLT users.

7. Article 16: Access and Availability of SLT to Minors

Article 16 of WHO FCTC focuses upon restricting tobacco sales to and by minors. Several studies have revealed that successful prohibition of sale of tobacco to minors can reduce youth tobacco usage.

Nearly two-thirds of the Parties (67%) have banned sale of SLT to minors. Nearly 10% of the Parties have notified all provisions of Article 16 (1) for SLT, implying a complete policy for ban on Sale to minor. These Parties mostly belonged to high-resource group. Most of the high SLT burden Parties do not have comprehensive ban on sale of SLT to minors. Nearly half of the Parties (45%) have banned sale of SLT by minors.

A comprehensive policy formulation on banning sale of tobacco to minors and its proper enforcement is required to prevent access and availability of tobacco including SLT to the minors.

8. Article 20: Research, Surveillance and Exchange of Information on SLT

Data on SLT use among adults is available at a national level in 129 Parties. Of these, only 10% of Parties have recent data (2012–17). Globally, nearly 2 in 10 adults smoke and nearly one in 10 adults use SLT. Unlike other regions, in SEAR, SLT use among adults is greater than smoking. SEAR has double burden of high prevalence of smoking (1 in 5) and SLT use (1 in 5). Among women tobacco users globally, SLT is the predominant form of tobacco used. SLT use is higher in rural areas (1.25–3 times) and in the poorest communities (3–17 times) in SEAR and African Region. SLT use among adults decreased in India from 25.9% in 2010 to 21.4% in 2016. Meanwhile SLT use is on the rise in Myanmar.

Data on SLT use among adolescent at national level is available for 103 parties. Of these, only 20% of Parties have recent data (2012–17). Unusually SLT use among adolescents in SEAR is higher than smoking. SLT product prevalence for both adults and adolescents is available for limited number of Parties (n=5). SLT use among adolescents has markedly increased in few of the SEAR Parties.

Only 10 Parties have SLT-attributable morbidity and mortality data. Only 35 Parties have price and tax incidence rates for SLT. Bangladesh has one health cost study specific to SLT and India has two in series.

It is recommended that Parties conduct tobacco specific surveys and include SLT usage and its related indicators or should include standard tobacco questions (TQS) in their ongoing health surveys at periodic intervals. The Parties should be supported for engaging in SLT control research as per their needs.

9. Prohibition on Import, Manufacture and Sale of SLT

Almost one-quarter of the Parties have enacted laws to ban the trade of SLT in some form. However, the impact of these laws on the use of SLT has been different for different Parties. Most of these trade restrictions are partial, either on manufacture, import, sale or a combination. However four Parties (Bhutan, Australia, Singapore and Sri Lanka) have prohibited all three. The prohibition on different aspects of SLT trade has been imposed under different laws and not only under a tobacco control law. For example, India used the food safety law; Brazil used its national health and sanitary surveillance agency; and European countries used the Tobacco Product Directives of the European Union. However, these prohibitions have led to mixed outcomes with limited effect on prevalence of SLT use. For example, there has been a 1% reduction in the percentage of adult population using *Gutkha* in India, while in Bhutan there has been an increase of almost 12% among adolescents using SLT.

10. Ban on Spitting and SLT use in Public Places

SLT-related spitting in public places presents a complex and widespread challenge to public health. Opinions of experts globally are divided about the adverse health consequences of exposure to public spitting. However, there is historical precedence of countries imposing bans on public spitting to curb the epidemic of infectious diseases. Public notice with this effect was common sight in US, France and England in late 19th century and early 20th centuries. Public spitting due to chewing tobacco, betel quid and others, is a highly disturbing issue in public hygiene management. It is considered a leading cause behind the spread of communicable diseases like tuberculosis, swine flu, avian flu, pneumonia and gastro-intestinal diseases. Chewing tobacco increases the frequency of public spitting. People not only endanger their life by using SLT products, but also of the people around them by spitting.

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However, several Parties, provinces and Cities continue to prohibit spitting in public places. Such prohibition has been imposed with different intentions in different parts of the world. The reasons mainly included are, to control communicable diseases, maintain public cleanliness and hygiene and as a preventive measure to reduce SLT use. For example, among developed Parties, Singapore has a complete prohibition on spitting in public places. The London Borough of Brent (United Kingdom) and Fairfield Municipal Area (Australia) have also implemented such prohibition. Among developing Parties, Nepal, Bhutan, Papua New Guinea and several states and cities in India have prohibited using SLT and spitting in public places. The majority of respondents in a study among SLT users wanted to quit because they felt embarrassed of the SLT-induced spitting in public.

CONCLUSION

Since the effort to include SLT in tobacco control policies under the WHO FCTC started, there has been considerable progress in its compliance, especially with Article 1(f) in defining SLT by the Parties and in surveillance of SLT use (Article 20). More participation is needed from the parties to initiate implementing these articles.

For the rest of the articles very little progress has been made. SLT prevention has received much less attention than smoking prevention.

Where there are policies on SLT, all provisions of the relevant FCTC articles have not been covered. Since there is evidence that partial policies are not very effective, more attention needs to be given to make them comprehensive. Even where there are policies on SLT, often they have not yet been implemented effectively.



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INTRODUCTION

This report on '*Global Smokeless Tobacco Control Policies and their Implementation*' is the first attempt to document the progress made in smokeless tobacco discourse within the realm of the Framework Convention. It has been prepared by the WHO FCTC Global Knowledge Hub on Smokeless Tobacco (KH-SLT) in accordance with the decisions taken by the Conference of the Parties (COP) at its sixth session [FCTC/COP/6/9]. The WHO FCTC Convention Secretariat initiated and supported development of this report.

The scope of this report is to:

1. Provide a comprehensive global review and report of the current knowledge on SLT control policy progress made under the various Articles of the Convention, and their implementation through systematic and standard methodology. The report has been reviewed by internal reviewers and further evaluated by two independent external reviewers outside the Hub.
2. Provide comparative assessment of similar indicators for cigarettes and SLT products for clear understanding.
3. Document key observations on the progress made in SLT prevention and control by Parties with respect to the following important articles of the Convention:
 - a. Articles 1(f), 6, 9, 10, 11, 12, 13, 14, 16 and 20.
 - b. In addition, the report includes information about the progress made by the Parties in implementing a full or partial prohibition on manufacture, sale and import of SLT products within their jurisdiction.
 - c. The report also includes information on bans on spitting and SLT use in public places.
4. Outline the prevalence of SLT use by both adults and youth, particularly in high burden Parties, based on the secondary analysis of data collected through national and global surveys.
5. Give an overview of opportunities and challenges related to the specific Articles under the Convention, providing the COP with information to be used when considering possible approaches to strengthening the implementation of SLT prevention and control.
6. Identify the existing gaps in the implementation of laws to enforce FCTC articles by various Parties.
7. Provide feasible recommendations based on the findings and expert opinion.

INTRODUCTION

METHODOLOGY

The report is based on the compiled information on the Parties' progress in their implementation of the provisions of the Convention on SLT products. Information was collected from:

1. Tobacco control legislation, regulation, decree of individual country.¹
2. FCTC reporting instrument of different reporting cycles, 2012², 2014³ and 2016.⁴
3. WHO Report on the Global Tobacco Epidemic 2013,⁵ 2015⁶ and 2017.⁷ (MPOWER)
4. WHO smokeless tobacco survey report (contained in FCTC/COP/6/9).⁸
5. Global, regional and country level smokeless tobacco control reports, survey reports, monographs etc.⁹⁻¹⁰
6. Published articles in peer reviewed journals (provided in different chapters).

Parties' implementation reports or any other available documents were further reviewed and systematically confirmed against country's legislation, regulations and programmatic documents. Similarly, information gathered from other sources was either validated by Parties' documents or other validated documents. In short, information was validated by at least one additional document.¹⁻¹⁰

This report has collected information on cigarettes and SLT for comparative evaluation and clear understanding.

Parties' classification by region

There are 181 Parties to the Convention including 'European Union' as Party and 'Mozambique' as a very recent Party. This report includes information from 179 Parties for calculations. Global values indicated in this document relate to 181 Parties of the Convention. WHO Regions were included for analysis at regional level.

Parties' classification by income group

For this report, the Parties were categorized in two major income groups (from the World Bank definition). High-resource Parties refer to high income (HIC) and upper middle income (UMIC) Parties combined, while low-resource Parties refer to lower middle income (LMIC) and lower income (LIC) Parties combined.¹¹

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Parties' classification by prevalence and number of users

Based on the various national and global sources of information on tobacco use, Parties having >1 million SLT users or prevalence of $\geq 10\%$ in males or females were classified as high SLT burden Parties. Overall, 36 Parties have >1 million or $\geq 10\%$ male or female SLT users. These 36 Parties are home to more than 95% of global SLT users. Parties in South-East Asia Region (SEAR) are home to over 80% of global SLT users (Fig. 1.1).

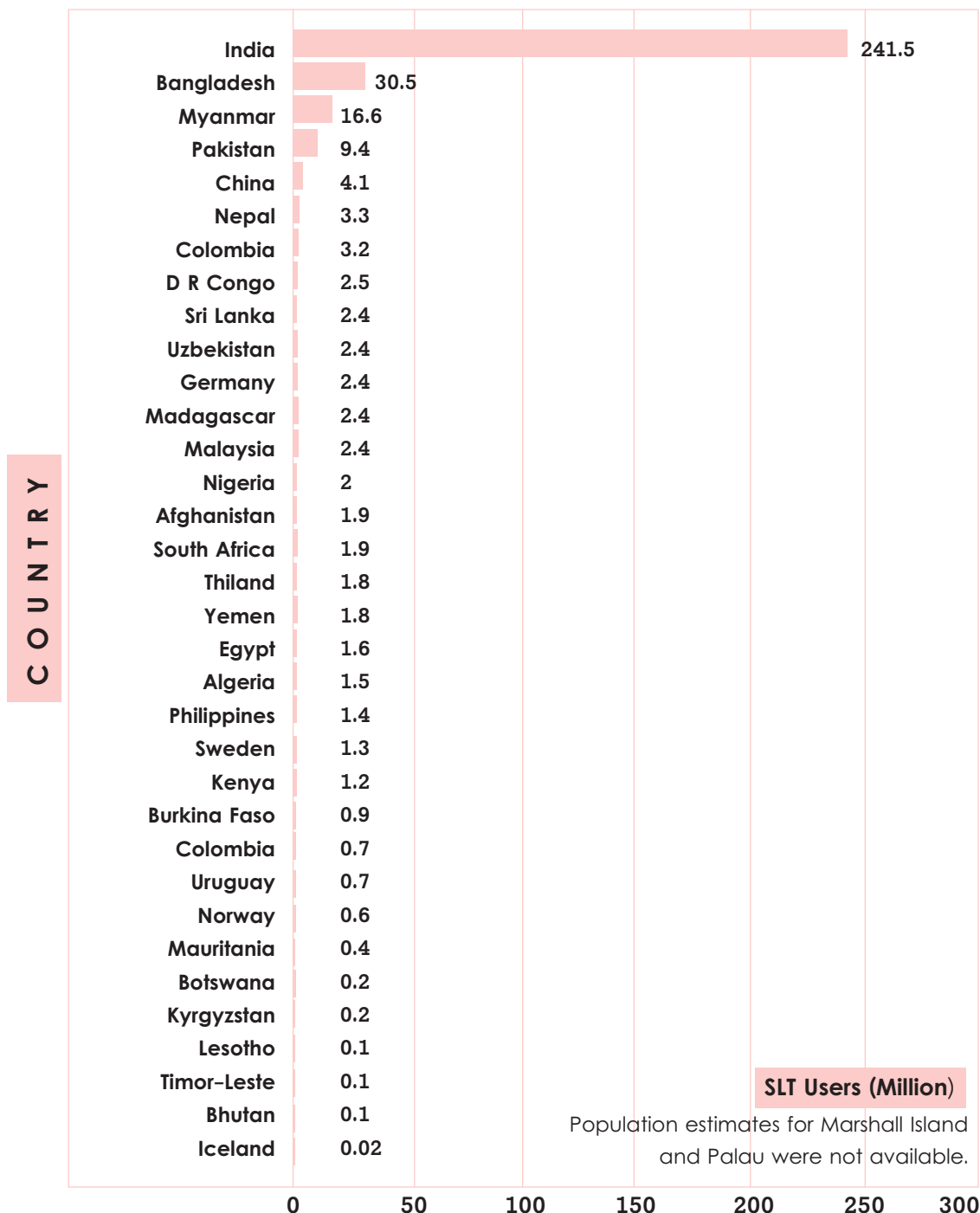


Fig.1.1: Distribution of high SLT burden Parties.

INTRODUCTION

Policy progress of the Convention is analyzed on following levels:

1. As a number and percentage of Parties' policy progress on key articles including key measures at global, regional and by Parties income.
2. Party percentage for different provisions has been calculated with denominator 179.
3. Policy progress has been mapped by year.

The report also provides instances of how far Parties have progressed in their policy development and implementation of the Convention by individual Articles. Examples of recent and innovative activities, legislative processes and other significant actions have been included. Major findings of the report are presented in tabular and graphic forms.

DEFINITION OF SMOKELESS TOBACCO

One of the biggest difficulties in collating information on SLT products with respect to various FCTC provisions is the way Parties have defined the term 'tobacco product' in their domestic legislation. Therefore, the research team compiled information on the definition of 'tobacco products', i.e. in the national tobacco control legislation or any other laws, and whether such definition includes smokeless tobacco or such laws define smokeless tobacco separately. For this purpose, the domestic laws, regulations and decrees were screened to analyse the terms defining, including or mentioning SLT products or SLT use in such legal documents. Of the 179 Parties covered in this report, 135 (75%) Parties have defined the term 'SLT product' in their domestic legislation in several different and unique ways which have been classified in the following four broad categories:

Express definition

Parties using any of the following terms in defining 'tobacco products' were considered as express definition including SLT.

Chew, Chewing, Snuff, Sniffing, Suck, Sucking, Suction, Inhale, Inhaling, Smell, Smelling, Dipping, Oral, Oral use, Nasal, Nasal use or Smokeless tobacco.

Based on this classification, 112 Parties were found to use above terminologies in their laws (Fig. 1.2).

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General Definition

In addition, 13 Parties with the following categories also defined SLT, (Fig. 1.2) where there is a general reference to any kind of tobacco product that:

- a. is wholly/entirely or partly/partially made of tobacco/tobacco plant/tobacco leaf/tobacco extract; or
- b. contains tobacco and is intended for human consumption in any manner; or
- c. is used in “any other way” “any manner” or “any form” other than cigarettes/cigar/smoking.

Obscure definition

Further, 10 Parties have weakly (obscurely) define SLT products under the definition of 'tobacco products' or refer to SLT, but not clearly indicate inclusion of SLT in such definition (Figure. 1.2).

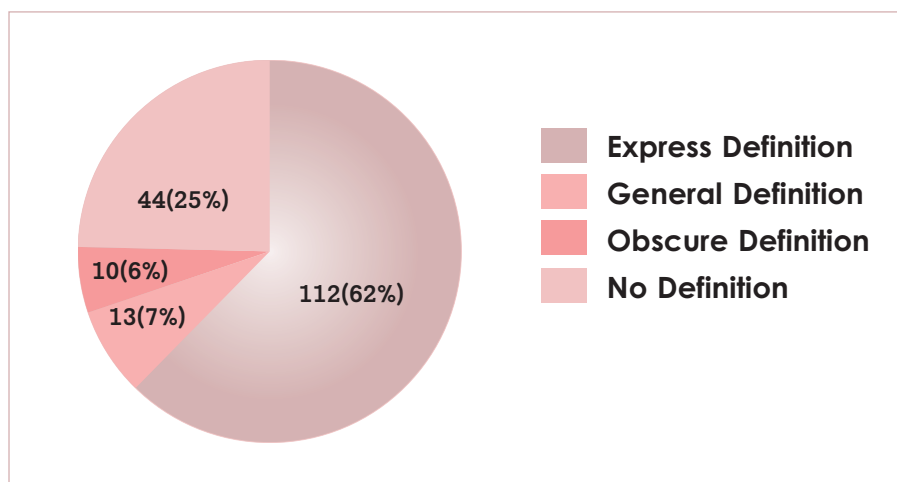


Figure. 1.2: Proportion of Parties defining SLT

No definition

Forty-four Parties have either not defined SLT or not provided any definition of tobacco products, including 10 Parties whose laws were not available in English language (Figure. 1.2).

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Definition by income group of Parties

Nearly three-fourth of the low- and high-resource Parties have included SLT in their tobacco control legislation (Figure. 1.3).

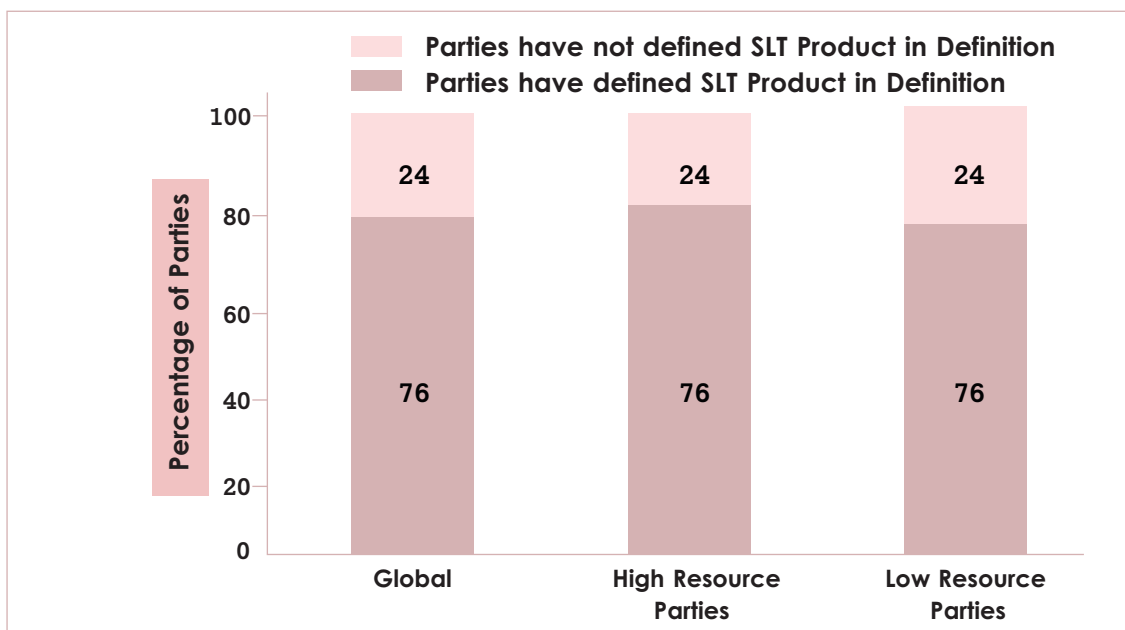


Figure. 1.3: Percentage of Parties defining SLT by income group

Definition by WHO Regions

Proportion of Parties defining SLT varied widely by region, from 90% in the European Region to 55% of Parties in the American Region (Figure. 1.4).

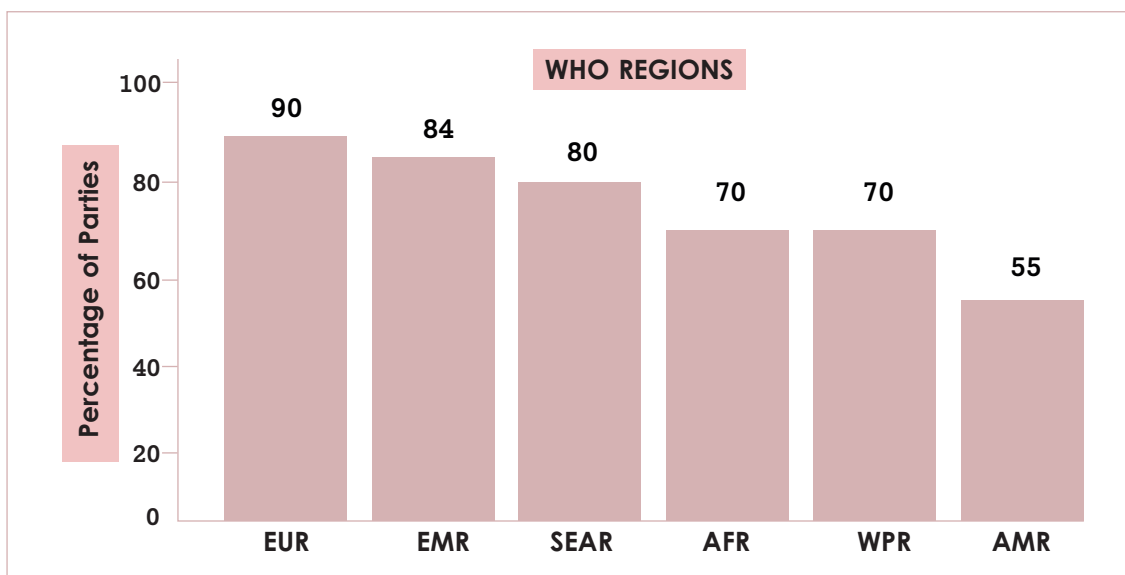


Figure. 1.4: Percentage of Parties defining SLT by WHO region

INTRODUCTION

To avoid the multitude of definitions and the risk of excluding SLT from the regulations, it is recommended that Parties uniformly consider incorporating the FCTC definition of '**tobacco products**' as provided under Article 1(f) of the treaty in their domestic laws. However, to have an inclusive definition of SLT, Parties may consider adding a concluding phrase i.e. "**or used in any other form or manner**", in the FCTC definition while amending or proposing their domestic laws.

INTRODUCTION

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Article-wide findings on progress made by Parties in policy formulation on SLT and implementation are presented in this section.



FINDINGS ARTICLE 6



2.1 PRICE AND TAX MEASURES ON SLT

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FINDINGS-ARTICLE 6

2.1: PRICE AND TAX MEASURES ON SLT

WHO FCTC – Article 6

Price and tax measures to reduce the demand for tobacco

Price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons. While determining tax policies, Parties should take into account the national health objectives concerning tobacco control and:

- (a) Implement tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption; and
- (b) Prohibit or restrict, as appropriate, sales to and/or importations by international travelers of tax- and duty-free tobacco products.

The health impacts of SLT are well documented and it is known to cause a variety of cancers including oral, esophageal, and pancreatic cancer.^{1,2} SLT consists of a wide range of heterogeneous products such as *chewing tobacco*, *betel quid with tobacco*, *gutkha*, *snuff*, *snus* and others. Each product has diverse characteristics, methods of usage and modes of packaging. Consequently, regulating SLT use through fiscal policy has been a major challenge. SLT also imposes an enormous economic burden on developing countries. In India, for example, the total economic costs from all diseases attributable to SLT use in the year 2011 for persons aged 35–69 years was INR 233.6 billion. In comparison, the excise tax revenue collected from SLT in that year amounted to only INR 12.6 billion.

While public policy research on cigarettes and other smoked tobacco products are far more advanced, there is a paucity of similar research, in particular that on economics of SLT. As a result, tax and price measures, are not utilized/employed effectively to adequately address the challenges from SLT use. Unabridged use of SLT is observed among the youth especially in SEAR region. Data from the Global Youth Tobacco Survey (GYTS) shows that students aged 13–15 years surveyed in 132 countries were more likely to report using non- cigarette tobacco products including SLT products (11.2%) than to report smoking cigarettes (8.9%).²

FINDINGS-ARTICLE 6

Apart from the traditional forms of SLT use found in regions such as South Asia, Central Asia, South America, and Sub-Saharan Africa, the markets for which are largely dominated by informal cottage type production, there is also a new generation of SLT products largely found in Scandinavia and North America supplied by multinational corporations and are commercially manufactured. However, the available estimates indicate that, by volume, 91.3% (648.2 billion tons) of the SLT products sold worldwide (710.2 billion tons) are sold in traditional markets.² Due to heterogeneous nature of SLTs they are manufactured and sold in a variety of forms. This makes it difficult to quantify them with a standardized unit for the purposes of pricing or taxing. Price and tax measures on SLTs are often confusing. Tax policies on SLT can be made more effective by providing more clarity on price and taxation issues.

This report aimed to review issues around tax policies on SLTs with the objective of providing explicitness on the use of taxation as an effective fiscal policy instrument to regulate the use of SLT. The present report reviewed available data to assess the prevalence of SLT use across regions in the world, production of SLTs, taxation issues on SLT and affordability of SLT over time with the purpose of providing best practice recommendation on fiscal policies to regulate SLT use.

Prevalence of SLT and its trend

There are approximately 350 million adult SLT users worldwide.⁴ In last few years, SLT use has seen decreasing trend in India⁵ and Bangladesh.⁶

Production of Smokeless Tobacco

As indicated earlier 91.3% (648.2 billion tons) of the SLT products sold worldwide (710.2 billion tons) by volume are sold in traditional markets². Hence this report focuses only on SLT in traditional markets which are found in South Asia, Central Asia, South America and Sub-Saharan Africa.

The market for SLT in these regions are less concentrated, trading a large variety of products made under loosely defined standards, also including cottage industry products and custom-made products².

FINDINGS-ARTICLE 6

In 2007–2008, in India, out of 493.03 thousand tons of tobacco produced, 83.3 thousand tons and 9.11 thousand tons were used in making chewing tobacco and snuff products respectively. Thus, 18.74% of tobacco produced was destined for manufacturing SLT products⁷.

Table 2.1.1 shows the gross value added (GVA), defined as the total outputs minus total inputs, an indicator to measure the size of India's SLT industry. It depicts the GVA for both registered and unregistered manufacturing for the period 2000 to 2011. One can see that the GVA declined by about 23% during the period in absolute terms for SLT industry as a whole. The period also witnessed the share of unregistered manufacturing in the total SLT manufacturing increasing from 3% to 11%.

Table 2.1.1: Gross value added of the SLT industry (in INR millions) (percent) for both unregistered and registered manufacturing in India

Type of ST product	2000-01			2005-06			2010-11		
	UNREGISTERED	REGISTERED	TOTAL	UNREGISTERED	REGISTERED	TOTAL	UNREGISTERED	REGISTERED	TOTAL
Snuff	16.40	1060.00	1076.40 (8.60)	136.00	86.10	222.10 (2.63)	97.00	274.00	371.00 (3.86)
Zarda	7.40	1200.00	1207.40 (9.65)	88.80	1870.00	1958.80 (23.17)	89.80	3780.00	3869.80 (40.25)
Catechu (katha) and chewing lime	38.20	126.00	164.20 (1.31)	160.00	295.00	455.00 (5.38)	92.70	494.00	586.70 (6.10)
Pan masala and related products	115.00	632.00	747.00 (5.97)	1330.00	3540.00	4870.00 (57.6)	280.00	1720.00	2000.00 (20.80)
Chewing tobacco and other tobacco products	181.00	9140.00	9321.00 (74.47)	404.00	545.00	949.00 (11.22)	497.00	2290.00	2787.00 (28.99)
Total SLT	358.00	12158.00	12516.00 (100)	2118.80	6336.10	8454.90 (100)	1056.50	8558.00	9614.50 (100)
Share of registered and unregistered (%)	2.86	97.14	100	25.06	74.94	100	10.99	89.01	100
Share in total tobacco (%)			19			10			7

Source: Estimated from the unit-level records of the Annual Survey of Industry (ASI) (registered units) and National Sample Survey (NSS) data (unregistered units) as given in Selvaraj et al, 2017.7

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The SLT manufacturing is less labour-intensive than other forms of tobacco, because most activities involved in SLT manufacturing, including packaging, are done by machines.⁷ Table 2.1.2 shows the employment in SLT manufacturing in India for the year 2011–12. Smokeless manufacturing contributed only about 1.37% of the total employment generated in all tobacco manufacturing in India. Moreover, within SLT manufacturing, the employment contribution was highest (65%) from the manufacturing of *pan masala* and related products followed by chewing tobacco (22%).

Table 2.1.2: Employment in SLT manufacturing in India

Type of ST Product	2011-12	% of all ST manufacturing
Snuff	307	0.44
Zarda	7,229	10.31
Catechu (Katha) and chewing lime	1,795	2.56
Pan masala and related products	45,623	65.04
Chewing tobacco and other tobacco products	15,196	21.66
Total employment in SLT manufacturing	70,151	100
Total employment in all tobacco manufacturing	5,127,471	100

Source: Estimated from unit level records of National Sample Survey 2011-12 as given in Selvaraj et al, 2017⁷

The important thing to understand about SLT production is that the majority of SLT products are made in informal cottage type settings and packaged in packs of different size and shapes. This makes it extremely difficult to find a standardized unit quantification for taxation purposes. Some SLT products like *mawa* or betel quid with tobacco can be assembled on the spot by the vendor, or the users can assemble it on their own using ingredients bought separately from the vendor. Taxing and regulating products of this nature becomes extremely challenging for the law enforcement authorities.

Taxation of Smokeless Tobacco

Taxation of SLT products, especially those from traditional markets, have been a challenge for many Parties as these products are not sold in homogeneous units or packs and sometimes assembled over the counter at the point of sale either by the vendor or the buyer.

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However, it is important to understand the best practices used in countries so that this knowledge may help other countries where similar products are consumed.

Effectiveness of taxing tobacco

Tobacco users, neither have full information of the possible health consequences of using tobacco nor do they account for the external costs associated with its consumption. Hence, regulating its use is socially desirable and warranted. Since most tobacco products resist increase changes in prices, taxation can be an effective tool in reducing tobacco use by promoting cessation among current users, deterring young people from taking up tobacco use, and reducing how much continuing users consume. A substantial body of research, which has accumulated over many decades and from many countries, shows that significantly increasing the excise tax and price of tobacco products is the single most consistent effective tool for reducing tobacco use⁴. This is also well recognized by the countries to the WHO FCTC and is clearly expressed as such under Article 6 of the Treaty.

Several countries use tobacco taxation as a tool both to regulate tobacco use as well as to generate tax revenue. However, the type and structure of taxes used varies substantially between countries and between tobacco products within countries. In most countries, both consumption taxes and customs duties are imposed on tobacco products. Consumption taxes can take the form of either excise taxes or retail sale taxes or both. Excise taxes are levied at the stage of production itself, whereas sales tax is applied at various stages of the distribution chain including at the final sale.

These taxes can be of three kinds:

1. Specific tax which is a tax per unit of production;
2. *ad valorem* tax which is tax on the value of the product; and
3. Mixed tax which is a combination of both specific and *ad valorem* taxes⁸

Although each type of tax has its merits and vices, the literature on tobacco taxation tend to favor specific taxes on tobacco in order to achieve better health outcomes as it is more efficient at reducing consumption.⁹

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Effectiveness of taxing smokeless tobacco

A systematic review of tobacco control policies relating to SLT use in USA (not a Party to the Convention) recently concluded that price elasticities of SLT products lie mostly in the inelastic range and SLT taxes are an effective tool in reducing tobacco use¹⁰. Estimates of price elasticities on SLT products are rarely available from South-East Asian Countries. Available studies in India¹¹⁻¹⁴ show the price elasticity for SLT products is in the range -0.1 to -0.9 and those from Bangladesh¹⁵ show the elasticity to be in the range -0.39 to -0.64 . If price elasticity lies within the range of 0 to -1 such products are considered to be inelastic. A given percentage increase in prices of such product, through taxation, for example, would result in reducing consumption (to a proportion less than the increase in price) and increase tax revenue. As in the case of cigarettes, taxation can be an effective tool to reduce consumption of, and increase tax revenue from, SLT products.

Studies from India and Bangladesh indeed show that tax increases have been effective in reducing SLT use. Successive GATS surveys in India 2010 and 2017 and ITC surveys, in Bangladesh 2009 and 2012 revealed significant reductions in the prevalence of SLT use in the general adult population. Significant tax hike on SLT products during this period could be the prime cause of reduced consumption in these countries.

India, in particular found that increasing the price of SLT products may discourage SLT use among men¹³ and youth.¹⁴ The impact of an increase in the prices on consumption of the two most popular varieties of SLT products, (*khaini* and *zarda*) on consumption were examined in a recent study¹⁶ in India. It reported that 58% rise in the prices of *khaini*, resulted in a 51% decline in the consumption during the period 2008–2013. A rise in the price of *zarda* of 28% led to a 24% decline in the consumption during the same period.

A recent study⁸ in Bangladesh observes that “the negative effect of the increase in tax that was presumably passed on to the price increase was at work in inducing SLT users to quit”. An earlier study from Bangladesh¹⁵ had also confirmed the inverse relationship between tax increases and SLT use.

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Tax incidence and price of SLT

While the literature on taxing cigarettes and similar smoked tobacco products are fairly well established⁴, the same is not true in case of SLT products owing to their heterogeneous nature. Though the provisions of implementation of Article 6 apply to all tobacco products, specifically to prevent product substitution within and across categories, still very little is known about the nature of taxes on SLT products or the extent to which higher SLT taxes translate into higher SLT prices, and how these prices affect the consumption and affordability of SLT products. The available literature is reviewed here.

The WHO report on the global tobacco epidemic in the year 2015 and 2017 described the tax incidence proportion of overall taxes in retail prices of SLT products along with their prices (in international dollars at purchasing power parity (PPP\$) for the most common type of SLT products, as reported by 32 Parties^{17,18}. As one can see from Figure 2.1.1, there is huge variation in both prices and tax incidence on SLT products across Parties from an absolute 0% (i.e., no tax of any kind in seven Parties), to as high as 72.4% in Sudan. Only four Parties (Canada, Norway, Sudan and Tunisia) out of the 32 had total tax incidence at or above 70%. This is despite the WHO's Technical Manual on Tobacco Tax Administration recommending that tobacco excise taxes alone should account for at least 70% of the retail prices of tobacco products¹⁹. In SEAR, although Indonesia (non-Party) has the highest price for SLT products, it has the lowest tax incidence at 10.72%. On the other hand, India has one of the lowest price per unit of SLT and second highest tax incidence on SLT in SEAR.

Out of the 28 Parties imposing some kind of taxes on SLT products 15, including Nepal and Indonesia (not a Party to the Convention) from the SEAR, levy specific excise on SLT. Singapore levies the highest specific excise at 70%. Twelve countries including India and Bangladesh (from the SEAR), impose ad valorem excise on SLT. In addition to specific excise or ad valorem excise, most Parties impose VAT on sale of SLT. Algeria, Tunisia and Morocco (not a Party to the Convention) are the only Parties that impose a mix of all the three kinds of taxes on SLT products. It is clear that most Parties, where SLT products are sold, utilize taxation as a tool to regulate their consumption.

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However, in countries like the Republic of Korea, Belarus, Ukraine, Indonesia (non-Party), and Japan have relatively high prices for SLT products, whilst their tax incidence is relatively low. It implies that the tax policy may not be the deciding factor in these countries for setting the price level of SLT products.

On the other hand, there are also Parties where both tax and price are high (e.g. Serbia, Canada, Norway, Iceland and Suriname). There is no discernible pattern in tax incidence across income group, but one can clearly see that the retail prices (PPP \$) are generally lower for SLT products in LIC and LMIC and higher in HIC. This explains the relatively high prevalence of SLT use to some extent in LICs and LMICs.

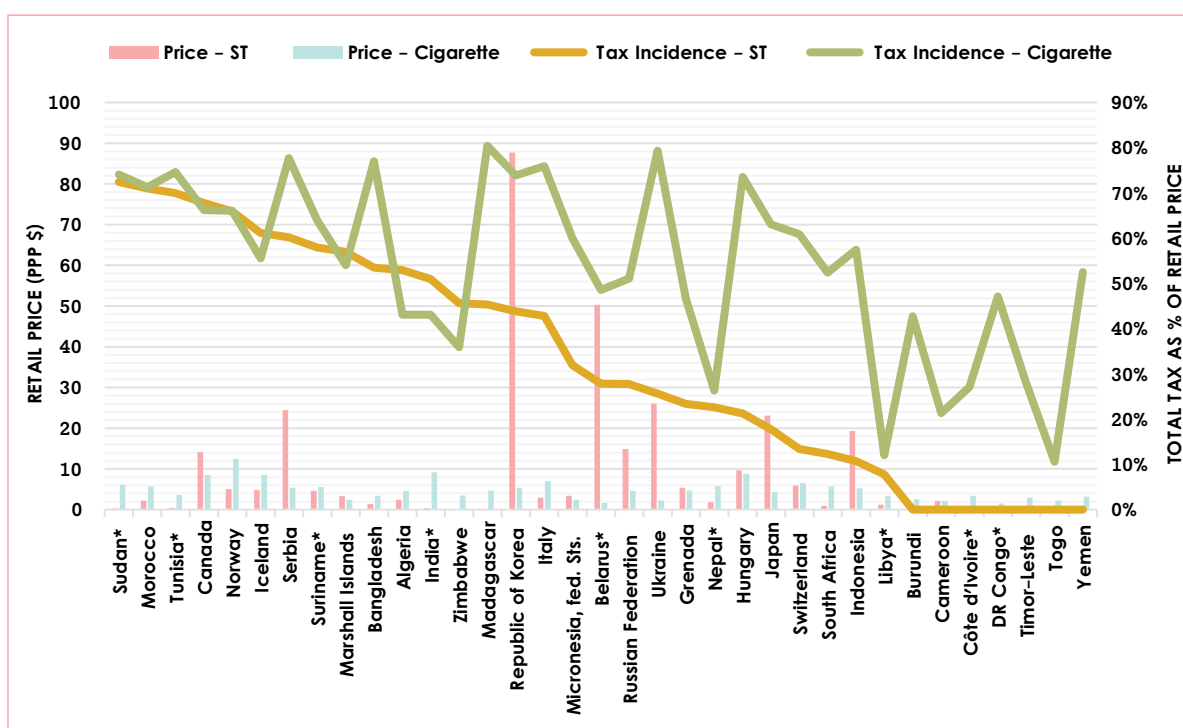


Figure 2.1.1: Comparison of retail price and tax incidence between SLT and cigarettes

Note: Retail Price PPP \$ shows the retail price in International Purchasing Power Parity Dollars for a 20 cigarettes pack of the most sold brand and 20 gram pouch of the most sold SLT brand in each country.

Source: WHO report on the global tobacco epidemic 2015 and 2017, online appendices IX, Table 9.1 and 9.3. Countries with a superscript * are from the 2015 report showing data belonging to 2014 whereas the rest of the countries are from 2017 report showing data from 2016.

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Figure 2.1.1 presents a comparison of retail prices (international PPP \$) and tax incidence for a 20-cigarette pack of the most sold brand of cigarette and a 20-gram pouch of the most sold SLT brand in each Party. Parties are sorted on the basis of tax incidence on SLT products starting with the highest to the lowest. There are 12 Parties where per unit price of SLT products is higher than that of cigarettes. Belarus and Republic of Korea seem to be exceptions as they have unusually high unit prices on SLT products. Nineteen out of the 32 Parties have unit prices of cigarettes at least two PPP \$ larger than that of SLT. Such differences in prices between two tobacco products within a single Party may not be a positive sign from a tobacco control perspective, because tax increases on either or both products can result in people switching from higher priced products to lower priced products. Harmonization of taxes and prices of tobacco products are necessary in order to regulate tobacco use more effectively. Although there are some exceptions, largely one can see that Parties with high incidence of tax on cigarettes also have relatively larger incidence of tax for SLT.

SLT taxation in India and Bangladesh

SLT taxation in India and Bangladesh needs special attention as these two Parties, together contribute roughly 68% of the total SLT users in the world. India follows a compounded levy scheme (or presumptive taxation) to tax SLT products. This is because most SLT products in India like chewing tobacco, *pan masala* and *gutkha* are packed in pouches with the aid of packing machines. Under this system, a manufacturer is required to pay a lump sum amount of duty per packing machine installed in the production facility. The amount of duty would depend on the retail price of the pouch/pack that is produced using that packing machine. In other words, the manufacturer would pay duty on the basis of a normative assessment of production and not on the actual declared production²⁰. This often incentivizes manufacturers to under-report the capacity of their machines or produce beyond the declared capacity.

Due to several limitations of this scheme and its inability to check the evasion of excise payable on SLT products the Government of India (GoI) in its budget for financial year (FY) 2015-16 made maximum speed of packing machine a factor for determining both the deemed production and excise duty payable under the Compounded Levy Scheme.

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This scheme was applied to *pan masala*, *gutkha* and chewing tobacco. Packing speed had to be typically determined by a Government-approved Chartered Engineer. Both deemed production and duty payable per machine per month were notified in respect to these SLT products, with reference to the speed range in which the maximum speed of a packing machine for packages of various retail sale prices falls.

Table 2.1.3 provides a sample of a compounded levy scheme in India as taken from the FY 2016–17 budget documents. It shows the different rates of excise taxes charged on SLT products based on the speed/capacity of machine and the retail price in which each pouch is sold ranges from less than INR 1 to more than INR 50 per pouch.

Table 2.1.3: Example of a compounded levy scheme in India (FY 2016–17)

Retail Sale Price (per pouch)	Excise Rate of duty per packing machine per month (INR in Lakhs)						
	Chewing Tobacco (other than filter Khaini)						Khaini
	Up to 300 pouches per minute		301–450 pouches per minute		451 pouches per minute or above		Any Speed
	Without limetube	With limetube	Without limetube	With limetube	Without limetube	With limetube	
Up to INR 1.00	30.51	28.98	43.58	41.4	92.61	87.98	18.52
Exceeding INR 1.00 but not exceeding INR 1.50	45.76	43.47	65.37	62.1	138.91	131.97	27.78
Exceeding INR 1.50 but not exceeding INR 2.00	54.91	51.86	78.44	74.09	166.69	157.43	35.19
Exceeding INR 2.00 but not exceeding INR 3.00	82.37	77.79	117.67	111.13	250.04	236.15	50.15

Source: Central Board of Excise and Customs, Ministry of Finance, Govt. of India, 2017

Following the amendments that made speed of packing machines a determining factor for deemed production as well as excise duty payable, the excise tax revenue from *pan masala* and chewing tobacco increased by 66% and 48%, respectively, in the FY 2015–16. In comparison, in FY 2014–15, the excise revenue had seen a decline of 0.4% and 7.8%, respectively, for *pan masala* and chewing tobacco compared to the previous financial year.

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The modifications to the compounded levy introduced in the taxation of SLT products in India point to the importance of an effective tax administration. It is important to have an effective method to tax SLT products as well as good enforcement of it. According to data obtained from the Ministry of Finance, Government of India, of the total excise tax of INR 217.2 billion on all tobacco products collected in the FY 2016–17, only INR 21.5 billion (9.9%) came from SLT products. The share of SLT products in all tobacco excise has been consistently growing in the past several years. It increased from about 6.8% in the FY 2010–11 to 9.9% in FY 2016–17.

After the implementation of most recent Goods and Services Tax (GST) reform in India, on 1st of July 2017, SLT products are categorized under a demerit product category. Highest GST rate of 28% is imposed upon them, which is equally shared by both the central and state governments. There is an additional cess that varies by different SLT product varieties as shown in Table 2.1.4. Most chewing tobacco products has a cess of 72% while pan masala containing tobacco has a cess of 204%. A simple average of cess across all SLT products is about 104%. There is also a National Calamity Contingent Duty (NCCD) of 10% imposed on all SLT products apart from the regular taxes. However, with all these rates the effective tax incidence of SLT products in India is still around 59%* which is far below the recommendations by WHO. In other words, the existing GST regime on SLT products in India leaves plenty of room to increase the taxes to a much higher level.

This was estimated using a 28% GST, an average of 104% cess, and 10% NCCD that are applied on most SLT products under GST as well as assuming a 12.5% retail margin and a retail price of about INR 74 for a 100 gram SLT pouch.

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Table 2.1.4: Tax rate on various smokeless tobacco products in India from 1 July 2017

Tariff Item	Smokeless Tobacco Product	GST(%)	Cess(%)	NCCD(%)
2403 99 10	Chewing tobacco (without lime tube)	28	160	10
2403 99 10	Chewing tobacco (with lime tube)	28	142	10
2403 99 10	Filter khaini	28	160	10
2403 99 30	Jarda scented tobacco	28	160	10
2403 99 90	Pan masala containing tobacco 'Gutkha'	28	204	10
2403 91 00	"Homogenised" or "reconstituted" tobacco, bearing a brand name	28	72	10
2403 99 20	Preparations containing chewing tobacco	28	72	10
2403 99 40	Snuff	28	72	10
2403 99 50	Preparations containing snuff	28	7	10
2403 99 60	Tobacco extracts and essence bearing a brand name	28	72	10
2403 99 60	Tobacco extracts and essence not bearing a brand name	28	65	10
2403 99 70	Cut Tobacco	28	20	-
2403 99 90	All goods, other than pan masala containing tobacco 'gutkha', bearing a brand name	28	96	10
2403 99 90	All goods, other than pan masala containing tobacco 'gutkha', not bearing a brand name	28	89	10

Source: Central Board of Excise and Customs, Ministry of Finance, Govt. of India, 2017

Unlike cigarettes, SLT products were historically not taxed in Bangladesh. Only in 2008–09 the government of Bangladesh recognized SLT as a manufacturing industry rather than a cottage industry.² SLT was brought under the tobacco control mechanism for the first time in 2008 with the imposition of 15% Value Added Tax (VAT) on *zarda* (chewing tobacco) and *gul* (tooth powder) which are the most common forms of smokeless tobacco products in the country.⁶ A 10% supplementary duty on the ex-factory price of *zarda* and *gul* was also introduced in 2009.

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In the years 2010–11 and 2011–12 the supplementary duty was further revised to 20% and 30% respectively.⁶ These supplementary duties were again revised to 60% and later to 100% in the years 2015–16 and 2016–17, respectively.²¹

Affordability of Smokeless Tobacco

One of the objectives of taxing tobacco products is to make them less affordable over time. This is because there is general price inflation happening in the country that reduces the real price of a product in the absence of increases in nominal price at a rate faster than inflation. Besides, people's income and purchasing power of the consumer are growing with time. Both inflation and income growth can have the effect of increasing the affordability of a product. Unless tobacco taxes are raised sufficiently every year to more than offset the income growth and inflation effects, tobacco products would become more affordable resulting in increased consumption. Affordability of tobacco products are usually measured in terms of Relative Income Price (RIP) which is defined as the percentage of per capita income needed to purchase a given number of pack of a tobacco product.

Available data¹⁷ suggest cigarettes are becoming less affordable in high-resource Parties and much more affordable in low-resource Parties. However, data on affordability of SLT across Parties is limited. Earlier studies¹¹ in India showed that SLT products have become more affordable over the period 2001 to 2007. More recent studies¹⁶ using data for 2006–2012 also suggest that SLT products are becoming more affordable in India. The study indicated that despite a higher increase in the price of SLT compared to general prices, the SLT products became more affordable due to a greater increase in the per capita GDP. Using data from 2009 to 2015, a recent study²² from Bangladesh showed that the affordability of SLT products remained unchanged between 2011–12 and 2014–15. The study also observed that “despite the increase in price in real terms, affordability did not changedue to offsetting income growth of smokeless tobacco users”. Moreover, it also suggests the “growth in affordability of cigarettes relative to SLT may have induced switching from SLT use to cigarette smoking resulting in the higher prevalence of cigarette smoking and lower prevalence of SLT use in recent years in Bangladesh.”

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Affordability studies on SLT products from both India and Bangladesh underlines the need to increase taxes on tobacco products regularly to keep up with growth in income and purchasing power in order to make tax measures for SLT control more meaningful and effective. It is also important to decrease the affordability of all tobacco products in a Party in order to discourage switching from relatively unaffordable products to more affordable products.

Conclusion

There are approximately 346 million adult SLT users in the world and the SEAR accounts for nearly 86% of them. India and Bangladesh are the two major countries that constitute much of the SLT user base. The literature on price and tax measures to control SLT use has not been well documented unlike in the case of cigarettes. This is primarily because SLT consists of a wide range of heterogeneous products and finding a uniform unit for quantification is quite challenging. It was found that, by volume, out of 91.3% (648.2 billion tons) of the SLT products sold worldwide, (710.2 billion tons) are sold in traditional markets. This report reviewed various issues about prevalence, production, taxation and affordability of SLT products, focusing more on the traditional markets.

Available studies on price elasticities of SLT products in India, although few in number, concluded that the elasticity of SLT products fell in the inelastic range of less than 1. Consequently, taxation can be an effective tool to reduce the consumption of SLT products, as well as a tool to generate more tax revenue.

Recommendations

From the literature reviewed here it is evident that taxation is an effective tool to reduce the use of SLT products. However, how taxes are implemented is crucial in making the best use of this tool. Taxation should be as simple as possible and its administration should be efficient in order to meet both public health and fiscal needs.

Determining a standard unit of quantification for the purpose of taxation can be quite challenging for SLT products. Unit for taxation of SLT can either be the retail price of pouch/pack in which the product is sold, weight of the pack/pouch, or weight of dry tobacco leaf used in the product.

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The experience from India shows that taxation based on the pre-notified capacity of packing machine that takes into account the speed of these machines can be effective. Whichever method is used for taxation, it should make the tax administration and tax structure simple. Continuous monitoring of the supply chain (from manufacturing to retail distribution) of SLT products should be in place in order to make taxation effective. Taxation of SLT products should follow the following principles:

- It should be able to revise frequently (at least once a year) to keep the affordability of SLT products low. In other words, taxation should more than offset the inflation and the income growth of the population;
- It should not make the SLT products cheaper than the alternative tobacco products available in a country such as cigarettes, bidis or other smoked tobacco products. This should be of particular concern in countries where risk of substitution with other tobacco products exist;
- Tax should be such that the minimum price per pouch or pack of SLT will be at least as high as a pack of alternative smoked tobacco products available in the same market;
- Given the SLT products are already much cheaper than cigarettes in most markets where SLT is sold, the incremental changes in SLT tax need to be much larger than that of cigarettes to bring about parity in taxation and retail price across tobacco products; and
- Taxation of SLT products should be geared more towards a specific system instead of an *ad valorem* system as the former has greater impact on reducing consumption.

FINDINGS-ARTICLE 6

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FINDINGS
ARTICLE 9 & 10



2.2
REGULATION OF
SLT CONTENTS
AND ITS
DISCLOSURES

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2.2: REGULATION OF SLT CONTENTS AND ITS DISCLOSURES

Article 9 – Regulation of the contents of tobacco products

The Conference of the Parties, in consultation with competent international bodies, shall propose guidelines for testing and measuring the contents and emissions of tobacco products and for the regulation of these contents and emissions. Each Party shall, where approved by competent national authorities, adopt and implement effective legislative, executive and administrative or other measures for such testing and measuring, and for such regulation.

Article 10 – Regulation of tobacco product disclosures

Each Party shall, in accordance with its national law, adopt and implement effective legislative, executive, administrative or other measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products. Each Party shall further adopt and implement effective measures for public disclosure of information about the toxic constituents of the tobacco products and the emissions that they may produce.

Increasing use of smokeless tobacco (SLT) products across the globe and their attendant health hazards has necessitated the formulation of control policies and regulations. WHO Framework Convention on Tobacco Control (WHO FCTC) was developed owing to the growing epidemic of tobacco and addresses this concern in different articles. *The Article 9 provides regulation of the contents of tobacco products while Article 10 provides regulation of tobacco product disclosures.* Since both the articles are closely related, the guidelines for implementation have been provided together. Such regulation will act as a milestone if the long-term objective of reducing the danger of SLT products is to be achieved by the Parties.

Progress in Implementation of Article 9 and 10

Average implementation rate of Article 9 was nearly 50% while for Article 10 it was slightly higher than 50% during 2012–2016.^{1,2}

WHO Report on the global tobacco epidemic, MPOWER, 2017 provides following information:

FINDINGS-ARTICLE 9 & 10

Banning the display of quantitative information on emission yields

The quantitative information showing the levels of tar, nicotine and other emission yields on SLT packaging may provide a wrong impression that certain SLT products with lesser quantity of these hazardous chemicals are better than the ones containing higher quantity. This is likely to boost the marketing of such products. Therefore, WHO recommends banning the display of quantitative information on emission yields.

Forty-one and 31 Parties with majority of high-resource countries, have laws banning the display of quantitative information on emission yields (such as tar, nicotine and carbon monoxide) on cigarettes and SLT packaging respectively (Figure. 2.2.1).

Mandating the display of qualitative information on constituents and emissions

The qualitative information includes displaying the harmful effects of the constituents and emissions of SLT packaging. This information should be enforced and thereby has to be mandated as a recommendation by WHO to the Parties.

The law mandates the display of qualitative information on relevant constituents and emissions of cigarettes and SLT packaging in 64 and 22 Parties respectively. Chile, Costa Rica, Ecuador, Kenya, Nigeria, Panama, Togo and Uruguay have laws for banning quantitative and mandating qualitative display.

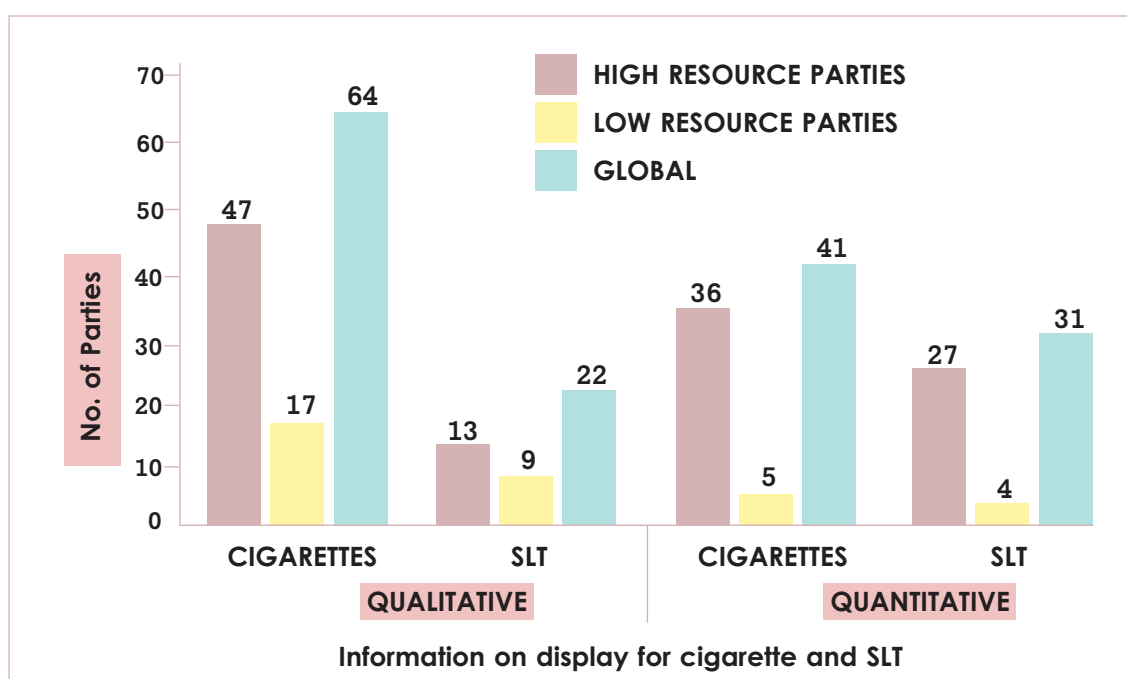


Figure. 2.2.1: Parties according to income groups having law for ban on display of quantitative information and mandating display of qualitative information on cigarette and SLT products

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Data from scientific research on analysis of chemical composition of SLT products reveals that:

- Thirteen percent (n=24) of the Parties (Brazil, Canada, Denmark, Germany, India, Sudan, Sweden, UK, South Africa, Nigeria, Ghana, Turkey, Norway, Pakistan, Oman, Uzbekistan, Kyrgyzstan, Tunisia, Belgium, Thailand, Japan, Venezuela, Libya and Ethiopia) have done analysis of the chemical composition of SLT on ad hoc basis. The laboratories in USA (not a Party to the Convention), Sweden, India, Oman, Nigeria, Pakistan, Ethiopia and Canada are presently conducting such analysis.
- Not all SLT products available in these Parties have been analyzed.
- Products have not been analyzed on periodic basis.

The most toxic and carcinogenic compounds identified are the tobacco specific nitrosamines (TSNA), especially Nicotine-derived nitrosamine ketone (NNK) and N-Nitrosornicotine (NNN) and polycyclic aromatic hydrocarbon, benzo[a]pyrene (B[a]P). Third Report of **“WHO Study Group On Tobacco Product Regulation”** (TobReg) has recommended setting upper limits for two nitrosamines, NNN and NNK. The report recommends that the combined concentration of NNN and NNK in SLT products should not be more than 2 µg/g dry weight of tobacco, while the concentration of B[a]P in SLT should be limited to 5 ng/g dry weight of tobacco.³

The present research on the subject reveals that recommendations of the WHO TobReg are not strictly implemented by Parties. The range of NNK, NNN and Nicotine from different brands of *Gutkha* available in India has been provided in Table 2.2.1. It is quite clear that there is a large variation in the levels of NNN (39.4–76.9 µg/g) and NNK (2.34–28.4 µg/g) in *Khaini*. Concentration levels of NNN and NNK are found to be quite high in *Gutkha and Zarda*. Similarly, Table 2.2.1 provides the data on, the range of different constituents in various brands and types of SLT products available in Oman, Sweden, Canada, Kyrgyzstan, Uzbekistan and Turkey Table 2.2.2 displayed, the concentration of B[a]P and heavy metals in various SLT products which is higher than WHO TobReg and GothiaTek® standards.

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Table 2.2.1: Range of NNK, NNN and Nicotine from different brands of SLT products available in India⁴, Oman⁵, Sweden⁶, Canada⁷, Kyrgyzstan, Uzbekistan⁸ and Turkey⁹

Countries	SLT Products	NNN (µg/g)	NNK (µg/g)
India	<i>Khaini</i>	39.4–76.9	2.34–28.4
	<i>Zarda</i>	4.81–19.9	3.09–16.4
	<i>Gutkha</i>	0.09–1.09	0.04–0.43
Oman	<i>Afzal</i>	1.18–1.22	1.01–1.02
Sweden	<i>Snus</i>	0.42–3.28	0.13–1.1
Canada	<i>Moist Snuff</i>	0.8–6.78	0.38–2.5
Kyrgyzstan	<i>Nasvai</i>	1.12–1.26	0.17–0.21
Uzbekistan	<i>Nasvai</i>	0.59–0.69	0.07–0.07
Turkey	<i>Maras Powder</i>	2.2–2.8	0.63–0.77
USA*	<i>Iq'mik</i>	1.99–4	0.13–0.96
	<i>Snus</i>	0.95–5.30	0.08–0.36
	<i>Moist Snuff</i>	0.89–42.55	0.20–9.95
Sudan	<i>Toombak</i>	141–3085	188–7870
Germany	<i>Dry Snuff</i>	2.4–18.1	0.58–6.4

*not a Party to the Convention

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Table 2.2.2: Concentration of B[a]P in different SLT products along with the recommended regulatory standards of WHO and **GothiaTek®**¹⁰

Brand	BaP	WHO TobReg	GothiaTek®
	ng/g	ng/g	ng/g
<i>DalalMisti Zarda</i> ¹¹	8.89	5	1.25
<i>Quardir Gul</i> ¹¹	5.98	5	1.25
<i>Baba 120 (Zarda)</i> ¹¹	2.83	5	1.25
<i>Copenhagen (Snuff)</i> ¹¹	19.33	5	1.25
<i>Loose snus</i> ¹²	2.93	5	1.25
<i>Portion snus</i> ¹²	2.53	5	1.25
<i>Chewing tobacco</i> ¹²	6	5	1.25
<i>Dry snuff</i> ¹²	80.4	5	1.25
<i>Soft pellet</i> ¹²	117	5	1.25
<i>Moist snuff</i> ¹²	87.4	5	1.25
<i>Plug</i> ¹²	3.25	5	1.25
<i>Square dry snuff</i> ¹³	86.7	5	1.25
<i>Lucky strike Original snus</i> ¹³	3.45	5	1.25

Table 2.2.3: Concentrations of different heavy metals in smokeless tobacco products as compared to **GothiaTek® Standards**

	Heavy Metals			
	Lead (Pb) (µg/g)	Arsenic (As) (µg/g)	Nickel (Ni) (µg/g)	Cadmium (Cd) (µg/g)
GothiTek® Standard Limits (µg/g) ¹⁰	1	0.25	2.25	0.5
Smokeless Tobacco Products				
<i>Naswar</i> ¹⁴	12.4–111.15	0.15–14.04	2.2–64.85	0.25–9.2
<i>Moist snuff</i> ⁷	0.3–1.2	0.17–0.44		
<i>Afzal (Mean of 3 samples)</i> ⁵	1.62		1.57	1.85

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The composition of SLT products influences the absorption of nicotine at the buccal surface. An alkaline pH increases the absorption as compared to the acidic pH.¹⁵ The pH level ranges, from 4.36 to 11.8 in different SLT products as depicted in Table 2.2.4; The variation of nicotine in different SLT products is provided in Table 2.2.5. Recent work by Stepanov et al, 2017 done in Mumbai, India, shows that total nicotine level varied from 5.3 to 57.8 mg/g (dry weight) while unprotonated nicotine content ranged from 0.13 to 99.8% of total nicotine. The fifth report of "WHO Study Group On Tobacco Product Regulation" (TobReg) suggested setting limits on free nicotine and pH.¹⁷

Table 2.2.4: Distribution of pH among samples from various Parties

Countries	pH range
Brazil	4.36–5.34
Canada	5.34–5.63
Germany	5.71–5.73
India	5.78–7.3
Sweden	7.45–10.2
USSR	11–11.8
USA*	5.05–8.88

* Not a Party to the Convention

WHO Tobacco Laboratory Network

WHO has established WHO Tobacco Laboratory Network (TobLabNet) with the aim to regulate the contents and emissions of tobacco products.

Its major goal is to establish testing and research capacity of tobacco products for regulatory compliance. There are 16 WHO collaborating centers for tobacco control which work closely with Tobacco Free Initiative (TFI). Among these, 6 collaborating centers are working on tobacco testing and research (Table 2.2.6). However, the laboratories at these centers mainly focus on technical training, testing compounds and emissions of smoking products, especially cigarettes.

Table 2.2.5: Range of nicotine from different brands of smokeless tobacco products available in India⁴, Sweden⁶, Canada⁷, Brazil¹⁸ and Pakistan.¹²

SLT Products	Nicotine (mg/g)
India	
<i>Khaini</i>	19.6–21.3
<i>Zarda</i>	13.8–65
<i>Gutka</i>	1.23–11.4
Canada	
<i>Moist snuff</i>	2.44–31.2
Brazil	
<i>Rapé</i>	6.32–47.6
Sweden	
<i>Snus</i>	12.8–28.2
Pakistan	
<i>Naswar</i>	7.35–26.68

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Table 2.2.6: WHO collaborating centers working on tobacco content

S. No.	WHO Collaborating Center	Laboratory Name	WHO region
1	WHO Collaborating Center on Tobacco Product Testing and Research, Burkina Faso	Laboratoire National de Santé Publique Rue TansobaKiém	AFR
2	WHO Collaborating Centre for Tobacco Product Regulation and Control, Netherlands	Laboratory for Health Protection Research	EUR
3	WHO Collaborating Centre for Tobacco Product Testing and Research, USA	Center for the Study of Tobacco Products	AMR
4	WHO Collaborating Centre for Tobacco Testing and Research, Japan	Department of Environmental Health	WPR
5	WHO Collaborating Centre for Tobacco Testing and Research, Singapore	Cigarette Testing Laboratory	WPR
6	WHO Collaborating Centre on Tobacco Control, Germany	German Cancer Research Centre	EUR

The report by WHO at Conference of Parties 7 (COP7) states that the WHO TobLabNet methods for analysis of TSNA_s, B[a]P and nicotine can be adapted or applied to a number of SLT.¹⁹ Also, owing to wide range of SLT products, there is a need to perform product specific analysis as South Asia. This is not presently performed by the TobLabNet due to lack of relevant laboratory expertise and/or capacity. The analysis procedures for metals, humectants, aldehydes and many other toxicants present in SLT need to be standardized. It is also recommended that the Parties be invited to consider requiring SLT manufacturers to disclose pH level and toxicants (TSNA_s, B[a]P and nicotine) using WHO recommended methods/SOPs, from approved laboratories as currently recommended for cigarettes.

More information on the TobLabNet and TobReg Activities in Relation to SLT is available in **Annexure-I**.

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Case Study: Development of National Tobacco Testing Laboratory (NTTL) in India

Ministry of Health and Family Welfare, Government of India is in the process of establishing three NTTLs at ICMR–National Institute of Cancer Prevention and Research (NICPR), Noida; Central Drug Testing Laboratory (CDTL), Mumbai; and Regional Drug Testing Laboratory (RDTL), Guwahati with sole purpose of providing scientific and analytical information on tobacco products to Government of India and other organizations such as WHO.

Gaps in understanding article 9 and 10

The available data clearly indicates that there are very few autonomous or self-reliant laboratories which are working on the analysis of chemical composition of tobacco. Most of their work is primarily on cigarettes.

Almost 90% of SLT users reside in South–East Asian countries. However, there is only one functional tobacco testing laboratory located in Guwahati, India. Out of 179 Parties, only 2 have functional laboratories where most of the SLT samples are being tested.

There is a dearth of information about brand wide quantification of Group I carcinogens such as NNN and NNK. Non-availability of resources has thus led to lack of research and gaps in understanding of the toxic effects of the ingredients of SLT products is a major limitation.

Mapping of the few available studies has been carried out at small independent laboratories as a part of ongoing project. There is no centralized facility in almost all Parties to perform these tests and furnish results with certain regulatory standards. It becomes extremely difficult for researchers to compare the results and bring them on the same scale. Presently, no standards are allocated for testing and quantifying most of the constituents of SLT products. There is no regulation for additives and other flavoring agents in SLT products. Moreover, only partial guidelines have been proposed by WHO FCTC for Article 9 and 10.

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RECOMMENDATIONS

1. Parties should emphasize the establishment of tobacco testing laboratories in every region to identify and quantify the toxic and hazardous constituents of SLT products. These laboratories will be the precise driving force behind the successful implementation of Articles 9 and 10 of WHO FCTC. Several programs and expert groups recommends establishment of tobacco testing laboratories globally. The report by Ministry of Health and Family Welfare, Government of India has also recommended that '*Laboratories should be established that are mandated to test harmful ingredients in all SLT products registered under the Trademarks Act as tobacco products*'.⁴
2. Major initiatives to promote collaborations between academia, researchers, scientists and governments are required to ensure that reports from the laboratory presented in standard format are quickly analyzed and efficiently translated for implementation.
3. SOPs should be developed and practiced for tobacco testing across all laboratories. All research laboratories must adhere to a standard protocol in order to provide results for easy interpretation and implementation.
4. Global co-operation and collaboration among Parties is a prerequisite for effective progress on regulation of SLT. Parties that do not have a tobacco testing should encourage collaboration and support in technical matters concerning testing of SLT products. Successful strategies by Parties can be shared with others, and cross-border issues that require international collaboration should be addressed in an inclusive manner.
5. Parties should encourage and invest more in research on SLT products, their components and emissions, for effective regulation of SLT products. Smaller or independent laboratories working on tobacco should be empowered and funding opportunities should be provided to them.
6. Permissible upper limits of all chemical constituents of SLT products should be set and regulated.
7. Detailed guidelines on 9 and 10 including information on SLT should be framed. Parties should contribute towards formulation of these comprehensive guidelines and support their adoption.

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**FINDINGS
ARTICLE 11**



**2.3
PACKAGING AND
LABELING OF SLT**

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2.3: PACKAGING AND LABELING OF SLT

Article 11 of WHO FCTC pertains to effective packaging and labeling of tobacco products. It recommends Health Warnings on 'all' tobacco product packages, covering at least 30%, to a desirable 50% or more of the pack and recommends including pictures. The provision has to be implemented within three years of ratification of the Treaty by the Party. Further guidelines for facilitating its implementation (adopted during COP3 in November 2008) provide detailed information and recommendations in terms of design, content and number of health warnings. With Australia leading adoption of plain packaging of tobacco products, implementation of Article 11 has been given a considerable attention in recent years.

Health warning (HW) labels on tobacco product packages have been established as one of the most cost-effective tools for creating awareness about the health risks of tobacco use among both tobacco users as well as non-users.^{1,2} These warnings aim to reduce tobacco use by communicating hazards of tobacco use, encouraging quitting among users, preventing non-users from initiating, and preventing former users from relapse.^{3,4} Larger warnings with pictorial representations have a higher impact and effectiveness, as they are easily noticeable and communicate the ill effects of tobacco use even to people with low literacy.⁵

Most studies on impact and effectiveness of health warnings have been conducted on cigarettes, with minimal focus on other tobacco products, especially SLT products⁶; although available evidence supports that effectiveness of health warnings is applicable to smokeless tobacco products as well.^{7,8}

This report summarizes the global progress on policies pertaining to Article 11 of WHO FCTC on SLT products and its comparison with Cigarettes among FCTC Parties under the following indicators:

1. Parties' progress in notifying 30% Health Warning (HW)
2. Large Health Warnings ($\geq 50\%$)
3. Pictorial Health Warnings (PHW)
4. Multiple Health Warnings (≥ 2 specific warnings)

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A Party ensuring compliance with $\geq 30\%$ PHW with multiple HWs is considered to have complete provisions of Article 11 of the FCTC while a Party fulfilling any of the above four indicators has been considered partially compliant.

KEY OBSERVATIONS

1. Parties' progress in notifying HW ($\geq 30\%$) on cigarette and SLT:

By 2005, only 6 Parties notified HWs ($\geq 30\%$) on SLT packaging whereas 21 Parties notified the same on cigarette.

By 2010, only 32 Parties notified HWs on SLT, as compared to 71 Parties on cigarette. This number increased to 80 Parties for SLT and 128 Parties for cigarette in 2015. By the end of 2016, 91 Parties (51%) had notified HW on SLT, whereas 137 Parties (77%) did the same on cigarette (Figure 2.3.1).

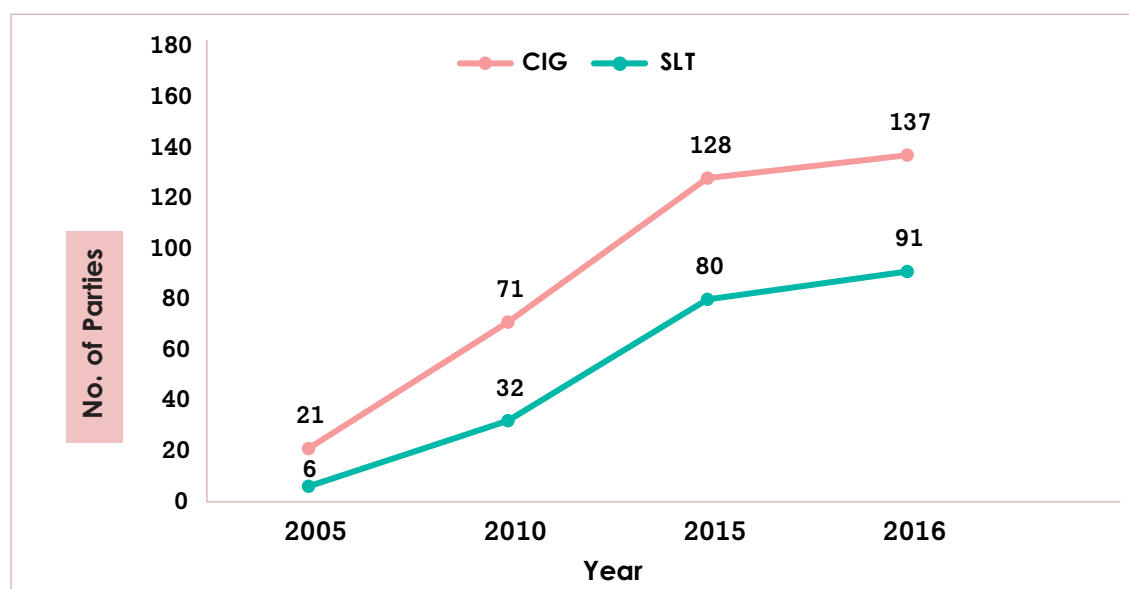


Figure 2.3.1: Parties' progress in notifying HW ($\geq 30\%$) on cigarette and SLT

For SLT, more low-resource Parties had notified $\geq 30\%$ HW (55%) as compared to high-resource Parties (48%). For cigarette, the findings were reversed; more high-resource Parties had notified the policy (80%) as compared to low-resource Parties (71%) (Figure 2.3.3).

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All WHO regions had $\leq 60\%$ of Parties notifying the policy on SLT, whereas, for cigarette, the coverage was $\geq 60\%$. Among WHO regions, SEAR and EMR had the highest proportion of Parties notifying $\geq 30\%$ HW on SLT (60% and 53% respectively), as compared to cigarette, where EUR had the highest proportion (94%).

2. Large Health Warnings ($\geq 50\%$ size):

For SLT, 27% Parties had notified large HWs in comparison to 56% on cigarette (Figure 2.3.2). Low-resource Parties had higher proportion (37%) of large HW for SLT as compared to high-resource Parties (20%). For cigarette, the findings were reverse for this indicator as well, with 58% in high-resource Parties and 52% in low-resource Parties (Figure 2.3.3). SEAR had the maximum proportion of Parties specifying large HWs (50% for SLT and 70% for cigarette).

3. Pictorial Health Warnings (PHW):

PHW of $\geq 30\%$ size on SLT packages were notified by 20% Parties and by 56% of Parties for cigarette (Figure 2.3.2).

Findings similar to Large HWs were noticed for PHWs as well, with low resource Parties scoring more for SLT (26%) and high resource Parties scoring more for cigarette (64%) (Figure 2.3.3). SEAR and EUR had highest proportion of Parties with PHWs for SLT and cigarette respectively (40% and 74%). Eleven Parties had notified 'text-only' large HWs ($\geq 50\%$ size) on cigarette (Albania, Cameroon, Cook Islands, Ghana, Kiribati, Nicaragua, Nigeria, Swaziland, Timor-Leste, Togo and Uganda) while 18 Parties had done the same on SLT (Albania, Brunei Darussalam, Cameroon, Canada, Cook Islands, Djibouti, Gabon, Ghana, Kiribati, Madagascar, Nicaragua, Nigeria, Solomon Islands, Suriname, Swaziland, Timor-Leste, Togo and Turkey). Considering the minimum 30% HW size mandate, 36 Parties (20%) require PHWs on both SLT and cigarettes. Twenty-Eight Parties (16%) require PHWs on cigarettes, but textual warnings on SLT packages. Ten Parties (6%) require PHWs on cigarettes but no warnings on SLT packages. Twenty-seven Parties (15%) require textual warnings on both SLT and cigarette packages; and four Parties (2%) require textual warnings on cigarettes but no warnings on SLT packages.

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4. Multiple Health Warnings (≥2 specific warnings)

Globally, only 27% Parties had notified multiple HWs on SLT packages, while 66% Parties notified this on cigarette (Figure 2.3.2).

A total of 53 Parties had notified multiple HWs on SLT packages, mostly from low resource Parties (33%) and SEAR (60%).

Globally, a total of 28 Parties (16%) were fully complying as per the guidelines of Article 11 on SLT products, in comparison to 95 Parties complying fully for cigarettes (53%).

6. Implementation among high SLT burden Parties

Among 36 high SLT burden Parties (Parties having male/female smokeless tobacco use prevalence ≥10% and/or >1 million SLT users); only India, Nepal, Philippines, Egypt, Kenya, Uruguay and Kyrgyzstan have complete policy and implementation. In Bangladesh, Myanmar, Colombia, Cambodia and Burkina Faso complete law is in place but has not been implemented. In the rest of the Parties there is partial or no evidence of any implementation.

7. SLT definition and notification of HW on SLT

From among the 179 Parties, 135 have included or referred to SLT under their definition of tobacco products, or have separately defined SLT. Out of these, only 80 (45%) have notified HW on SLT products. This is a clear indication of inadequate policy formulation on SLT products.

The findings imply that though more than 2/3rd of Parties have taken a step ahead and included SLT in their policies for tobacco control, only half of the Parties have notified HWs on SLT products.

1. Indicator of Implementation: Case Studies

1. GATS report: India

Impact of HWs implementation was considered through outcomes of GATS-I (2009–10)⁹ and GATS-II (2017)¹⁰ surveys in India. Tobacco users (>15 years age) were asked a specific question 'Have you thought of quitting because of warnings seen on tobacco products pack?' GATS-1 revealed 29%–38% smokers and 34% SLT users agreeing to it, which increased to 54%–62% smokers and 46% SLT users in GATS-2. These findings corroborate with the change in HWs on tobacco product packages over the time period of the two GATS survey in India

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In 2009–10, 40% pictorial HWs size was implemented (2 warnings on smoking products and 1 on SLT products) in India. In 2016, Government of India implemented larger pictorial HWs that covered 85% of the principal display area both on front and back (Figure 2.3.4).¹¹ This change might have had an impact upon the tobacco user resulting in observed increase in the motivation to quit.

1. GATS Report: Thailand

Sale of SLT products is prohibited in Thailand. However, shredded tobacco is still typically used for both hand-rolled cigarette and SLT products. Impact of HWs implementation was considered through outcomes of GATS-I (2009) and GATS-II (2011) surveys in Thailand.¹² SLT users (>15 years age) were asked 'Have you thought of quitting because of warnings seen on raw tobacco packages?' In 2009, 15% users thought about quitting because of HWs, which increased to 49.5% in 2011.

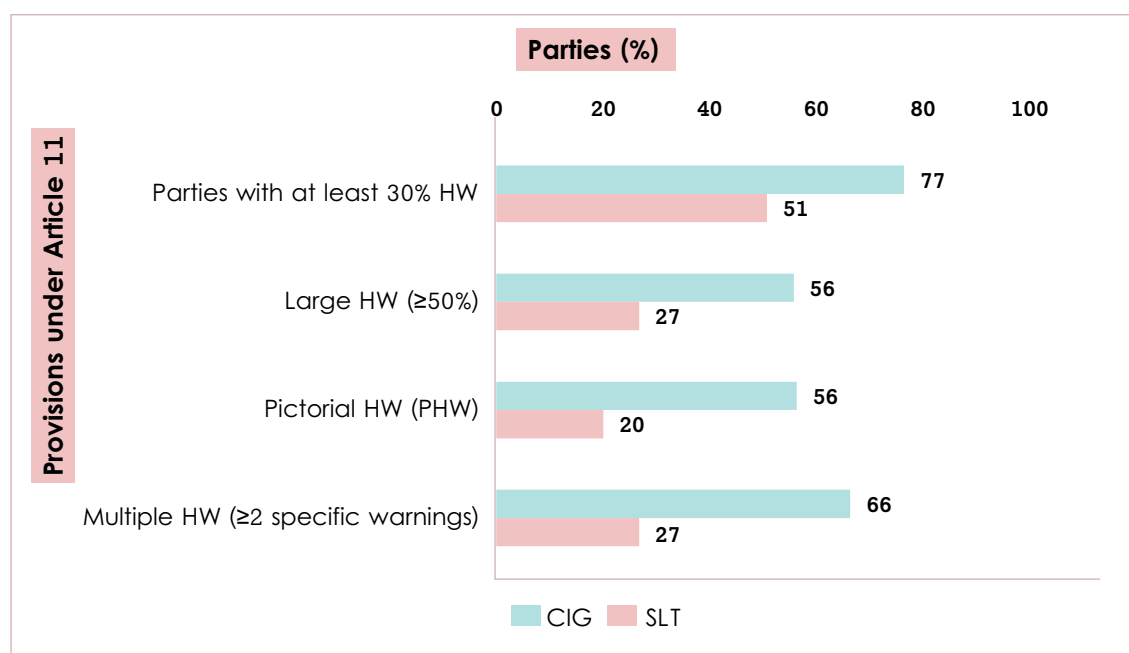


Fig 2.3.2: Parties (%) notifying provisions under Article 11

FINDINGS-ARTICLE 11

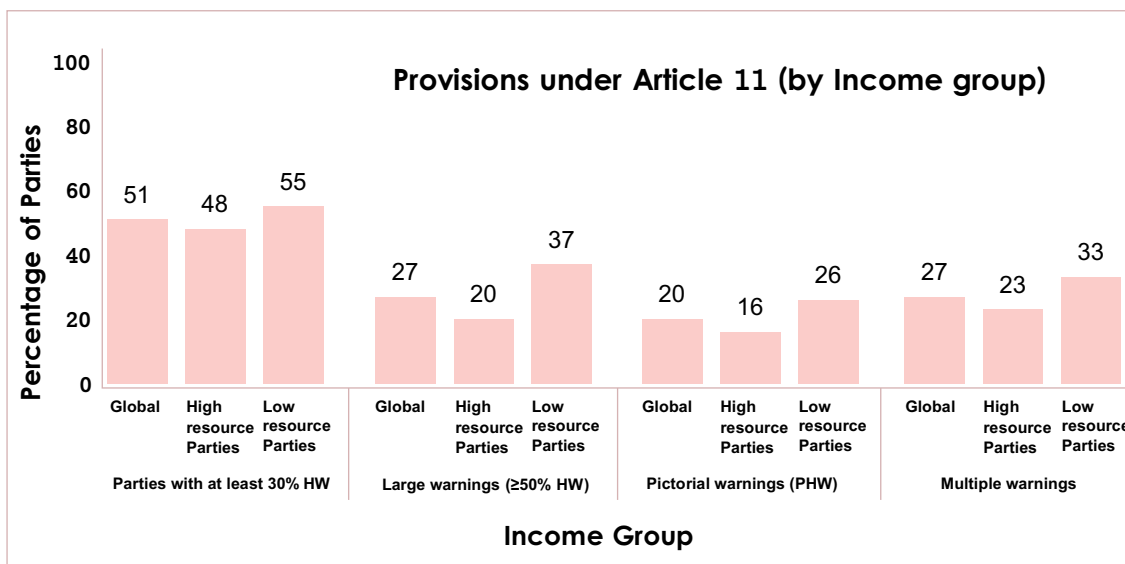


Figure 2.3.3: Parties (%) notifying provisions under Article 11 (by Income groups)



Figure 2.3.4: Transition of pictorial HWs on SLT products in India.⁹

GAPS

1. There is a huge variation among Parties in policy formulation and implementation of Article 11 on both cigarettes and SLT packages in terms of size, coverage and content of HWs.
2. Many Parties have not been able to formulate policies on implementing HWs on cigarettes and SLT products.
3. Most of the Parties including high SLT burden Parties have only partial or no policy in place for implementing HWs on SLT products.

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RECOMMENDATIONS

1. Parties should frame and implement comprehensive HW policies as per Article 11 of FCTC for all tobacco products, including SLT products.
2. All Parties should follow the recommended best practices while implementing HWs. The warnings should be large i.e. cover at least $\geq 50\%$ on the both/all sides, include pictures, have at least two or more specific warnings, and these should be rotated at periodic intervals.
3. Parties should notify multiple HW messages on various diseases caused due to SLT use and where available, should also display of quit-line numbers along with the HWs.
4. Parties should adopt comprehensive information and communication campaign, including through mass media, in line with the notified HWs for greater impact of the warnings.
5. Parties should consider making it mandatory that SLT is sold in packaged form allowing HWs to be clearly printed on the package.
6. Parties should consider implementing plain packaging on all tobacco products including smokeless tobacco.
7. Parties should periodically monitor the status and impact of implemented HWs on various SLT products among their populations.
8. Minimum size/dimensions should be fixed per unit package for appropriate visibility of the HWs to the consumer.

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FINDINGS ARTICLE 12

2.4 EDUCATION COMMUNICATION TRAINING AND PUBLIC AWARENESS ON SLT

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FINDINGS-ARTICLE 12

2.4: EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS ON SLT

Article 12: Education, communication, training and public awareness

Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Towards this end, each Party shall adopt and implement effective legislative, executive, administrative or other measures to promote:

- (a) broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke;
- (b) public awareness about the health risks of tobacco consumption and exposure to tobacco smoke and about the benefits of the cessation of tobacco use and tobacco-free lifestyles as specified in Article 14.2;
- (c) public access, in accordance with national law, to a wide range of information on the tobacco industry as relevant to the objective of this Convention;
- (d) effective and appropriate training or sensitization and awareness programmes on tobacco control addressed to persons such as health workers, community workers, social workers, media professionals, educators, decision-makers, administrators and other concerned persons;
- (e) awareness and participation of public and private agencies and non governmental organizations not affiliated with the tobacco industry in developing and implementing inter sectoral programmes and strategies for tobacco control; and
- (f) public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption.

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Article 12 of the WHO FCTC creates a broad and open-ended obligation on Parties to “*promote and strengthen public awareness of tobacco control issues, using all available communications tools, as appropriate.*” It requires Parties to adopt and implement effective measures to promote particular aspects of public awareness, including:

- Broad access to educational and public awareness programs;
- Public access to certain kinds of information;
- Awareness and participation of agencies and organizations not affiliated with the tobacco industry in developing and implementing tobacco control programs and strategies; and
- Training or sensitization and awareness programs for persons such as health workers, community workers, social workers, media professionals, educators, decision-makers and administrators.¹

Article 12 also reflects a core guiding principle of the FCTC i.e. “*every person should be informed of the health consequences, addictive nature and mortal threat posed by tobacco consumption and exposure to tobacco smoke*” (Article 4.1). The guidelines for implementation of Article 12 provide specific actions that Parties should take it includes:

- Establishing an infrastructure and building capacity to raise public awareness of tobacco control issues;
- Promoting social change through international collaboration, involvement of civil society and all other available means; and
- Ensuring that education, communication and training programs encompassing a wide range of information on tobacco industry its strategies and its products.

Article 12 covers all means of education, mass media, communication and awareness, including school curriculum and training materials. It also includes unpaid or low-cost forms of communication such as warning labels on tobacco products, press conferences or other events that aid the dissemination of information or generate earned media coverage.

FINDINGS-ARTICLE 12

KEY OBSERVATIONS

Based on the Global Progress Report on implementation of WHO FCTC 2016,² 65% of the Parties reported using the guidelines on Article 12 for implementation of the substantive provisions of the Article. The report also reveals that with 70% of the Parties complying, Article 12 is the fourth most implemented FCTC Article. Out of the 179 Parties, 64 (36%) had conducted at least one national mass media campaign³. The figure below provides the detailed distribution of mass media campaigns in all FCTC Parties.

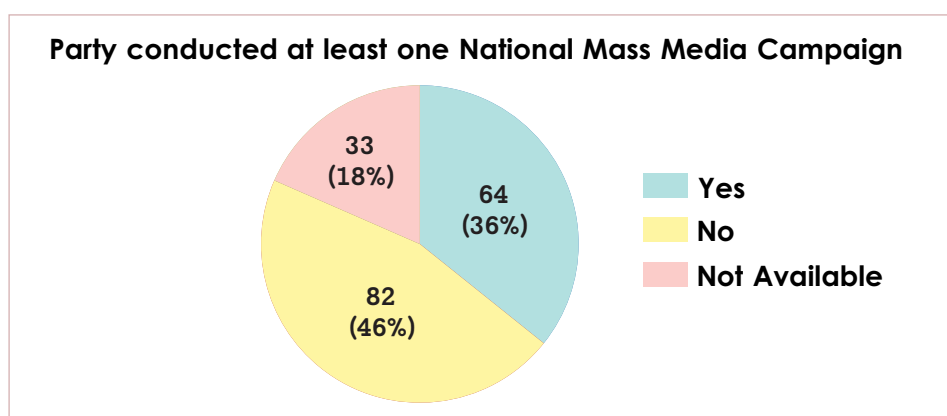


Figure 2.4.1: Party conducted at least one national mass media campaign³

The MPOWER report, 2017 reveals that the total number of Parties where at least one national mass media campaign was conducted, has decreased to 64 Parties from 70 in 2015. The changes under various indicators are given in table 2.4.1:

Table 2.4.1: Number of Parties with national mass media campaigns in 2014 and 2016

INDICATORS	2014 ⁴ (n = 70)	2016 ³ (n = 64)
It was part of a comprehensive tobacco control program	61	57
It was pre-tested with the target audience	43	40
Research about the target audience was conducted before hand	59	54
It was aired on television and/or radio	62	55
It utilized media planning	68	58
Earned media/public relations were used to promote the campaign	67	62
Process evaluation was employed to assess implementation	61	53
Outcome evaluation was employed to assess effectiveness	41	42

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The Global Progress Report on Implementation of WHO FCTC, 2016 and the MPOWER reports, (2015 and 2017) do not provide any specific information on implementation of Article 12 with respect to SLT products in the reporting Parties. However, several efforts have been made towards globally advancing education and awareness on the hazards of SLT. These have been conducted via mass media, community and school programs. A glimpse of such activities and efforts are highlighted below, with particular emphasis upon India.

Case Study: Media interventions, tobacco free villages & school-based interventions in India

Mass media interventions

The first dedicated pan-India mass media campaign on hazards of SLT, since the adoption of the FCTC, was designed and aired in 2009. The message was targeted towards high priority demographics: women, rural residents and low-income groups. This 30 seconds' documentary, referred to as '**Surgeon**' was filmed and pretested. It featured an oral cancer surgeon who described and presented the serious illnesses and disfigurements of his patients resulting from SLT related cancers. The campaign was evaluated and had a high recall value with 63% SLT users and 72% dual users recalling the campaign. Over 70% of people aware of the campaign admitted that it made them stop and think, was relevant to their lives, and provided new information. The campaign on awareness was associated with greater cessation-oriented intention and behaviours among SLT users⁵. A further cost-benefit analysis of the campaign found it to be highly cost-effective. The Campaign "*successfully generated 17,259,148 additional quit attempts, 431,479 permanent quits and 120,814 deaths averted. The cost per benefit was USD 0.06 per quit attempt, USD 2.6 per permanent quit and USD 9.2 per death averted. The campaign continued to be cost-effective in sensitivity analyses.*"⁶ An earlier systematic review of global evidence on the cost effectiveness of tobacco control mass media campaigns suggests that they offer good value for money.

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This campaign was followed up by 'Mukesh' the story of a 24-year-old SLT user. He was featured in the surgeon's campaign and died soon after the campaign was aired. The 'Mukesh campaign' was aired by the Government from February to April 2011. In 2014, the Government aired another campaign featuring Sunita. She narrated her personal testimony whilst suffering from mouth cancer. The campaign showed Sunita before and after a surgery to remove the cancerous growth and a part of her mouth. These campaigns were further supported by intense media activities including the Voice of Tobacco Victims (VoTV) highlighting the tragic consequences of SLT use.



Figure 2.4.2: Voice of Tobacco Victims from India

In Bangladesh a public service announcement on oral cancer was a part of the 2016 anti-tobacco campaign in the country to highlight the new graphic health warnings on tobacco products.⁸



Figure 2.4.3: Anti-tobacco campaign in Bagladesh

SOCIAL MEDIA

Civil society organizations have also shared mass media campaigns on the hazards of smokeless tobacco through social media like YouTube in Bangladesh. Several other countries (e.g. Pakistan, India) have also made use of YouTube and VoTV campaigns to educate the masses against the use of smokeless tobacco.

FINDINGS-ARTICLE 12

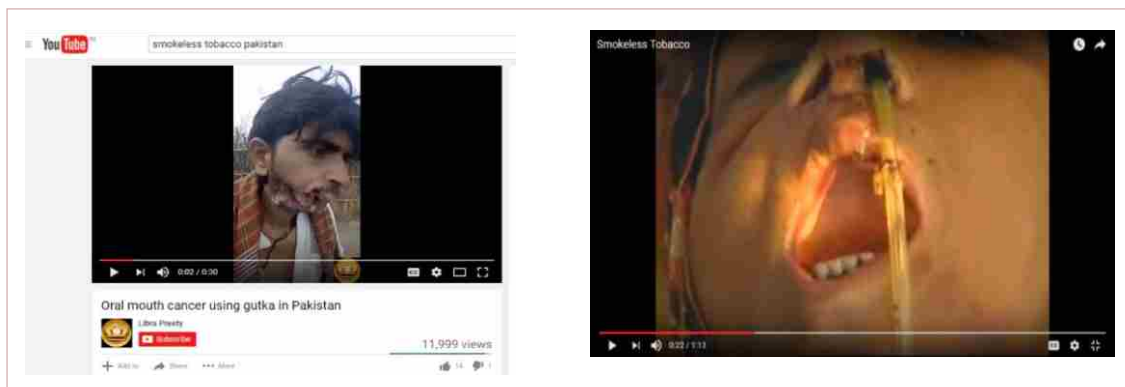


Figure 2.4.4: Mass media campaign on hazards of SLT through social media

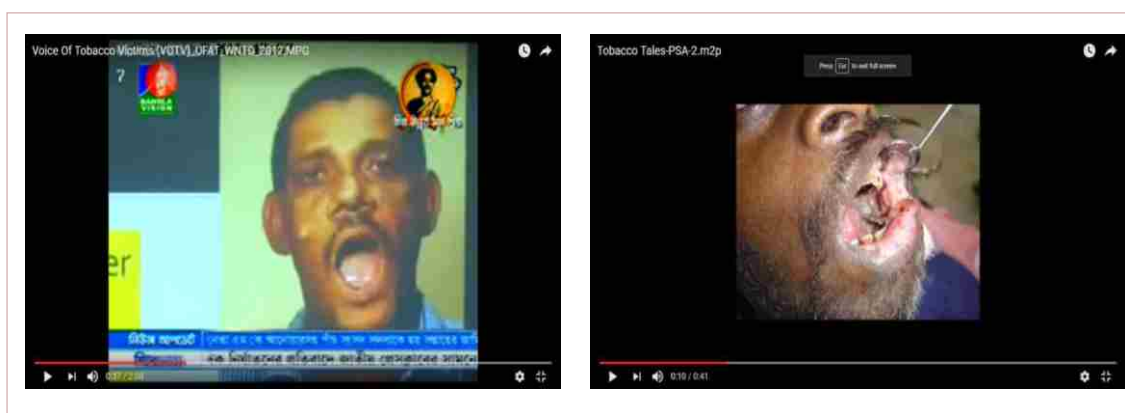


Figure 2.4.5: Public service announcements on health hazards of SLT in Nepal⁹ and Bangladesh¹⁰

Tobacco-free Villages Initiative in India

In Madhya Pradesh, Andhra Pradesh, Nagaland and several other states, innovative initiatives have been undertaken in villages that spread to neighboring areas. Gariphema village in Nagaland was declared a "tobacco-free village" on the occasion of "World No Tobacco Day" on May 31, 2014. It was the result of an initiative taken by the Gariphema village council, village vision cell and village students' union. A resolution was taken at the village that whoever sells alcohol and tobacco or gets drunk and disturbs peace would be fined INR 1000. Those consuming alcohol, 'bidi', 'paan', betel nut or smokeless tobacco on the street and public places would be fined INR 500.¹¹

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Several villages around Vishakhapatnam in Andhra Pradesh are making efforts to get the 'tobacco-free village' tag. These villages include RK Nagar and Pedagangudi in Arakumandal, Damsarai, Mardaguda and Chukumadatha in Ananthagirimandal, D Kollaput, Narinjalavasa and K Kosiguda in Dumbrigudamandal, Dabaputu in Paderu and Kunturla in Hukumpeta mandal.¹² According to research projects by the Public Health Foundation of India (PHFI) and Nature NGO, villages including Lingavaram, Pongalipaka, Degalapalem, Balabadram, Bheemavaram, Gondhipakalu, Chinarajupakalu, Boyapadu, Bangarammapeta, Tunivalasa and Ramakrishnapuram are some of the tobacco-free villages in Andhra Pradesh.^{13,14}

Noorundumalai village in Tamil Nadu is tobacco-free since 2002.¹⁵ Shankapura village in Haryana is another tobacco-free village in the country.¹⁶ Chinch Gohan village in Khandwa District of Madhya Pradesh was declared tobacco-free in 2006. The tribal village of Chikhli in Madhya Pradesh has shared this distinction since 2010.

Earned media

Both electronic and print media provide a great opportunity for disseminating information on the health hazards of tobacco use. This has been extensively used in India by the government and civil society.



Figure. 2.4.6: Addiction free model tribal village-Chikhli

The news media cover events, initiatives, research and evidence on smokeless tobacco and communicate it to the masses, informing them about the ill-effects of tobacco use. A study on earned media in Himachal Pradesh revealed that 55% news items focused on smoking, 23% on smokeless and 21% on both forms of tobacco use. 66% and 34% news items, respectively, were focused on youth and women. The earned media news items had a hypothetical value of US\$1,503,628.30.¹⁷

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Figure. 2.4.7: Glimpse of earned media

The earliest efforts of SLT health education and communication come from a 10-year controlled prospective intervention trial for primary prevention of oral cancer in Ernakulam, Kerala (1977–88). The trial specifically included in its communication strategy, the one to one discussion of the harms of SLT using photographs and pictorial booklets, as aids. Two documentary films were made and shown during home visits. Cinema slides, posters, folk dramas, local radio programmes and newspaper articles were used in the intervention areas. This resulted in greater quit rate among the intervention group (14% vs. 4%). Following the Ernakulam intervention, another controlled intervention as part of a cancer prevention program was implemented in the Kolar district of Karnataka between 1987 and 1990. The intervention revealed that the audio–visual medium of messaging was relatively more effective in encouraging cessation than the other communication message types.¹⁸

Project MYTRI was a project conducted by HRIDAY (Health Related Information Dissemination Amongst Youth), a New Delhi based NGO, in collaboration with University of Texas, USA. It was a large scale school based group randomized intervention trial, involving approximately 14,000 school-going adolescents in the two Indian cities of Delhi and Chennai. It was a two year teachers peer-led curriculum developed using social learning theory, encouraging tobacco-free norms and policies at school and home. It also nurtured students’ self-efficacy to refuse offers of tobacco and advocate for tobacco-free schools and homes. Over two years of intervention, tobacco use decreased by 17% among students in the intervention schools and increased by 68% in the control. Positive outcomes of MYTRI and related advocacy have informed NTCP, which includes school health programs. The recently released US Surgeon General Report 2012, which focuses on ‘preventing tobacco use among youth and young adults’, cites the effectiveness and results of MYTRI as evidence of a successful school-based multi-component tobacco control intervention.

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SCHOOL BASED PROGRAMMES

The earliest recorded school-based intervention was implemented in 46 villages in the Northern and Central zones of Goa between 1987 and 1988. The intervention included booklets on the harms of tobacco and ways to quit, which were taught during the academic year by teachers. The intervention suggested that attitudes toward tobacco became more negative and that quit rates increased in the intervention compared to the control sites. Two other school-based randomized controlled intervention trials have been reported in recent years (2002 and 2009). These studies reported greater resistance among students to consuming tobacco in the future.¹⁹

The recent Bihar School Teachers Study also provides insights on role of teachers in preventing tobacco use among students. The study aimed to promote Tobacco Free Teachers. The Tobacco Free Society trained more than 700 teachers in more than 70 schools in the state of Bihar. Immediately after the intervention the 30-day quit rate among teachers was 50% in the intervention and 15% in the control group.²⁰

Though the school-based interventions have been implemented in some developed countries, they have not yielded the desired outcomes. However, imparting awareness against tobacco use in schools has worked for developing countries. This is because teachers are role models for students and influential members of society; they are capable of influencing both policies and social norms related to tobacco control in their society. Therefore, teachers represent a priority population for tobacco control efforts in many LMICs.

Information on Article 12 under Global Youth Tobacco Survey (GYTS)

The GYTS data reveal that nearly 60% of the students from among the 65 Parties are reported having been taught about the dangers of smoking tobacco in their school. The GYTS presents a great opportunity for Parties to collect information on awareness, exposure to anti-SLT education and communication materials by the students.²¹

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Information on Article 12 under Global School Personnel Survey (GSPS)

The GSPS provides information on the status of education, awareness, and training on tobacco control in the schools and for the school personnel. A quick analysis of the GSPS data reveals that in most of the Parties, where the survey was conducted, an average of 64% respondents (from 33 reporting Parties) said that tobacco use prevention was included in school curriculum.²¹

The GSPS also provides information on programs and activities on tobacco use prevention that are conducted beyond classrooms. Only about 37% school personnel from 34 reporting Parties indicated that non-classroom programs or other activities (such as an assembly) are used to teach tobacco use prevention to students in their schools. However, in seven Parties (Papua New Guinea, Malawi, Oman, Kyrgyzstan, Estonia, Myanmar, Bhutan, Republic of Moldova) more than 50% school personnel reported to conduct these activities.

According to the GSPS only 46% school personnel from the 32 Parties reported having access to teaching and learning materials. However, in 11 Parties, including Sri Lanka, Nepal and Myanmar from the South-east Asia region, more than 50% school personnel reported having access to teaching and learning materials.²¹

However, overall only 12% school personnel reported having ever received training on youth tobacco use prevention. Conversely, nearly 54% school personnel in Kyrgyzstan reported having received such training.

Education through health warnings on tobacco packages

Health warnings on tobacco product packages are the most cost-effective means of informing tobacco users about the dangers of tobacco use. However, many Parties still do not mandate PHWs on SLT products. Even among the 36 high SLT burden Parties only 14 have PHWs on SLT products.

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Table 2.4.2: High SLT burden Parties and PHW on SLT

S. No	Countries	Pictorial HW
1	India	√
2	Bangladesh	√
3	Myanmar	√
4	Pakistan	X
5	Democratic Republic of Congo	X
6	China	X
7	Nepal	√
8	Colombia	√
9	Malaysia	X
10	Madagascar	X
11	Germany	X
12	Uzbekistan	X
13	Sri Lanka	Not Applicable
14	Nigeria	X
15	South Africa	X
16	Afghanistan	√
17	Yemen	√
18	Thailand	Not Applicable
19	Egypt	√
20	Algeria	X
21	Philippines	√
22	Sweden	X
23	Kenya	√
24	Marshall Islands	X
25	Palau	X
26	Burkina Faso	√
27	Uruguay	Not Applicable
28	Bhutan	X
29	Norway	X
30	Timor-Leste	X
31	Iceland	X
32	Kyrgyzstan	√
33	Lesotho	X
34	Botswana	√
35	Cambodia	√
36	Mauritania	X

Information on Article 12 under GATS

The Global Adult Tobacco Survey has the following two questions regarding the exposure to anti-SLT information:

- Percentage of adults who have noticed information about the dangers of using smokeless tobacco or that encourages quitting from various sources in the last 30 days
- Percentage of current smokeless tobacco users who noticed health warnings on smokeless packages in the last 30 days.

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The response to these questions is available only from India; no other Party has collected information on these two important indicators of awareness about SLT products. Several Parties, including the high SLT burden Parties, have HWs on SLT products. However, data under GATS on current SLT users who noticed HWs on smokeless package is only available for India.²²

Studies clearly identify lack of awareness on SLT use:



BANGLADESH

There is a lack of public awareness and inappropriate knowledge about the harmful effects of SLT use. Most anti-tobacco campaigns in Bangladesh focused on cigarette or bidi smoking without much information about SLT use. There is a need to focus on increasing Bangladeshis' awareness of the relative harms of all tobacco products including SLT use. Given the wide acceptance of SLT use by women in Bangladeshi culture, interventions to raise awareness of the harms of SLT use should target women as a key group.²³

Control of the use of SLT in Bangladeshi society requires a massive social awareness program utilizing the education system and various electronic media alongside the tobacco control program. Even the traditional approach of labeling packages with warnings will not work for products like '*sadapatha*' as it is not industrially produced and does not have any packaging. They are presented as dried tobacco leaves. *Sadapatha* and *zarda* are mixed in *paan* without the customer getting to look at the *zarda* package.²⁴



MYANMAR

The use of SLT is prevalent with many different types of tobacco being used in Myanmar. Socio-cultural acceptance and myth compound the lack of specific SLT control component in the adoption of National Tobacco Control Legislation.

FINDINGS-ARTICLE 12

This needs to be addressed as a priority through intensified community awareness programs, public education programs, and advocacy campaigns. Community awareness campaigns should be implemented with the involvement of NGOs and relevant ministries. Public education on the dangers of SLT is the most important step and needs to be followed by advocacy and effective law enforcement.²⁵



SRILANKA

The increasing popularity of SLT use among the youth and adolescents in Sri Lanka is a cause for concern. The level of awareness about health risks such as oral cancer and oral potentially malignant disorders (OPMD) related to the consumption of smokeless tobacco products is low, particularly among people of low socio-economic status. There are studies demonstrating the harmful effects of SLT use, especially on the oral mucosa. However, the level of public awareness is low.²⁶

One study found that estate workers were significantly less aware of the harmful effects of SLT usage than villagers, even though the SLT use is higher among these workers. Most estate workers knew that tobacco can cause health problems, but were unaware that the major risk of consuming SLT products was oral cancer. Most of the rural and estate sector users did not know the symptoms of oral cancer. Many users believed that the use of SLT products would make them feel manly, energetic and excited. Spitting by betel quid users is also a common problem in Sri Lanka. Most of the users are unaware that this could be the cause of tuberculosis and other diseases.²⁶

However, the GYTS 2015 from Sri Lanka reports that 78.9% students were taught in school about the dangers of tobacco use in the past 12 months while 88.0% saw anti-tobacco (focused on anti-smoking) media messages.²⁶

To combat the harms of SLT in Sri Lanka a new 'betel tray concept' has been established among religious leaders. This entails serving a mix of nutmeg, mace, cardamom, clove and aromatic ginger to continue the tradition, instead of serving tobacco, areca nut and lime.²⁷

FINDINGS-ARTICLE 12



NEPAL

In Nepal, educational and awareness activities on the harmful effects of tobacco use and health warnings have been disseminated through the mass media. This includes radio, television, FM (Frequency Modulator) and print media and channels of interpersonal communication. Interactive activities at the community-level have been ongoing. School textbooks also include content about the harmful effects of smoking and tobacco use.²⁸ However, there is a low level of awareness among people regarding the tobacco control laws and regulations. The monitoring mechanism and roles of responsible institutions have not been clearly defined in the law, thus limiting multi-sectoral collaboration and efforts. Conducting awareness programs and monitoring in rural Nepal is equally difficult because of physical barriers.²⁹



PAKISTAN

There is inadequate knowledge about the health problems associated with SLT in Pakistan. Appropriate interventions including health education campaigns are needed to raise awareness of the health risks and to prevent SLT use.³⁰ Doctors make one of the best avenues of such education to people and have immense potential to influence patients' tobacco use. Medical colleges should provide greater education about the myths and hazards of SLT.³¹

GAPS

1. Most of the high SLT burden countries do not have pictorial health warnings on SLT products, which is the first source of information against the hazards of SLT use.
2. Existing data from various sources suggest there is an absence of dedicated mass media or communication strategy to reduce SLT use.

FINDINGS-ARTICLE 12

3. All the studies on SLT from the South-East Asia Region reveal a lack of comprehensive education and communication efforts to prevent SLT use, especially among women, youth and vulnerable groups.
4. There is a lack of national education, awareness and communication program to curb SLT use.
5. It is necessary to evaluate the existing mass media and other education; awareness and communication campaigns being implemented on SLT.

RECOMMENDATIONS

1. The communication programs should be made more strategic, participatory and interactive. They should seek to understand the target audiences, address their needs and motivation to quit using SLT.
2. Parties should implement dedicated national mass media campaign focused on reducing SLT use. Social marketing campaigns that utilise mass media are also feasible and efficacious interventions for SLT control.
3. All media campaigns and other such interventions should be evaluated for their impact and effectiveness.
4. Parties should ensure that no SLT product is sold without pictorial health warnings. No exemptions should be provided to SLT products from packaging and labelling as well as other rules and regulations applicable to smoking products in that country.
5. Parties should start reporting status of SLT use on various indicators of education, training, communication and awareness under the FCTC reporting instrument, GYTS, GSPS and GATS. In particular, Parties should consider adding a question for students' survey under GYTS to assess if students are taught about the dangers of SLT in their school.

FINDINGS-ARTICLE 12

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**FINDINGS
ARTICLE 13**



**2.5
BAN ON SLT
ADVERTISEMENT
PROMOTION
AND
SPONSORSHIP**

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2.5: BAN ON SLT ADVERTISEMENT, PROMOTION AND SPONSORSHIP

Article 13: The provisions are based upon established evidence, summarized under the following guidelines:

- a. Implement a comprehensive TAPS ban and undertake the measures necessary to implement the ban within 5 years of ratification
- b. For signatories whose constitution does not allow for a comprehensive ban, should apply restrictions on all TAPS
- c. At a minimum, signatories should
 1. Prohibit all marketing that promotes tobacco products in false or misleading ways;
 2. Require that marketing be accompanied by health warnings;
 3. Restrict the use of incentives that encourage tobacco purchase;
 4. Restrict marketing on radio, television, print and new media; and
 5. Restrict tobacco sponsorship of international events, activities, and/or participants
- d. Co-operate in international efforts to eliminate and ban cross-border advertising entering a country's territory that violates that country's restrictions.

Article 13 of the WHO Framework Convention on Tobacco Control provides guidelines for successful enforcement and implementation of effective measures against tobacco advertising, promotion and sponsorship (TAPS). It gives Parties guidance for a comprehensive ban on TAPS or, for those Parties that are not in a position to undertake a comprehensive ban owing to their constitutions or constitutional principles, for applying restrictions on TAPS that are as comprehensive as possible.¹

Evidence suggests that TAPS bans reduce tobacco use, especially among young people, while partial advertising bans provide opportunities for tobacco companies to find new ways to market their products.^{2,3}

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KEY OBSERVATIONS

1. Ban on Advertisement:^{4,5}

Direct advertisement in 'National TV and Radio', 'National Print media' and 'Billboards' is banned in >65% Parties for SLT products in comparison to >75% Parties for cigarettes.

Nearly 60% Parties have banned 'Advertisement on International TV and Radio' for SLT, while nearly 70% Parties have done the same for cigarettes. The majority of the Parties have not banned 'Advertisement at Point of Sale'(54% for cigarettes and 58% for SLT) and in 'International Print Media' (56% for cigarettes and 47% for SLT) (Figure 2.5.1).

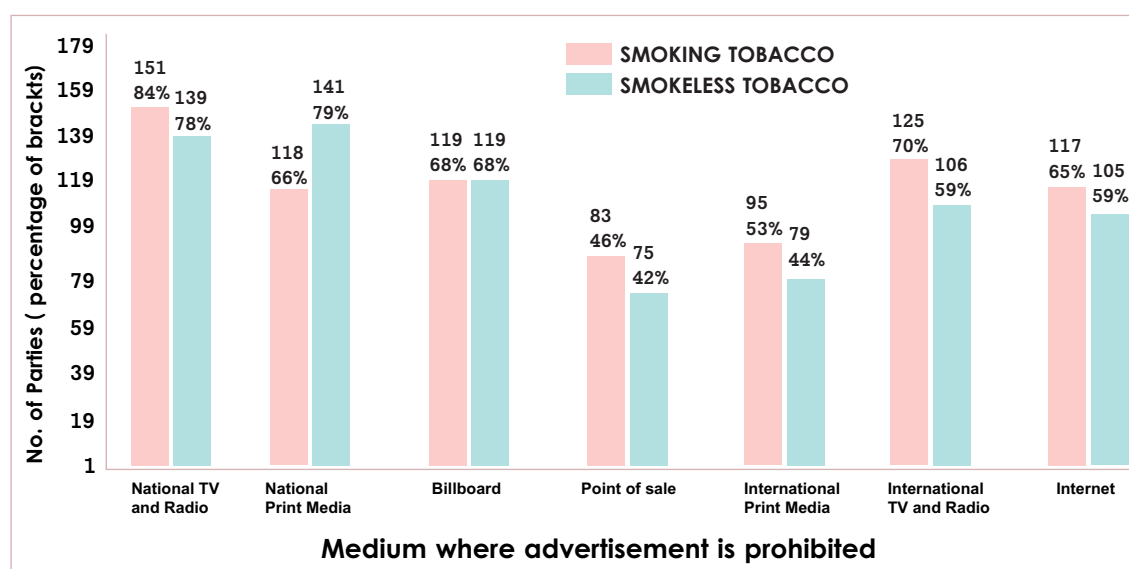


Figure. 2.5.1: Number and percentage of Parties prohibiting mediums of direct advertisement

Nearly 60% Parties have banned advertisement through internet for cigarettes and SLT. Internet advertisement and sale of SLT products are rampant, especially in SEAR and EUR.

Ban of Snus sale through internet; Case of European Union

The European Union (EU) Tobacco Products Directive bans the sales of snus in all EU countries except Sweden. The snus is being sold in the market via the internet and is easily purchased in most EU Member States.

FINDINGS-ARTICLE 13

The majority of online sites are from Sweden targeting non-Swedish EU citizens. Inadequate age verification methods and price-based promotions are widespread in the online sale of *snus*. Online vendors do not always supply accurate information concerning the tax responsibilities of vendor and customer.⁶ The wide availability of SLT products online enables young individuals to buy the products around the globe. There is no decrease in the use of tobacco by the adolescents due to the *snus* sale through internet in the EU. It is necessary to formulate a policy to reduce the sale of online SLT products.

2. Ban on Promotion and Sponsorship:^{4,5}

Less than 60% of the Parties have banned Promotions and Sponsorship for SLT and less than 75% have done the same for cigarettes on different provisions of Promotion and Sponsorship. However, 'Appearance of tobacco products in TV and in films' and 'Use of brand name of non-tobacco products for tobacco product' are still some of the neglected area by the Parties.

Nearly one-quarter of the Parties (26%) have a complete ban on sponsorship for both cigarettes and SLT products (47 and 46 parties for cigarettes and SLT respectively) (Figure 2.5.2).

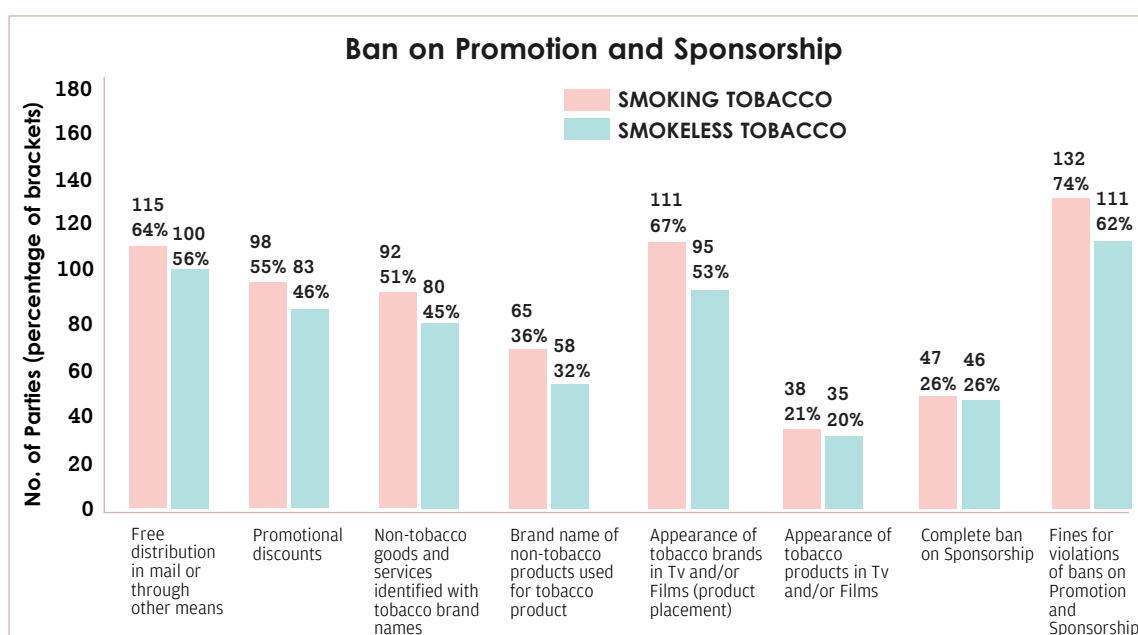


Figure. 2.5.2: Number and percentage of Parties notifying ban on promotion and sponsorship advertisement

FINDINGS-ARTICLE 13

In India, SLT products are manufactured and highly advertised through surrogate advertisement. 'India Trade Mark Act' of 1999 allows registration of various non-tobacco products such as food and clothing. Many SLT products such as *Kamala Pasand*, *Manikchand Goa*, *Soni* and *Chaini* have the same brand name for tobacco and non-tobacco products (*Pan masala*). Package design and color for tobacco and non-tobacco products are also similar to mislead the consumer. (Figure. 2.5.3)



Figure. 2.5.3: Tobacco and non-tobacco products having similar packaging in India⁷

In India non-tobacco brands are heavily advertised through same tobacco brand name on billboards (Figure 2.5.4) and at the point of sale (Figure 2.5.5)



Figure. 2.5.4: Hoardings of *Rajnigandha* which had similar advertisements for tobacco products in the past

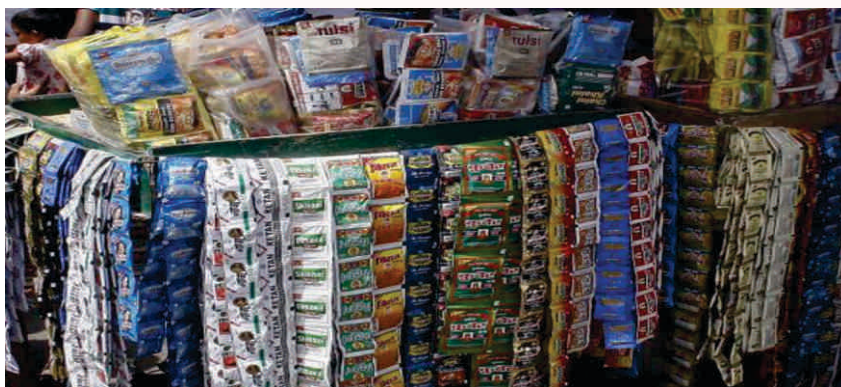


Figure. 2.5.5: Ribbons of *Pan masala* with similar brands of tobacco products

FINDINGS-ARTICLE 13

3. Monitoring Implementation of Article 13

Exposure to SLT advertisement among adults

Implementation of Article 13 varies considerably as mere notification of the provisions does not ensure effective execution of the law. Exposure to Cigarette advertisement has been monitored in high-resource Parties through various studies and in low-resource Parties, to some extent, through Global Youth Tobacco Survey (GYTS) and Global Adult Tobacco Survey (GATS). However, a limited number of Parties (notably India^{8,9} and Bangladesh¹⁰) have also investigated exposure to SLT advertisement and promotion in their GYTS and GATS.

Exposure to SLT advertisement in India⁷

The report from GATS in India (2009–10) revealed that the percentage of adults exposed to SLT advertisements and promotion was higher than that of smoked products. Nearly one-quarter of adults were exposed to advertisement and promotion of cigarettes, while nearly half of the adults were exposed to SLT advertisement and promotion (Figure 2.5.6).

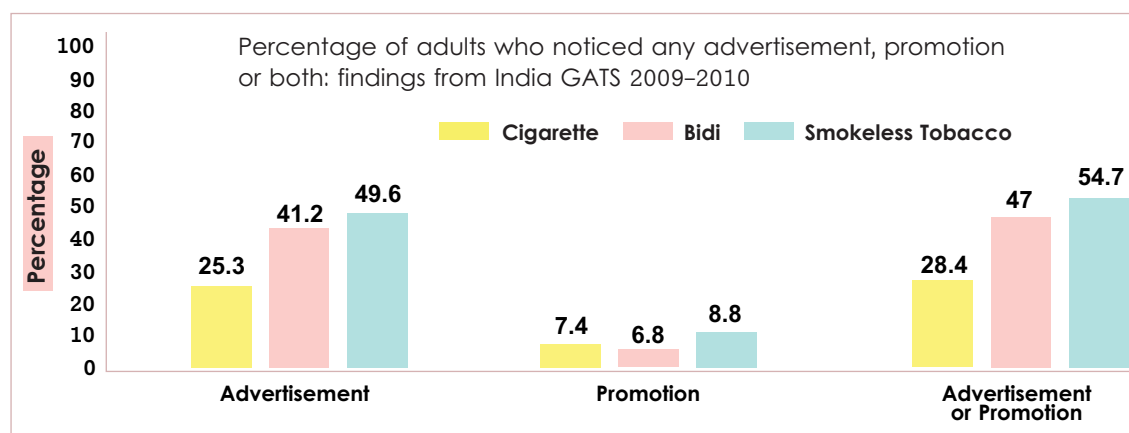


Figure. 2.5.6: Percentage of adults who noticed any advertisement, promotion or both (India GATS 2009–10):

Figure 2.5.7 illustrates exposure of SLT advertisements and promotion among adults through different means of media. Point of sale advertisement of SLT seems to be the highest. Over 10% of adults reported having seen SLT advertisement at 'Point of sale' in India and Bangladesh. The most significant means of SLT promotion was via distribution of items such as bags or T-shirts with SLT brand logo (Figure 2.5.7). These indicators imply that effective implementation of Article 13 has not been conceded to in a high-burden Parties such as India.

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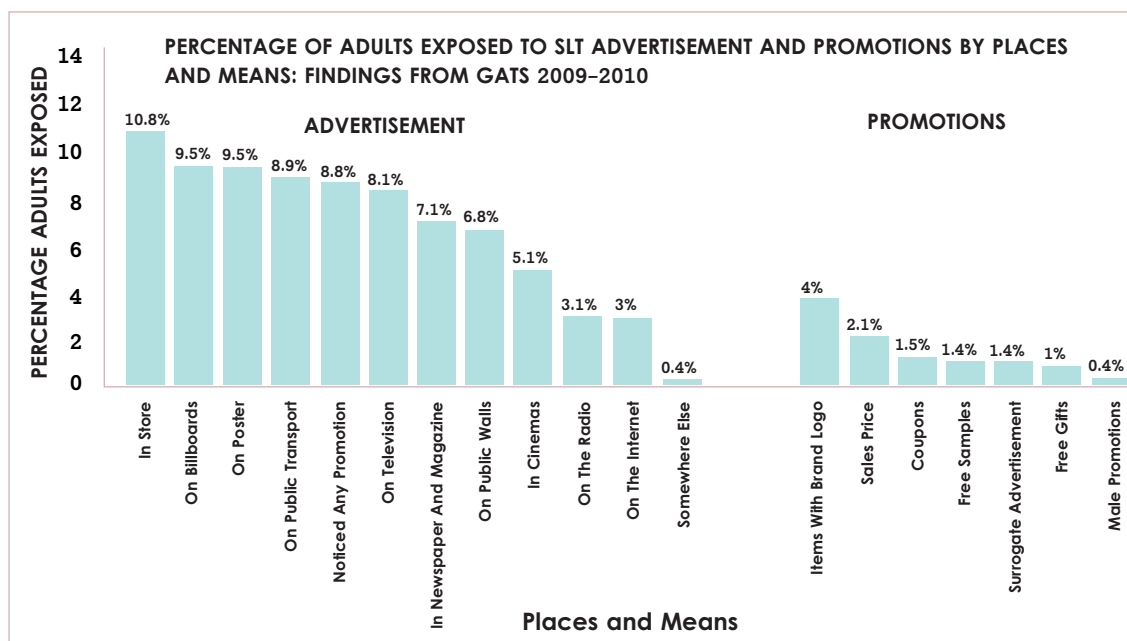


Figure. 2.5.7: Adults (%) exposed to SLT advertisements and promotions: by places and means (India GATS 2009-10)⁸

On comparing results of India GATS 2010 and 2016, it is very clear that there is a significant reduction from 45.3% in 2010 to 16.8% in 2016. In exposure to SLT advertisements in places other than at point of sale Figure 2.5.8.

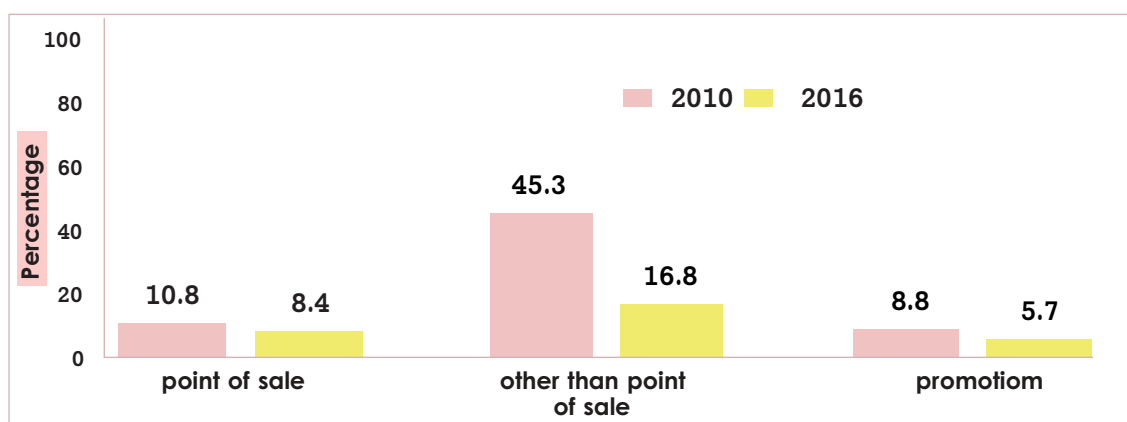


Figure. 2.5.8: Exposure to SLT advertisements and promotion in India by year^{8,9}

Exposure to SLT advertisement among youth and adolescent⁷

GYTS India surveys 2006 and 2009 revealed that

- About 7 out of 10 students saw advertisements for SLT products on 'Billboards'.
- Over 50% of the students reported having seen 'Appearance of SLT on TV and/or Films'.⁷

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CONCLUSIONS

1. Less than 8% of Parties have comprehensive SLT-TAPS ban policy.
2. There is a distinct gap between Cigarettes and SLT products for all TAPS related provisions under Article 13. This shows unequal attention by Parties on TAPS ban policies for SLT.
3. Bans on 'Advertisement at Point of Sale' and in 'International Print media' are the least notified regulations. Similarly, prohibition of promotion through 'Appearance of tobacco products in TV and/or Films' and 'Brand name of non-tobacco product used for tobacco product' are notified minimally.
4. In Parties like India, exposure to SLT advertisement and promotion is higher than for cigarettes and other smoking products.
5. Except Bangladesh and India, Parties have not developed indicators for implementation of SLT policies. Less than half of the Parties have provisions prohibiting SLT promotion.

RECOMMENDATIONS

1. The adoption of a comprehensive ban of TAPS is required by all Parties towards implementation of Article 13 of WHO FCTC for SLT products.
2. Implementation should follow the notified regulations. The specified provision should be implemented within the time frame and addressed without any ambiguity.
3. Parties should regularly monitor the exposure of SLT advertisement and promotion using standard protocols.

FINDINGS-ARTICLE 13

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FINDINGS ARTICLE 14



2.6 DEMAND REDUCTION MEASURES CONCERNING SLT DEPENDENCE AND CESSATION

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2.6: DEMAND REDUCTION MEASURES CONCERNING SLT DEPENDENCE AND CESSATION

“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.”

Article 14 of the WHO FCTC includes guidelines on measures for reducing tobacco dependence and promoting tobacco cessation.¹

Further guidelines for effective implementation of the Article have been developed and adopted at Conference of the Parties (COP) 4 in 2010.

On an average, around 50% of the Parties implemented Article 14 between 2012–16 as reported in the Global Progress Report on Implementation of the WHO FCTC during these years.^{2,3}

Key Observations

Findings from MPOWER 2017

1. Tobacco Cessation Support:

Tobacco cessation support was available in less than 20% of Parties' various health care facilities, such as primary health care centers, hospitals, offices of health professionals, the community and other similar set ups (Figure 2.6.1). Most of these settings reported having most experience of providing cessation support to smokers.⁴

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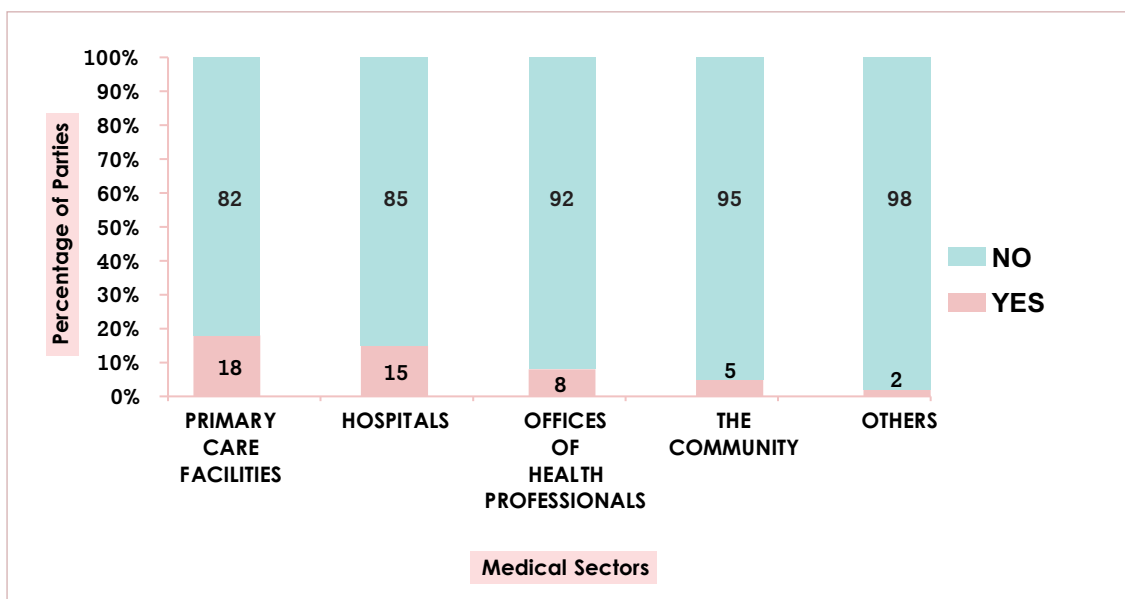


Figure. 2.6.1: Availability of various tobacco cessation facilities in different medical sectors

Less than 30% Parties provided full or partial cost coverage of the tobacco cessation interventions in various medical facilities (Figure 2.6.2).⁴

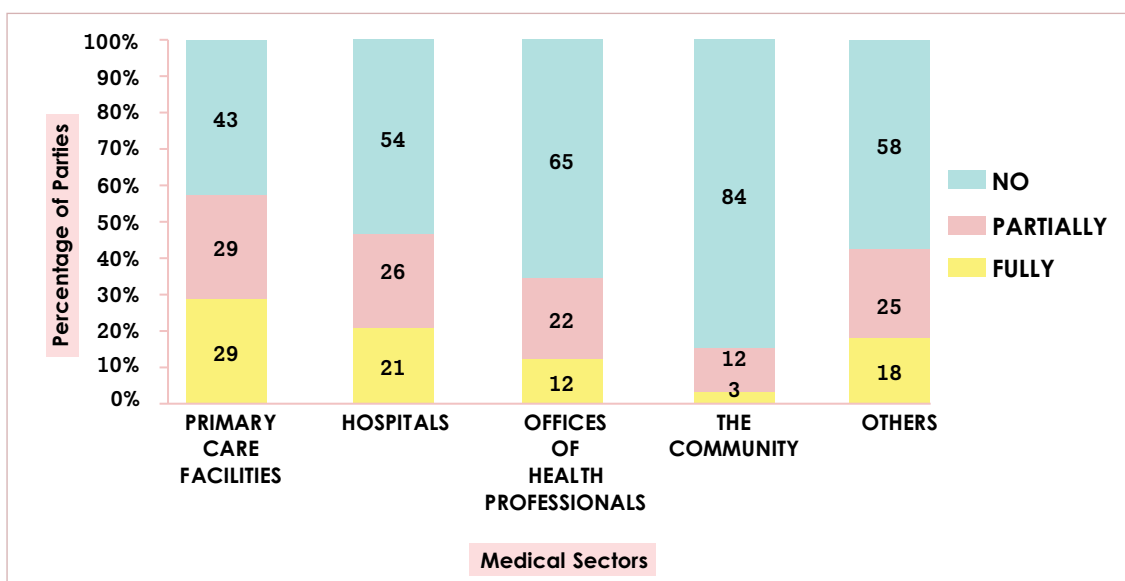


Figure. 2.6.2: Cost coverage of the various tobacco cessation interventions in the Parties

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1. National Toll Free Quitlines (NQL):

Only 31% Parties provided cessation support through national toll-free quitlines (NQL), mostly available in high-resource Parties (Figure 2.6.3).⁴

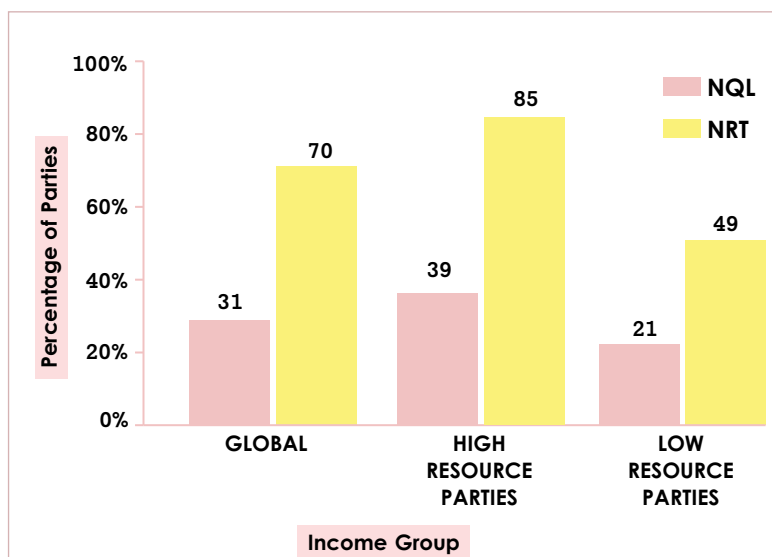


Figure. 2.6.3: Availability of NQL and NRT

Over 52% of the Parties in EUR and 9% Parties in the AFR had NQL (Figure 2.6.4).⁴

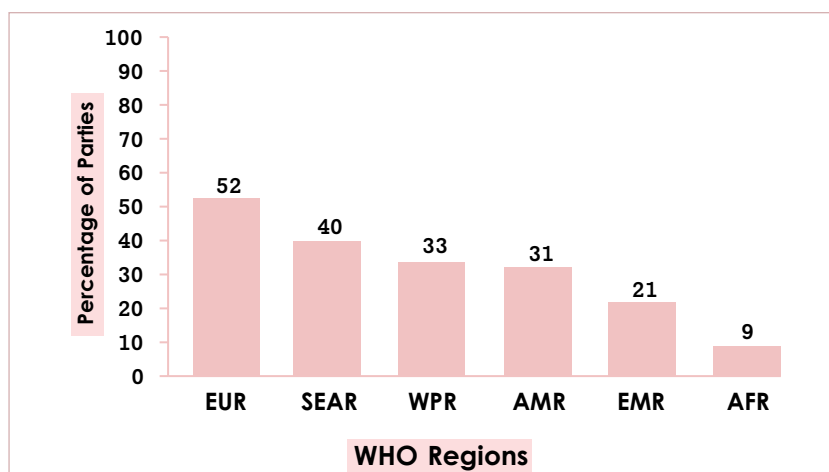


Figure. 2.6.4: Availability of NQL in WHO regions

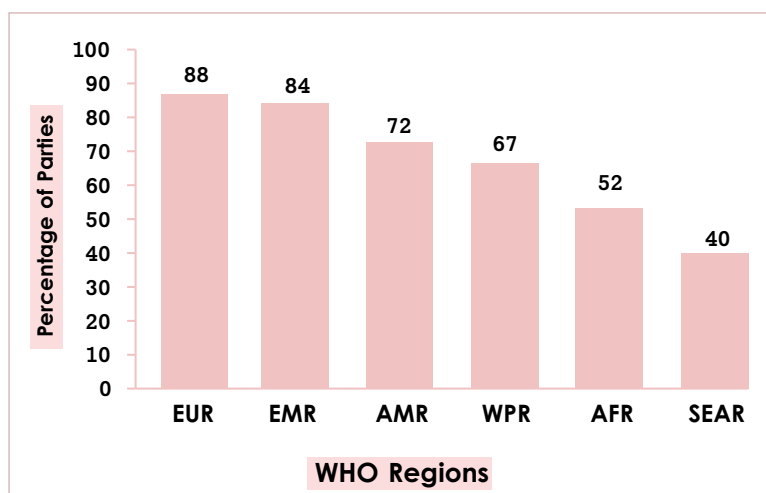
1. Nicotine Replacement Therapy (NRT):

70% of Parties had NRT available at either pharmacy (with or without prescription) or general stores (Figure. 2.6.3).⁴

The proportion of availability of NRT for Parties varied on income group. It was available in 85% of high-resource Parties, as compared to 49% in the low-resource Parties (Figure 2.6.3).⁴

Among WHO regions, EUR (88% Parties) had the highest provision for availability of NRT, followed by the EMR and AMR (84% and 72% Parties respectively). NRT was available in 67% of WPR Parties and 52% of AFR Parties. NRT provision was lowest in the SEAR, at only 40% of Parties (Figure 2.6.5).⁴

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In terms of NRT cost coverage, only 16% Parties provided full and partial coverage each.⁴ Only 24% Parties included NRT products in their list of essential medicines.⁴

Fig. 2.6.5: Availability of NRT in WHO regions

High SLT Burden Parties:

NRT was available in most high SLT burden Parties. However, it was included in the 'Essential medicines list of Malaysia, South Africa, Algeria, Sweden, Marshall islands, Uruguay, Timor-Leste and Iceland (Table 2.6.1).⁴

The cost of NRT was not covered in most parties. In India, Nigeria, Colombia, Philippines, Marshall Islands and Palau, the cost was partially covered. The cost of NRT was fully covered only in Malaysia and Uruguay (Table 2.6.1).⁴

33% Parties in the high burden group had NQL (India, Germany, Sri Lanka, Thailand, Egypt, Sweden, Kenya, Bhutan, Norway, Iceland, Kyrgyzstan, Cambodia) (Table 2.6.1).⁴

Table 2.6.1. Tobacco Cessation in high SLT burden Parties

NAME OF PARTY	NATIONAL TOLL FREE QUITLINE	NICOTINE REPLACEMENT THERAPY		
		AVAILABILITY	COST COVERED	INCLUDED IN ESSENTIAL MEDICINES LIST
India	√	√	√ (partially)	X
Bangladesh	X	X	X	X
Myanmar	X	X	X	X

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Pakistan	X	X	X	X
China	X	X	X	X
Nepal	X	X	X	X
Colombia	X	√	√ (partially)	X
Democratic Republic of the Congo	X	√	X	X
Malaysia	X	√	√ (fully)	√
Madagascar	X	√	X	X
Germany	√	√	X	X
Uzbekistan	X	√	X	X
Sri Lanka	√	√	X	X
Nigeria	X	√	√ (partially)	X
South Africa	X	√	X	√
Afghanistan	X	√	X	X
Yemen	X	√	X	X
Thailand	√	√	X	X
Egypt	√	√	X	X
Algeria	X	√	X	√
Philippines	X	√	√ (partially)	X
Sweden	√	√	X	√
Kenya	√	√	X	X
Marshall Islands	X	√	√ (partially)	√
Palau	X	√	√ (partially)	X
Uruguay	X	√	√ (fully)	√
Bhutan	√	X	X	X
Norway	√	√	X	X
Timor-Leste	X	X	X	√
Iceland	√	√	X	√
Kyrgyzstan	√	X	X	X
Lesotho	X	X	X	X
Botswana	X	√	X	X
Cambodia	√	√	X	X
Burkina Faso	X	X	X	X
Mauritania	X	X	X	X

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mCessation –

24 Parties (13%) provide mCessation facilities for tobacco cessation, mostly belonging to the high-resource group.⁵ MPOWER 2017 reports that the national, bilingual mCessation program (mobile phone-based support for tobacco cessation) began from 2016 in India. Evaluation of more than 12,000 registered users, at the end of the first year, demonstrated an average quit rate of about 7% among both smokers and SLT users, 6 months after enrollment.

Apart from this, literature mainly exists for mobile phone-based smoking cessation. According to the Cochrane review 2016, smokers who received the mobile phone-based support (text messages) were around 1.7 times more likely to quit than those who did not, proving this intervention efficacious and useful for SLT cessation. This review was based on information from 12 studies largely performed in high-resources Parties such as Australia, UK and New Zealand, as well as the USA and Switzerland (both non-ratified).

Findings from the Literature Search on SLT Cessation Intervention Trials –

As per the Cochrane Review 2012, the odds ratio reported in SLT cessation intervention trials among adults and adolescents was 1.70 [1.36, 2.11], and for smoked tobacco it was 1.74 [1.33,2.27]. Based on the cessation intervention types, as found in the Cochrane review 2015, the risk ratio reported for Varenicline, for successful quitting at 6 months, was 1.34 [1.08, 1.68], and for Bupropion, it was 0.89 [0.54,1.44]. Among NRT, the risk ratio of the nicotine patch, nicotine gum and nicotine lozenges was 1.13 [0.93, 1.37], 0.99 [0.68, 1.43], and for nicotine lozenges it was 1.36 [1.17,1.59] respectively. In the same review, statistical heterogeneity was noted among the trials of behavioral interventions: eight of them showed statistically and clinically significant benefits, six suggested benefits but with wide confidence intervals (CIs) but no statistical significance, while three had similar intervention and control cessation rates and relatively narrow CIs. Hence, it was concluded that Varenicline, nicotine lozenges and behavioral interventions may assist SLT users to quit. However, these reviews cannot be considered global as the trials included were mostly performed in USA (non-ratified) and a few in Scandinavian countries (Sweden & Norway); in the SEAR (India), Pakistan and United Kingdom were excluded (a similar review of these countries is forth coming).

FINDINGS-ARTICLE 14

Capacity Building of Health Professionals and other stake holders of Tobacco Control– Findings from the Global Adult Tobacco Survey (GATS):

At a global level, India, Bangladesh and Kenya have used five indicators on SLT cessation:

- SLT users who made a quit attempt in past 12 months
- Current SLT users who planned to or were thinking about quitting
- SLT users advised to quit by a health care provider in past 12 months
- Current SLT users who thought about quitting because of a warning label on SLT packet
- Adults who noticed information about dangers of using SLT or that encourages quitting on television or radio.

As seen in India in GATS 1 (2009–10) and GATS 2 (2016–17), about half the smokers and a quarter of SLT users were advised to quit the habit by health care provider. This highlights the wide variation of counselling by health professionals, with SLT use having relatively lower consideration than smoking. A similar observation was also seen in Parties like Bangladesh, Kenya, Pakistan, Thailand and Uganda, where the percentage of smokers who were advised to quit by a health care provider was higher than that of SLT users (Figure 2.6.6)¹⁰. In India, GATS 2 showed that about 46.2% SLT users thought of quitting because of a warning label on the SLT packet, as compared to 33.2% of users in GATS 1.⁹

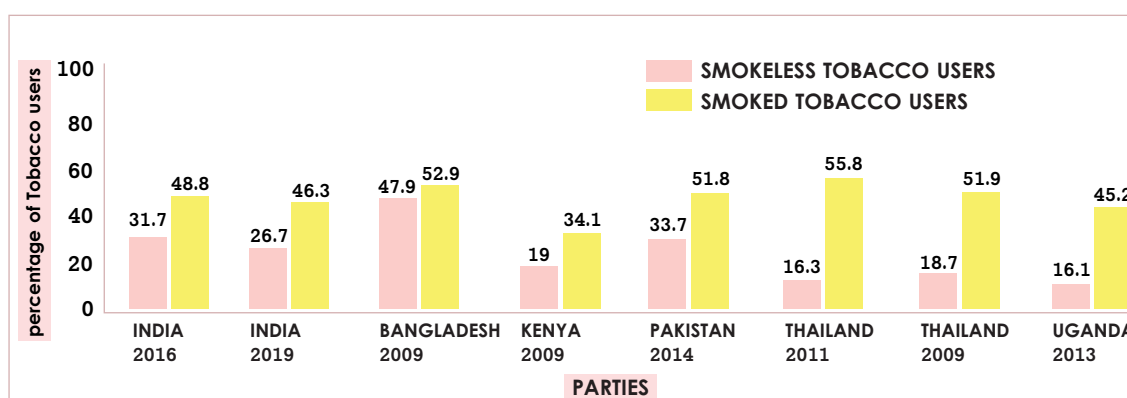


Figure. 2.6.6: Tobacco users advised to quit by health care provider in past 12 months

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Findings from the Global Health Professions Student Survey (GHPSS) and Global School Personnel Survey (GSPS):

Global data for medical, dental, pharmacy and nursing students revealed the lack of knowledge and adequate training in tobacco cessation among the majority of health care providers and school teachers.¹¹

Limitations and Gaps

1. Tobacco cessation support is available in very few Parties, mostly in high resource Parties and those of the EUR.
2. National Toll-Free Quitlines have been notified by one third of the Parties. NRT is legally available in the jurisdiction of three-quarters of the Parties.
3. Very few Parties report full coverage of the costs of tobacco cessation treatment or availability of pharmaceutical products for the purpose.
4. Globally, there is a dearth of literature with regard to SLT cessation intervention trials which have been reported only for 3% Parties (5/179 Parties) i.e. Sweden, Norway, India, United Kingdom (UK) and Pakistan. Data is also available from the United States of America (USA; non-ratified). Most studies have been carried out among the adult population.
5. There is a lack of formal training in tobacco cessation among health professionals, health profession students and school personnel.
6. Most Parties, including High SLT burden Parties, are not providing complete information on SLT cessation. Though GATS provides information for five indicators on the same, It is available only for India, Bangladesh and Kenya.

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RECOMMENDATIONS

1. Tobacco cessation support needs to be strengthened, especially in the low-resource and high SLT burden Parties.
2. Cost coverage of these tobacco cessation support facilities must be provided to make them accessible and affordable to a larger population of tobacco consumers, including SLT users. Also, mHealth services for SLT cessation must be encouraged as an easy and cost-effective option, akin to those for smoking cessation, especially in the low-resource Parties
3. Studies assessing the efficacy of tobacco cessation interventions, especially for SLT products, must be carried out by Parties with emphasis upon those with a high burden of SLT consumption. Effective SLT prevention and cessation programs must be encouraged from the school level onwards, particularly among those belonging to the lower strata of the society who and who are more prone to tobacco habit adoption (smoking and/or SLT or both) from an early age.
4. Faculty and students in dental, medical, nursing and pharmacy colleges and school teachers need to be trained in tobacco cessation by experts. tobacco cessation training could be included in the course curriculum of these specialties.
5. Parties, especially those with a high SLT burden, should include questions on SLT cessation under their tobacco surveillance system and report on the progress made. This will help improve the policy structure to make tobacco cessation more accessible and affordable across the globe.

FINDINGS-ARTICLE 14

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**FINDINGS
ARTICLE 16**



**2.7
ACCESS AND
AVAILABILITY OF
SLT TO MINORS**

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2.7: ACCESS AND AVAILABILITY OF SLT TO MINORS

Article 16 describes that each Party shall adopt and implement effective legislative, executive, administrative or other measures at the appropriate government level to prohibit the sales of tobacco products to persons under the age set by domestic law, national law or eighteen. Article 16 also specifies other measures that Parties are required to take limiting the access of underage persons to tobacco products. These include selling of tobacco products individually or in small packets, distribution of free tobacco products, ensuring that tobacco vending machines are not accessible to minors, and propose, for consideration by the Parties, options to a total ban of tobacco vending machines. Guidelines for Article 16 have not yet been developed.

BACKGROUND

Tobacco experimentation by naïve youth frequently develops into regular consumption, typically turning into a strong addiction. The earlier the child one initiates tobacco use, the more likely he or she is to develop a severe and persistent addiction.^{1,2} Tobacco companies use targeted strategies and marketing techniques to attract the youth. Aggressive advertising and marketing coupled with glamorized and attractive packaging of tobacco products, unduly influences youth to use tobacco and develop a lifelong addiction. Evidence strongly supports that exposure and access to tobacco products increases the risk of taking up the habit by the youth.^{3,4} The prevention of tobacco use among youths is a necessity.

Restricting tobacco sales to minors is an important component of tobacco control strategy to reduce youth tobacco use and access.⁵ Article 16 of WHO FCTC focuses upon limiting the supply and exposure of tobacco to minors. The introduction of this provision has also raised the question of whether its enforcement would prevent the youth uptake of tobacco by the youth.

There has been a number of local⁶ as well as regional^{7,8} reports that have comprehensively observed that successful prevention of tobacco sales to youth can reduce youth tobacco usage.⁹ However, exposure through advertisements and promotions play a confounding role.¹⁰

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KEY OBSERVATIONS

1. Policy progress on Article 16:

Since the adoption of the FCTC, there has been a rapid increase in Parties banning sale of tobacco to minors. By 2005, 31 Parties had formulated policies pertaining to Article 16 and SLT products. This expanded to 84 Parties in 2010, 117 Parties in 2015, and 120 Parties by the end of 2016. Parties with notified policies relating to Article 16 and cigarettes began from a total of 39 in 2005, increasing to 99 in 2010, 138 by 2015, and a further 141 Parties by 2016 (Fig2.7.1).

2. Legal Age of 'Minor':

A total of 141 Parties (79%) have specified the age of 'minor' under the law. The legal age for purchasing tobacco products range from 16 to 21 years. Nearly 130 Parties have specified 18 years as the legal age. The distribution of the rest of the age groups was 16 years for 4 Parties, 20 years for 2 Parties, and 21 years for 5 Parties.

3. Ban on Sale to Minors:

Nearly 67% (n=120) and 80% (n = 141) of Parties have banned sales of SLT and cigarettes to minors respectively (Figure 2.7.2). No marked difference was noticed between high- and low-resource Parties in this distribution (Figure 2.7.2).

Among WHO regions, EUR had the highest proportion of Parties notifying the ban (90%), with 80% including SLT under the ban.

Treaty requirements for the ban on sale to minor:

The Treaty provides process measures that Parties require to ensure compliance with the ban on sale to minors. Provisions under Article 16(1) have not been included in the domestic laws by several Parties that have banned the sale of tobacco products to minors. These provisions include: (a) Placing indicator at the point of sale; (b) Prohibition of tobacco product display in such a manner that it is directly accessible; (c) Ban on tobacco products in form of sweets, toys, candies, etc.; and (d) Prohibition of vending machines.

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Although the provisions under Article 16 (1) are non-mandatory, it is commendable that nearly 10% Parties (n = 18) have comprehensively notified these provisions under ban of sale to minors for SLT, implying complete policy in place. Nearly 12% parties (n = 21) notified the same ban of sale to minors for cigarettes (Figure 2.7.3 and Figure 2.7.4). Most of these Parties belong to high resource income group.

4. Prohibition on distribution of free tobacco products:

Globally, 47% of Parties have specific prohibitions on free tobacco product distribution to minors as a means of promotion, and 40% Parties included SLT products under these regulations. Distribution among high- and low-resource Parties was nearly similar (46% and 49% respectively) (Figure 2.7.5). Among WHO regions, the SEAR (70%) had the maximum proportion of Parties specifying this regulation.

5. Prohibition on sale of loose/individual cigarettes and/or SLT products:

Globally, 42% of Parties have specified prohibition on the sale of cigarettes packs having less than 20 sticks. A total of 18 Parties (11%) have specific prohibitions on the sale of SLT in packs weighing fewer than 30 grams. Distribution among income groups was similar for cigarettes; but for SLT, more Parties in low-resource group (19%) notified the provision as compared to high-resource Parties (5%) (Figure 2.7.6).

6. Ban on sale by Minors:

Globally, a total of 51% of Parties have banned the sale of tobacco products by minors, and 45% of the Parties included SLT under this provision. Distribution among high- and low-resource Parties were 49% and 53% respectively (Figure 2.7.7). Among WHO regions, SEAR had the maximum proportion of Parties specifying the ban (70%).

7. High SLT burden Parties:

Among the 36 high SLT burden Parties only Colombia, South Africa, Philippines and Kenya have complete provisions by banning sales to minors (by including all provisions under Article 16(1)) and other Parties have partial provisions of the ban. Algeria, Timor-Leste, Lesotho and Mauritania have not banned sales to minors.

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Penalty for violation:

Globally, 125 Parties (70%) have specific penalty provisions against the seller for violating the law against sale to minor, and 107 (60%) included SLT under such provision.

Indicator of Implementation

GYTS¹¹ uses one indicator: 'Subjects (%) who bought cigarettes from stores but were NOT refused because of their age'. Such an indicator may be developed for SLT as well. Similar information for minors can also be extracted from GATS. To control access and availability, many Parties have banned sales of tobacco products around schools and colleges.

Case study: India

Sales of tobacco products has been banned within 100 yards of school/ institutional buildings. However, studies report negligible compliance towards the ban.¹²⁻¹⁴ GYTS indicator 'subjects (%) who bought cigarettes from stores but were NOT refused because of their age' reports a 56% positive response.¹¹

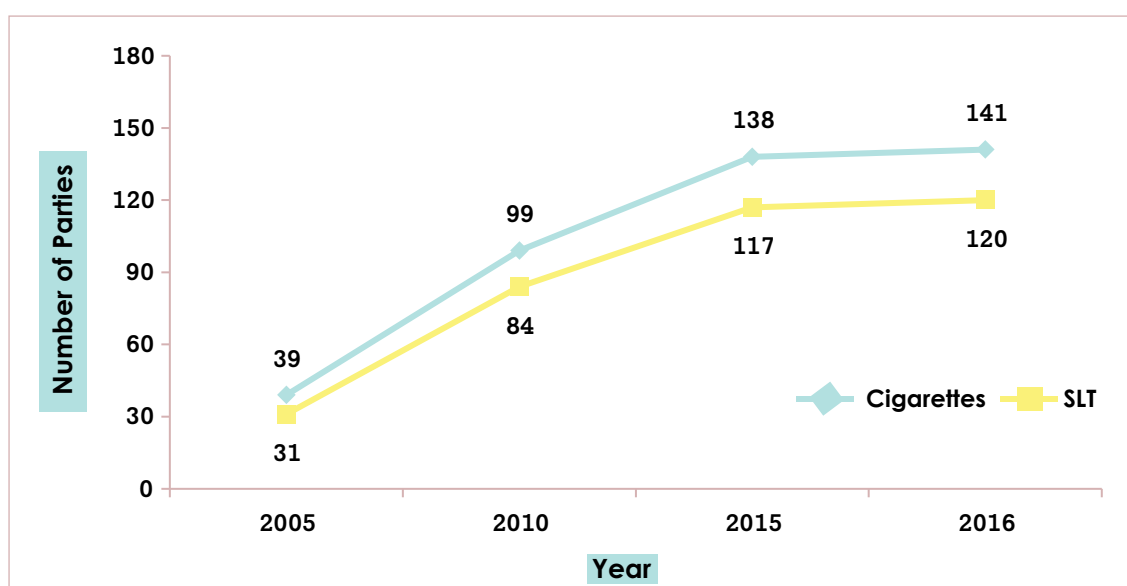


Figure 2.7.1: Progress in policy formulation pertaining to Article 16

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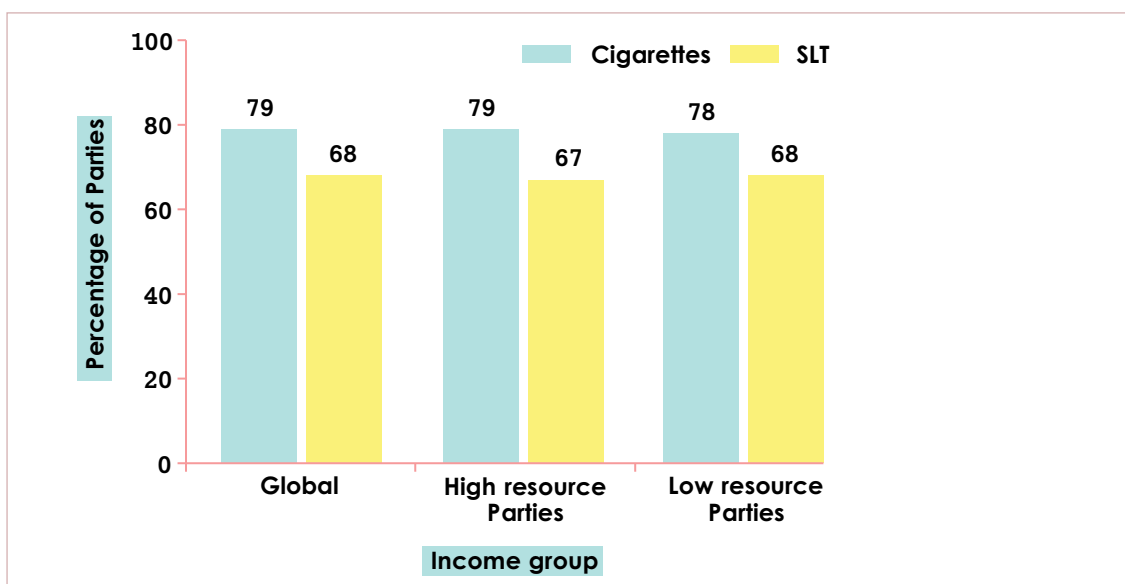


Figure 2.7.2: Parties (%) notifying ban of sale to minor

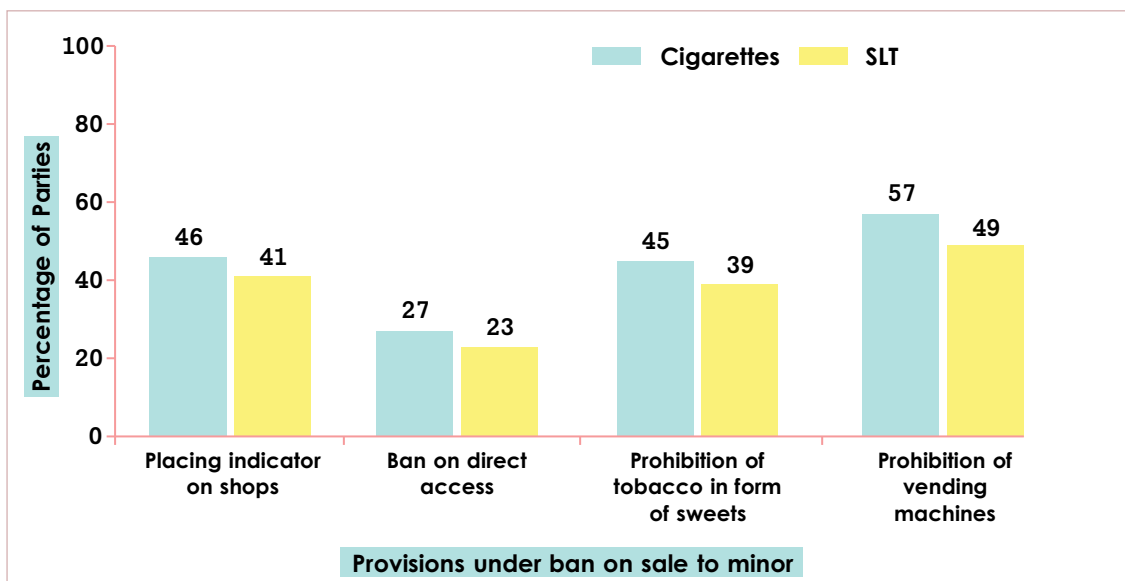


Figure 2.7.3: Parties (%) notifying various provisions under ban on sale to minor

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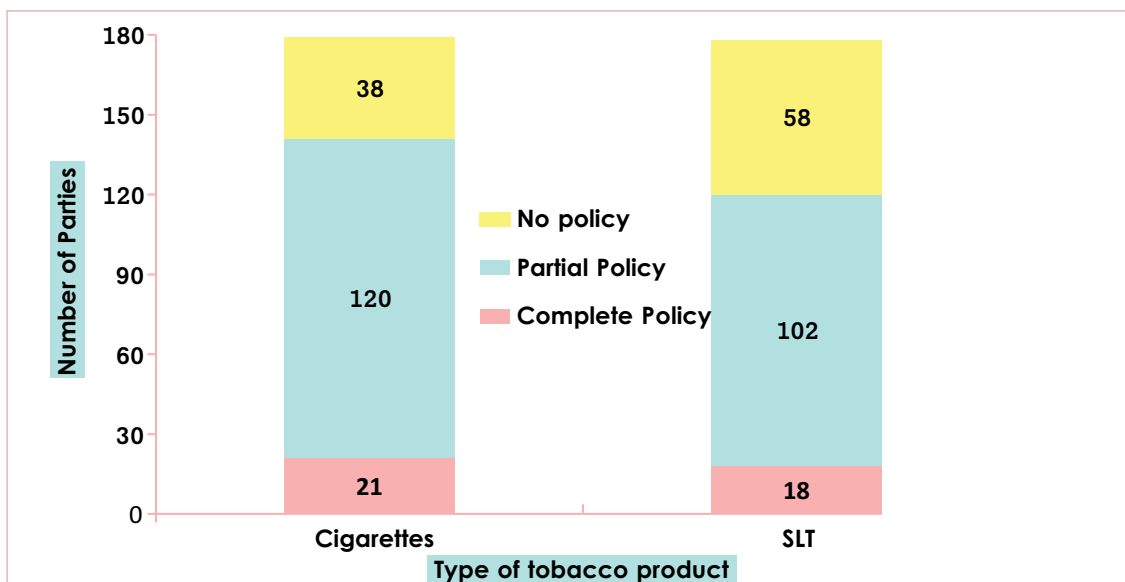


Figure 2.7.4: Number of Parties having policy on ban of sale to minor

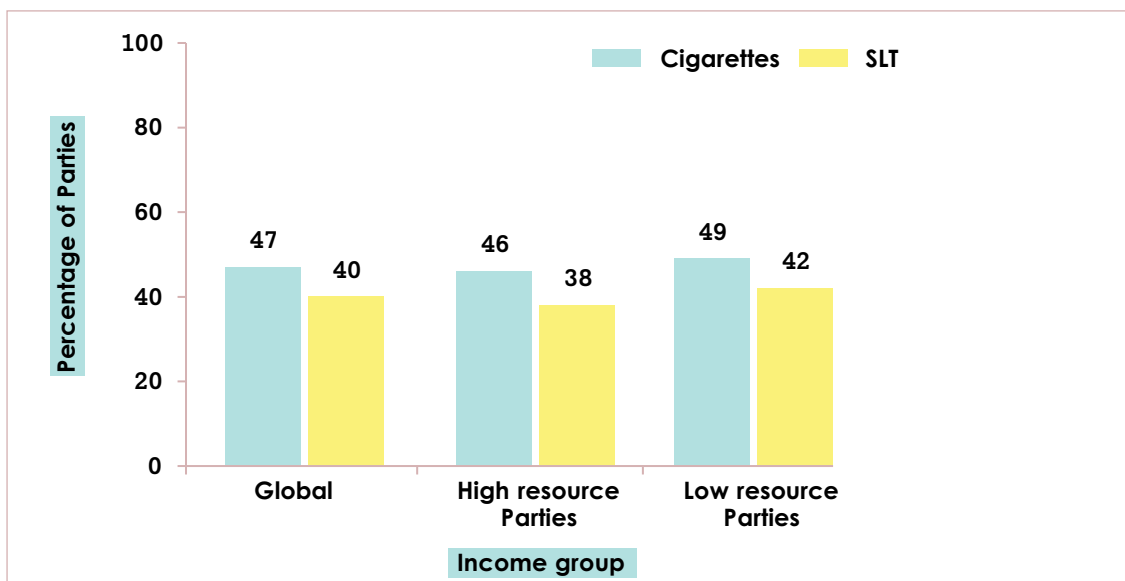


Figure 2.7.5: Parties (%) notifying ban on distributing free tobacco products to minor

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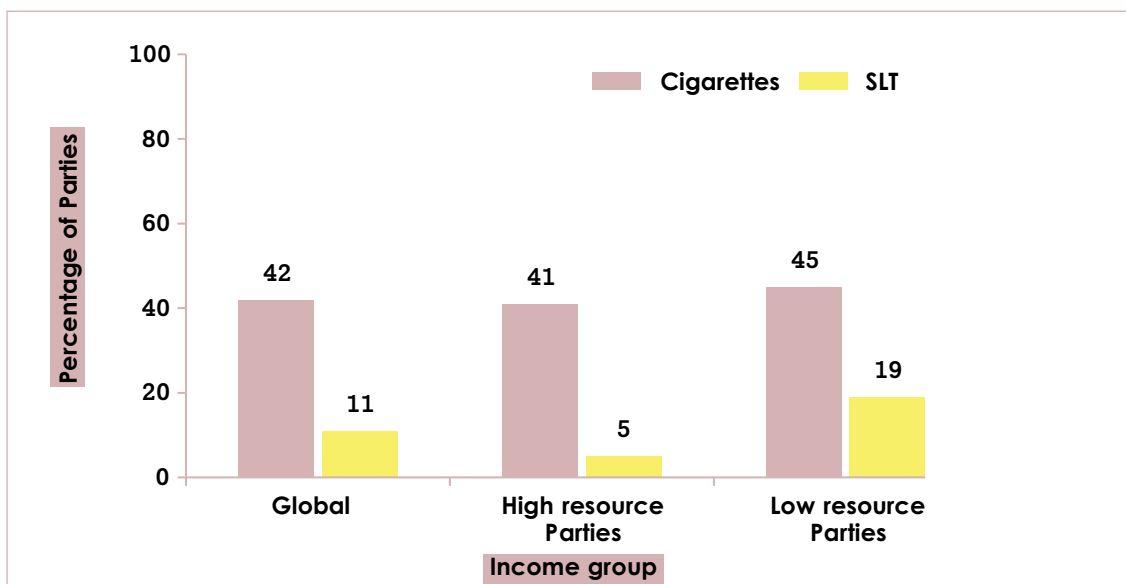


Figure. 2.7.6: Parties (%) notifying ban on sale of loose cigarette/SLT by income group

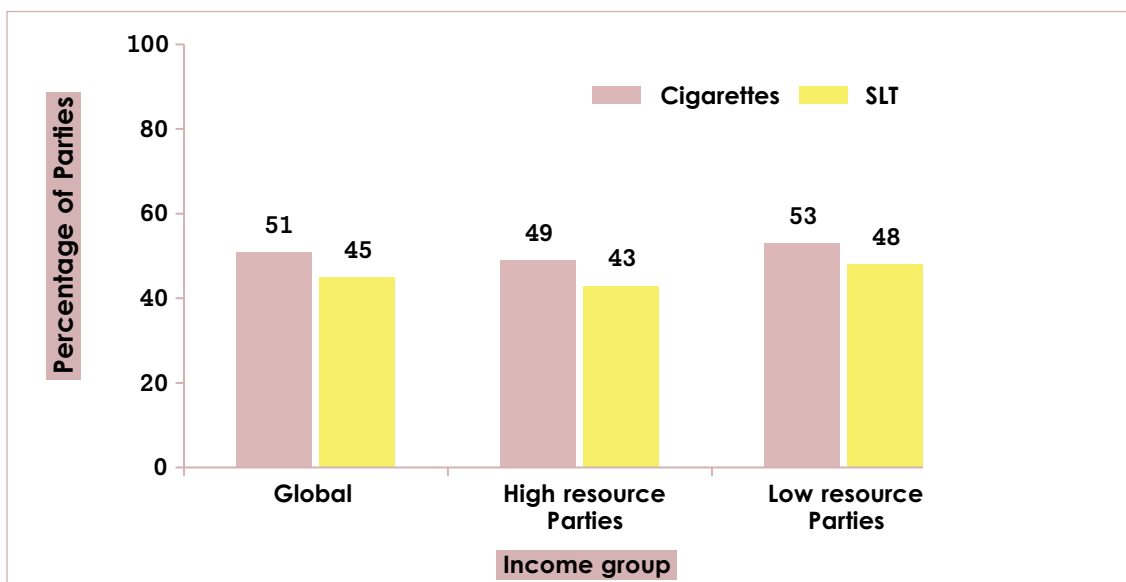


Figure 2.7.7: Parties (%) notifying ban of sale by minor by income group

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GAPS

1. Majority of the parties have formulated policies on Article 16 for cigarettes, and to a significant extent for SLT as well, however, most of them Parties have partially implemented these policies.
2. Ban on directly accessible tobacco products at 'point of sale' and 'ban on sale of loose cigarette/SLT' were the least notified provisions.
3. Several Parties do not include indicators on SLT sale and purchase by minors in GYTS.

RECOMMENDATIONS

1. A comprehensive policy formulation on banning sales of tobacco to minors and its proper enforcement is required to prevent access and availability of tobacco, including SLT.
2. Parties should share information on minors' access and exposure to SLT products for better analysis of the SLT problem among youth and to initiate an effective future policy response.
3. Parties should consider implementing a comprehensive ban on sales of tobacco products to and by minors in line with Article 16. In particular, they should prohibit all display of tobacco products and sales of tobacco products in individual units and small packs.
4. Parties may consider licensing their all sales of tobacco products to restrict minors' access and exposure to tobacco products.
5. GYTS should consider including SLT indicators in collecting the data.

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**2.8
RESEARCH
SURVEILLANCE AND
EXCHANGE OF
INFORMATION
ON SLT**

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2.8: RESEARCH, SURVEILLANCE AND EXCHANGE OF INFORMATION ON SLT

1. The Parties undertake to develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control.....
2. The Parties shall establish, as appropriate, programmes for national, regional and global surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke. Towards this end, the Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analysed at the regional and international levels, as appropriate.
3. Parties recognize the importance of financial and technical assistance from international and regional inter-governmental organizations and other bodies.....
4. The Parties shall, subject to national law, promote and facilitate the exchange of publicly available scientific, technical, socio-economic, commercial and legal information, as well as information regarding practices of the tobacco industry and the cultivation of tobacco, which is relevant to this Convention and in doing so shall take into account and address the special needs of developing country and Parties with economies in transition.....
5. Parties should cooperate in regional and international inter-governmental organizations and financial and development institutions of which they are members, to promote and encourage provision of technical and financial resources to the Secretariat to assist developing country Parties and Parties with economies in transition, to meet their commitments on research, surveillance and exchange of information.

Article 20 deals with research, surveillance and exchange of information on tobacco products and their use. In the context of Smokeless Tobacco (SLT) control, the article mandates to carry out appropriate scientific national research and the establishment of surveillance mechanisms. It also mandates the undertaking of programs that address the magnitude, patterns, determinants, related social, economic and health indicators and consequences of SLT consumption.

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This article also includes information regarding how to facilitate the cooperative exchange of SLT control-related information and provision of support, with special focus on developing Parties.

Key Observations

Strong research, surveillance systems and surveillance programs are critical to the success of addressing the global SLT epidemic.

There has been considerable progress in the implementation of Article 20 provisions as far as SLT is concerned. The first significant development took place when COP6, held in 2014, considered SLT as a global epidemic.¹ Subsequent to the decision of COP6, the Convention Secretariat strengthened the reporting system to focus on and detect changes in the evolution of the use of SLT and other tobacco products.

The second most important development was establishing the WHO FCTC Global Knowledge Hub on Smokeless Tobacco in India, one of the high SLT burden Parties.

I. According to the FCTC global implementation report 2014 & 2016;^{2,3}

1. About 91% (n=121) of the reporting Parties (n=132) provided data on the prevalence of tobacco smoking among adults, and 47% (n=62) did so for the use of SLT among adults.
2. Around 40% (n=53) of the reporting Parties were identified as having at least two comparable datasets across all reporting cycles for adult tobacco smoking. However, only 12% (n=16) of Parties were identified as having comparable datasets across all reporting cycles for adult SLT use.
3. Around 88% (n=117) of the reporting Parties provided data on the prevalence of tobacco smoking among adolescent and 59% (n=78) provided it for the use of SLT among adolescent.
4. Among adults, a larger proportion (56%) was found to experience a decrease in male smoking than in female smoking (51%). The same pattern was identified for boys (67%) and girls (60%) among adolescents. For SLT, no conclusions can be drawn due to the limited availability of the recent comparable data among Parties.

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5. There are large data gaps regarding SLT use because many Parties are not conducting surveys for this type of tobacco, even though anecdotal evidence points to it being used worldwide. Consequently, there is insufficient data to measure changes over time at the global level. According to the most recent data on current SLT use reported in surveys completed by Parties since 2006, the average global prevalence among Parties globally in the period 2007–2014 was 7% (9% among males and 5.1% among females). As fewer Parties (n=89) have collected data on SLT use since 2006, these averages are only indicative (Around 5% of boys and 3% of girls among the reporting Parties consume SLT).
6. Nearly 64% of the reporting Parties have SLT available in their markets. For Parties with SLT available on the national market, 64% also have policies or regulations, in place, for SLT.
7. Most Parties of the European Union, as well as Australia, Bahrain, Iran (Islamic Republic of) and New Zealand have reported banning the import and sale of SLT products.

II. Other findings of Research and surveillance

a. SLT use among Adults

- i. Prevalence of SLT use among adults at a national level is available for 72% (N=129) of the Parties. In addition, there are sub-national estimates for SLT use among adults in 2.2 % of the Parties i.e, Chad, Guinea, Sudan and Federated States of Micronesia.
- ii. One in 10 adults uses SLT in one form or other. Prevalence of SLT use is higher among males (10.8%) as compared to females (5.7%).
- iii. Prevalence of SLT use among Parties in SEAR is higher than smoking. (Figure. 2.8.1).

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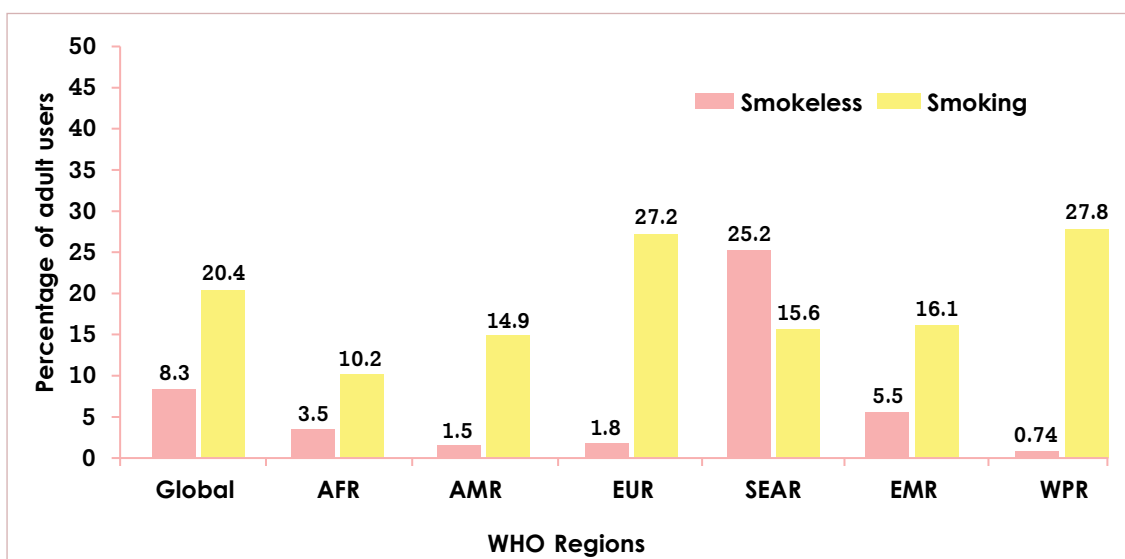


Figure. 2.8.1: Prevalence of SLT use and smoking among adults by WHO region and income of Parties

- iv. Prevalence of SLT use is high in rural areas and among the poorest families in low-resource Parties (LMIC+LIC) (Fig. 2.8.2)

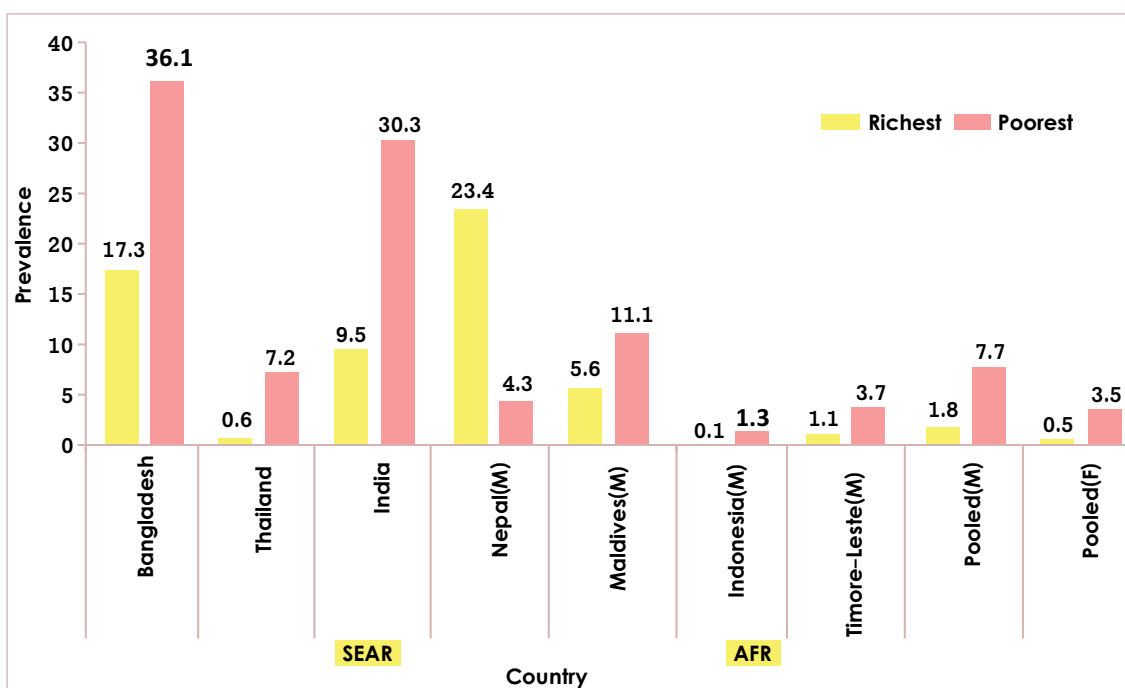


Figure. 2.8.2: Prevalence of SLT use among adults by family income in countries of South-East Asia and Africa region

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- v. Among the 129 parties, there are around 357 million SLT users.
- vi. Of these 357 million SLT users 95% live in India, Bangladesh, Myanmar, Pakistan, Dem. Rep. of Congo, China, Nepal, Colombia, Malaysia, Madagascar, Germany, Uzbekistan, Sri Lanka, Nigeria, South Africa, Afghanistan, Yemen, Thailand, Egypt, Algeria, Philippines, Sweden, Kenya, Marshall Islands, Palau, Uruguay, Bhutan, Norway, Timor-Leste, Iceland, Kyrgyzstan, Lesotho, Botswana, Cambodia, Burkina Faso, Mauritania. These Parties have been identified as high SLT burden Parties (where the number of SLT users exceeds one million or prevalence $\geq 10\%$ [either male or female]).
- vii. Nearly 93% of adult SLT burden is borne by low-resource Parties. (Figure. 2.8.3)

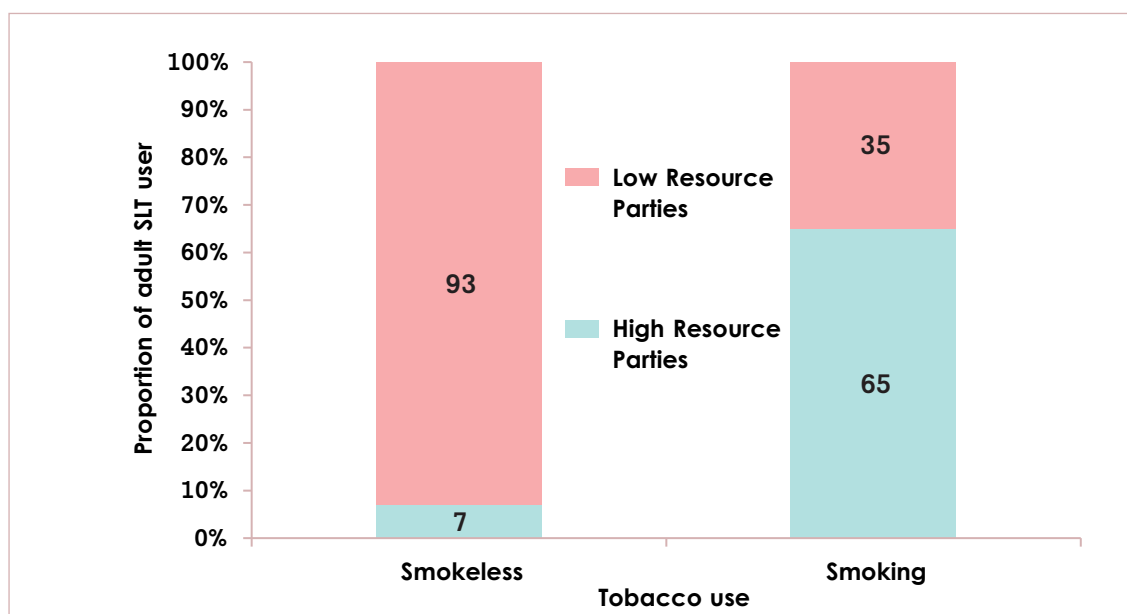


Figure. 2.8.3: Proportion of adult SLT users and smokers by income group of Parties

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viii. Over 80% of SLT burden is in Parties belonging to SEAR (Figure. 2.8.4)

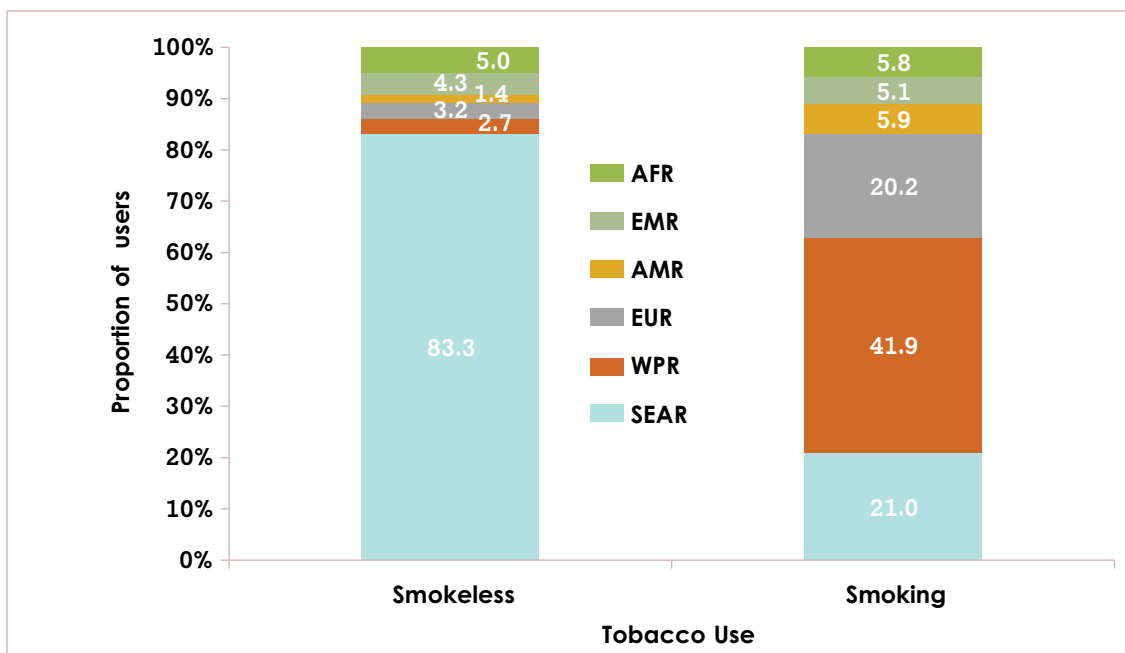


Figure. 2.8.4: Proportion of adult SLT users and smokers by WHO region

ix. Of 129 Parties, (n=82) 45.8% have recent data (2012–2016) on adult SLT prevalence; most of them belong to high-resource Parties (Figure. 2.8.5).

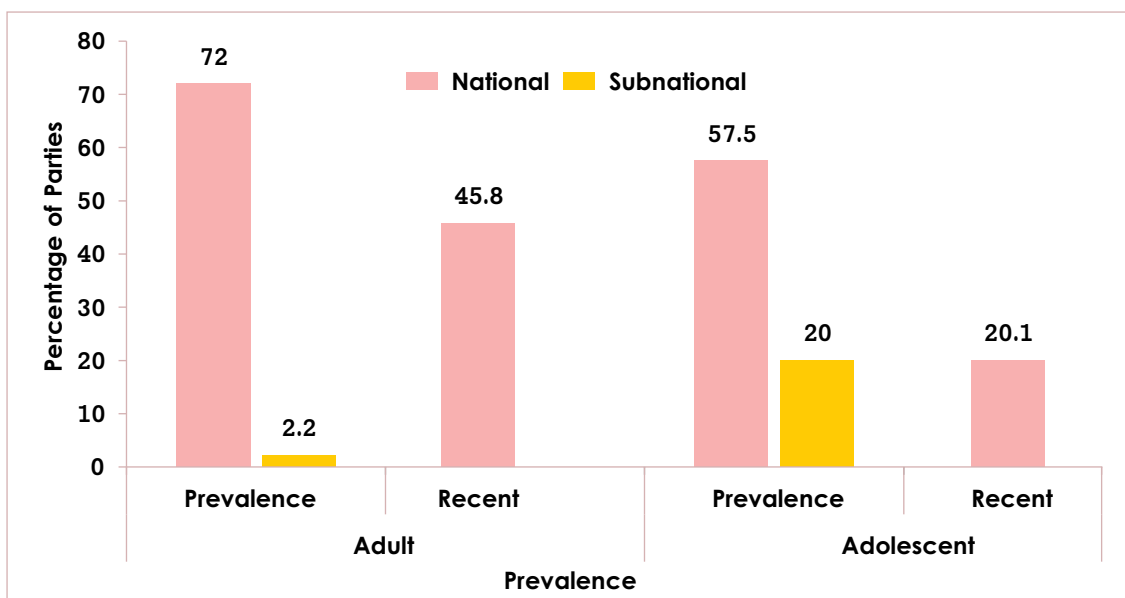


Fig. 2.8.5: Percentage of Parties having SLT prevalence data and recent data

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- x. Two-time point data on SLT prevalence among adults is available for 10 % of the Parties. Majority of them are from high- resource Parties (Benin, Czech Republic, Denmark, Estonia, Finland, Iceland, Mexico, Norway, Seychelles and Sweden, as well as Bangladesh, India, Malaysia, Myanmar, Nepal, Sri Lanka, Thailand and Yemen).
- xi. Increasing trend of SLT use has been observed in Malaysia, Myanmar, Iceland and Sweden.
- xii. Although some studies indicate rise in SLT use prevalence among adults, in India^{4,5} recent reports shows a decrease in prevalence of SLT from 25.9% in 2010 to 21.4% in 2016.⁶
- xiii. SLT use has reportedly increased among adults, aged 25–64 years, in Myanmar between 2008 and 2016.⁷
- xiv. There are conflicting reports on trends of SLT use in Bangladesh.
- xv. It is difficult to perform trend analysis, especially in low-resource Parties, due to application of different methodology, ignorance about using standard protocol, loss of periodicity and non-availability of data for public use.

b. SLT use among Adolescents

- i. Out of 179 (n=103), 57.5% of the Parties reported SLT use among adolescents at national level. Afghanistan, Angola, Brazil, Burkina Faso, Cameroon, Central African Republic, Democratic Republic of the Congo, Gambia, Liberia, Nigeria and Zambia provide sub-national data (6% of the Parties).
- ii. Of 103 Parties, only 20% of the Parties have recent data (2012–2016) on adult SLT prevalence, mostly from HICs and UMICs (Figure 2.8.5).
- iii. Prevalence of current smoking was higher than current SLT use in all regions except SEAR where prevalence of SLT use was higher than smoking. In EMR and AFR prevalence of smoking and SLT use was comparable to Figure 2.8.6.

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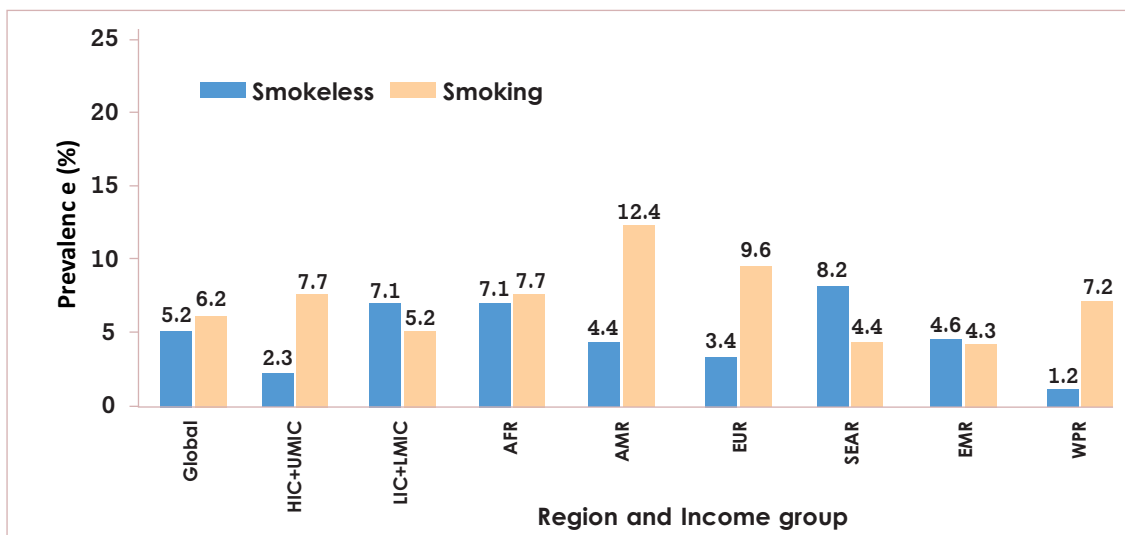


Figure 2.8.6: Prevalence (%) of smoking and SLT use among adolescents by region and income group Parties

- iv. Prevalence of SLT use varied from 1.2% in WPR to 8.2% in SEAR among adolescents aged 13–15 years (Figure 2.8.6).
- v. Out of 12.2 million adolescent SLT users 82.5% live in low-resource Parties (Figure 2.8.7). Nearly 60% of adolescent users live in SEAR, 13% in AFR and 12% in EMR (Figure 2.8.8).

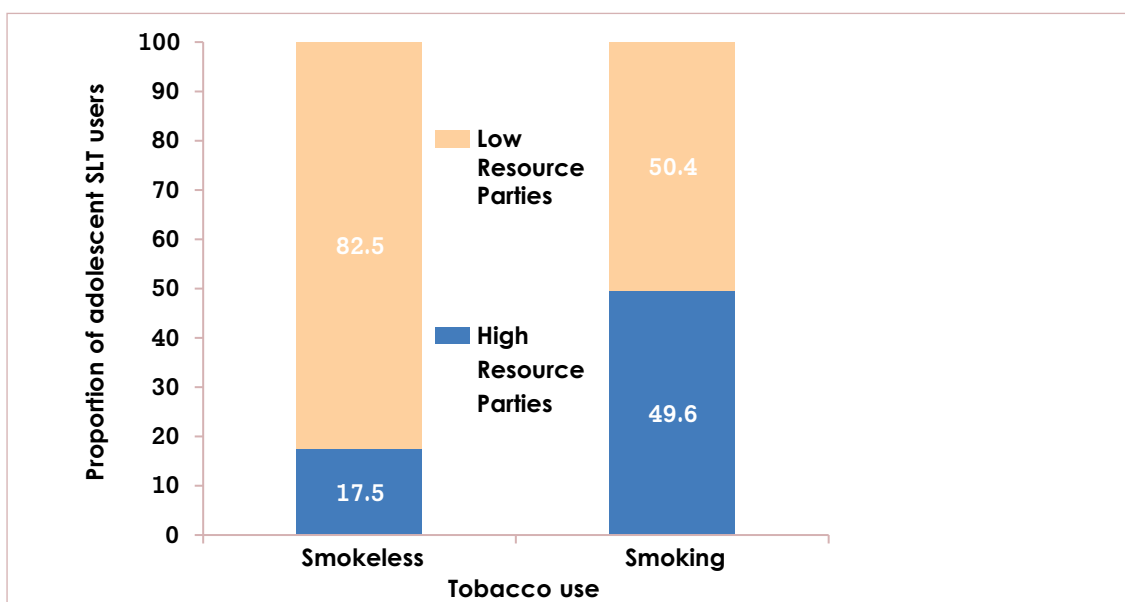


Figure. 2.8.7: Proportion of smokers and SLT users among adolescents by income group

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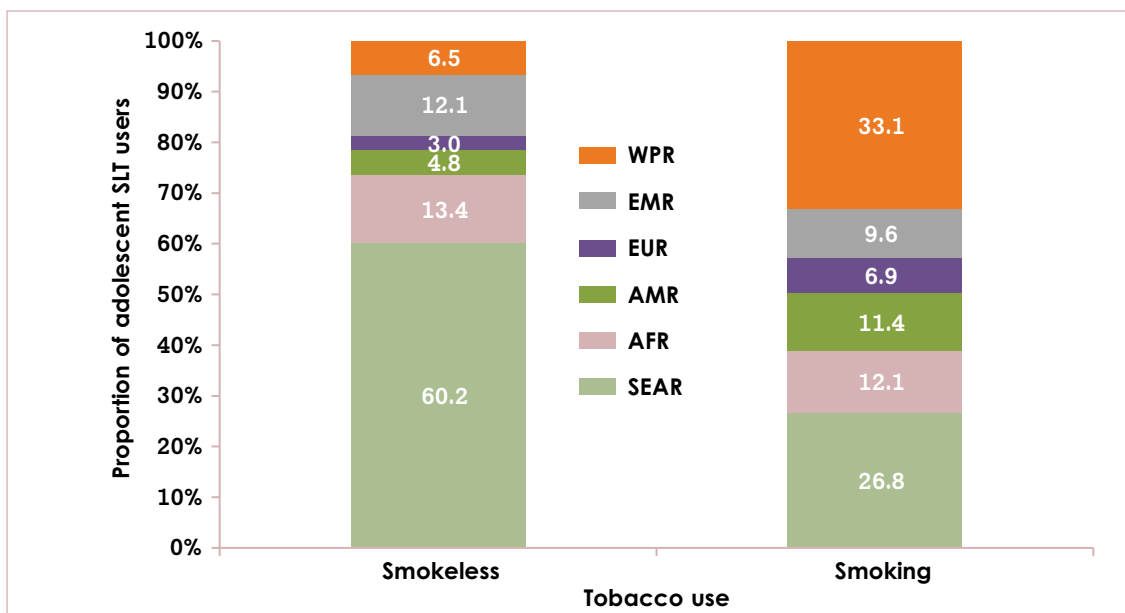


Figure. 2.8.8: Proportion of smokers and SLT users among adolescents by WHO region

III. Health and economic consequences:

There has been a progressive increase in the number of reporting Parties indicating that they have carried out research on the consequences of tobacco consumption. National epidemiological surveillance systems of the Parties report covering social, economic, and health indicators related to tobacco consumption are mostly limited to smoking products. Few Parties (n=10) have such data for SLT.⁸⁻³⁵

IV. Economic Consequences

- i. Twenty-three parties have comparable price and tax incidence rates for cigarettes and SLT. (Figure. 2.8.9).³⁵

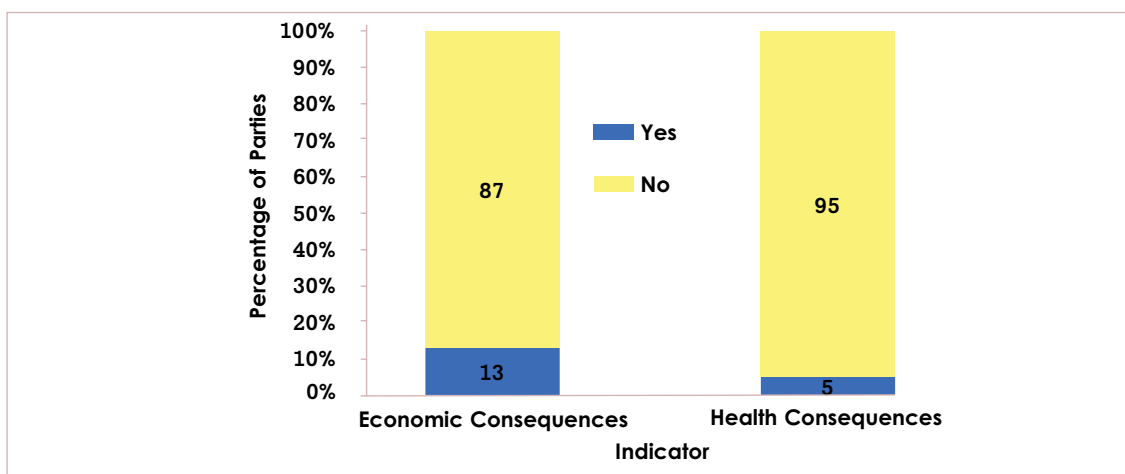


Figure. 2.8.9: Percentage of parties having data on economic and health consequences of SLT

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- ii. In 2004–2006 health cost studies in India^{36,37} and Bangladesh³⁸ individually analyzed smokeless tobacco products. There is no second report yet. India has done two rounds of health cost studies including SLT.

V. Social Consequences

Challenges in the Implementation of Article 20:

- Few Parties (Australia, Finland, Mexico, Sweden, and the United Kingdom) have established training programs and strategies that aim to strengthen tobacco control capacity.
- Less than half of reporting Parties have conducted research on tobacco use among women. However, a few Parties identified effective tobacco dependence treatment programs focused on SLT.
- There is an absence of a comprehensive legal database on SLT regulations. Several Parties have not included SLT in their definition of tobacco products, or have ambiguous definitions of SLT and thereby exempt SLT products from regulations.
- Very few Parties have conducted research to identify alternative crops for tobacco growers.
- Parties do not use questions on SLT, especially standard questions, and do not conduct periodic surveys.

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Recommendations:

1. Parties (especially in SEAR and in low and low-resource Parties) should establish sustainable resources for periodically monitoring the magnitude, patterns, determinants and related social, economic and health consequences of using tobacco products.
2. Parties should contact and communicate with international partners to strengthen the resource and capacity building to monitor and conduct research on specific tobacco control issues in their respective jurisdiction.
3. Parties should use standard protocols and methods for comparing data within country and with other Parties.
4. Parties should be prepared to exchange information with international partners by sharing the details of their research outcomes and monitoring results in public.
5. Parties should include SLT in research conducted on health, economic and social consequences of tobacco products.
6. Parties should progressively establish and maintain an updated database of laws and regulations on SLT control and share them through the Convention Secretariat/reporting instrument and cooperate in the development of programs for regional and global smokeless tobacco control.

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FINDINGS PROHIBITION



2.9 PROHIBITION ON IMPORTATION MANUFACTURING AND SALE OF SLT

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2.9: Prohibition on Import, Manufacturing and Sale of SLT

Background

Over the past decade the WHO FCTC¹ has served as a powerful tool to initiate, support, and advance national, regional and global tobacco control efforts. In order to sustain the gains made and to ensure continued progress, future efforts will need to address ongoing challenges to the implementation of the convention. This must emphasise actions to counter industry interference with policy making.

This document examines the status of prohibition of import, sale and manufacturing of SLT products, the associated impacts and challenges for the Parties to the convention. One of the technical report series of WHO dedicated to SLT control recommends that the Parties that do not have SLT use problem at present should ban it as a pre-emptive measure.²

Key Observations

A review of SLT control policies from across the world reveals that the sale of SLT products is prohibited in 45 Parties: Australia, Bhutan, Bahrain, DPR Korea, Fiji, India, Kazakhstan, Macedonia, Moldova, New Zealand, Oman, Qatar, Saudi Arabia, Singapore, Sri Lanka, Thailand, Uganda, Vanuatu and 27 European countries (except Sweden). However, most of these bans are partial. For instance, in Europe only oral tobacco products are prohibited while chewable tobacco is allowed. In India, a commonly used SLT product *gutkha* is banned while other SLT products like *Zarda* are allowed.

Few Parties (n=11) (Australia, Bhutan, Bahrain, India, Kuwait, Maldives, Qatar, Singapore, Sri Lanka, Saudi Arabia and United Arab Emirates) have prohibited the manufacturing of SLT products. Six Parties (Australia, Bhutan, Oman, Singapore, Sri Lanka and Thailand) have imposed a ban on the importation of SLT products. Among the earliest Parties to ban the import of SLT products was Thailand, in 1992. This was followed by Singapore a year later in 1993. In 2016, Sri Lanka became the most recent party to ban the import of SLT products. Australia, Bhutan, Singapore and Sri Lanka have banned all three.³⁻⁵

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The figure 2.9.1 gives an overview of the global scenario in terms of prohibitions on the sale, manufacturing & importation of SLT products:

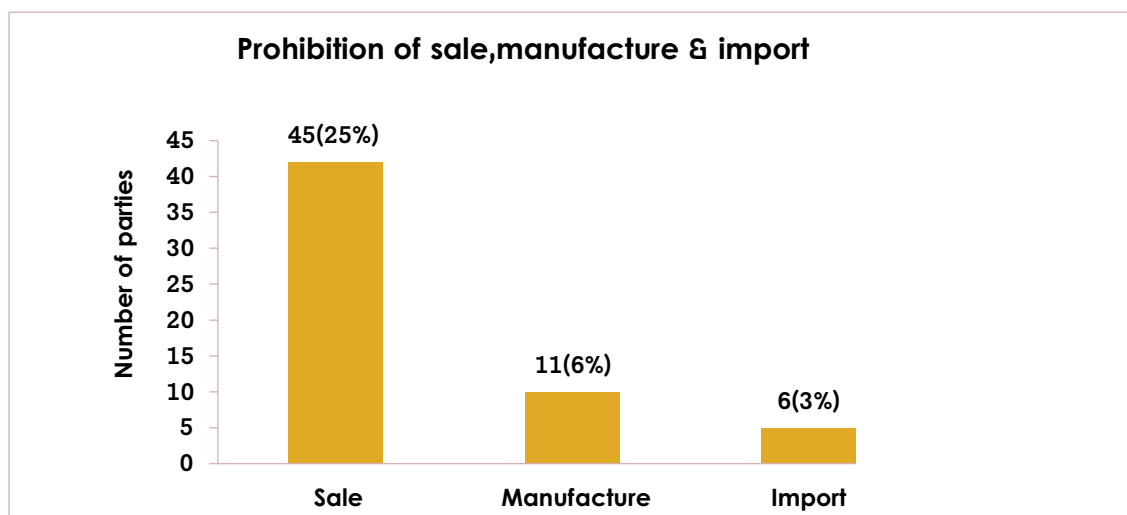


Figure 2.9.1: Prohibition of sale, manufacturing & importation of SLT products

In the graph shown above, figures in parentheses give the percentage of prohibiting sale, manufacturing or import of SLT products. WHO region-wise status of these prohibitions is described below:

WHO African Region

Uganda has banned the sale of all forms of SLT products. A number of Parties in the region are now adopting comprehensive tobacco control policies and legislation that cover all tobacco products, including SLT. Since SLT is primarily produced by cottage industry in this region, distribution and marketing of these products often takes place on a local rather than national or international scale.^{2,4,5}

WHO American Region

In Brazil, sale of SLT products is allowed, if they are registered with the national health regulatory agency, ANVISA. However, no one has registered or selling SLT products in Brazil, any sale of SLT therefore, is practically illegal.

In the United States (not a Party to the Convention), laws have been enacted which include provisions for product registration, warning labels on all products, enforcement of a minimum age of sale, and limits on the amount of nicotine, toxicants, and additives. In other Parties of the region SLT products have a negligible market share.^{2,4,5}

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WHO Eastern Mediterranean Region

Oman has adopted policies to ban the import and sale of SLT products.⁵ In 2009 the government of Bahrain introduced strong anti-smoking regulations and a law that prohibits the sale and manufacturing of SLT products.⁶ Similarly, Saudi Arabia and Qatar have also banned both the sale and manufacturing of SLT products.^{4,5}

United Arab Emirates and Kuwait have banned the manufacturing of SLT products in their respective territories.⁵ In 2008, one of the municipalities of UAE, the Ajman Municipality went ahead and banned the sale, import, storage, and possession of SLT and imposed heavy fines on violators.⁷

WHO European Region

With the exception of Sweden, the sale of oral tobacco is prohibited in the European Union (EU) under Article 17 of the 2014 EU Tobacco Products Directive (TPD). The TPD defines 'tobacco for oral use' as tobacco products for oral use, except those intended to be inhaled or chewed, made wholly or partly of tobacco, in powder or in particulate. This includes moist snuff and snus, but does not include chewing tobacco or nasal snuff.⁸

Some of the EU Parties have taken additional measures. Albania, Czech Republic, Finland, Hungary, Latvia, Lithuania and Slovakia have prohibited the sale of most forms of SLT. A few non-EU countries like FYR Macedonia, Republic of Moldova and Kazakhstan have also banned the sale of SLT products.⁹

WHO South-East Asia Region

Many Parties in the Region have initiated steps to regulate SLT. Bhutan introduced a policy to ban the manufacture and sale of tobacco products, including SLT, in 2004 and revised it in 2010. Comprehensive legislation was introduced to implement the 2004 policy.¹⁰ India invoked food safety laws in 2011 to ban *gutkha* and *pan masala* containing tobacco. In December 2016, India's health ministry asked states to enforce a ban on manufacture and sale of *pan masala* containing nicotine or tobacco, irrespective of whether it is available as one product or sold by mixing with other ingredients. In this context, states such as Bihar, Karnataka, Kerala, Madhya Pradesh, Maharashtra and Mizoram have already issued orders to ban the manufacturing or production of SLT products.¹²

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In Maldives, it is prohibited to grow any type of tobacco plant to any extent. Further, it has prohibited the manufacture of tobacco using leaves from the tobacco plant.⁵ The National Authority on Tobacco and Alcohol Act, passed in 2006 (amended in 2015), is the law governing tobacco control in Sri Lanka. In 2016, the minister issued regulations prohibiting the manufacture, importation and sale of SLT products.⁵ Thailand has banned the sale and import of SLT products.¹³

WHO Western Pacific Region

Singapore has banned the sale of chewing tobacco since 1993. In July 2010, an amendment was passed that expanded the scope of this Act. Novel and emerging forms of tobacco products, such as tobacco derivatives (dissolvable tobacco) and nicotine-based products are now subject to the same regulatory control as the existing SLT products.¹⁴ Singapore has now become one of the few Parties in the world to ban all three i.e. sale, manufacturing and importation of all SLT products.

Australia has banned the sale, manufacture and import of many forms of SLT products. New Zealand, Fiji and Vanuatu have banned the sale of most SLT forms. DPR Korea has gone ahead and banned the sale of all forms of SLT products.⁹ Other Parties of the region have begun regulating SLT products to keep pace with industry developments and to take steps to pre-empt the entry and spread of products in local markets.

Status among high SLT burden Parties

Amongst the 36 high SLT burden Parties, only Sri Lanka has banned the import, sale and manufacture of SLT products while India has banned manufacture and sale of *gutkha* and Thailand has banned the import and sale of SLT products. Germany has banned the sale of tobacco products meant for oral use and chewable tobacco has not been banned (Table 2.9.1)

FINDINGS-PROHIBITION

Table 2.9.1. Ban on import, manufacturing & sale of SLT products in high SLT burden Parties

Party	Region	Income	Ban on Import	Ban on manufacture	Ban on Sale
India	SEAR	LMIC	N	Y	Y
Bangladesh	SEAR	LMIC	N	N	N
Myanmar	SEAR	LMIC	N	N	N
Pakistan	EMR	LMIC	N	N	N
China	WPR	UMIC	N	N	N
Nepal	SEAR	LIC	N	N	N
Colombia	AMR	UMIC	N	N	N
DPR Congo	AFR	LIC	N	N	N
Malaysia	WPR	UMIC	N	N	N
Madagascar	AFR	LIC	N	N	N
Germany	EUR	HIC	N	N	Y
Uzbekistan	EUR	LMIC	NS	NS	NS
Sri Lanka	SEAR	LMIC	Y	Y	Y
Nigeria	AFR	LMIC	N	N	N
South Africa	AFR	UMIC	N	N	N
Afghanistan	EMR	LIC	N	N	N
Yemen	EMR	LMIC	N	N	N
Thailand	SEAR	UMIC	Y	N	Y
Egypt	EMR	LMIC	N	N	N
Algeria	AFR	UMIC	N	N	N
Philippines	WPR	LMIC	N	N	N
Sweden	EUR	HIC	N	N	N
Kenya	AFR	LMIC	N	N	N
Marshall Islands	WPR	LMIC	N	N	N
Palau	WPR	UMIC	N	N	N
Uruguay	AMR	HIC	N	N	N
Bhutan	SEAR	LMIC	Y	Y	Y
Norway	EUR	HIC	N	N	N
Timor-Leste	SEAR	LMIC	N	N	N
Iceland	EUR	HIC	N	N	Y
Kyrgyz Republic	EUR	LMIC	N	N	N
Lesotho	AFR	LMIC	N	N	N
Botswana	AFR	UMIC	N	N	N
Cambodia	WPR	LMIC	N	N	N
Burkina Faso	AFR	LIC	N	N	N
Mauritania	AFR	LMIC	NA	NA	NA

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Case Studies

India

A study conducted in 7 states (Assam, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Odisha) and the National Capital Region revealed that most of the users were purchasing tobacco and mixing it with *pan masala* to get their mix of *gutkha*. This innovation adversely affected the impact of *gutkha* ban in the country.

Another Indian study, evaluating the impact of the *gutkha* ban, found that financial and social cost of selling *gutkha*, as well as public penalties, had an effect on reducing, but not eliminating local *gutkha* supply, demand and use. However, the ban could also be contributing to increased profits and promotional activities associated with the sale of other tobacco products as well as increased use and initiation of other types of smokeless and smoked tobacco products.¹⁶ A study conducted in Chennai to assess the availability of *Gutkha* after it was banned in Tamil Nadu found that even after 3 years of the ban, *gutkha* and *pan masala* products were widely and easily available in the market. All vendors in the study claimed that they were selling tobacco only.¹⁷

The Euromonitor report on SLT in India revealed that post-ban, there was an 84% decline in sales by volume and an 82% decline in value sales compared to the peak in 2010.⁹ The recently released GATS 2 report reveals an overall decrease in prevalence of SLT use between 2010 and 2016 (from 25.9% to 21.4%) and 1% decrease specifically in *gutkha* use.¹⁸

Bhutan

The Tobacco Control Act of Bhutan was enacted by parliament on the 16th June 2010. It regulates tobacco and tobacco products by banning the cultivation, harvesting, production, and sale of tobacco and tobacco products. The consumption of tobacco is not totally prohibited in Bhutan, though it is largely banned in places of public accommodation. The Act largely targets smoking in particular, though any form of tobacco is subject to the act.¹⁰ Despite the ban on manufacture and sale of all tobacco products and enactment of the Tobacco Control Act, SLT use among adults remains high at 19.7% as per the STEPs survey conducted in 2014. Among adolescents aged 13–15 years SLT use increased significantly, from 18.8 % in 2006 to 30.3 % in 2013.¹⁹ Possible reasons for this upswing despite the ban may be effective implementation of smoking ban in public places and consequently smokers switching to SLT use.²⁰

FINDINGS-PROHIBITION

Thailand

Thailand was the first Party to impose a ban on import of SLT (1992).²¹ The Party has a distinctive tobacco control model. It is based on close cooperation between the Ministry of Public Health, the Thai Health Promotion Foundation, and a very active coalition of tobacco control non-governmental organizations. This model has allowed Thailand to undertake a number of strong policy measures to protect the Thai population from the dangers of tobacco. It resulted in a substantial decrease in SLT use in the Party and decreases between recent years. As per the latest GATS (2011), Thailand, only 3.2% people currently use SLT products. Such measures include key approaches to reduce tobacco consumption, particularly in the areas of taxation, packaging and labeling, advertising bans, import bans, and smoke-free public areas.²² However, It is worth noting that an increase in smoking prevalence among men is seen as it is considered more modern than chewing tobacco.²³

Limitations & Gaps

- There is a high degree of diversity in smokeless tobacco product which are largely homemade or made in small locally owned businesses, posing regulatory challenges.
- In India, some states and union territories have been relatively successful in enforcing the ban on gutkha. However, tobacco industry is circumventing these bans by selling pan masala and tobacco in separate pouches.
- The lack of capacity to test the constituents of SLT products in SEAR Parties is a major roadblock in implementing the ban on manufacturing and sale of SLT products.
- State-ownership of the tobacco industry also poses challenges for the implementation of a ban on manufacture and sale of tobacco products at national level.

FINDINGS-PROHIBITION

RECOMMENDATIONS

1. Parties should consider using existing legal provisions under food safety, consumer protection, environmental laws, etc. for limiting use of SLT.
2. Once implemented, SLT ban should be effectively monitored and enforced.
3. A prohibition should be backed by cost-effective SLT cessation services which should be a part of National Tobacco Control programs and be made available for all SLT users who wish to quit.
4. Impact assessments and evaluations of SLT related policy and regulatory practices need to be conducted in order to help Parties adopt comprehensive, WHO FCTC compliant policies and programs that encompass the regulation of SLT products.
5. Tobacco testing laboratories should be established in all high SLT burden Parties, testing methods should be standardized and ideally, coordinated by region. This could be achieved through the WHO Tobacco Laboratory Network.

CONCLUSION

A comprehensive tobacco control strategy with effective tobacco cessation program needs to be formulated that assists SLT users in quitting. In addition, multi-sectoral efforts are necessary for effective implementation of the bans imposed by governments.

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FINDINGS BAN ON SPITTING



2.10 BAN ON SPITTING AND SLT USE IN PUBLIC PLACES

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FINDINGS-BAN ON SPITTING

2.10: BAN ON SPITTING AND SLT USE IN PUBLIC PLACES

Background

SLT products present a complex and widespread challenge to public health from prevalence, pattern and exposure. Most of the SLT products induce spitting in public places, presenting unique problems for public health. Globally, experts are divided in their opinion about the adverse health consequences of exposure to public spitting. There is historical precedence of countries imposing bans on public spitting to curb the epidemic of tuberculosis. Public notice with this effect was a common sight in US, France and England in the late 19th century and early 20th century.^{1,2} However with the end of tuberculosis and the rise of smoking, gradually, these public notices were replaced with warnings against smoking in public places.

However, several countries, provinces and cities continue to prohibit spitting in public places. Such prohibitions on spitting in public places have been imposed with different intentions in various parts of the world. Commonly cited reasons include: for the control of communicable diseases, maintenance of public cleanliness and hygiene as well as a preventive measure to reduce SLT use.

Ban on spitting in high-resource Parties

United Kingdom

In the UK and several other countries, spitting in public places was banned with the intention of controlling communicable diseases. In 1990, with the control of tuberculosis this policy was withdrawn. However, in 2010 the London Borough of Brent classified spitting paan/khillipaan juice as criminal damage, which is liable to a fixed penalty enforcement to maintain clean pavements.

Australia

The Sydney suburb of Fairfield implemented a regulation against spitting in 2006. It declared the Fairfield Municipal area a spit-free zone, with sign age to be painted on footpaths and an awareness program launched to deter offenders. The council officers were empowered to slap spitters with fines ranging from AUD 110 to AUD 1100.³

FINDINGS-BAN ON SPITTING

Singapore

Spitting is prohibited in coffee shops and markets, public roads, side walks and any other place that is open to the public in Singapore. Any violation of the law attracts a fine of up to SGD 1,000.

Thailand

Spitting, nose blowing and littering in public places is banned in Bangkok and any violation of this regulation of the Bangkok Metropolitan Administration attracts a fine of 2,000 Baht.⁴

United Arab Emirates

Spitting on streets and corners of buildings are prohibited in Abu Dhabi and violators have to cough up Dh 1,000. Spitting on the streets is a violation of the health and hygiene rules. The prohibition on spitting is not only restricted to spitting betel leaves [*paan*] and *neswar* [tobacco] but extends to all kinds of spitting. Fines, for anyone caught spitting in public, were increased from Dh 200 to Dh 1,000 in 2015.⁵

BAN ON SPITTING IN LOW-RESOURCE PARTIES

Nepal

Nepal is the only country that has banned the use of any kind of tobacco product in public places. However, its compliance and impact has not been evaluated.

Bangladesh

Several metropolitan cities in Bangladesh prohibit spitting in public places.

Bhutan

As part of the national cleaning campaign in Bhutan, a newly amended rule prohibits smearing lime and spitting Doma in public area. Non-compliance with the regulation attracts a penalty of Nu 100.

China

In the Chinese province of Hangzhou and the host city of the 2016 G20 summit, a law has been passed banning spitting and littering in public places.

FINDINGS-BAN ON SPITTING

Sri Lanka

Sri Lanka has banned using tobacco and areca nut in betel quids apart from smokeless tobacco products and mixtures that contain tobacco. The island country also prohibits spitting on roads under its transport regulations.

Myanmar

There is a ban on spitting red betel juice in the streets and public places, mainly for sanitary reasons.⁶ Several establishments where the general public (including pregnant women and young children) has access have markedly begun posting "*Kun Ta-twe Ma HtweYa*" (spitting of saliva from chewing *Kun* is prohibited) stickers, together with the "no smoking" signs.⁷

Malaysia

The Prohibition Against Spitting (Federal Territory of Kuala Lumpur) By-Laws 2017, that came into operation on 15 March 2017, prohibits spitting in public places. The law under Section 3 states that "No person shall spit in any public place except in a place designated for cleansing or into any apparatus provided for spitting." Further more, section 4 of the By-laws provides punishment for violation, stating, "Any person who contravenes the provisions of these By-laws commits an offence and shall, upon conviction, be liable to a fine not exceeding two thousand ringgit or to imprisonment for a term not exceeding one year or to both."⁸

Papua New Guinea

Since 2013, chewing betel nut and spitting betel nut juices have been banned from the streets of Papua New Guinea amidst concerns that spitting it out spreads tuberculosis. There is a hefty fine of up to PGK 120 for violation of the chewing and spitting ban. However, enforcement of the provision remains a challenge for the authorities.⁹

FINDINGS-BAN ON SPITTING

INDIA

- Indian Railways has banned spitting in railway properties. However, the implementation remains a challenge.
- Metro Rail Corporations across India have also prohibited spitting in metro properties. This has worked well with greater enforcement and public compliance.
- Spitting ban under provincial legislation.
- This was replicated in subsequent state level tobacco control legislation. The Goa Prohibition of Smoking and Spitting Act 1997, The Tamil Nadu Prohibition of Smoking and Spitting Act 2002, and The West Bengal Prohibition of Smoking and Spitting and Protection of Health of Non-smokers and Minors Act 2001, are some of the examples where spitting is banned as part of tobacco control policy.
- The 2003 West Bengal Prevention of Spitting in Public Place Act banned spitting in public places. Section 7 of the Act provides for a fine up to INR 200.
- Public spitting was banned in Kerala through a court order in 2006. This was based on a High Court directive since it posed a health threat.
- The 1997 Andhra Pradesh Prevention of Disfigurement of Open Places and Prohibition of Obscene and Objectionable and Advertisements Act prohibits spitting.
- Recently, Uttar Pradesh Government has banned spitting in government buildings.
- The 2013, Karnataka Municipal Corporations (Amendment) Act prevents spitting in public. It empowers corporations to fine offenders INR 100 for the first time and INR 200 for subsequent infractions.
- The Bombay Police Act of 1951, Section 116, prohibits smoking and spitting in Maharashtra government premises.
- In Telangana, the Greater Hyderabad Municipal Corporation can call out violators under sanitation By-laws and fine them INR 500 upwards.
- The Bihar Municipal Act 2007 makes spitting an offence, along with urinating or throwing garbage, with a penalty of INR 200. Enforcement of the law is weak.

FINDINGS-BAN ON SPITTING

Need for assessment of public spitting from a public health perspective

A study conducted among patients attending a private dental institution in Jodhpur, India revealed that the most frequently cited reason for quitting tobacco usage was spitting and ash dropping, which was embarrassing in front of others. This study provides evidence to study the effect of prohibition on public spitting and its effect on cessation of SLT use.¹⁰

RESEARCH GAPS AND RECOMMENDATIONS

1. There is a lack of scientific research on the adverse effects and impacts of public spitting. More research should be undertaken to create, collect and collate evidence on the adverse effects of spitting in public places. Research should inform policy decisions on limiting/restricting exposure to public spitting.
2. Research evidence should be collected and published on the possibility of swallowing of SLT juices and the exposure to carcinogens if SLT juices are swallowed due to ban on spitting.
3. Evidence should be collected on the impact of the spitting ban on intentions to quit SLT use.
4. There should be greater evidence on and research into interventions on cultural practices and perceptions on spitting ban.

FINDINGS-BAN ON SPITTING

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3

CONCLUSION
RECOMMENDATIONS
AND WAY FORWARD

CONCLUSION

CONCLUSION

In 2014 at the WHO FCTC COP6, the Parties agreed to accelerate implementation of the Convention including on SLT products and agreed for strict regulation of new and existing SLT products. This report is a maiden effort towards compiling the progress made by Parties in the regulation and enforcement provisions of the Convention on SLT. In keeping with the intent of the Parties, this review reveals that some progress has been made on most of the Treaty Articles.

Article 1(f) provides a clear definition of all kinds of tobacco products. Out of 179 Parties to the Treaty, 135 Parties have included SLT in their definition of tobacco products. Among these 135 Parties, 112 have clearly and categorically defined SLT (Figure 3.1).

Since COP6 in 2014, Parties resolved to increase focus on SLT prevention and control. This has led to an increase in research, surveillance and exchange of information (Article 20) related to SLT. Nearly three quarters of the Parties (72%) have data on SLT use among adults at a national level (Figure 3.1). Among them, less than half of the Parties (44%) have recent data. Only 10% of the Parties have two time points of data on SLT prevalence (Figure 3.1), mostly from high-resource Parties. The good news is that the Parties that are home for nearly three-quarters of global SLT users have two or more-time point data with which to observe the trend. SLT use among adolescents is known for nearly 60% of the Parties. Some information is also available on health (10 Parties) and economic (32 Parties) consequences of SLT use. Besides strengthening and substantiating the existing systems, further efforts are required to develop research surveillance and information networks on SLT.

Nearly 72% Parties have prohibited direct SLT advertisement on TV and radio (Figure 3.1). However, less than 20% of Parties have implemented a comprehensive ban on TAPS on SLT and cigarettes (Figure 3.1). Online exposure to SLT product promotion remains a challenge for all Parties, especially in SEAR and European Region. Unlike smoking, most Parties, except India and Bangladesh, have not collected data on exposure to SLT advertisement under GTSS. In India, exposure to SLT advertisement is higher than that of smoking products. However, there has been a decrease in this exposure between 2010 and 2016, especially advertisements in contexts other than at point-of-sale.

CONCLUSION

A total of 120 Parties (67%) have implemented the provisions of Article 16 for SLT products, i.e. restricting its access to minors. Only 10% of Parties have implemented a comprehensive policy against minors' access to SLT. The accessibility of cigarettes to minors has been monitored at a national level by most of the Parties, but none of them monitored for SLT.

Pictorial Health Warnings (PHWs) are one of the most effective tobacco control measures. Around half of the Parties (51%) implemented PHWs on SLT, whilst over three-quarters of the Parties implemented PHWs on cigarettes (77%). A higher proportion of low-resource Parties (55%) implemented PHW on SLT as compared to high-resource Parties (48%). Conversely, a significantly higher proportion of high-resource Parties (80%) implemented PHW on cigarettes as compared to low resource Parties (71%). Among the high SLT burden Parties only five have implemented complete policy, encompassing large and multiple PHWs. Nepal is the frontrunner, with PHWs coverings of 90% on both sides of the packages.

Mass media, education, communication, training, specific interventions targeted to different audience and different tobacco products, and awareness against harmful effects of tobacco through school and institutional programs were undertaken by several Parties. In 2016, 36% of Parties conducted at least one national mass media campaign (Figure 3.1). However, inclusion of an SLT component in these campaigns is not known. Four Parties from Asia have used mass media, earned media, social media etc. for raising awareness on harmful effects of SLT use. India is the only Party to have implemented a comprehensive mass media campaign against SLT use. Unlike smoking products, Parties do not include SLT indicators related to Article 12 while conducting surveys under GTSS. Several opportunities for implementing Article 12 by using technology-driven media and social media have not been explored for SLT products.

Nearly one-third of the Parties (31%) have a national quitline. However, only a few Parties (2%) have experience in SLT cessation (Figure 3.1). Further, tobacco cessation support in health care facilities is available in less than 20% Parties, while national quitlines and NRT are largely available in high-resource Parties, especially in European Region. More smokers (50%) are advised to quit by health care professionals than by SLT users (25%).

CONCLUSION

There is a lack of formal training in SLT cessation among health professionals, health profession students and school personnel. Cessation practices by health care providers for SLT users have only been studied in three Parties, namely India, Bangladesh and Kenya.

With regard to Article 6, a key demand reduction measure requires data on price and tax of SLT. This information is only available for 32 Parties. Tax on SLTs varies considerably across Parties. It ranges from 0% in seven Parties (i.e. no tax of any kind on SLTs) to 72.4% in Sudan. Tax incidence of 70% or more is reported in only four Parties. Analyses of chemical composition of SLT products have been done by only 18 Parties on an *ad hoc* basis where government initiatives may not be involved.

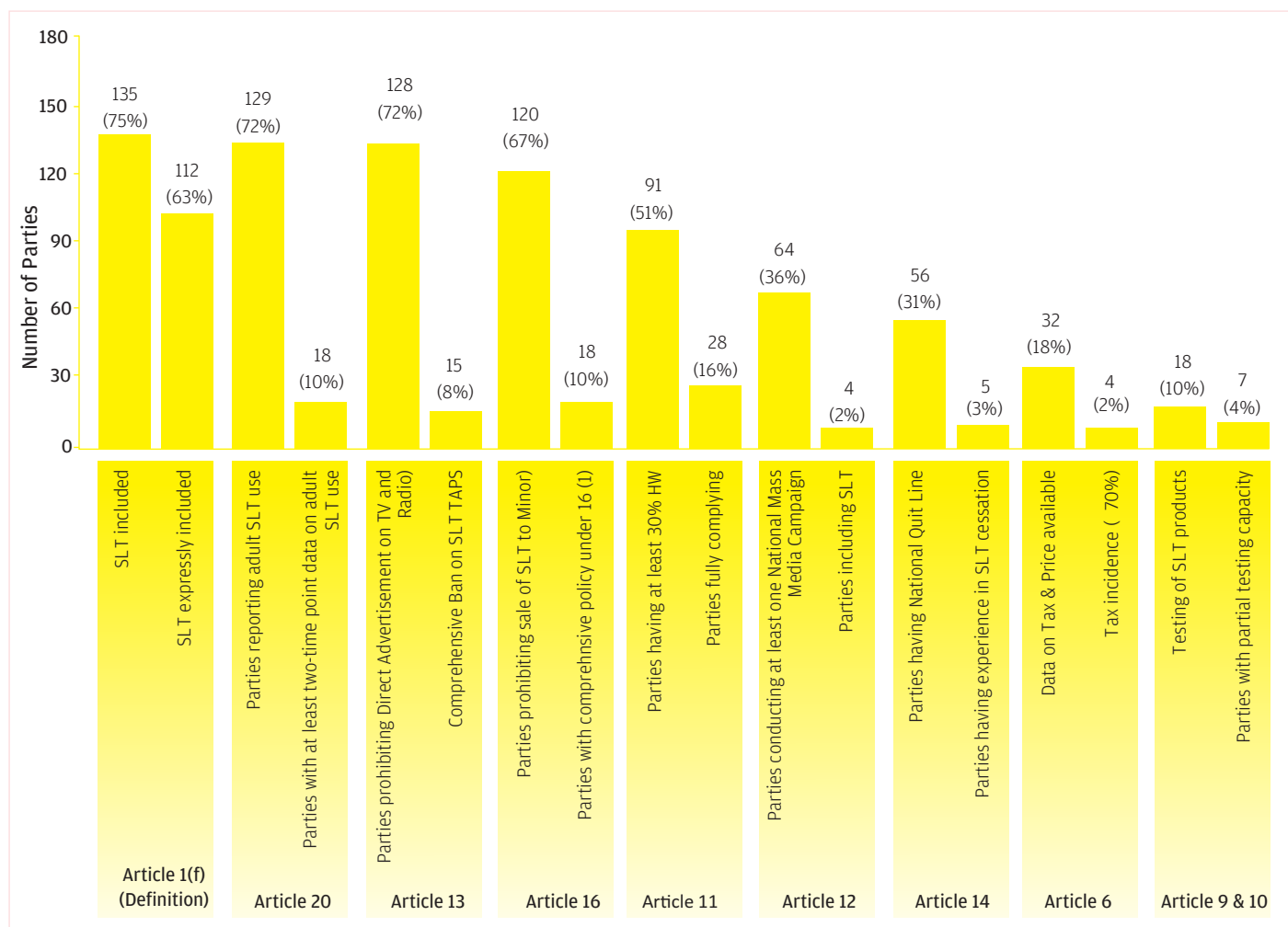


Figure. 3.1: Number and percentage of Parties implementing different FCTC provisions with reference to SLT (percentage in bracket)

CONCLUSION

Moreover, not all available SLT products were analyzed and product analysis occurs irregularly. Most Parties do not have tobacco testing laboratories. Testing has been done only in seven Parties and one non-Party (the USA). There is no regulation on the chemical composition of SLT products. The levels of carcinogens detected in SLT products are beyond the standards recommended by the WHO.

Although not mandatory under the FCTC, it has been recommended that the countries that do not have burdensome levels of SLT use should ban its manufacture, sale and import as a pre-emptive measure. Three Parties, viz. Australia, Bhutan and Sri Lanka, have already implemented the prohibition. Further, sale of SLT products is prohibited by 45 Parties, mostly from the European Region. Among the high SLT burden Parties, prohibition is implemented completely in Sri Lanka, and partially in India and Germany. With the ban on *gutkha* in India, there has been a reduction in *gutkha* use from 7% to 6%. However, in spite of a complete ban on SLT in Bhutan, there is an increase in SLT use among adolescents. Effective enforcement is crucial for the successful implementation of these policies.

SLT use inducing spitting that may be responsible for spreading communicable diseases. It is a definite impediment to public cleanliness and hygiene. Several Parties have already prohibited spitting and/or use of SLT in public places at the national, state or sub-national level.

Overall Limitations

Articles 5.3 (Industries unique tactics of interference in SLT prevention and control policy making and implementation), 15 (Illicit trade in tobacco), 17 (Provision of support for economically viable alternative activities), 18 (Protection of the environment), and 19 (Liability) are out of the scope of this report.

RECOMMENDATIONS

RECOMMENDATIONS

Based on the above review and conclusions, adherence to key recommendations may be considered by the Parties in order to effectively implement SLT prevention and control measures in line with the Treaty mandates:

1. Adopt the FCTC Article 1(f) definition of “tobacco products” under domestic law explicitly for comprehensive regulation of all kinds of tobacco products including SLT.
2. Consider taxing all kinds of SLT products at a rate uniform with other smoking products. Such taxation should be inflation-adjusted.
3. For effective regulation of SLT product content and emissions, build capacity for product testing.
4. Adopt comprehensive guidelines for Articles 9 and 10 with special reference to SLT.
5. Implement large, effective, multiple and rotating SLT-specific PHWs on all SLT products, based on scientific evidence.
6. Implement comprehensive mass media, education, communication, training and awareness programs and activities on the health effects of SLT. Collect and report such efforts and their effects through a standard tobacco surveillance system.
7. Implement comprehensive TAPS ban for SLT, including cross border TAPS.
8. Train and build the capacity of the health professionals to provide behavioral interventions specifically for SLT cessation.
9. Prevent sale of SLT products to and by minors with strict enforcement of all provisions under Article 16.
10. The KH-SLT, WHO and other stake holders of tobacco control should help in increasing the capacity of SLT prevention control in low-resource Parties as their SLT burden is high.
11. While adopting a ban on manufacture, sale and import of SLT, use a comprehensive approach with effective enforcement strategies.
12. Consider implementing regulations against spitting in public places, which might help in denormalizing SLT use and help SLT users quit.

WAY FORWARD

WAY FORWARD

In accordance with the work plan and budget adopted by the sixth session of the FCTC Conference of the Parties for the financial period 2016–2017, KH-SLT prepared a report reviewing smokeless tobacco (SLT) policies across FCTC Parties. The Hub, along with the Convention Secretariat of the WHO Framework Convention on Tobacco Control (WHO FCTC) and the WHO Regional Office for South-East Asia, organized an inter-country meeting to discuss the findings of the report. The meeting brought together Party representatives from within and outside the Region, as well as subject experts from international agencies, to discuss policy options for prevention and control of SLT products.

Participants' key observations about the global SLT policy scenario and their proposals on the way forward to address the challenges identified are summarised here. These are meant to inform the work of Parties to the Convention, of states non-Parties and other interested stakeholders on policies to prevent and control SLT use and to also inform future agenda of the COP as well as other international efforts on SLT controls

KEY OBSERVATIONS AND THE WAY FORWARD

ARTICLE	KEY OBSERVATIONS	WAY FORWARD
	Parties' implementation of FCTC provisions on smokeless tobacco (SLT) products, their promotion, trade and use lags behind in comparison to cigarettes.	FCTC provisions need to be applied to all types of tobacco products, including SLT.
1(f)	All national tobacco control laws, related policies and programmatic documents do not apply or explicitly refer to SLT.	The definition of tobacco products in the Use of terms in FCTC Article 1 (f) includes SLT products and is to be utilized. It is as follows: "products entirely or partly made of the leaf tobacco as raw material which are manufactured to be used for smoking, sucking, chewing or snuffing".

WAY FORWARD

ARTICLE OF THE CONVENTION	KEY OBSERVATIONS	WAY FORWARD
	Tobacco is used in ways other than those defined in the FCTC, including in unmanufactured forms and preparations self-made by users or prepared by the vendors by mixing tobacco with other ingredients such as betel nut, herbs, flavouring agents, lime, etc., in several Parties.	In addition, as FCTC Article 2.1 encourages Parties to implement measures beyond those required by the Convention, national laws need to define tobacco products comprehensively and contextually to cover all products in use by the population.
6	Taxes on SLT products are still very low compared to cigarettes in most Parties.	FCTC Article 6 Guidelines to progressively increase taxes on all tobacco products including SLT. Taxes on SLT products should meet the WHO recommendation for the proportion of taxes in their price, ensuring that they are not affordable and avoid substitution between products.
	Tax administration is weak and tax evasion along the supply chain is rampant in many Parties.	In addition to FCTC Article 6 Guidelines, other measures to strengthen tax administration and prevent tax evasion can be found in the Protocol to Eliminate Illicit Trade of Tobacco Products.
9 & 10	Parties' capacity for testing contents of SLT products is inadequate.	Develop new or facilitate use of existing laboratory capacity in the WHO regions to test and measure contents of SLT products. (For example, three tobacco testing laboratories are being established by the Government of India, one of which is going to be established in the institution hosting the Global Knowledge Hub on Smokeless Tobacco. These laboratories will test all tobacco products, including SLT.)

*One Party reported using a broader definition for SLT in its national legislation.

WAY FORWARD

ARTICLE OF THE CONVENTION	KEY OBSERVATIONS	WAY FORWARD
	Standard operating procedures (SOPs) to test and measure exist only for a limited number of contents of SLT products, but there are no internationally agreed approaches for testing the contents or emissions of SLTs. (e.g.: SOPs to test and measure microbial contamination of SLT is currently unavailable).	Continue the efforts to develop and verify or validate SOPs for testing key contents of SLT (e.g. aflatoxin), as required under decision FCTC/COP7 (14) para 5) and to internationally agree SLT methods which could be utilised by parties.
	The applicability of Article 9 and 10 (partial) guidelines to testing and measuring SLT products is incomplete.	Evidence-based practices and lessons should be documented and shared to inform the further development of the guidelines on Articles 9 and 10.
	Assessment presented at the meeting did not include measures to reduce SLT toxicity, addictiveness and attractiveness.	Future work needs to examine the Parties efforts to address toxicity, addictiveness and attractiveness of SLT products. This will further inform the development of the guidelines on articles 9 and 10
11	Low-resource Parties † tend to have better policy adoption to implement Article 11 provisions on SLT products compared to high-resource Parties ‡.	FCTC Article 11 guidelines require parties to implement large, pictorial warnings on all tobacco products. Practices and learning from low-resource Parties can be shared with high-resource Parties to improve the implementation of Article 11 Specify multiple messages relevant to SLT products.
	Tailor-made and home-made SLT products do not carry health warnings.	Health warnings (both graphic and text) at points of sale can provide the necessary information to users of such products.

†Low-Resource Parties are Low and Lower Middle Income Countries

‡High-Resource Parties are High Income and Upper Middle Income Countries

WAY FORWARD

ARTICLE OF THE CONVENTION	KEY OBSERVATIONS	WAY FORWARD
	<p>Absence of specific dimensions of health warnings (HW) on SLT packages allows manufacturers to make them invisible. This problem is compounded by non-standardised SLT packs that differ in size, quantity, shape and other package characteristics.</p>	<p>Good practices of prescribed minimal dimensions that make the HW visible and effective are already available in some Parties, they should be collected and shared among Parties. The KH could serve as repository for such good practices.</p>
	<p>SLT specific pictures in the WHO health warnings database are limited and do not include an SLT category.</p>	<p>KH-SLT to collect existing SLT package pictures for eventual addition to the WHO Health Warnings Database; WHO to create a SLT category in the database.</p>
<p>12</p>	<p>There are limited SLT specific mass media campaigns and even fewer evaluated ones.</p>	<p>KH-SLT to develop an inventory of SLT media campaigns and practices of culturally relevant interventions and make them available through their website.</p> <p>Parties to undertake anti-tobacco campaigns, including mass media, social and digital media campaigns and evaluate their outcomes.</p>
	<p>Existing cultural practices and the misconception that SLT is beneficial to health present specific challenges for their control and related communication (e.g. offering betel leaf tray with tobacco is offered to monks [Sri Lanka], or offering tobacco during marriages [Bangladesh, India, Nepal]).</p>	<p>Explore locally relevant community and policy interventions to address the socio-cultural roots of using and spitting smokeless tobacco. (For instance, the initiative promoting new betel leaf tray without tobacco and areca nut).</p> <p>Education and communication strategies, messages and materials need to be tailor-made to dispel myths among specific target populations and aimed at behavior change.</p>

WAY FORWARD

ARTICLE OF THE CONVENTION	KEY OBSERVATIONS	WAY FORWARD
	Some Parties have successfully engaged media for tobacco control messaging at low to no cost.	There needs to be more SLT related earned media such as by requiring anti-tobacco spots in movies, and TV.
13	<p>The majority of Parties have no law prohibiting tobacco advertising, promotion and sponsorship (TAPS) at points of sale, including of SLT.</p> <p>Surrogate advertising, brand-sharing and brand-stretching of SLT products and their ingredients is prevalent and increasing in several Parties.</p>	<p>FCTC Article 13 guidelines recommend comprehensive measures that Parties can implement to ban all forms of TAPS across tobacco products. Additionally, resources available from other Parties (from the website of the convention secretariat) could also be utilised.</p>
	<p>SLT advertising, promotion and sponsorship via the Internet and social media is a global phenomenon.</p> <p>Cross border TAPS of all tobacco products, including on social media, is an area of concern.</p>	<p>These need to be brought to the attention of the FCTC Expert Group on cross border advertising established at COP7.</p>
14	<p>Lack of availability, accessibility and affordability of cessation interventions specific to SLT. (E.g. meta-analysis of data from diverse parties show that only 25% of SLT users received advice to quit in comparison to 50% of smokers).</p>	<p>Parties could make brief advice, mhealth and quitlines more broadly to promote SLT cessation in line with FCTC Article 14 guidelines.</p> <p>Health care professionals should be further sensitized and trained to enquire about any tobacco use and give cessation advice equally to users of all forms of tobacco.</p> <p>Health systems need to be more responsive to address the need for quitting tobacco use</p>

WAY FORWARD

ARTICLE OF THE CONVENTION	KEY OBSERVATIONS	WAY FORWARD
	Even brief behavioral interventions are effective in facilitating quitting SLT use.	Identify opportunities to integrate SLT cessation into relevant health programs and services, including but not limited to TB control, oral health, substance abuse and NCDs.
16	Few Parties have provisions prohibiting the sale of SLT to minors.	In order to help Parties to meet their obligations with respect to FCTC Article 16, this provision could form part of tobacco control or any relevant legislation, including those on child and juvenile protection.
	Availability of SLT products in small packs/sachets makes it affordable to minors.	Sale of SLT products in small packs/sachets to be prohibited.
20	SLT prevalence is increasing among several high burden Parties	This calls for full implementation of the FCTC and improved enforcement of existing laws in relation to SLT.
	SLT use data collected so far is insufficient to monitor prevalence and establish trends.	<p>Conduct periodic surveys (at regular intervals) to track population level trends in prevalence and health, economic, social and environmental consequences of SLT, especially for high burden Parties.</p> <p>SLT related questions should be included in national data collection systems such as national surveys on tobacco use, morbidity and mortality.</p>
	The additional questions (optional module) of the FCTC reporting instrument that features a section on SLT policies is under-utilised by the Parties.	Use the existing FCTC reporting instrument, the core questionnaire and the optional module and the WHO FCTC Indicator Compendium.

WAY FORWARD

ARTICLE OF THE CONVENTION	KEY OBSERVATIONS	WAY FORWARD
MANUFACTURE, SALE & IMPORTATION	Several Parties, including a few high burden Parties have banned the manufacture, sale and/or import of SLT or other forms of tobacco products.	<p>In line with Decision FCTC/COP6(8), Parties may consider prohibiting the manufacture, sale, transportation and import of SLTs through appropriate regulatory mechanisms to help achieve their tobacco control objectives.</p> <p>Parties may also use relevant existing consumer, food safety and environmental laws to limit SLT manufacture, sale, as relevant to national context.</p>
	<p>Existing challenges include :</p> <ul style="list-style-type: none"> -State ownership of tobacco industry -Illegal supply of SLTs from countries that have banned the manufacture, sale and/or import. -Personal importation of tobacco products by international travelers 	<p>Address matters related to state tobacco monopolies as recommended in the guidelines on Article 5.3.</p> <p>Parties should consider ratifying or acceding to the Protocol to Eliminate Illicit Trade in Tobacco Products as early as possible to help address the illegal trans-boundary supply of SLTs. Parties should strengthen implementation of FCTC Article 6 and its guidelines to prohibit or restrict such importations.</p>

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

OTHER MATTERS CONSIDERED	<p>Spitting behavior related to smokeless tobacco use gives rise to unhygienic conditions in public places.</p> <p>Not banning spitting in public places facilitates continued tobacco use.</p>	<p>Evidence on the economic, social and environmental impact of spitting tobacco should be generated.</p> <p>Discourage spitting in public places, and consider regulating it.</p>
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WAY FORWARD

	Areca nut as a key ingredient of several SLT products and raises serious health concerns.	Policies and interventions to address SLT products need to apply, as relevant, to its harmful ingredients, such as areca nut.
	Insufficient capacity for comprehensive SLT control in Parties with SLT burden.	<p>The FCTC Secretariat, KH-SLT, WHO and other stakeholders of tobacco control should help Parties in increasing capacity for SLT control, including efforts to raise awareness of Parties on existing technical resources</p> <p>Organise a lunchtime seminar on SLT at COP 8</p> <p>Consider including SLT on the agenda of COP 8.</p>
	SLT related industry tactics do not get as much attention as those of the cigarette industry.	Consider setting up tobacco industry observatories to monitor SLT industry tactics and campaigns.
RESEARCH RECOMMENDATIONS	<ol style="list-style-type: none"> 1. Continue the research on the health effects of SLT products (e.g. the effects of SLT use in pregnancy, impact on the health of mother and child). 2. Research on the effectiveness of policy interventions to control SLT products (related to various articles of the Convention, including that of public awareness campaigns). 3. Research examining the impact of exposure to tobacco products and their marketing on youth tobacco use. 4. Economic research on affordability and price elasticities of SLT products and health cost related to their use. 5. Impact evaluation of measures such as displaying graphic health warnings at points of sale, and programmes that inform users of unmanufactured and self-prepared forms of SLT. 6. Review evidence of the effectiveness and cost benefit analysis of SLT-cessation interventions, including pharmacological interventions, and alternative and traditional methods. Document and share indigenous methods that are evaluated to be effective in cessation. 7. KH-SLT could serve as a repository, facilitating, collation and dissemination, of SLT related research. 	

ANNEXURE 1

ANNEXURE – I

TobLabNet and TobReg Activities in Relation to SLT

The Conference of the Parties (COP) to the Framework Convention on Tobacco Control (WHO FCTC)¹, convened in India in November 2016, requested² the Convention Secretariat to invite WHO to collaborate with the Knowledge Hub on smokeless tobacco (SLT) by assisting tobacco testing laboratories:

- i. to collect scientific information on the chemicals in smokeless tobacco products and their emissions that contribute to their toxicity, addictiveness and attractiveness. Data should also be gathered on the analytical methods used to measure them, and the levels of these chemicals found in products on the market;
- ii. to finalize the standard operating procedures for measuring nicotine, tobacco specific nitrosamines (TSNAs) as requested by decision FCTC/COP6(12) 2b.ii;³
- iii. to advise on the applicability of WHO Tobacco Laboratory Network (TobLabNet) standard operating procedures to measure humectants and ammonia in smokeless tobacco products;
- iv. to identify any available technical approaches to reduce toxicants in smokeless tobacco; and
- v. to report progress at the future sessions of the COP.

Since COP7, WHO has been working closely with its advisory bodies. These include the WHO Tobacco Laboratory Network (TobLabNet), the WHO Study Group on Tobacco Product Regulation (TobReg), the WHO FCTC Knowledge Hub on smokeless tobacco and other experts, to examine the areas above and develop recommendations to COP at its next session in 2018.

WHO Tobacco Laboratory Network (TobLabNet)

The WHO Tobacco Laboratory Network is a global network of government, academic and independent laboratories that aim to strengthen national and regional capacity for the testing and research of the contents and emissions of tobacco products, pursuant to Articles 9 and 10 of the WHO FCTC⁴. Established in April 2005, the network supports national governments fulfil their requirements in accordance with the WHO FCTC by (1) providing scientific information and laboratory support, and (2) developing methods for measuring contents and emissions of tobacco product. TobLabNet comprises 33 laboratories from 28 countries, representing all six WHO regions. It functions to:

ANNEXURE 1

- Provide remedial support for laboratory staff to improve current capabilities to meet testing requirements;
- Develop a method compendium for use by laboratories seeking to expand their capabilities for analysis of tobacco products and emissions;
- Train laboratory staff in new analytical methodologies using experts experienced in a wide range of analysis methods and techniques;
- Develop common materials for standardization, proficiency testing, and quality control to provide better consistency of results;
- Identify best laboratory practices so that more reliable laboratory information can be generated for research and regulation;
- Test new methods using multiple laboratories to determine ruggedness and applicability under widely varying infrastructures;
- Carry out projects for analyzing, evaluating, and comparing global and regional tobacco products and emissions;
- Perform collaborative research on improving methods for tobacco and smoke testing, better understanding product use, and the impact of different products on biomarkers of exposure and adverse health effects;
- Provide access to world-wide expertise in laboratory techniques, instrumentation, product and smoke analysis methods, product regulation, toxicology and addiction
- Provide means for electronic communications within the network for accessing information and sharing expertise.

In response to COP requests 5b. ii, iii and iv of Decision FCTC/COP7(14)², TobLabNet convened a working group meeting on smokeless tobacco in New Delhi, India from 10–11 August, 2017. Following the assessment of the applicability of WHO TobLabNet standard operating procedures (SOPs) 04⁵ and 03⁶ for nicotine and TSNA to SLT, the group concluded that WHO TobLabNet SOP04⁵ and SOP03⁶ are applicable to SLT, with some modifications. These methods are specific, with acceptable selectivity and the facilities required are commonly available in general analytical testing laboratories. However, there will be a need to adjust the calibration range, as appropriate, to cover the diverse range of SLT products. The counterpart SOPs for SLTs are currently being developed and are expected to be presented to the Conference of the Parties at its eight session (COP8). The assessment of the applicability of WHO TobLabNet's SOP06⁷ and SOP07⁸ for humectants and ammonia to smokeless tobacco products, which is currently being undertaken within TobLabNet, was also discussed.

ANNEXURE 1

These methods are deemed applicable to SLT by TobLabNet, with a few modifications. Further, participants deliberated on available technical approaches for the reduction of toxicants in smokeless tobacco and came up with meaningful recommendations that will be presented to COP8. In preparation for the eighth session of the COP, the WHO is working on background papers in collaboration with experts to present findings on the COP requests in relation to SLT.

In response to COP request 5b.i of Decision FCTC/COP7 (14)², WHO convened a special meeting on 14 August 2017 to assist laboratories in collecting scientific information on chemicals in contents and emissions in smokeless tobacco products that contribute to the toxicity, addictiveness and attractiveness, the analytical methods used to measure them, and the levels found in products on the market. Following discussions, participants proposed a list of 13 chemicals in SLT based on toxicity and addictiveness. The main groups of chemicals are TSNA, nicotine, heavy metals, PAHs, specifically B[a]P, and nitrates/nitrites. This builds on existing knowledge of chemicals that contribute to addictiveness and toxicity based on work previously undertaken by scientific groups, including TobReg, the International Agency for Research on Cancer (IARC) and the United States Food and Drug Administration (FDA). It was further noted that other factors, such as pH (due to its effect on nicotine), measurement of moisture, the role of microorganisms, and areca nut merit further consideration. There are simple and applicable methods for chemicals for which TobLabNet methods do not currently exist. It is considered that most laboratories can easily set up for the measurement of these chemicals using these verifiable methods. Additionally, TobLabNet laboratories are working on building the capacity of laboratories to test smokeless tobacco. The current TobLabNet laboratories with capacity to test SLT are listed below:

- ➔ Centers for Disease Control and Prevention (United States) – PAHO
- ➔ Battelle (United States) – PAHO
- ➔ Laboratoire National de Sante Publique (Burkina Faso) – AFRO
- ➔ National Institute of Public Health (Japan) – WPRO
- ➔ RIVM National Institute for Public Health and Environment (Netherlands) – EURO
- ➔ HSA Health Sciences Authority (Singapore) – WPRO
- ➔ Chemisches und Veterinaruntersuchungsamt Sigmaringen (Germany) – EURO

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The Indian Government's National Tobacco Testing Laboratories have joined TobLabNet as interested Parties, as India works to build its tobacco testing capacity. It is expected that these laboratories will participate as testing members in the future, which would be particularly valuable in the smokeless tobacco work. India is also in the process of drafting guidelines on the requirements of setting up a tobacco testing laboratory, the testing and measurement of the contents of tobacco products, and the testing and measurement of the emissions of tobacco product for countries in the WHO South East Asian Region. The purpose of the guidelines is to harmonize testing approaches for the contents and emissions of tobacco products in South East Asia and to facilitate the implementation of Articles 9 and 10 of the WHO FCTC in South East Asia.

WHO Study Group on Tobacco Product Regulation (TobReg)

The WHO Study Group on Tobacco Product Regulation⁹, formerly known as the Scientific Advisory Committee on Tobacco Product Regulation (SACTob), was established in October 2000. It has had its status formalized from a scientific advisory committee to a study group in November 2003. The group comprises scientists and experts in the fields of tobacco product regulation, laboratory analyses of the contents, emissions and design features of tobacco products, toxicology and tobacco dependence. The Study Group reports to the WHO Executive Board through the Director-General to draw the attention of WHO Member States to the Organization's work in tobacco product regulation, and aid countries in implementing the product regulation provisions of the WHO FCTC.

TobReg meets on a biennial basis to discuss pertinent issues in tobacco product regulation and works by commissioning scientific background papers. These are reviewed and discussed by members who in turn make recommendations on each of the commissioned papers. These recommendations are then compiled and presented in a Technical Report (WHO Technical Report Series), which is presented to the WHO Director General. Following each meeting, the report is published on the WHO website and is made publicly available. TobReg's next meeting will be held in December 2017. Background papers have been commissioned, including specifically on smokeless tobacco products. These papers will address approaches to reducing toxicant concentrations in smokeless tobacco (SLT) products. Other TobReg background papers, including those on flavourings and sugars in tobacco products, and update on addictiveness may also cover aspects relevant to SLTs.

Reference

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