DRAFT REPORT ON
GLOBAL SMOKELESS TOBACCO
CONTROL POLICIES AND
THEIR IMPLEMENTATION

WHO FCTC GLOBAL KNOWLEDGE HUB ON SMOKELESS TOBACCO
ICMR – NATIONAL INSTITUTE OF CANCER PREVENTION AND RESEARCH, NOIDA, INDIA - 201301
DRAFT REPORT ON
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WHO FCTC Global Knowledge Hub on Smokeless Tobacco
National Institute of Cancer Prevention and Research
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<td>African Region</td>
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<td>AMR</td>
<td>American Region</td>
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<td>CDTL</td>
<td>Central Drug Testing Laboratory</td>
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<td>CoP</td>
<td>Conference of Parties</td>
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<td>EMR</td>
<td>Eastern Mediterranean Region</td>
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<td>EU</td>
<td>European Union</td>
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<td>EUR</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>FY</td>
<td>Financial Year</td>
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<td>GATS</td>
<td>Global Adult Tobacco Survey</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GHPSS</td>
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<td>GKH-SLT</td>
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<td>GSPS</td>
<td>Global School Personnel Survey</td>
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<td>GST</td>
<td>Goods and Service Tax</td>
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<td>GTSS</td>
<td>Global Tobacco Surveillance System</td>
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<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<td>HIC</td>
<td>High Income Country</td>
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<td>HRIDAY</td>
<td>Health Related Information Dissemination Amongst Youth</td>
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<td>HW</td>
<td>Health Warnings</td>
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<td>IHD</td>
<td>Ischemic Heart Disease</td>
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<td>INR</td>
<td>Indian National Rupee</td>
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<td>ITCP</td>
<td>International Tobacco Control Project</td>
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<td>LIC</td>
<td>Low Income Country</td>
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<td>LMIC</td>
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<td>MYTRI</td>
<td>Mobilizing Youth for Tobacco-Related Initiatives.</td>
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<td>NCD</td>
<td>Non Communicable Disease</td>
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<td>National Calamity Contingent Duty</td>
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<td>NFHS</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NICPR</td>
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<td>NIH</td>
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<td>NNK</td>
<td>Nicotine-derived Nitrosamine Ketone</td>
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<td>NNN</td>
<td>N-Nitrosonornicotine</td>
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<td>NQL</td>
<td>National Quit Lines</td>
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<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<td>NTTL</td>
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<td>OPMD</td>
<td>Oral Potentially Malignant Disorders</td>
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<td>pH</td>
<td>Power of Hydrogen</td>
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<td>PHFI</td>
<td>Public Health Foundation of India</td>
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<td>Pictorial Health Warnings</td>
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<td>RIP</td>
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<td>SDG</td>
<td>Sustainable Developmental Goal</td>
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<td>SEAR</td>
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<td>TFI</td>
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<td>Tobacco Product Regulation</td>
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<td>Tobacco Products Directive</td>
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<td>UADT</td>
<td>Upper Aero Digestive Tract</td>
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<td>UMIC</td>
<td>Upper Middle Income Country</td>
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<td>USA</td>
<td>United States of America</td>
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<td>VAT</td>
<td>Value Added Tax</td>
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<td>VoTV</td>
<td>Voices of Tobacco Victims</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>Western Pacific Region</td>
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A. Introduction

This report on smokeless tobacco (SLT) control policy and implementation by the Parties to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) is a first attempt to facilitate an exclusive discussion on SLT policy related matters in an Inter-Party Meeting cum Global Expert Consultation. This 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). This Report provides an overview of the status of SLT control policy progress under selected Articles of the FCTC. It contains a comparison with the progress indicators for cigarettes, key observations on the progress made in SLT control policy by Parties and points to opportunities and challenges related to the specific Articles under the Convention along with proposed recommendations.

B. Methodology

This report has been compiled through systematic collection of standard data validated by numerous cross-checks by a team of experts at the WHO FCTC Global Knowledge Hub on Smokeless Tobacco located in the National Institute of Cancer Prevention and Research (NICPR), Noida, Uttar Pradesh, India. Information from the WHO FCTC reporting instrument, WHO tobacco epidemic report 2013, 2015 and 2017, WHO smokeless tobacco survey report, tobacco control legislation, regulation, decree of individual country, and published articles in peer reviewed journals, all were used to prepare this report. Information was validated by at least one additional document. For regional analysis WHO regions were used. For country level analysis by income we categorized Parties 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, in this report, the high SLT burden Parties are considered as those having more than one million SLT users.

In this report, policy progress of the Convention is analyzed on the following levels:

1. As a 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 were also included.
2. Policy progress has been mapped by year.
3. Examples of recent and innovative activities, legislative processes and other actions have been presented as case studies.
EXECUTIVE SUMMARY

4. This report does not always include enforcement and compliance aspects unless some outcome or process indicators are cited in some reports at national level.

C. Findings

1. Article 1(f): Use of Terms – Defining Smokeless Tobacco (SLT)

Article 1(f) of the Treaty mentions that “Tobacco products” means products entirely or partly made of the leaf tobacco as raw material which is manufactured to be used for smoking, sucking, chewing or snuffing.”

Out of 179 Parties, 135 Parties have included SLT under ‘tobacco products’ in their laws. Of 135 Parties, 112 have expressly and 23 included either generally or in obscured way. Forty Four Parties have either not included SLT or laws were not available in English language.

2. Article 6: Price and Tax Measures on SLT

Smokeless tobacco (SLT) consists of a wide range of heterogeneous products which are manufactured and sold in a variety of forms making it difficult to establish a standardized unit for the purposes of pricing or taxing. Price and tax measures on these products are often confusing and it is important to provide more clarity on this so that tax policies on SLTs can be made more effective.

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

Taxation on SLT should be such that it keeps up with inflation while, at the same time, ensuring that their prices sufficiently go up with the objective of making SLTs less and less affordable. The tax rates should be standardized across the SLT products and in a manner not to encourage 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 SLTs to adequately raise their tax burden consistently.

3. Article 9: Regulation of Contents of SLT
Article 10: Regulation of SLT Disclosures

Article 9 deals with testing, measuring and regulating of the contents and emissions of tobacco products. Article 10 deals with disclosure by manufacturers and importers of tobacco products to governmental authorities of information about the contents and emissions of tobacco products, as well as the public disclosure of information about the toxic constituents of tobacco products and their emissions. Both the articles are closely related. Therefore, guidelines for implementation of Articles 9 and 10 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 these were mainly related to cigarettes. Forty-one and thirty-one 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. In 64 and 22 Parties, the law mandated the display of qualitative information on relevant constituents and emissions of cigarettes and SLT packaging respectively.

Ten percent \((n = 18)\) Parties have done analysis of the chemical composition of SLT on an ad-hoc basis. Not all SLT products available in these Parties had been analyzed; also, the products were not analyzed on a periodic basis.
It was further noted that levels of NNK, NNN, B[a]P, heavy metals, pH and nicotine content had a diverse range in various analysis. The estimated levels were dissimilar among various SLT products, individual brands of the same product and also within the brand in that Party. The establishment of a tobacco testing laboratory network across the globe is limited, with minimal focus on SLT.

Parties should encourage and invest in further research on SLT products, their ingredients and emissions for effective regulation of SLT products. Major initiatives are required that promote collaborations between academia, researchers, scientists and governments to ensure that reports from the 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 and support their adoption.

4. **Article 11: Packaging and Labeling of SLT**

Article 11 pertains to effective packaging and labeling of tobacco products, the impact of which has been proven outstanding for smoked products especially cigarettes. The emphasis on implementing the health warnings (HW) has always been on cigarettes, with minimal focus on other tobacco products; although available evidence supports that effectiveness of health warnings (HW) apply to SLT as well. Rapid progress in HW (≥30% size) is seen since FCTC adoption, however disproportionately focused on Cigarettes as compared to SLT. By 2016, nearly half of Parties (51%) had notified HW on SLT, whereas three-fourth Parties (77%) had HW on cigarettes. Large HWs (≥50% size) were notified by one-fourth Parties (27%) on SLT packages, as compared to more than half Parties (56%) for cigarettes packages. PHWs were notified by one-fifth (20%) Parties for SLT and more than half (56%) Parties for cigarettes. Similarly, multiple HWs (≥2 specific warnings) were notified by one-fourth (27%) Parties for SLT and two-third Parties (66%) for cigarettes. For cigarettes, all 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 complied the best in accordance with provisions of Article 11 for SLT. Among high-burden Parties for SLT, India, Nepal, Philippines, Egypt and Kenya have complete policies and their implementation. In Bangladesh, Myanmar and Colombia complete law is in place, however, it is not implemented. Globally, only 16% (n = 28) Parties have complete policies for SLT.
The current findings emphasize the need for comprehensive policy formulation and implementation of Article 11 for all tobacco products. Parties need to implement large warnings with pictorial representations and multiple messages on various diseases for all tobacco products.

5. **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. WHO Global Tobacco Epidemic Report (2015 and 2017) indicates 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 of the non-Party (United States) have implemented some kind of national and sub-national mass media campaign on SLT prevention and control. Parties have also gained earned media 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 (GATS India 2010).

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

Several national and local surveys have indicated that people were unaware about the harmful effects of SLT use; rather they have some myths regarding its use.

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

6. **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, while partial advertising bans provide opportunities for tobacco companies to find new ways to market their products.

According to the WHO Global Tobacco Epidemic Report 2017, >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’. Majority of the Parties have not banned ‘advertisement at point of sale’ (58%) and in ‘international print media’ (47%). Nearly 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 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.

7. **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 (<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 3/4th Parties (70%). Very few Parties (12%) have reported full coverage of the costs of tobacco cessation treatment or available pharmaceutical products, at least in one of the 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 only 25% of SLT users for the same.

Global Health Professions Students Survey indicates that medical, dental, 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.

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 are the most suitable solutions and are thus recommended. Health care providers need to be sensitized to provide equal care to both smokers as well as to SLT users.

8. **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 (67%) of the Parties 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 in place. These Parties mostly belonged to high resource group. Most of the high SLT burden Parties (n = 20) 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.

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

   Data on SLT use among adults is available at national level in 129 Parties. Of them 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 higher 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. SLT use is on rise in Myanmar.

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

10. **Prohibition on Import, Manufacture and Sale of SLT**

Almost one-fourth of the Parties have enacted laws to ban the trade of SLT in some form or the other. 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. 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.

11. **Ban on Spitting and SLT use in Public Places**

Spitting in public places, induced from SLT use, presents a complex and widespread challenge to public health. Though, experts globally, are divided in their opinion about the adverse health consequences of exposure to public spitting, there is historical precedence of countries imposing ban on public spitting to curb the epidemic of tuberculosis. Public notice with this effect was common sight in US, France and England in late 19th Century and early 20th Century. Public spitting due to chewing tobacco, betel quid among others is highly vexing issue while managing public hygiene. 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.

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, for controlling 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, whereas, 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. 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 compliance, especially with Article 1(f) in defining SLT by the Parties and in surveillance of SLT use (Article 20). More Parties need to start implementing these articles.

For the rest of the articles, very little progress has been made, and there has been much less attention to SLT, compared to the attention given to smoking.

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, in many cases they have not all yet been implemented effectively.

Recommendations

1. Parties should monitor SLT prevalence and its policy indicators using a standard protocol on a periodic basis.
2. Parties should develop comprehensive SLT control policies, covering all points under each article.
3. Parties should plan for the proper implementation of their policies.
4. COP should develop guidelines for Article 16 and strengthen guidelines for Articles 9 and 10, taking SLT control into consideration.

5. The WHO FCTC Global Knowledge Hub on SLT, WHO and other stakeholders of tobacco control should help in increasing capacity of SLT control in Low Resource Countries as their SLT burden is high
2. **INTRODUCTION**
The 2017 Global Smokeless Tobacco (SLT) Control Policy and its implementation document is the first attempt to discuss the framework in an inter-party meeting with global expert consultations. It has been prepared 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 described as under:

1. It provides 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 was reviewed by internal reviewers and further evaluated by two independent external reviewers outside the Hub.

2. This report provides comparative assessment of similar indicators for cigarettes and SLT products for clear understanding.

3. It contains 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 also includes information about the progress made by Parties in implementing a full or partial prohibition on manufacture, sale and import of SLT products within their jurisdiction.
   c. Also, the report includes information on ban on Spitting and SLT use in Public Places

4. The report outlines the prevalence of SLT use by both adults and youth, particularly in high burden Parties, based on secondary analysis of data collected through national and global surveys.

5. It gives 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. The report identifies several gaps in the implementation of laws to enforce FCTC articles by various Parties.

7. It provides feasible recommendations based on the findings and expert opinion.
2. METHODOLOGY
This 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, 2012,² 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**

Global values indicated in this document relate to 181 Parties of the Convention. There are 181 Parties to the Convention including ‘European region’ as Party and ‘Mozambique’ as a very recent Party. We included only 179 Parties for calculations in this report. WHO Regions were included for analysis at regional level.

**Parties’ classification by income group**

For this report, we used the World Bank definition and categorized Parties into two major groups for this; 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

**Parties’ classification by number of users**

Based on the various national and global sources of information on tobacco use, Parties having >1 million SLT users were classified as high SLT burden Parties. Overall, 23 Parties have >1 million SLT users. These 23 Parties are home to 95% of global SLT users.
Parties in South East Asia Region (SEAR) are home to over 80% of global SLT users. These 23 Parties are India, Bangladesh, Myanmar, Pakistan, China, Nepal, Colombia, Democratic Republic of the Congo, Malaysia, Madagascar, Germany, Uzbekistan, Sri Lanka, Nigeria, South Africa, Afghanistan, Yemen, Thailand, Egypt, Algeria, Philippines, Sweden and Kenya (Fig. 2.1).

![Number of SLT users (in million)](image)

**Fig. 2.1: Distribution of High SLT burden Parties**

In this report, 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 Parties income group level.
2. Party percentage for different provisions have been calculated with denominator 179
3. Policy progress has been mapped by year.

The report also provides examples of how far Parties have progressed in their policy development and their implementation of the Convention by individual articles. This report includes examples of recent and innovative activities, legislative processes and other actions. Main findings of the report are presented in tabular and graphic forms.
References:


3. FINDINGS

Article-wise findings on progress made by Parties in policy formation on SLT and implementation are presented in this section.
3.1: Use of Terms – Defining Smokeless Tobacco (SLT)

Article 1 defines the key terms used under the Convention, wherein clause (f) defines the term “tobacco products as under:

“Tobacco products mean products entirely or partly made of the leaf tobacco as raw material which are manufactured to be used for smoking, sucking, chewing or snuffing.”

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 analyze the terms defining or including or mentioning SLT products or SLT use in such legal documents. Of the 179 Parties, 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, Smokeless tobacco

Based on this classification, 112 Parties were found to have used above terminologies in their laws (Fig. 3.1.1).

General Definition

In addition, 13 Parties with the following categories of definitions were also considered to include SLT (Fig. 3.1.1) 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 weakly (obscurely) defined SLT products under the definition of ‘tobacco products’ or referred to SLT but do not clearly indicate inclusion of SLT in such definition (Fig. 3.1.1).

**No definition**
Forty-Four Parties have either not defined SLT or not provided any definition of tobacco products including 10 Parties whose laws are not available in English language (Fig. 3.1.1).

**Definition by income group of Parties**
Nearly three-fourth of the low and high resource Parties have included SLT in their tobacco control legislation (Fig. 3.1.2).
Definition by WHO Regions

Proportion of defining SLT by Parties, varied widely by region. It varied from 90% in the European to only 55% of Parties in the American Region (Fig. 3.1.3).

To avoid the multitude of definitions and the risk of dropping 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.
3.2: 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 travellers of tax- and duty-free tobacco products.

The health effects of SLT are well documented and it is known to cause a variety of cancers including oral, oesophageal, 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 having diverse product 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 countries. In India, for example, the total economic costs attributable to SLT use from all diseases in the year 2011 for persons aged 35-69 was INR 233.6 billion.\(^3\) 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 to adequately address the challenges from SLT use are not used effectively. The same, on the other hand, continues unabated in many regions of the world, especially in the SEAR and also among the youth. Data from the Global Youth Tobacco Survey (GYTS) shows that students aged 13–15 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%).\(^2\)

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 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. Due to the heterogeneous nature of SLTs they are manufactured and sold in a variety of forms which make it difficult to quantify with a standardized unit for the purposes of pricing or taxing. Price and tax measures on SLTs are often confusing and it is important to provide more clarity on this so that tax policies on SLTs can be made more effective.

This report aims to review issues around tax policies on SLTs with the objective of providing better clarity on the use of taxation as an effective fiscal policy instrument to regulate the use of SLT. The present report will review available data to discuss 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 objective 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. SLT use is decreasing in India and Bangladesh.

**Production of Smokeless Tobacco**

As indicated earlier, by volume, 91.3% (648.2 billion tons) of the SLT products sold worldwide (710.2 billion tons) are sold in traditional markets. 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 which would include cottage industry products and custom-made products. Data on production of these products are hardly available from most countries except India where the market is the largest. In 2007–2008, India produced about 83.3 thousand tons of tobacco to be used in making chewing tobacco products, and 9.11 thousand tons of tobacco to be used in snuff products, out of a total of 493.03 thousand tons of tobacco produced. Thus, 18.74% of tobacco produced was destined for making SLT products.

Table 3.2.1 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. Table shows 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 3.2.1: Gross value added of the SLT industry (in INR millions) (percent) for both unregistered and registered manufacturing in India

<table>
<thead>
<tr>
<th>Type of ST product</th>
<th>2000-01</th>
<th>2005-06</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unregis tered</td>
<td>Registere d</td>
<td>Total</td>
</tr>
<tr>
<td>Snuff</td>
<td>16.40</td>
<td>1060.00</td>
<td>1076.40 (8.60)</td>
</tr>
<tr>
<td>Zarda</td>
<td>7.40</td>
<td>1200.00</td>
<td>1207.40 (9.65)</td>
</tr>
<tr>
<td>Catechu (katha) and chewing lime</td>
<td>38.20</td>
<td>126.00</td>
<td>164.20 (1.31)</td>
</tr>
<tr>
<td>Pan masala and related products</td>
<td>115.00</td>
<td>632.00</td>
<td>747.00 (5.97)</td>
</tr>
<tr>
<td>Chewing tobacco and other tobacco products</td>
<td>181.00</td>
<td>9140.00</td>
<td>9321.00 (74.47)</td>
</tr>
<tr>
<td>Total SLT</td>
<td>358.00</td>
<td>12158.00</td>
<td>12516.00 (100)</td>
</tr>
<tr>
<td>Share of registered and unregistered (%)</td>
<td>2.86</td>
<td>97.14</td>
<td>100</td>
</tr>
<tr>
<td>Share in total tobacco (%)</td>
<td>19</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Estimated from the unit-level records of the Annual Survey of Industry (ASI) (registered units) and National SampleSurvey (NSS) data (unregistered units) as given in Selvaraj et al, 2017.
The SLT manufacturing is not quite labour-intensive as most activities involved in SLT manufacturing, including packaging, are done by machines. Table 3.2.2 shows the employment in SLT manufacturing in India for the year 2011-12. Smokeless manufacturing contributes only about 1.37% of the total employment generated in all tobacco manufacturing in India. Moreover, within SLT manufacturing, one can see that, the employment contribution is highest (65%) from the manufacturing of pan masala and related products followed by chewing tobacco (22%).

Table 3.2.2: Employment in SLT manufacturing in India

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


The important thing to understand, however, about the SLT production is the fact that a good portion of SLT products is made in the informal cottage type settings and are packaged in packs of different size and shapes so that it becomes extremely difficult to find standardized unit quantification for the purpose of taxing. Some of the 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 become extremely challenging for the law enforcement authorities.

Taxation of Smokeless Tobacco

Taxation of SLT products, especially the ones from traditional markets, have been a challenge for many countries 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. However, it is important to understand the best practices used in countries so that this knowledge may inform other countries where similar products are consumed.
FINDINGS – Article 6

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 respond negatively to 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 consistently effective tool for reducing tobacco use.4 This is also well recognised by the Parties to the World Health Organization Framework Convention on Tobacco Control (WHO-FCTC) and is clearly expressed as such under Article 6 of the Treaty.

Although several countries use tobacco taxation as a tool to both regulate tobacco use and generate tax revenue, the type and structure of taxes used vary 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. \textit{ad valorem} tax which is tax on the value of the product; and
3. Mixed tax which is a combination of both specific and \textit{ad valorem} taxes.8

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

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 use. Estimates of price elasticities on SLT products are rarely available from South East Asian Countries. Available studies in India\textsuperscript{11–14} show the price elasticity for SLT products is in the range -0.1 to -0.9 and those from Bangladesh\textsuperscript{15} 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. In other words, just as in the case of cigarettes, taxation can be an effective tool to reduce consumption of and increase tax revenue from SLT products.

Experiences in both India and Bangladesh indeed show that tax increases have been effective in reducing SLT use. Successive GATS surveys done in 2010 and 2017 in India and ITC surveys done in 2009 and 2012 in Bangladesh show significant reductions in the prevalence of SLT use in the general adult population as already detailed earlier. Significant tax increases on SLT products also have occurred during this period in both countries.

In India, in particular, it was found that increasing the price of SLT products may discourage SLT use among men\textsuperscript{13} and youth.\textsuperscript{14} The impact of an increase in prices of the two most popular varieties of SLT products (khaini and zarda) on consumption were examined in a recent study\textsuperscript{16} in India. It found that 58\% rise in the prices of khaini, resulted in a 51\% decline in the consumption during the period 2008–2013 and a 28\% rise in the price of zarda led to a 24\% decline in the consumption during the same period.

In Bangladesh, on the other hand, a recent study\textsuperscript{6} 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 Bangladesh\textsuperscript{15} had also confirmed the inverse relationship between tax increases and SLT use in Bangladesh.

**Tax incidence and price of SLT**

While the literature on taxing cigarettes and similar smoked tobacco products are fairly well established,\textsuperscript{4} the same is not true in case of taxation of SLT products owing to their heterogeneous nature. This is despite the fact that the provisions of Article 6 apply to both smoking and SLT and the guidelines to implement the Article recommend measures to specifically address all tobacco products, in particular to prevent product substitution within and
across categories. Yet, 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 year 2015 and 2017 reported the tax
incidence proportion of overall taxes in retail prices of SLT products along with their prices (in
international dollars at purchasing power parity) for the most common type of SLT products, as
reported by 32 Parties. As one can see from Fig. 3.2.1, 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
on SLT products 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% while the
WHO’s Technical Manual on Tobacco Tax Administration recommends tobacco excise taxes
alone should account for at least 70% of the retail prices of tobacco products. 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, while Algeria, Tunisia and
Morocco (non-Party) were 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 utilizes taxation as a tool
to regulate consumption of SLT products.

Examining price variation of SLT products across Parties also reveals interesting insights.
Some Parties such as Morocco (not a Party to the Convention), Sudan, and Tunisia although
have relatively high tax incidence their unit price of SLT products is relatively cheaper than
several other Parties where tax incidence is low.

Republic of Korea, Belarus, Ukraine, Indonesia (non-Party), and Japan, for example,
have relatively high price for SLT products although 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. On the other hand, there are also Parties where both tax and price are high (e.g. Serbia, Canada, Norway, Iceland and Suriname). Although there is no discernible pattern in tax incidence across income group, one can clearly see that the retail prices (PPP dollars) are, in general, lower for SLT products in LIC and LMIC and higher in HIC. This, to an extent, explains the relatively high prevalence of SLT use in LICs and LMICs.

Figure 3.2.1: Comparison of retail price and tax incidence between SLT and cigarettes

![Figure 3.2.1: Comparison of retail price and tax incidence between SLT and cigarettes](image)

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.

Figure 3.2.1 presents a comparison of retail prices (international PPP $) and tax incidence for a 20 cigarette pack of most sold brand of cigarette and a 20 gram pouch of 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 twelve Parties where per unit price of SLT products are larger than that of cigarettes. In this 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 had 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 good from a tobacco control perspective as 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. In general, one can see that Parties with high incidence of tax on cigarettes also have relatively larger incidence of tax for SLT although there are exceptions.

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 production. 20 This often incentivises manufactures 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 FY 2015-16, made maximum speed of packing machine as a factor for determining both the deemed production and excise duty payable under the Compounded Levy Scheme and it was applied to *pan masala*, *gutkha* and chewing tobacco. Packing speed would be typically determined by a Government approved Chartered Engineer. Both deemed production and duty payable per machine per month were notified in respect of 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 3.2.3 provides a sample snapshot 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 which ranges from less than INR 1 to more than INR 50 per pouch.

Table 3.2.3: Example of a compounded levy scheme in India (FY 2016-17)

<table>
<thead>
<tr>
<th>Retail Sale Price (per pouch)</th>
<th>Excise Rate of duty per packing machine per month (INR in Lakhs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chewing Tobacco (other than filter Khaini)</td>
</tr>
<tr>
<td></td>
<td>Up to 300 pouches per minute</td>
</tr>
<tr>
<td></td>
<td>Without limetube</td>
</tr>
<tr>
<td>Up to INR 1.00</td>
<td>30.51</td>
</tr>
<tr>
<td>Exceeding INR 1.00 but not exceeding INR 1.50</td>
<td>45.76</td>
</tr>
<tr>
<td>Exceeding INR 1.50 but not exceeding INR 2.00</td>
<td>54.91</td>
</tr>
<tr>
<td>Exceeding INR 2.00 but not exceeding INR 3.00</td>
<td>82.37</td>
</tr>
</tbody>
</table>

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

Following the amendments that made speed of packing machines as 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 Financial Year (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. The modifications to the compounded levy introduced in the taxation of SLT products in India points 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 the same. 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 alone. The share of excise 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 most recent Goods and Service Tax (GST) reform in India which was implemented on the 1st of July 2017, the SLT products are categorized under a demerit product
FINDINGS – Article 6

category and are imposed the highest GST rate of 28%. In addition to the 28% GST 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 3.2.4. Most chewing tobacco products get a cess of 72% while *pan masala* containing tobacco is imposed 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 taxes detailed above. With all these rates, however, 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 taxes much larger.

Table 3.2.4: Tax rate on various smokeless products in India from 1 July 2017

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

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

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* 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.
(oral powder) which are the most common forms of smokeless tobacco products in the country. A 10% supplementary duty on the ex-factory price of zarda and gul was also introduced in 2009. In the years 2010–11 and 2011–12 the supplementary duty was further revised to 20% and 30% respectively. These supplementary duties were again revised to 60% and later to 100% in the years 2015-16 and 2016-17, respectively.

**Affordability of Smokeless Tobacco**

One of the objectives of taxing tobacco products is to make them less affordable as the time goes. 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 grow over 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 data suggest cigarettes are becoming less affordable in high resource Parties and much more affordable in low resource Parties. Data on affordability of SLT across Parties is, however, limited. Earlier studies in India showed that SLT products have become more affordable over the period 2001 to 2007. More recent studies using data for 2006-2012 also suggest that SLT products are becoming more affordable in India. The study observed that despite higher increase in the price of SLT compared to general prices, the SLT products became more affordable due to a higher increase in the per capita GDP. Using data from 2009 to 2015, a recent study 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 change due 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.”
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 developed 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, 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 around 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 less in number, concluded that the elasticity of SLT products fell in the inelastic range of less than 1 and, as a result, taxation can be used as 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 tax is implemented is crucial to make the best use of this tool. Taxation should be as simple as possible and it should be efficient 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 be either 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. The experience in India shows that taxation based on the pre-notified capacity of packing machine that take 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 better impact on reducing consumption.

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3.3: 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 have 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


*Banning the display of quantitative information on emission yields*

The quantitative information showing the quantity of tar, nicotine and other emission yields on SLT packaging may provide a wrong impression that certain SLT products with lesser quantity are better than the ones with 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 thirty one Parties had laws banning the display of quantitative information on emission yields (such as tar, nicotine and carbon monoxide) on cigarettes and SLT packaging respectively. Majority of them were high resource countries (Fig. 3.3.1).

*Mandating the display of qualitative information on constituents and emissions*

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

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

![Fig. 3.3.1: 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](image)
Data from scientific research on analysis of chemical composition of SLT products revealed that:

- 10% (N=18) of the Parties (Brazil, Canada, Denmark, Germany, India, Sudan, Sweden, UK, South Africa, Nigeria, Ghana, Turkey, Norway, Pakistan, Oman, Uzbekistan, Kyrgyzstan and Ethiopia) have done analysis of the chemical composition of SLT on ad-hoc basis. In analysis, laboratories in USA (not a Party to the Convention), Sweden, India, Oman, Nigeria, Pakistan, Ethiopia and Canada were involved.
- All SLT products available in these Parties have not 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-Nitrosonornicotine (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 and B[a]P. The report suggested 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 revealed 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 3.3.1. It is quite clear from the table 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. The variation in levels of Gutkha and Zarda is also quite high. Similarly, the range of different constituents in various brands and types of SLT products available in Oman, Sweden, Canada, Kyrgyzstan, Uzbekistan and Turkey is provided in Table 3.3.1. The concentration of B[a]P in various SLT products higher than WHO TobReg and GothiaTek® standards have been provided in Table 3.3.2. The concentrations of heavy metals along with their comparison with GothiaTek® standards are provided in Table 3.3.3 showing concentrations higher than the standards.
### Table 3.3.1: Range of NNK, NNN and Nicotine from different brands of SLT products available in India\(^4\), Oman\(^5\), Sweden\(^6\), Canada\(^7\), Kyrgyzstan, Uzbekistan\(^8\) and Turkey\(^9\)

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

*not a Party to the Convention

### Table 3.3.2: Concentration of B[a]P in different SLT products along with the recommended regulatory standards of WHO and GothiaTek\(^10\)

<table>
<thead>
<tr>
<th>Brand</th>
<th>BaP</th>
<th>WHO TobReg</th>
<th>GothiaTek®</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ng/g</td>
<td>ng/g</td>
<td>ng/g</td>
</tr>
<tr>
<td>Dalal Misti Zarda(^11)</td>
<td>8.89</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Quadir Gul(^12)</td>
<td>5.98</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Baba 120 (Zarda)(^11)</td>
<td>2.83</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Copenhagen (Snuff)(^11)</td>
<td>19.33</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Loose snus(^2)</td>
<td>2.93</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Portion snus(^2)</td>
<td>2.53</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Chewing tobacco(^2)</td>
<td>6</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Dry snuff(^2)</td>
<td>80.4</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Soft pellet(^2)</td>
<td>117</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Moist snuff(^2)</td>
<td>87.4</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Plug(^2)</td>
<td>3.25</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Square dry snuff(^3)</td>
<td>86.7</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Lucky strike Original snus(^3)</td>
<td>3.45</td>
<td>5</td>
<td>1.25</td>
</tr>
</tbody>
</table>
Table 3.3.3: Concentrations of different heavy metals in smokeless tobacco products as compared to GothiaTek® Standards

<table>
<thead>
<tr>
<th>Heavy Metals</th>
<th>Lead (Pb) (μg/g)</th>
<th>Arsenic (As) (μg/g)</th>
<th>Nickel (Ni) (μg/g)</th>
<th>Cadmium (Cd) (μg/g)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GothiaTek® Standard Limits (μg/g)</td>
<td>1</td>
<td>0.25</td>
<td>2.25</td>
<td>0.5</td>
</tr>
<tr>
<td>Smokeless Tobacco Products</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naswar(^2)</td>
<td>12.4-14</td>
<td>0.15-14</td>
<td>2.2-64.85</td>
<td>0.25-9.2</td>
</tr>
<tr>
<td>Moist snuff</td>
<td>0.3-14-111.15</td>
<td>0.17-14-0.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afzal (Mean of 3 samples)(^3)</td>
<td>1.62</td>
<td>1.57</td>
<td>1.85</td>
<td></td>
</tr>
</tbody>
</table>

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 levels range from 4.36 to 11.8 in different SLT products as depicted in Table 3.3.4; the maximum pH values were found in Nass and Rapé. The variation in nicotine in different SLT products is provided in Table 3.3.5. Recent work done by Stepanov et al., 2017 shows that total nicotine varied from 5.3-57.8 mg/g (dry weight) while unprotonated nicotine content ranged from 0.13-99.8% of total nicotine for the samples collected from Mumbai, India.\(^{16}\) The fifth report of “WHO Study Group On Tobacco Product Regulation” (TobReg) suggested setting limits on free nicotine and pH.\(^{17}\)

Table 3.3.4: Distribution of pH among samples from various Parties

<table>
<thead>
<tr>
<th>Countries</th>
<th>pH range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>4.36-5.34</td>
</tr>
<tr>
<td>Canada</td>
<td>5.34-5.63</td>
</tr>
<tr>
<td>Germany</td>
<td>5.71-5.73</td>
</tr>
<tr>
<td>India</td>
<td>5.78-7.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>7.45-10.2</td>
</tr>
<tr>
<td>USSR</td>
<td>11-11.8</td>
</tr>
<tr>
<td>USA*</td>
<td>5.05-8.88</td>
</tr>
</tbody>
</table>

*Not a Party to the Convention
Table 3.3.5: Range of nicotine from different brands of smokeless tobacco products available in India, Sweden, Canada, Brazil and Pakistan.

<table>
<thead>
<tr>
<th>SLT Products</th>
<th>Nicotine (mg/g)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khaini</td>
<td>19.6-21.3</td>
</tr>
<tr>
<td>Zarda</td>
<td>13.8-65</td>
</tr>
<tr>
<td>Gutkha</td>
<td>1.23-11.4</td>
</tr>
<tr>
<td>Moist snuff</td>
<td>2.44-31.2</td>
</tr>
<tr>
<td>Rapé</td>
<td>6.32 - 47.6</td>
</tr>
<tr>
<td>Snus</td>
<td>12.8-28.2</td>
</tr>
<tr>
<td>Naswar</td>
<td>7.35-26.68</td>
</tr>
</tbody>
</table>

WHO Tobacco Laboratory Network

WHO has established WHO Tobacco Laboratory Network (TobLabNet) with the aim to regulate and provide testing and research of 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, six collaborating centers are working on tobacco testing and research (Table 3.3.6). However, the laboratories of these centers focus on technical training, testing compounds and emissions of smoking products especially cigarettes.

Table 3.3.6: WHO collaborating centers working on tobacco content

<table>
<thead>
<tr>
<th>S. No.</th>
<th>WHO Collaborating Center</th>
<th>Laboratory Name</th>
<th>WHO region</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WHO Collaborating Center on Tobacco Product Testing and Research, Burkina Faso</td>
<td>Laboratoire National de Santé Publique Rue TansobaKiém</td>
<td>AFR</td>
</tr>
<tr>
<td>2</td>
<td>WHO Collaborating Centre for Tobacco Product Regulation and Control, Netherlands</td>
<td>Laboratory for Health Protection Research</td>
<td>EUR</td>
</tr>
<tr>
<td>3</td>
<td>WHO Collaborating Centre for Tobacco Product Testing and Research, USA</td>
<td>Center for the Study of Tobacco Products</td>
<td>AMR</td>
</tr>
<tr>
<td>4</td>
<td>WHO Collaborating Centre for Tobacco Testing and Research, Japan</td>
<td>Department of Environmental Health</td>
<td>WPR</td>
</tr>
<tr>
<td>5</td>
<td>WHO Collaborating Centre for Tobacco Testing and Research, Singapore</td>
<td>Cigarette Testing Laboratory</td>
<td>WPR</td>
</tr>
<tr>
<td>6</td>
<td>WHO Collaborating Centre on Tobacco Control, Germany</td>
<td>German Cancer Research Centre</td>
<td>EUR</td>
</tr>
</tbody>
</table>
The report by WHO at Conference of Parties 7 (COP7) states that the already available WHO TobLabNet methods for analysis of TSNAs, B[a]P and nicotine can be adapted or applied to a number of SLT. Also, owing to wide range of SLT products, there is a need to perform product specific analysis in South Asia which 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 needs to be standardized. It was also recommended that the Parties be invited to consider requiring SLT manufacturers to disclose pH level and toxicants (TSNAs, B[a]P and nicotine) using WHO recommended methods/SOPs, as currently recommended for cigarettes, from approved laboratories.

**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 NTTL at 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 to Government of India and other organizations such as WHO.

**Gaps in understanding article 9 and 10**

The available data clearly indicates that very few laboratories, which are not funded by industry, are working on the chemical composition of tobacco. Most of this work is primarily on cigarettes with only meager focus on SLT.

Almost 90% of SLT users reside in South-East Asian countries and there is only one functional tobacco testing laboratory in this region, located in Guwahati, India. Out of 179 Parties, there are only 2 where most of the SLT samples are being tested. There is a dearth of information about brand wise quantification of Group I carcinogens such as NNN and NNK. The 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.

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 produce results with certain regulatory standards. Researchers, thus find it extremely difficult to compare the results and bring them on the same scale. No standards are provided for testing and measuring most of the compounds of SLT products.
FINDINGS – Article 9 & 10

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.

Recommendations

1. Parties should emphasize on the establishment of tobacco testing laboratories in every region to identify the toxic and hazardous effects of SLT products. These laboratories will be precisely the driving force behind the successful implementation of Articles 9 and 10 of WHO-FCTC. Several programs and expert groups have also recommended 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’.

2. Major initiatives are required that promote collaborations between academia, researchers, scientists and governments to ensure that reports from the laboratory are given in standard format and are quickly analyzed and efficiently translated for implementation.

3. SOPs should be developed and practiced for tobacco testing across all laboratories. A standard protocol is essential which different research laboratories must adhere to in order to provide results which can be easily interpreted and used for implementation.

4. International cooperation and collaboration: Cooperation and collaboration among Parties is a prerequisite for effective progress on regulation of SLT globally. Parties having a tobacco testing lab 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 in further research on SLT products, their ingredients and emissions, for effective regulation of SLT products. Smaller or independent laboratories working on tobacco should be empowered and funding opportunities should be provided.

6. Permissible upper limits of all chemical ingredients of SLT products should be introduced 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.
References


### 3.4: Packaging and Labeling of SLT

Article 11 of WHO FCTC pertains to effective packaging and labeling of tobacco products. It recommends HWs 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 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 are aimed 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 the 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 products\(^6\); although available evidence supports that effectiveness of health warnings apply to smokeless tobacco products as well.\(^7\)\(^8\)

The current review 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 (≥50%)
3. Pictorial Health Warnings (PHW)
4. Multiple Health Warnings (≥2 specific warnings)

A Party ensuring compliance with ≥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 (≥30%) on cigarette and SLT:

By 2005, only 6 Parties required HWs (≥30%) on SLT packaging whereas 21 Parties required 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 (Fig 3.4.1).

For SLT, more低 resource Parties had notified ≥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%) (Fig 3.4.3).

All WHO regions had ≤60% proportion of Parties notifying the policy on SLT, whereas, for cigarette, the coverage was ≥60%. Among WHO regions, SEAR and EMR had the highest proportion of Parties notifying ≥30% HW on SLT (60% and 53% respectively), as compared to cigarette, where EUR had the highest proportion (94%).
2. Large Health Warnings (≥50% size):

   For SLT, 27% Parties had notified large HWs, in comparison to 56% on cigarette (Fig 3.4.2). Low resource Parties had higher proportion (37%) 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 (Fig 3.4.3). SEAR had the maximum proportion of Parties specifying large HWs (50% for SLT and 70% for cigarette).

3. Pictorial Health Warnings (PHW):

   PHW of ≥30% size on SLT packages were notified by 20% Parties and by 56% Parties for cigarette (Fig 3.4.2).

   Findings similar to Large HWs were noticed for PHW as well, with low resource Parties scoring more for SLT (26%) and high resource Parties scoring more for cigarette (64%) (Fig 3.4.3). 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 (≥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).

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 (Fig 3.4.2).

   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 high SLT burden Parties, India, Nepal, Philippines, Egypt and Kenya have complete policy and implementation. In Bangladesh, Myanmar and Colombia complete law is in place but has not been implemented. In 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, whereas out of them, 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 around half 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) and GATS-II (2017) 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-I revealed 29%-38% smokers and 34% SLT users agreeing to it, which increased to 54%-62% smokers and 46% SLT users in GATS-II. These findings corroborate with the change in HWs on tobacco product packages over the time period of the two GATS survey in India.

In 2009-10, 40% pictorial HWs size was implemented (2 warnings on smoking products and one 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 (Fig 3.4.4). This change might have created an impact over the tobacco user and resulted in the observed increase in the motivation to quit.
2. *GATS Report: Thailand*

Sale of SLT products is prohibited in Thailand. However, shredded tobacco is 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.\(^\text{12}\) 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% users in 2011.

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![Graph](image.png)

**Fig 3.4.2: Parties (%) notifying provisions under Article 11**

![Graph](image.png)

**Fig 3.4.3: Parties (%) notifying provisions under Article 11 (by Income groups)**
FINDINGS – Article 11

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 HW size, coverage by HW and warning content.
2. Many Parties have not been able to formulate policies on implementing HW on cigarettes and SLT products.
3. Most parties including high SLT burden countries have only partial or no policy in place for implementing HW on SLT products.

Recommendations
1. Parties should frame comprehensive HW policies as per Article 11 of FCTC for all tobacco products, including SLT products.
2. Parties should effectively implement the provisions of Article 11 and the guidelines adopted thereunder without any exemptions.
3. All Parties should follow the recommended best practices while implementing HW. The warnings should be large i.e. cover at least ≥50% on the both/all sides, include pictures, have at least two or more specific warnings, and should be rotated at periodic intervals.
4. Parties should notify multiple HW messages on various diseases caused due to SLT use, and where available, require display of quit-line numbers along with the HWs.
5. Parties should adopt comprehensive information and communication campaign, including through mass media, in line with the notified HWs for greater impact of the warnings.
6. Parties should consider making it mandatory that SLT is sold in packaged form allowing HWs to be clearly printed on the package.

References:

4. Partos TR, Borland R, Yong HH, Thrasher J, Hammond D. Cigarette packet warning labels can prevent relapse: Findings from the International Tobacco Control 4-country policy evaluation cohort study. Tob Control 2013;22(e1):e43-50


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 nongovernmental organizations not affiliated with the tobacco industry in developing and implementing intersectoral 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.

Article 12 of the WHO Framework Convention on Tobacco Control (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 define specific actions that Parties should take to effectively implement it including:

- Establish an infrastructure and build capacity to raise public awareness of tobacco control issues
- Promote social change through international collaboration, involvement of civil society, and all other available means.
- Ensure that education, communication, and training programs include 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, training materials, and unpaid or low-cost communications such as warning labels on tobacco products, or press conferences or other events that help in dissemination of information or generate earned media coverage.

**Key Observations**

Based on the Global Progress Report on implementation of WHO FCTC 2016, 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 parties complying, Article 12 is the fourth highest implemented FCTC Article. Out of the 179 Parties, 64 (36%) had conducted at least one national mass media campaign. The figure below provides the detailed distribution of mass media campaigns in all FCTC Parties.

![Party conducted at least one National Mass Media Campaign](image)

Figure 3.5.1: Party conducted at least one National Mass Media Campaign
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 below in table 3.5.1:

Table 3.5.1: Number of Parties having national mass media campaign in 2014 and 2016

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2015(^4) (n = 70)</th>
<th>2017(^3) (n = 64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was part of a comprehensive tobacco control programme</td>
<td>61</td>
<td>57</td>
</tr>
<tr>
<td>It was pre-tested with the target audience</td>
<td>43</td>
<td>40</td>
</tr>
<tr>
<td>Research about the target audience was conducted beforehand</td>
<td>59</td>
<td>54</td>
</tr>
<tr>
<td>It was aired on television and/or radio</td>
<td>62</td>
<td>55</td>
</tr>
<tr>
<td>It utilized media planning</td>
<td>68</td>
<td>58</td>
</tr>
<tr>
<td>Earned media/public relations were used to promote the campaign</td>
<td>67</td>
<td>62</td>
</tr>
<tr>
<td>Process evaluation was employed to assess implementation</td>
<td>61</td>
<td>53</td>
</tr>
<tr>
<td>Outcome evaluation was employed to assess effectiveness</td>
<td>41</td>
<td>42</td>
</tr>
</tbody>
</table>

It may be noted that the Global Progress Report on implementation of WHO FCTC 2016 as well as 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 thorough mass media, community and school programs. Glimpse of such activities and efforts, especially from India, are highlighted below.

**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 priority audience including women, rural residents and low-income groups. This 30 second documentary,
referred to as ‘Surgeon’ was filmed and pre-tested. It featured an oral cancer surgeon who described and presented the serious illnesses and disfigurement of his patients, which had been caused by cancers resulting from the use of SLT. The campaign was evaluated and had a high recall value with 63% SLT users and 72% dual users recalling the campaign. Over 70% who were aware of the campaign said 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 users.5

This campaign was followed up by ‘Mukesh’ the story of a 24 year old SLT user. He was featured in the surgeon campaign and died soon after the campaign was aired. The ‘Mukesh campaign’ was aired by the Government from February to April 2011. Later in 2014, the Government aired another campaign featuring Sunita, suffering from mouth cancer, where she narrates her personal testimony. The campaign shows 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 a Voices of Tobacco Victims (VoTV) highlighting the tragic consequences of SLT use.

In Bangladesh a public service announcement on oral cancer was part of the 2016 anti-tobacco campaign in the country, highlighting the new graphic health warnings on tobacco products.6
Social Media

Civil society organizations have also shared mass media campaign on hazards of smokeless tobacco through social media like You Tube in Bangladesh. Several other countries (e.g. Pakistan, India) have also made use of You Tube and Voice Of Tobacco Victim campaigns to educate the masses against the use of smokeless tobacco.
**Tobacco-free Villages Initiative in India**

In Madhya Pradesh, Andhra Pradesh, Nagaland and several other states where many innovative initiatives have been undertaken in villages that have spread to neighboring areas. Gariphema village in Nagaland was declared "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 whoever gets drunk and disturbs peace would be imposed a fine of INR 1000 while those consuming alcohol, 'bidi', 'paan', betel nut or smokeless tobacco on the street and public places would be fined INR 500.

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 Araku mandal, Damsarai, Mardaguda and Chukumadatha in Ananthagiri mandal, D Kollaput, Narinjvalasala and K Kosiguda in Dumbriguda mandal, Dabaputi in Paderu and Kunturla in Hukumpeta mandal. 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 AP.

Noorundumalai village in Tamil Nadu is tobacco free since 2002. Shankapura village in Haryana is another tobacco free village in the country. Chinch Gohan village in Khandwa District of Madhya Pradesh was declared tobacco-free in 2006 while Chikhli is another tribal village with this distinction in Madhya Pradesh since 2010.

Fig. 3.5.6: Addiction free Model tribal village - Chikhli
Earned media

Both electronic and print media provide 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. The news media cover events, initiatives, research and evidence on smokeless tobacco and send across the communication 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. Sixty-six percent and 34% news items, respectively, were focused on youth and women. The earned media news items had a hypothetical value of US$1503 628.3.\textsuperscript{15}

Fig. 3.5.7: Earned Media

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 included in its communication strategy, specifically, the harms of SLT use were discussed individually 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 programme was implemented in the Kolar district of Karnataka between 1987 and 1990. The intervention revealed that the audiovisual medium of messaging was relatively more effective in encouraging cessation than the other communication message types.\textsuperscript{16}
School based programmes

The earliest recorded school-based intervention was implemented in 46 villages in the Northern and Central zones of Goa in 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). The evaluation reported greater resistance among students to consuming tobacco in the future.\textsuperscript{17}

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, 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.\textsuperscript{18}

Though the school based interventions have been implemented in some developed countries, they have not yielded desired outcomes. However, imparting awareness against tobacco use in schools has worked for developing countries because teachers are role models for students and influential members of society, 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 reveals that nearly 60% of the students from among the 65 Parties, 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 and exposure to anti-SLT education and communication materials by the students. 19

**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’. The figure below (Figure 3.6.9) provides the Party representation of the response by school personnel that tobacco use prevention is included in their school’s curriculum. 19

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 eight Parties i.e. Papua New Guinea, Malawi, Oman, Kyrgyzstan, Estonia, Myanmar, Bhutan, Republic of Moldova, more than 50% school personnel reported these activities.

According to the GSPS only 46% school personnel from the 32 reporting 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. 19
Whereas, overall only 12% school personnel reported having ever received training on youth tobacco use prevention. However, nearly 54% school personnel in Kyrgyzstan reported having received such training.

**Education through health warnings on tobacco packages**

Health warnings on tobacco products 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 23 high SLT burden Parties only nine have prescribed HWs on SLT products.

Table 3.5.2: High SLT Burden Parties and PHW on SLT

<table>
<thead>
<tr>
<th>S. No</th>
<th>Country</th>
<th>Warning labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>India</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Bangladesh</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Myanmar</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>Pakistan</td>
<td>X</td>
</tr>
<tr>
<td>5.</td>
<td>China</td>
<td>X</td>
</tr>
<tr>
<td>6.</td>
<td>Nepal</td>
<td>✓</td>
</tr>
<tr>
<td>7.</td>
<td>Colombia</td>
<td>✓</td>
</tr>
<tr>
<td>8.</td>
<td>DR Congo</td>
<td>X</td>
</tr>
<tr>
<td>9.</td>
<td>Malaysia</td>
<td>X</td>
</tr>
<tr>
<td>10.</td>
<td>Madagascar</td>
<td>X</td>
</tr>
<tr>
<td>11.</td>
<td>Germany</td>
<td>X</td>
</tr>
<tr>
<td>12.</td>
<td>Uzbekistan</td>
<td>X</td>
</tr>
<tr>
<td>13.</td>
<td>Sri Lanka</td>
<td>X</td>
</tr>
<tr>
<td>14.</td>
<td>Nigeria</td>
<td>X</td>
</tr>
<tr>
<td>15.</td>
<td>South Africa</td>
<td>X</td>
</tr>
<tr>
<td>16.</td>
<td>Afghanistan</td>
<td>✓</td>
</tr>
<tr>
<td>17.</td>
<td>Yemen</td>
<td>✓</td>
</tr>
<tr>
<td>18.</td>
<td>Thailand</td>
<td>NA</td>
</tr>
<tr>
<td>19.</td>
<td>Egypt</td>
<td>✓</td>
</tr>
<tr>
<td>20.</td>
<td>Algeria</td>
<td>X</td>
</tr>
<tr>
<td>21.</td>
<td>Philippines</td>
<td>✓</td>
</tr>
<tr>
<td>22.</td>
<td>Sweden</td>
<td>X</td>
</tr>
<tr>
<td>23.</td>
<td>Kenya</td>
<td>✓</td>
</tr>
</tbody>
</table>
Information on Article 12 under GATS

The global adult tobacco survey has following two questions on 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.

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. Though several Parties including the high SLT burden Parties have HWs on SLT products, data under GATS on current SLT users who noticed HWs on smokeless package is only available for India.20

Studies clearly identify lack of awareness on SLT use:

Bangladesh

There is 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 any information about SLT use. There is 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.21

Control of the use of SLT in Bangladeshi society requires a massive social awareness programme using the education system and various electronic media alongside the tobacco control programme. Even the traditional approach of labeling packages with warnings will not work for ‘sadapatha’ as it is not industrially produced and does not have any packaging—they are presented as dried tobacco leaves. Also sadapatha and zarda are mixed in paan without the customer getting to look at the zarda package.22
Myanmar

The use of SLT is prevalent with many different types of tobacco being used in Myanmar. The socio-cultural acceptance and the myths are compounded by the lack of specific SLT control component in the National Tobacco Control Legislation adopted. 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 that needs to be followed by advocacy and effective law enforcement.23

Sri Lanka

The increasing popularity of SLT use among the youth and adolescents is a cause for concern in Sri Lanka. The level of awareness about health risks like oral cancer and oral potentially malignant disorders (OPMD) related to the consumption of smokeless tobacco products is low, particularly among the people with 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 on this aspect is low.24

In one study, estate workers were found to be significantly less aware than villagers even though the SLT use is higher among these workers. Most estate workers only knew that tobacco can cause health problems, but were not aware 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 spread tuberculosis and other diseases.24

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.24

To avoid 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.25
Nepal

In Nepal, educational and awareness activities on the harmful effects of tobacco use and health warnings have been disseminated through the mass media, including radio, television, FM (Frequency Modulator) and print media and through 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. 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 programmes and monitoring in rural Nepal is equally difficult because of physical barriers.

Pakistan

There is inadequate knowledge about the health problems associated with SLT. Appropriate interventions including health education campaigns are needed to raise awareness of the health risks and to prevent SLT use. 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.

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 that there is absence of dedicated mass media or communication strategy to reduce SLT use.
3. All the studies on SLT from the South-east Asia Region reveal lack of comprehensive education and communication efforts to prevent SLT use, especially among women, youth and vulnerable population group.
4. There is lack of national education, awareness and communication programs to curb SLT use.
Recommendations

1. The communication programs should be made more strategic, participatory, and interactive and should seek to understand the target audiences and 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. 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 and other rules and regulations applicable to smoking products in that country.

4. 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 to consider adding a question for students’ survey under GYTS to assess if students are taught about the dangers of SLT in their school.

References:


5. Murukutla et al. Results of a national mass media campaign in India to warn against the dangers of smokeless tobacco consumption. Tobacco Control 2012; 21: 12-17


3.6: Ban on SLT Advertisement, Promotion and Sponsorship

---

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

- Implement a comprehensive TAPS ban, and undertake the measures necessary to implement the ban within 5 years of ratification.
- For signatories whose constitution does not allow for a comprehensive ban, apply restrictions on all TAPS.
- 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.
- Cooperate in international efforts to eliminate cross-border advertising, and ban any cross-border advertising entering a country’s territory that violates that country’s restrictions.

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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.  

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.  

**Key Observations**

1. **Ban on Advertisement**

   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. 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 SLT and 47% for SLT) (Figure 3.6.1).
Nearly 60% Parties have banned advertisement through internet for cigarettes and SLT respectively. Internet advertisement and sale of SLT products are rampant, especially in SEAR and EUR. The WHO FCTC GKHS LT (Global Knowledge Hub on Smokeless Tobacco) is working on this issue in detail and analysis is underway.

**Ban of Snus sale through internet; Case of European Union**

The European Union (EU) Tobacco Products Directive bans the sales of snus in EU countries other than Sweden. The snus is being sold in the market via the internet and is easily purchased in most of EU Member States. The majority of online sites are from Sweden targeting non-Swedish EU citizens. Inadequate age verification methods and price-based promotions are widespread in 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 the 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. The need of the hour is to formulate a policy to reduce the sale of online SLT products.
2. Ban on Promotion and Sponsorship:\textsuperscript{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’ and vice versa are some of the neglected areas of Parties.

Nearly one-fourth of Parties (26\%) have a complete ban on sponsorship for both cigarettes and SLT products (47 and 46 countries for cigarettes and SLT respectively) (Figure 3.6.2).

![Bannnnn.on Promotion and Sponsorship](image)

**Fig. 3.6.2:** Number and percentage of Parties notifying ban on Promotion and Sponsorship

In India, manufactured SLT products are 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 (Figure 3.6.3).
Fig. 3.6.3: Tobacco and non-tobacco products having similar packaging in India⁷
Non-tobacco brands are heavily advertised through same tobacco brand name on billboards (Fig 3.6.4) and at the point of sale in India (Fig 3.6.5)

Fig. 3.6.4: Hoardings of Rajnigandha which had similar advertisements for tobacco products in past

Fig. 3.6.5: Ribbons of Panmasala with similar brands of tobacco products
3. Monitoring Implementation of Article 11

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 GATS. However, a limited number of Parties (notably India\(^8,9\) and Bangladesh\(^10\)) have additionally investigated exposure to SLT advertisement and promotion in their GYTS and GATS.

Exposure to SLT advertisement in India\(^7\)

Report from Global Adult Tobacco Survey (GATS) of India (2009-10) revealed that percentage of adults exposed to SLT advertisements and promotion is higher than that of smoked products. Nearly one-fourth of adults were exposed to advertisement and promotion of cigarettes while nearly over half of the adults were exposed to SLT advertisement and promotion in India in 2010 (Figure 3.6.6).

Fig. 3.6.6: Percentage of adults who noticed any advertisement, promotion or both (India GATS 2009-10):

Figure 3.6.7 illustrates exposure of SLT advertisements and promotion among adults through different media and means. Point of sale advertisement of SLT seems to be the highest among all (10.8%). Around 10% of adults reported having seen SLT advertisement at ‘Point of
sale’ in India and Bangladesh. SLT promotion was being undertaken through distribution of items with SLT brand logo (such as bag or T-shirt) (Figure 3.6.7). These indicators implied that effective implementation of Article 13 has not been conceded to in a high-burden Party such as India.

By comparing results of India GATS 2010 and 2016 it is very clear that there is significant decrease on exposure to SLT advertisements at points other than point of sale from 45.3% in 2010 to 16.8% in 2016 (Fig 3.6.8).

Fig. 3.6.7: Adults (%) exposed to SLT advertisements and promotions: by places and means (India GATS 2009-10)

Fig. 3.6.8: Exposure to SLT advertisements and promotion in India by year
Exposure to SLT advertisement among youth and adolescent\textsuperscript{2}

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’\textsuperscript{7}.

Conclusions

1. Less than 8\% of Parties have comprehensive SLT TAPS ban policy.
2. A distinct gap is noticed among CIG and SLT products for all TAPS provisions under Article 13 showing unequal attention by Parties on TAPS ban policies for SLT.
3. Ban 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. Parties with the exception of Bangladesh and India, have not developed indicators for implementation of their policies. Less than half of the Parties have provisions prohibiting SLT promotion.
6. The good news is that exposure to SLT advertisement and promotion among adults has decreased significantly.

Recommendations

1. A comprehensive ban of TAPS is required to be adopted by all Parties towards implementation of Article 13 of WHO FCTC for all tobacco products (inclusive of SLT).
2. Implementation should follow the notified regulations with specified execution method of the provision within the time frame and should be addressed without any ambiguity.
3. Parties should regularly monitor the exposure of SLT advertisement and promotion using standard protocol.
References:
2. Hiilamo H, Glantz S. FCTC followed by accelerated implementation of tobacco advertising bans. Tob Control 2016; 0: 1-6. doi:10.1136/tobaccocontrol-2016-053007
3.7: 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.

Average implementation of Article 14 as reported in the Global Progress Report on Implementation of the WHO FCTC in 2016 has been by around 50% of the Parties between 2012-16.²³

Key Observations

**Findings from MPOWER 2017:**

1. Tobacco Cessation Support:

Tobacco cessation support was available at various health care facilities, like primary health care centres, hospitals, offices of health professionals, the community and other similar set ups in less than 20% Parties (Figure 3.7.1). Most of these settings reported having experience largely with providing cessation support to smokers.⁴

![Fig. 3.7.1: Availability of various tobacco cessation facilities in different medical sectors](image)
Less than 30% Parties provided full or partial cost coverage of the tobacco cessation interventions in the various medical facilities (Fig 3.7.2).4

Fig. 3.7.2: Cost Coverage of the various tobacco cessation interventions in the Parties

2. National Toll Free Quitlines (NQL):

Only 31% Parties provided cessation support through national toll free quitlines (NQL), mostly available in high resource countries (Figure 3.7.3).4

Fig. 3.7.3: Availability of NQL and NRT
Over 52% of the Parties in EUR and 9% Parties in the AFR had NQL (Figure 3.7.4).4

Fig. 3.7.4: Availability of NQL in WHO Regions

3. Nicotine Replacement Therapy (NRT):

A total of 70% Parties had NRT available at either the pharmacy (with or without prescription) or at the general store (Fig. 3.7.3).4 The proportion of availability of NRT for Parties varied based on the income group. It was available in 85% of high resource Parties as compared to 49% of the low resource Parties (Figure 3.7.3).4

Among WHO regions, EUR had the highest provision for availability of NRT i.e. in about 88% Parties followed by the EMR and AMR (84% and 72% Parties respectively). In the WPR, NRT was available in 67% Parties and in 52% Parties in AFR. The SEAR had the least provision for NRT i.e. in 40% Parties (Figure 3.7.5).4
In terms of cost coverage of NRT, only 16% Parties provided full and partial coverage each. Only 24% Parties had included NRT products in their list of essential medicines.

**High SLT Burden Parties:**

NRT was available in most high SLT burden Parties, however it was included in the ‘Essential medicines list’ only in Malaysia, South Africa, Algeria and Sweden (Table 3.7.1).

In most Parties, the cost for NRT was not covered. In India, Nigeria, Colombia and Philippines, the cost was partially covered while only in Malaysia the same was covered fully. (Table 3.8.1).

Only 30% Parties in the high burden group had NQL (India, Germany, Sri Lanka, Thailand, Egypt, Sweden, Kenya) (Table 3.7.1).
Table 3.7.1. Tobacco Cessation in High SLT Burden Parties

<table>
<thead>
<tr>
<th>NAME OF PARTY</th>
<th>NATIONAL TOLL FREE QUITLINE</th>
<th>NICOTINE REPLACEMENT THERAPY</th>
<th>COST COVERED</th>
<th>INCLUDED IN ESSENTIAL MEDICINES LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AVAILABILITY</td>
<td></td>
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<tr>
<td>India</td>
<td>√</td>
<td>√</td>
<td>√ (partially)</td>
<td>X</td>
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<tr>
<td>Bangladesh</td>
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<td>Myanmar</td>
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<tr>
<td>Colombia</td>
<td>X</td>
<td>√</td>
<td>√ (partially)</td>
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<tr>
<td>Democratic Republic of the Congo</td>
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<td>√</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Malaysia</td>
<td>X</td>
<td>√</td>
<td>√ (fully)</td>
<td>√</td>
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<td>Madagascar</td>
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<td>Sri Lanka</td>
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<td>√ (partially)</td>
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<td>Philippines</td>
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<td>√</td>
<td>√ (partially)</td>
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<tr>
<td>Sweden</td>
<td>√</td>
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<td>Kenya</td>
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</tbody>
</table>

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 for SLT quitting 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 per 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, for nicotine patch the risk ratio reported was 1.13 [0.93, 1.37], for nicotine gum it was 0.99 [0.68, 1.43] and for nicotine lozenges it was 1.36 [1.17, 1.59]. 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 benefit but with wide confidence intervals (CIs) and 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 those performed in USA (non-ratified) and few in Scandinavian countries (Sweden & Norway); those done in the SEAR (India), Pakistan and United Kingdom were not included (review with regard to the same is in process).

**Capacity Building of Health Professionals and other stake holders of Tobacco Control**

*Findings from the Global Adult Tobacco Survey (GATS):*

At the global level there are five indicators on SLT cessation which have been used by India, Bangladesh and Kenya:

a. SLT users who made a quit attempt in past 12 months  
b. Current SLT users who planned to or were thinking about quitting  
c. SLT users advised to quit by a health care provider in past 12 months  
d. Current SLT users who thought about quitting because of a warning label on SLT packet  
e. 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 a health care provider. This highlights the considerable variation while counseling by health professionals, with SLT use having relatively lower consideration as compared to smoking. A similar observation was seen in other 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.
FINDINGS – Article 14

(Fig.3.7.6). Also, in India, about 46.2% SLT users according to GATS 2, as compared to 33.2% as per GATS 1, thought of quitting because of a warning label on the SLT packet.

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 lack of adequate training in tobacco cessation among the majority of health care providers and school teachers.

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 1/3rd Parties. NRT is legally available in the jurisdiction of 3/4th 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 altogether reported only for 3% Parties (5/179 Parties) i.e. Sweden, Norway, India, United Kingdom (UK) and Pakistan, apart from the United States of
FINDINGS – Article 14

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. Parties, including High SLT burden Parties, are not providing information on SLT cessation, though GATS provides for five indicators on the same. Information is available only for India, Bangladesh and Kenya.

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 and support facilities must be provided to make them accessible/affordable to a larger population of tobacco consumers, including SLT users.

3. Studies assessing the efficacy of tobacco cessation interventions, especially for SLT products, must be carried out by Parties especially those having a high burden of SLT consumption. Effective SLT prevention and cessation programs must be encouraged school level onwards, especially among those belonging to the lower strata of the society, 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. Also, the same might be included in the course curriculum of these specialties.

5. Parties, especially with the high SLT burden, should include questions on SLT cessation under their tobacco surveillance system and report on the progress made. This will help in improving the policy structure on making tobacco cessation more accessible and affordable across the globe.
References:


3.8: 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 use experimentation by naive youth frequently develops into regular consumption, which typically turns into a strong addiction. The earlier a person initiates tobacco use the more likely he or she is to develop a severe and persistent addiction.\textsuperscript{1,2} Tobacco companies use targeted strategies and marketing techniques to appeal and attract the youth. With aggressive advertising and marketing coupled with glamorized and attractive packaging of tobacco products, youth are unduly influenced to use tobacco and hence get addicted to it for a lifetime. Evidence strongly supports that youth’s exposure and access to tobacco products increases the risk of taking up the habit.\textsuperscript{3,4} The prevention of tobacco use among youths thus becomes a paradigmatic necessity.

Restricting tobacco sales to minors is an important component of tobacco control strategy to reduce youth tobacco use and access.\textsuperscript{5} Article 16 of WHO FCTC focuses upon limiting the supply and exposure of tobacco to minors. The introduction of Article 16 has, in fact, led to the question of whether its enforcement actually restricts youth uptake.

There had been a number of local\textsuperscript{6} as well as regional\textsuperscript{7,8} reports, which comprehensively state that successful prevention of sale of tobacco to youth can reduce youth tobacco usage.\textsuperscript{9} However, exposure through advertisements and promotions play a confounding role.\textsuperscript{10}
Key Observations

1. Policy progress on Article 16:

Since adoption of FCTC, a rapid increase in Parties banning sale of tobacco to minors has been observed. By 2005, for SLT products, 31 Parties had formulated policies pertaining to Article 16, increasing to 84 Parties in 2010, 117 Parties in 2015 and 120 Parties by the end of 2016. For cigarettes, starting from a total of 39 Parties in 2005, it increased to 99 Parties in 2010, 138 Parties by 2015, and 141 Parties by 2016 notified policies pertaining to Article 16 (Fig 3.8.1).

2. Legal Age of ‘Minor’:

A total of 141 Parties (79%) specified the age of ‘minor’ under the law. The legal age for purchasing tobacco products range from 16 to 21 years, and nearly 130 Parties have specified eighteen as the legal age. The distribution of the rest of the age groups was relatively minimal: 16 years for four Parties, 20 years for two Parties, and 21 years for five Parties.

3. Ban on Sale to Minors:

Nearly 67% (n = 120) and 80% (n = 141) Parties have banned sales of SLT and cigarettes to minors respectively (Fig 3.8.2). No marked difference among high and low resource Parties was noted in this distribution (Fig 3.8.2).

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 to ensure compliance with the ban on sale to minors. Provisions under Article 16(1) i.e. (a) Placing indicator at the point of sale (b) Prohibition of display of tobacco products in 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; has not been included in the domestic laws by all Parties which have banned sale of tobacco products to minors.
Nearly 10% of the Parties (n = 18) notified all provisions of Article 16(1) under ban of sale to minor for SLT, implying complete policy in place, and nearly 12% parties (n = 21) notified the same for cigarette (Fig 3.8.3 and Fig 3.8.4); these Parties mostly belonged to high resource income group.

4. Prohibition on distribution of free tobacco products:

Globally, 47% Parties had specified prohibition on distribution of free tobacco products to minors as a means of promotion, and 40% Parties included SLT products under the regulation. Distribution among high and low resource Parties was similar (46% and 49% respectively) (Fig 3.8.5). 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% Parties had specified prohibition on sale of cigarettes in less than pack of 20 sticks. A total of 18 Parties (11%) had specified prohibition on sale of SLT in packs weighing less 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%) (Fig 3.8.6).

6. Ban on sale by Minors:

Globally, a total of 51% Parties banned sale of tobacco products by minors, and 45% of the Parties included SLT under this provision. Distribution among high and low resource Parties was similar (49% and 53% respectively) (Fig 3.8.7). Among WHO regions, SEAR had the maximum proportion of Parties specifying the ban (70%).

7. High SLT burden Parties:

Out of the total of 23 high-burden Parties (Parties having>1 million SLT users) Pakistan, China, Colombia, Malaysia, Algeria and Sweden had not banned sale of SLT to minors. South Africa, Philippines and Kenya had complete provisions of ban (by including all provisions under Article 16(1)) and other 14 Parties had partial provisions of ban. Other provisions were notified
by more than half of the Parties, except ban on sale of SLT products less than 30 grams, which was regulated only by Nepal and Nigeria.

**Penalty for violation:**

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

**Indicator of Implementation**

GYTS\(^{11}\) uses one indicator: ‘Subjects (%) who bought cigarettes from stores but was NOT refused because of their age’. Such indicator may be developed for SLT as well. Similar information for minors can also be extracted from GATS. To control the access and availability many Parties have banned sales of tobacco products around schools and colleges.

**Case study: India**

Sale of tobacco products has been banned around 100 yards of school/ institutional buildings. However, many studies report negligible compliance towards the ban.\(^{12-14}\) GYTS indicator ‘subjects (%) who bought cigarettes from stores but was NOT refused because of their age’ reports 56% positive response.\(^{11}\)

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**Fig 3.8.1: Progress in policy formulation pertaining to Article 16**

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79
Fig 3.8.2: Parties (%) notifying Ban of sale to minor

Fig 3.8.3: Parties (%) notifying various provisions under ban on sale to minor
Fig 3.8.4: Number of Parties having policy on ban of sale to minor

Fig 3.8.5: Parties (%) notifying ban on distributing free tobacco products to minors
Gaps

1. Though majority of FCTC ratified nations have formulated policies on Article 16 for cigarette and to a significant extent for SLT as well; most of the Parties have only partial policies in place.
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. The GYTS only provides data on cigarettes, except for India and Bangladesh. It does not include indicators on SLT sale and purchase by minors.

Recommendations

1. 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 minors.
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 effective policy response thereon.
3. Parties should consider implementing a comprehensive ban on sale of tobacco products to and by minors in line with Article 16, especially, prohibit all display of tobacco products and prohibit sale of tobacco products in individual units and small packs.
4. Parties may consider licensing of retail sale of tobacco products to restrict minors’ access and exposure to tobacco products.
5. GYTS should consider including SLT use (prevalence) in the data recording for all Parties.

References:


8. DiFranza J. Which interventions against the sale of tobacco to minors can be expected to reduce smoking? Tobacco Control 2011; doi:10.1136/tobaccocontrol-2011-050145


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 intergovernmental organizations and other bodies.

4. The Parties shall, subject to national law, promote and facilitate the exchange of publicly available scientific, technical, socioeconomic, 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 so doing shall take into account and address the special needs of developing country Parties and Parties with economies in transition.

5. Parties should cooperate in regional and international intergovernmental 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 context of Smokeless Tobacco (SLT) control the article mandates to carry out appropriate scientific national research and establish surveillance mechanism as well as programs that address the magnitude, patterns, determinants, related social, economic and health indicators and consequences of SLT consumption. This article also includes facilitation of the cooperative exchange of SLT control-related information and provision of support, with special focus on developing Parties.

**Key Observations**

Strong research and surveillance systems and 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 developments took place when COP6, held in 2014, considered SLT as a global epidemic. Subsequent to the decision of COP6, the Conference
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 (GKH-SLT) in India, one of the high SLT burden Parties.

I. According to the FCTC global implementation report 2016;\textsuperscript{2,3}

1. About, 91\% (121) of the reporting Parties (n=132) provided data on the prevalence of tobacco smoking among adults, and 47\% (62) did so for the use of SLT among adults.

2. Around 40\% (53) of the reporting Parties were identified as having at least two comparable datasets across all reporting cycles for adult tobacco smoking while only 12\% (16) Parties were identified as having comparable datasets across all reporting cycles for adult SLT use.

3. Around 88\% (117) of the reporting Parties provided data on the prevalence of tobacco smoking among adolescent and 59\% (78) provided it for the use of SLT among adolescent.

4. Among adults, a larger proportion (56\%) were found to experience a decrease in male smoking than in female smoking (51\%), and 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.

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 are 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 prevalence among Parties globally in the period 2007–2014 was 7\% (9\% of males and 5.1\% of females). As fewer Parties (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. Salient findings of Research carried out at WHO FCTC Global Knowledge Hub on SLT

a. SLT use among Adults

i. SLT use prevalence for adults at national level is available for 72% (N=129) of the Parties. In addition there are sub-national estimates for SLT use among adults in Chad, Guinea, Sudan and Federated States of Micronesia (2.2 % of the Parties).

ii. One in 10 adults use SLT in one or another form. 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. (Fig. 3.9.1).

iv. Prevalence of SLT use is high in rural areas and among poorest families in low resource Parties (LMIC+LIC) (Fig. 3.9.2)

Fig. 3.9.1: Prevalence of SLT use and smoking among adults by WHO Region and income of Parties
v. Among the 129 parties, there are 357.4 million SLT users.

vi. Of these 357 million SLT users 95% live in India, Bangladesh, Myanmar, Pakistan, China, Nepal, Colombia, Democratic Republic of the Congo, Malaysia, Madagascar, Germany, Uzbekistan, Sri Lanka, Nigeria, South Africa, Afghanistan, Yemen, Thailand, Egypt, Algeria, Philippines, Sweden, Kenya. These Parties have been identified as high SLT burden Parties (where the number of SLT users exceeds one million).

vii. Nearly 93% of adult SLT burden is borne by low resource Parties. (Fig. 3.9.3)
viii. Over 80% of SLT burden is in Parties belonging to SEAR (Fig. 3.9.4)

ix. Of 129 Parties, (N=82) 45.8% have recent data (2012-2016) on adult SLT prevalence; most of them belong to HIC and UMICs. (Fig. 3.9.5)
x. Two time point data on SLT prevalence among adults is available for 10% of the Parties. Majority of them are from HICs and UMICs (Benin, Czech Republic, Denmark, Estonia, Finland, Iceland, Mexico, Norway, Seychelles, Sweden, and Thailand, Bangladesh, India, Malaysia, Myanmar, Nepal, Sri Lanka and Yemen).

xi. Increasing trend of SLT use has been observed in Myanmar, Sweden, Malaysia and Iceland.

xii. Though some studies indicate rise in SLT use prevalence among adults in India\textsuperscript{4,5} recent reports shows a decrease in prevalence of SLT from 25.9% in 2010 to 21.4% in 2016.\textsuperscript{6}

xiii. SLT use reportedly increased among adults aged 25-64 years in Myanmar between 2008 and 2016.\textsuperscript{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 public use data.

Fig. 3.9.5: Percentage of Parties having SLT prevalence data and recent data
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, 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; most of them belong to HIC and UMICs (Fig 3.9.5).
   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 almost similar as shown in Fig 3.9.6.

![Fig 3.9.6: Prevalence of Smoking and SLT use among Adolescent by Region and Income Group Parties](image)

iv. Prevalence of SLT use varied from 1.2% in WPR to 8.2% in SEAR among adolescents aged 13-15 years (Fig 3.9.6).

v. Out of 12.2 million adolescent SLT users 82.5% live in LIC and LMICs (Fig 3.9.7). Nearly 60% of adolescent users live in SEAR, 13% in AFR and 12% in EMR (Fig 3.9.8)
Fig. 3.9.7: Proportion of smokers and SLT users among adolescents by income group

Fig. 3.9.8: 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. Parties report that their national epidemiological surveillance systems covering social, economic, and health indicators related to tobacco consumption are mostly limited to smoking products. Only limited number of Parties (10 Parties) have such data for SLT.\textsuperscript{8-35}

IV. Economic Consequences

i. Twenty three parties have comparable price and tax incidence rates for cigarettes and SLT. (Fig. 3.9.9).\textsuperscript{35}

![Fig. 3.9.9: Percentage of parties having data on economic and health consequences of SLT](image)

ii. India\textsuperscript{36,37} and Bangladesh\textsuperscript{38} have health cost studies analyzed for smokeless tobacco products separately. Bangladesh did it in 2004-2006. 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

- Limited number of 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 and however a few parties identified effective tobacco dependence treatment programmes especially focused on SLT.

- There is absence of a comprehensive legal database on SLT regulations. Several Parties do not include SLT in the definition of tobacco products or have ambiguous definitions of SLT and thereby exempt SLT products from regulations.

- Very few Parties have conducted research is the identification of alternative crops for tobacco growers.

- Parties do not use questions on SLT, especially standard questions and do not implement periodic surveys.

**Recommendations:**

1. Parties (especially in SEAR and in low and low- middle income countries) should establish sustainable resources for periodically monitoring the magnitude, patterns, determinants and related social, economic and health consequences of tobacco products use.

2. Parties should contact and communicate with international partners to strengthen capacity building and resources for monitoring and research on specific tobacco control issues in their respective countries.

3. Parties should use standard protocol and methods for comparison of data within country and with other Parties.

4. Parties should be ready for exchange of information with international partners by sharing the details of their research outcomes and monitoring results, in public domain.

5. Parties should conduct research on health, economic and social consequences of tobacco products including SLT.

6. Parties should progressively establish and maintain an updated database of laws and regulations on SLT control and share through the Convention Secretariat/reporting instrument and cooperate in the development of programmes for regional and global smokeless tobacco control;
References:


### 3.10: Prohibition on Import, Manufacture and Sale of SLT

**Background**

Over its first 10 years, the WHO FCTC\(^1\) 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, with a strong focus on actions to counter industry interference with policymaking.

This document examines the status of prohibition of importation, sale and manufacturing of SLT products and associated impact and challenges for the Parties to the Convention. One of the technical report series of WHO dedicated to SLT control recommended that the countries that do not have SLT use, should ban it as an preemptive 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, Thailand, Sri Lanka, 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 commonly used SLT product - Gutkha is banned while other SLT products like Zarda are allowed.

Eleven Parties (Australia, Bhutan, Bahrain, India, Kuwait, Qatar, Maldives, Singapore, Sri Lanka, Saudi Arabia and United Arab Emirates) have prohibited manufacturing of SLT products. Six Parties (Australia, Bhutan, Oman, Sri Lanka, Singapore and Thailand) have imposed a ban on importation of SLT products. Among the earliest Parties to put a ban on import of SLT products was Thailand, in 1992, followed by Singapore a year later in 1993, and the most recent is Sri Lanka having done so in 2016. Australia, Bhutan, Singapore and Sri Lanka have banned all three.\(^3-5\)
The figure 3.10.1 below gives an overview of the global scenario in terms of prohibitions:

In the graph shown above, figures in parenthesis give the percentage of parties 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 countries in the Region are now adopting comprehensive tobacco control policies and legislation that cover all tobacco products, including SLT products. 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, SLT products are allowed for sale if they are registered with the national health regulatory agency, ANVISA. However, since none are registered, SLT products sold in Brazil are 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.\(^2,\,4,\,5\)

**WHO Eastern Mediterranean Region**

Oman has adopted policies banning the import and sale of SLT products.\(^5\) In 2009 the government of Bahrain introduced strong antismoking 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 & 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, Hungary, Finland, Latvia, Lithuania, Slovakia and Czech Republic have prohibited the sale of most forms of SLT. A few non-EU countries like TFYR 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 products, in 2004 and in 2010 introduced comprehensive legislation to implement the 2004 policy.\(^10\) India invoked
FINDINGS

food safety laws in 2011 to ban gutkha and pan masala containing tobacco, some of the most common forms of SLT used in the Party. 11 In India, the health ministry in December 2016 asked states to enforce ban on manufacture as well as 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, Mizoram, Kerala, Madhya Pradesh and Maharashtra have already issued orders to ban the production of SLT products. 12

In Maldives, it is prohibited to plant or grow any type of tobacco plant to any extent in the Party. It is prohibited to manufacture 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 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 sale, manufacturing and import of many forms of SLT products. New Zealand, Fiji and Vanuatu have banned the sale of most forms of SLT. 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 preempt the entry and spread of products in local markets.

Status among high SLT burden Parties

Amongst the 23 high SLT burden Parties, only Sri Lanka has banned the importation, sale and manufacturing of SLT products while India has banned manufacturing and sale of commonly used SLT product (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 not chewable tobacco (Table 3.10.1)

Table 3.10.1. Ban on import, manufacture and sale of SLT among high SLT burden Parties

<table>
<thead>
<tr>
<th>Party</th>
<th>Region</th>
<th>Income</th>
<th>Ban on import</th>
<th>Ban on manufacture</th>
<th>Ban on sale</th>
</tr>
</thead>
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<tr>
<td>India</td>
<td>SEAR</td>
<td>LMIC</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
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<td>LMIC</td>
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<tr>
<td>Myanmar</td>
<td>SEAR</td>
<td>LMIC</td>
<td>N</td>
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<td>N</td>
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<tr>
<td>Pakistan</td>
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<td>LMIC</td>
<td>N</td>
<td>N</td>
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<tr>
<td>China</td>
<td>WPR</td>
<td>UMIC</td>
<td>N</td>
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<tr>
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<tr>
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<td>LMIC</td>
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</tbody>
</table>
Case Studies

India

A study conducted in seven states (Assam, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Orissa) and the National Capital Region revealed that that most of the users were purchasing tobacco and mixing it with a packet of pan masala with zarda. This innovation adversely affected the impact of ban.\textsuperscript{15}

Another Indian study done for impact evaluation of 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, at the same time, the ban could also be contributing to increased profits and promotional activities associated with the sale of other tobacco products and increased use as well as initiation of other types of smokeless and smoked tobacco products.\textsuperscript{16} Vidhubala et al conducted a study in Chennai to assess the availability of Gutkha after it was banned in Tamil Nadu. The study found that even after 3 years of 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.\textsuperscript{17}

The Euromonitor report on SLT in India revealed that post-ban (in 2013), there was 84% decline in volume sales and 82% decline in value sales compared to the peak in 2010.\textsuperscript{9} 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 also one percent decrease specifically in gutkha use.\textsuperscript{18}

Bhutan

The Tobacco Control Act of Bhutan was enacted by parliament on 16 June 2010. It regulates tobacco and tobacco products, banning the cultivation, harvesting, production, and sale of tobacco and tobacco products in Bhutan. The consumption of tobacco is not altogether 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{20}

\textit{Thailand}

Thailand was the first Party to impose a ban on import of SLT (1992).\textsuperscript{21} She has a distinctive tobacco control model 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 guided by a unique generation of creative civil society leaders. This model has allowed Thailand to implement a number of strong policy measures to protect the Thai population from the dangers of tobacco and a substantial decrease in SLT use in the Party and also decrease between recent years. As per the latest GATS (2011), 3.2% people currently use SLT products. Such measures include key approaches to reducing tobacco consumption, particularly in the areas of taxation, packaging and labeling, advertising bans, import bans, and smoke-free public areas.\textsuperscript{22} However, it would be worth noting that there has been an increase in smoking prevalence among men. Smoking is considered more modern than chewing.\textsuperscript{23}

\textbf{Limitations & Gaps}

- There is a high degree of tobacco product diversity, and the SLT products are largely homemade or made in small locally owned businesses, posing regulatory challenges.
- In India, while some states and union territories have been relatively successful in enforcing the ban on \textit{gutkha}, industry is also circumventing these bans by selling \textit{pan masala} and tobacco in separate pouches.
- The lack of capacity to test for constituents of SLT products in SEAR countries 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 manufacturing and sale of tobacco products

\textbf{Recommendations}

1. Parties should consider using existing legal provisions under food safety, consumer protection, environmental laws, etc., limiting use of SLT.
2. Once in force, SLT ban should be effectively monitored and enforced.
3. A ban/prohibition should be backed by cost-effective SLT cessation services which should be a part of National Tobacco Control programmes and 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 programmes 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, perhaps through the WHO Tobacco Laboratory Network.

Conclusion

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

References:


3.11: 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, particularly in form of SLT use induced spitting in public places (most of the SLT products induce spitting). Globally, experts are divided in their opinion about the adverse health consequences of exposure to public spitting. There is historical precedence of countries imposing ban 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.\textsuperscript{1,2} With the end of tuberculosis and rise in smoking, slowly, these public notices were replaced with the warning against smoking in public places.

However, several countries, provinces and cities continue to prohibit spitting in public places. Such prohibition on spitting in public places has been imposed with different intentions in different part of the world. The reasons mainly included are: for controlling communicable diseases, maintaining public cleanliness and hygiene as well as a preventive measure to reduce SLT use.

Ban on spitting in high resource Parties

United Kingdom

In UK and several other countries, spitting in public places has been banned with the intention of controlling communicable diseases. In 1990, with the control of tuberculosis this policy has been withdrawn. However, the London Borough of Brent, in 2010, classified spitting paan/khilli paan 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 signage 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

Singapore

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

Ban on spitting in low resource Parties

Nepal

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

Bhutan

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

China

Hangzhou, a province in China and the host city of the year 2016, G20 summit, has passed a law to ban spitting and littering in public places.

Myanmar

There is a ban on spitting red betel juice in the streets and public places, mainly for sanitary reasons.4 Several establishments, to which the general public including pregnant women and young children have access to, have markedly begun posting "Kun Ta-twe Ma Htwe Ya" (spitting of saliva from chewing Kun is prohibited) stickers, together with the "no smoking" signs.5

Papua New Guinea
Since 2013, chewing betel nut and spitting betel nut juices has been banned from the streets of Papua New Guinea amidst concerns that spitting it out is spreading 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.6

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 which 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, 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 the tobacco control policies.
  - The West Bengal Prevention of Spitting in Public Place Act, 2003 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 an order in 2006, based on a High Court directive, since it posed a health threat.
  - Recently Uttar Pradesh Government has also banned spitting in government buildings.
  - The Karnataka Municipal Corporations (Amendment) Act, 2013 prevents spitting in public and empowers the corporations to fine offenders INR 100 the first time and INR 200 subsequently.
  - The Bombay Police Act of 1951, Section 116, prohibiting smoking and spitting in government premises in Maharashtra.
  - In Telangana, the Greater Hyderabad Municipal Corporation can pull up violators under sanitation byelaws and fine them INR 500 upwards.
The Bihar Municipal Act 2007 makes it an offence, along with urinating or throwing garbage with a penalty of INR 200. Enforcement of the law is weak.

A study conducted among patients attending a private dental institution in Jodhpur, India revealed that the most frequent 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.

References:


4. SUMMARY, CONCLUSIONS & RECOMMENDATIONS
In 2014 at the WHO FCTC COP6, Parties decided to begin giving attention to accelerate activities on various tobacco products including SLT 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 regulating and enforcing 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 them, 112 Parties have clearly and expressly defined SLT (Fig 4.1).

Since COP6, in 2014, Parties resolved to increase focus on SLT prevention and control, which has led to increase in research, surveillance and exchange of information (Article 20) related to SLT. Nearly three fourth (72%) of the Parties have data on SLT use among adults at national level (Fig 4.1), among them less than half (44%) of the Parties have recent data. Only 10% of the Parties have two time points of data on SLT prevalence (Fig 4.1), mostly from high resource Parties. Good news is that Parties which are home for nearly three fourth of global SLT users, have two or more time point data to see 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 & information networks on SLT.

Nearly 72% Parties have prohibited direct SLT advertisement on TV and radio (Fig 4.1). However, Less than 20% of Parties have implemented a comprehensive ban on TAPS on SLT and cigarettes (Fig 4.1). Online exposure to promotion of SLT products 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
SUMMARY AND CONCLUSION

decrease in this exposure between 2010 and 2016, especially of advertisements other than at point of sale advertisement.

A total of 120 Parties (67%) have implemented the provisions of Article 16 for SLT products, i.e. restricting its access to minors. Ten percent of Parties have implemented a comprehensive policy against minor’s access to SLT. Access to cigarettes to minor has been monitored at 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. Nearly half of the Parties (51%) implemented PHWs on SLT, and nearly three fourth of the Parties on cigarettes (77%). Higher proportion of low resource Parties (55%) implemented PHW on SLT as compared to high resource Parties (48%) while 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, with Nepal leading at 90% on both sides of the packages.

Mass media, education, communication, training, specific interventions targeted to different audience and different tobacco products, school and institutional programmes and awareness against harmful effects of tobacco were undertaken by several Parties. In 2016, 36% of Parties conducted at least one national mass media campaign (Fig 4.1). However, inclusion of SLT component in these campaigns are 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 Parties (31%) have a national quit line; but only a few Parties (2%) have experience in SLT cessation (Fig 4.1). Further, tobacco cessation support in health care facilities is available in less than 20% Parties while national quit lines 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 SLT users (25%). There is a lack of formal training in SLT
cessation among health professionals, health professions 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, data on price and tax of SLT is available only for 32 Parties. Tax on SLTs varies considerably across Parties, 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 only for four Parties. Analysis of chemical composition of SLT products has been done by only 18 Parties on an ad-hoc basis where the government initiatives may not be involved.
Fig. 4.1: Number and Percentage of Parties implementing different FCTC provisions with reference to Smokeless Tobacco (Percentage in bracket)
Moreover, all available SLT products are not analyzed and product analysis is not periodic. Most Parties do not have tobacco testing laboratories and the testing has been done only in seven Parties and one non-Party i.e. USA. There is no regulation on chemical composition of SLT products. The levels of carcinogens detected in SLT products are beyond the standards recommended by WHO.

Although not required under the FCTC, it has been recommended, that the countries that do not have burden of SLT use, should ban its manufacture, sale and import as a preemptive measure. Three Parties, Australia, Bhutan and Sri Lanka have already implemented this prohibition. Further, sale of SLT products is prohibited by 45 Parties, mostly from the European Region. Among the high SLT burden Parties, this 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 increased use of SLT use among adolescents Effective enforcement is crucial to the successful implementation of such policies.

SLT use induces spitting which may be responsible for spreading communicable diseases and 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-regional 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, following key recommendations maybe considered by the Parties 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 programmes 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 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 WHO FCTC Global Knowledge Hub on SLT, WHO and other stakeholders of tobacco control should help in increasing 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 as well as help SLT users quit.