

BRIEF REPORT

Smokeless Tobacco Control Policies in South Asia: A Gap Analysis and Recommendations

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ABSTRACT

Introduction: Almost a fifth of the world's tobacco is consumed in smokeless form. Its consumption is particularly common in South Asia, where an increasing array of smokeless tobacco (SLT) products is widely available. Mindful of the growing public health threat from SLT, a group of international academics and policy makers recently gathered to identify policy and knowledge gaps and proposed strategies to address these.

Methods: We reviewed key policy documents and interviewed policy makers and representatives of civil society organizations in 4 South Asian countries, Bangladesh, India, Nepal, and Pakistan. We explored if SLT features in existing tobacco control policies and, if so, the extent to which these are implemented and enforced. We also investigated barriers to effective policy formulation and implementation. The findings were presented at an international meeting of experts and refined in the light of the ensuing discussion in order to inform policy and research recommendations.

Results: We found that the existing SLT control policies in these 4 South Asian countries were either inadequate or poorly implemented. Taxes were low and easily evaded. Regulatory mechanisms, such as licensing and trading standards, either did not exist or were inadequately enforced to regulate the composition and sales of such products. There was little or no cessation support for those who wanted to quit.

Conclusions: Limited progress has been made so far to address the emerging public health threat posed by SLT consumption in South Asia. International and regional cooperation is required to advocate for effective policy and address knowledge gaps.

INTRODUCTION

Almost a fifth of world's tobacco is consumed in smokeless form, being particularly common in South Asia (Gupta & Subramoney, 2004). Besides nicotine, smokeless tobacco (SLT) products available in South Asia harbor carcinogens like N-nitrosamines and hydrocarbons (Critchley & Unal, 2003). Its carcinogenic propensity and dependency is enhanced by its combination with areca nut (another carcinogen) (Nair, Bartsch, & Nair, 2004) and calcium hydroxide (slaked lime) (World Health Organization [WHO], 2006). SLT use is known to be associated with an increased array of diseases, that is, tooth decay, gum disease (Tomar & Winn, 1999), oral and esophageal cancers (Critchley & Unal, 2003). An increased risk of acute myocardial

infarction has also been reported (Teo et al., 2006). In women, its consumption is associated with low birth weight babies and stillbirths (England et al., 2012; Gupta & Subramoney, 2004).

Since the introduction of the Framework Convention on Tobacco Control (FCTC), several countries have seen a significant decline in the prevalence of cigarette smoking (Myers, 2013). Most countries in South Asia have also ratified their policies according to FCTC. However, there is a lack of knowledge on how the existing policy framework relates to SLT. It is not surprising, therefore, that SLT has been a neglected policy area and SLT products remain inexpensive and widely available to people in South Asia, including minors. Being mindful of its growing threat in South Asia, an international expert meeting was held in March 2013 in York, United Kingdom (Siddiqi, Gupta, Prasad,

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Croucher, & Sheikh, 2013). The purpose was to identify policy and research gaps and propose key strategies to curb global use of SLT. This paper reports findings of the situation analysis and key recommendations proposed at the meeting.

METHODS

Focusing on Bangladesh, India, Nepal, and Pakistan, we carried out a policy gap analysis to explore if SLT features in existing tobacco control policies and, if so, the extent to which these are implemented and to identify relevant barriers and facilitators to implementation of such policies. For this, we conducted searches for pertinent policy documents and structured interviews with key informants. To extract relevant information from policy documents, we used a policy framework adapted from WHO's MPOWER strategy that consisted of (a) awareness raising campaigns; (b) surveillance and information gathering to inform policy; (c) regulating production, distribution, marketing, and sales; (d) raising taxes and using other fiscal measures; and (e) providing services to support people who wish to quit (WHO, 2007).

Semistructured interviews were conducted using an interview guide (Supplementary Annex 1) to explore (a) if there are any regulations/policies that require manufacturers to specify ingredients that are applicable to SLT products and (b) if such regulation/policies exist, what are the barriers in their implementation? Similar questions were asked to cover all aspects of tobacco control. Four researchers carried out the interviews, one in each country. They were also involved in developing and piloting the interview guide and had regular meetings with the principal investigator to clarify any ambiguities both before and after the first set of interviews. We recruited a purposive sample of key informants including at least one policy maker and one representative of civil society organizations from each country. Our sample was drawn from a list of central government departments responsible for tobacco control and civil society organizations that focus on advocating for strong tobacco control policies. We excluded governmental departments that are only indirectly responsible (such as tax office) and civil society organizations with broader remits. We contacted respective departments and organizations and requested for an interview with their representatives. Once nominated, the representatives were approached by telephone and in-person and consented (verbally) for the interview. Face-to-face interviews were carried out by appointment at a time and place of mutual convenience. If the appointment was not kept, at least one more attempt was made to rearrange the interview. Hand written notes were taken during the interviews. These notes were subsequently analyzed using a framework approach by two researchers. The analysis was presented to the respondents for validation. A total of 11 interviews were carried out and their findings were presented at the aforementioned meeting. The delegates discussed these and formulated key recommendations.

RESULTS

Policy Gap Analysis

Raising Awareness

In recent years, several media campaigns have been launched in South Asia (most notably in India) to make general public aware of the harmful effects of SLT. There is specific

budgetary allocation to run media campaigns against tobacco (including SLT) in India. Furthermore, two recent and notable campaigns on SLT in India were also supported by external grants. In Nepal, the Tobacco Product Control and Regulatory Bill, 2010, specifies that revenues from tobacco should be utilized for "controlling smoking and tobacco products consumption" and at least 15% of this spent on antitobacco campaigns. However, interviewees identified several challenges in raising public awareness including high social acceptance of SLT consumption, lack of awareness about public right to information, interference by the tobacco industry, and lack of specific budgetary allocation in many countries (see Table 1).

Information and Surveillance

Periodic national surveys have been the key source of information on SLT consumption. The Global Adult and Youth Tobacco Surveys (GATS & GYTS) in India and Bangladesh, and 2007 WHO survey in Nepal provide population distribution of SLT consumption. The 2014 GATS in Pakistan would obtain accurate SLT consumption figures for the first time. The interviewees identified several intelligence gaps that act as barriers to effective policy formulation. SLT use is generally not captured in medical records. There is neither any systematic information gathering on its production, sales, and revenue collection nor any liaison between relevant departments, for example, national statistics bureaus, customs and revenue, trade and commerce, for this purpose. Barriers to effective intelligence gathering included lack of political will and inadequate liaison, resources, and capacity to gather relevant information. Legislations and statutory language often exclude SLT, for example, in Pakistan, the relevant ordinance has the wording of "smoking," instead of tobacco.

Regulating Production, Distribution, Marketing, and Sales

There are several good examples of regulating and banning SLT products across South Asia. In India, the Food Safety and Standards Regulations, 2011, prohibits the sale of any food products that contain tobacco or nicotine. Several states in India including Maharashtra, Kerala, Tamil Nadu, Madhya Pradesh, Bihar, and Uttar Pradesh used this legislation to ban the manufacturing and sale of Gutka and paan masala. Similarly, sale of Gutka and Manipuri tobacco was also banned in Sindh province, in Pakistan, in 2012. A license is required to produce and sell SLT products in Bangladesh; however, this requirement applies only to packaged products. All tobacco products need to be registered and require a vendor's license in Nepal.

A legislative amendment expands the application of existing smoke-free laws to prohibit use of all forms of tobacco (including smokeless) in public areas in Bangladesh. The law prohibits tobacco consumption in all public and workplaces in Nepal too; however, it does not specify SLT. Legislation requires the display of graphic health warnings on tobacco packaging including smokeless products in Bangladesh, India, and Nepal, covering 50%, 40%, and 30% of the principal display area, respectively. Spitting (applies to SLT) is prohibited in public places in several states in India, Bangladesh, and in Pakistan under a range of municipality laws. Legislation also prohibits the sale of all tobacco products to minors and within 100 yards of educational institutions in India (Ministry of Law and Justice, 2003). Similarly, sale of SLT to and by minors is also prohibited in Pakistan and Nepal.

Table 1. Policy Gap Analysis

Policy framework	Indicator	Bangladesh	India	Nepal	Pakistan
Raising awareness	Statutory requirement to spend tax revenue on awareness raising	No	No	Yes	No
Information and surveillance	Existence of information on consumption of smokeless tobacco	Yes	Yes	Yes (but old)	No
	Specific policies to ensure routine dissemination and access to information	No ^a	No ^a	No	No
	Technical liaison with relevant departments and organizations	No	No	No	No
Regulating production, distribution, marketing, and sales	Legislation regarding license for sale	Yes	No	Yes	Yes
	Ban on the sales	No	Yes (of selective ban in most of the states)	No	Yes (selective ban in one province)
	Ban on advertisement and promotion	No	Yes	Yes	Yes
	Restrictions on Illicit sales	No	Yes	Yes	No
	Ban on maximum amount to be sold at one time/to an individual at any time	No	No	No	No
Price and taxation	Existence of fiscal policy in relation to taxation	Yes	Yes	Yes	No
Service provision	Existence of policy regarding provision of cessation services	No	Yes	No	No
	Availability of cessation services at public facilities	No	Yes	No	No

Note. ^aIndia and Bangladesh had Global Adult Tobacco Surveys and smokeless tobacco use information was well disseminated. Repeat surveys are under planning.

In India, there is a comprehensive ban on advertising, promotion, and sponsorship of all tobacco products, including SLT. There is also a ban on advertising in Nepal; however, sponsorship is not covered under the act ([Nepal Legislature-Parliament, 2011](#)). Promotion and sponsorship of SLT products are also restricted in Pakistan.

The interviewees highlighted that despite the above legislation, regulation remains weak across South Asia. Inadequate training of law enforcers, unclear roles and responsibilities of different government departments, and inadequate resources for enforcement are some of the barriers in implementing existing legislations. Various legislations often exist, which can indirectly affect SLT production, sale, promotion, and consumption. However, absence of specific wordings in such legislations (Pakistan) for SLT makes it difficult to enforce such

laws. There is also a sizeable cross border flow of SLT from India toward its neighboring countries.

Price and Taxation

Compared with cigarettes, taxation on SLT remains generally low in South Asia. There is an absence of annual systematic inflation-adjusted increase in tobacco taxation, in general. In India and Bangladesh, SLT is taxed at a much lower rate based on “ex-factory price.” In India between 2006 and 2009, taxation on the cigarettes has nearly doubled, while there has been no change in the taxation on SLT over the same period, which remained at 86% of the retail price ([John et al., 2010](#)). Between 2007 and 2012, excise tax on SLT only increased from 10% to 35% of the ex-factory price, in Bangladesh. Currently, tax on cigarettes ranges from 54% to 76% of the retail price, while

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taxes on Jarda and Gul are 45% of their ex-factory price. Pakistan has not imposed any tax on SLT products.

Weak tax administration and its evasion on tobacco products remain common in all South Asian countries. Sale of SLT products in informal establishments, often in unpacked forms, compounds this problem. Absence of annual systematic inflation-adjusted increase in tobacco taxation, inadequate understanding of tax policies within health ministries, poor coordination between governmental departments, lack of appropriate training, and resources within implementing agencies are some of the other constraints identified in this policy area.

Service Provision

In India, there are national guidelines and training provisions for health workers and teachers in tobacco cessation (including SLT). Cessation services (including SLT) are available in a select number of health care institutions both in public and private sector. In Bangladesh, except for a few nongovernmental pilot clinics, SLT cessation is not available. Similarly, in Nepal and Pakistan, cessation services are not available at any tier of public health facilities. Lack of political will to provide or enhance coverage of cessation services and little awareness among policy makers, health professionals, and users of such services were identified as some of the constraints.

Barriers

Some of the common barriers to effective policy formulation and its implementation to reduce SLT consumption, highlighted by the interviewees, include (a) high social acceptance, (b) growing influence of big tobacco conglomerates and their active interference in effective policy formulation, (c) lack of political will, (d) inadequate liaison between government departments, (e) little understanding of the SLT supply chain, (f) inadequate resources and capacity for law enforcement, (g) unclear roles of different government departments, (h) absence of specific wordings (“smoking” not “tobacco”) in existing legislations, (i) illicit trade between India and its neighboring countries, and (j) sale in informal establishments, often in unpackaged forms.

Recommendations

The delegates made several policy and research recommendations (see [Supplementary Table 1](#)), addressing concerns regarding the supply and demand of SLT. Key recommendations include emphasis on (a) greater surveillance of SLT products, their prices, supply chain, and consumption; (b) increasing taxes; (c) comprehensive ban on any new product and stricter regulation of those that already exist; and (d) offering cessation support to people who wish to quit.

DISCUSSION

Our findings reveal that there is a lack of relevant intelligence gathering and surveillance of SLT production, sales, and revenue generation. There is also limited capacity and resources for effective dissemination of gathered information and its translation into policy. Thus, SLT receives less focus than required within relevant antitobacco policies and legislation in these countries, along with poor policy implementation.

Weak tax administration and uncontrolled sale of the products in informal establishment compound the problem. Scarcity of resources for advocacy campaigns, policy research, and close to none cessation services are important factors that need prompt consideration.

Following on from the IARC Monograph (IARC, 2007), this paper summarizes our attempt to assess policy gaps in addressing SLT in South Asia and to generate consensus on a way forward. Given that the sociocultural and policy context for SLT users in South Asia is very similar, it was also useful to have a regional focus to this analysis. It highlighted inadequacies in the existing policy and regulatory frameworks and identified key barriers in formulating and implementing effective policies in South Asia. Literature on SLT suggests that inadequate policies and ineffective implementation are not just limited to South Asian countries. Even in developed countries, for example, in the United Kingdom, some forms of SLT are banned, yet others are widely available as unregulated products, mainly confined to South Asian consumers (McNeill et al., 2010). The U.K. legislation requires all tobacco-containing products to have health warnings. However, only 50% of SLT products have some form of health warning and only 15% fully comply with the legislation (Longman, Pritchard, McNeill, Csikar, & Croucher, 2010). The average price of a SLT product in the United Kingdom is around £1.82, approximately 3–4 times cheaper than a cigarette packet.

We acknowledge certain limitations of our paper. The gap analysis did not involve a systematic review of the literature and policy documents. Moreover, we did not gather intelligence on the SLT supply chain. Our analysis relied on the information provided by the key informants and therefore liable to information bias. However, we included civil society organizations in our key informants in order to get plurality in our findings.

We conclude that limited progress has been made so far to address the emerging public health threat posed by SLT consumption in South Asia. International and regional cooperation is required to advocate for effective policy and address knowledge gaps.

SUPPLEMENTARY MATERIAL

[Supplementary Annex 1](#) and [Supplementary Table 1](#) can be found online at <http://www.ntr.oxfordjournals.org>

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DECLARATION OF INTERESTS

None declared.

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