PRE-CONFERENCE

DAY 1: FRIDAY, FEBRUARY 8, 2019

9:00 am to 1:00 pm

4th National Conference began with Pre-conference workshops and first half of Friday, 8th February 2019 was entirely allotted to five workshops running simultaneously at five different halls in Tata Memorial Hospital. The pre-conference workshops touched upon various focus areas in tobacco control ranging from tobacco and non-communicable diseases, research and communication strategies in tobacco control, strengthening of national tobacco control programme and tobacco cessation training. Following are the details of five workshops conducted in the pre-conference

WORKSHOP 1: YOUTH AND NCDS- LESSONS FROM TOBACCO CONTROL

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

The Youth workshop was one of the major highlights of 4th NCTOH and it was jointly organized by Salaam Bombay Foundation and HRIDAY. The major objectives of this workshop were to facilitate knowledge exchange on global and local best practices by applying learnings from tobacco control to Non Communicable Disease (NCD) prevention and control, to strengthen youth voices in the national response to contribute towards achievement of SDG 3.a (Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control) by empowering participants with knowledge about youth-led initiatives and to initiate and harness a productive and sustainable dialogue exchange between experts and young participants for a common networking platform for tobacco control campaigns.

The two major expected outcomes of the workshop were to initiate building groups of motivated and empowered young people for informed activism on tobacco control campaigns through the

spirit of volunteerism and to form Youth-led collaborations for developing and executing innovative strategies to promote tobacco free norms.

The entire workshop was coordinated by Dr. Upendra Bhojani from Institute of Public Health, Bangalore, Dr. Kunal Oswal from Tata Trusts and Dr. Amrita Bahl from HRIDAY.

Student leaders of Salaam Bombay Foundation, Ms. Sejal Dubey and Ms. Aarti Gaikwad participated as youth leaders and shared their views and experiences of changing life styles of youth and increasing prevalence of NCDs and importance of tobacco control and role of sports to lead a healthy life.

The workshop was attended by more than 70 participants which included NSS volunteers, members of civil society organizations, representatives of NGOs, NTCP consultants etc. Each session in the workshop was followed by discussion and question and answers session in which the participants put forth their views on Youth and NCDs and also asked questions to the presenters.

WORKSHOP 2: STRATEGIC COMMUNICATION WORKSHOP

LECTURE HALL, GOLDEN JUBILEE BLOCK

A workshop proposed by Vital Strategies on "Strategic Health Communication for Tobacco Control" was one of the major highlights of the conference. The workshop aimed to build capacity and technical knowledge in development and implementation of population-level mass media campaigns based on a strategic health communication cycle so as to enable sustained tobacco control campaigns at national and state levels.

Following major topics were covered in the workshop

1. An overview of Strategic Health Communication for Tobacco Control
2. Campaign development and implementation – media production and media placement.
3. Audience segmentation
4. Data driven approach – message testing and evaluation
5. How to bring earned media to amplify campaigns and support policies.
6. How social media synergizes with mass media.
7. A discussion on Film Rule Laws under COTPA

These topics were divided over four major sessions in the workshop as follows:

1. Effective use of Media in Tobacco Control-Presentation and Discussion
2. Evaluation and Message testing with Presentation and Discussion along with an exercise
3. Developing effective messages- Exercise (Elevator pitch)
4. Social Media and Earned Media - How to integrate it in campaign pan- Presentation and Discussion

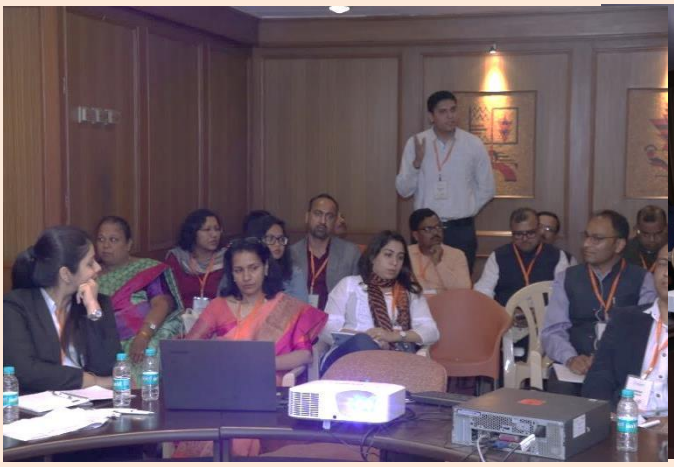
The sessions were facilitated by Mr. Praveen Sinha, National Professional Officer, WHO India country office and Ms. Vaishakhi Mallik, Associate Director, South Asia, Vital Strategies.

The entire workshop was chaired by Dr. L.Swasticharan, Chief Medical Officer, Ministry of Health and Family Welfare, Government of India and co-chaired by Dr. Nandita Murukutla, Vice President, Global Policy and Research, Vital Strategies.

The workshop was attended by about 37 delegates.

WORKSHOP 3: IDENTIFYING PRIORITIES AND SCALING UP RESEARCH IN TOBACCO CONTROL IN INDIA

BOARD ROOM, GOLDEN JUBILEE BLOCK



This was a research based workshop designed by The UNION. Dr. Gan Quan, Director for Tobacco Control, The UNION chaired the workshop along with Dr. Mangesh Pednekar, Director, Healis- Sekhsaria Institute for Public Health as a co-chair. The workshop was attended by over 40 delegates.

Following topics were covered in the workshop by mentioned speakers:

DR. SONU GOEL, ADDITIONAL PROFESSOR, DEPARTMENT OF COMMUNITY MEDICINE & SCHOOL OF PUBLIC HEALTH, PGIMER, CHANDIGARH

INTRODUCTION TO OPERATIONAL RESEARCH

Dr. Sonu Goel opened the workshop session by introducing the participants the basic concepts of the operational research and how it is different from basic science research or Randomized Controlled Trials (RCTs). Then he gave a brief history of origin around world war II and how it

has been used in health research for various interventions especially family planning programmes. He added that since 1990s the major focus of operational research has been to evaluate quality of care. Discussing on the efficiency of operational research, Dr. Goel mentioned that operational research helps to improve the programme outcomes; it assesses the feasibility of new strategies or interventions in new populations or settings and it also helps to advocate for policy change. Dr. Goel in concluding part of his presentation described in details major types of operational research i.e. diagnostic research and intervention research.

DR. MANGESH PEDNEKAR, DIRECTOR, HEALIS- SEKHSARIA INSTITUTE FOR PUBLIC HEALTH

FRAMING A RESEARCH QUESTION

Dr. Mangesh Pednekar began his presentation in an interactive way by asking the participants to list the most important research questions in tobacco control in India. After receiving responses from the participants, he summarized by explaining that a large number of research questions could be framed but we need to select specific questions, especially the questions which are of our interest, which we feel passionate about and we need to convince the superiors/funders etc to justify the research question/s we are going to select. By taking 'High tobacco use among school teachers' as an example Dr. Pednekar explained the participants that initially if research questions is sounding very huge, we must narrow it down to make it more specific till it seems very easy or even trivial. Further to this, the objectives of the research have to be identified. There is one primary objective and there could be some secondary objectives. But the entire research methodology, sample size, analysis etc. has to be planned keeping prime focus on primary objective.

In the later part of his presentation, Dr. Pednekar focussed on framing of primary and secondary objectives, choice of sampling methods, resources required for sampling, framing the questions, conducting pre and post evaluation etc. He concluded his presentation by briefly explaining the cycle of research with all the steps which starts with identification of research needs and ends with informing the stakeholders about the major findings of the research along with the formulated recommendations.

DR. P.C. GUPTA, DIRECTOR, HEALIS- SEKHSARIA INSTITUTE FOR PUBLIC HEALTH

ELEMENTS OF ROBUST PROTOCOL

Dr. P.C. Gupta covered the most important next step in research i.e. writing a research protocol. He described the process of initiating the designing of research protocol by answering four important questions- why, when, how and what. Further, he also described the important components of any research protocol and how to frame these components e.g. study title, synopsis, background and rationale, aims, objectives and hypotheses etc.

He concluded his presentation by asking the participants to develop a research protocol on the research question and objective they had worked on so far in the previous sessions of the workshop.

DR. UPENDRA BHOJANI, INSTITUTE OF PUBLIC HEALTH, BENGALURU

ETHICS IN RESEARCH

Dr. Upendra Bhojani spoke about significance of ethics in research. He began his session by briefly defining the word 'Ethics'. Then, he also mentioned about the dangerous experiments carried out across the world with human beings as subjects in the experiments which necessitated the introduction of ethics in health research.

Dr. Bhojani also explained in brief the main components of ethics in research i.e. autonomy which gives right to the individual to take right decision e.g. informed consent and confidentiality, justice which mandates to treat every person according to what is just or morally right, beneficence/non-maleficence which mean maximizing the research benefits and reducing the harms.

MR. PRANAY LAL SENIOR TECHNICAL ADVISOR, THE UNION

FROM WRITING TO SUCCESSFUL SUBMISSION OF MANUSCRIPT

Mr. Pranay Lal spoke about final stage in research i.e. development of the manuscript of research for the submission to the policymakers, research journals etc. He covered the entire process of writing the manuscript and dos and don'ts to be remembered while writing the manuscript.

WORKSHOP 4: STRENGTHENING NTCP MAHARASHTRA

LECTURE ROOM-1, HOMI BHABHA BLOCK

This workshop was designed and organized by Public Health Department of Maharashtra under the guidance and supervision of Dr. Sadahana Tayade, Joint Director (NCDs), Directorate of Health Services, Maharashtra. This workshop was exclusively organized for the officers and consultants in National Tobacco Control Programme of Maharashtra. About 45 NTCP officers and consultants participated in the workshop. Important topics like Tobacco Epidemiology, Enforcement of COTPA 2003 and concept of ideal tobacco cessation centre were covered by invited eminent and experienced speakers like Mr. Govind Tripathi, Technical Advisor, The UNION, Mr. Deepak Chhibba, Project Head & Partner, Sambandh Health Foundation and Dr. Himanshu Gupte, General Manager, Narotam Sekhsaria Foundation.

The presentations of the above mentioned speakers were followed by a panel discussion moderated by Mr. Deepak Chhibba. Following were the panellists in the discussion:

1. Dr.Sadhana Tayde, Joint Director (NCD)
2. Dr.Pankaj Chaturvedi,TMH , Mumbai
3. Dr.Govind Tripathi, Technical Advisor, The union Delhi.
4. Dr. Hemant Kumar Borse , Deputy Director, Latur
5. Dr. Anil Rudey,District Civil Surgeon, Gadchiroli
6. Dr. Raghunath Bhoye District Civil Surgeon, Nandurbar
7. Dr. Dr.Kanchan Vanire, District Civil Surgeon, Palghar

WORKSHOP 5: LIFEFIRST: TRAINING ON TOBACCO CESSATION

LECTURE ROOM-1, HOMI BHABHA BLOCK

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Following important topics were covered in the workshop by the mentioned speakers

1. Epidemiology and Prevalence of tobacco use- Dr. Dinesh Jagiasi
2. Tobacco control policy and laws- Dr. Dinesh Jagiasi
3. Health Effects of tobacco- Dr. Himanshu Gupte
4. Benefits of quitting tobacco- Dr. Himanshu Gupte
5. Tobacco depedence- A chronic disease- Ms. Ratandeep Chawla
6. Tobacco Treatment Model- Behaviour modification- Ms. Ratandeep Chawla
7. Motivational Interviewing- Ms. Ratandeep Chawla

MAIN CONFERENCE

DAY 1: FRIDAY, FEBRUARY 8, 2019

2:00 PM TO 6:30 PM

OPENING CEREMONY

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

2:00 PM TO 3:00 PM

4th National Conference on Tobacco or Health 2019 was inaugurated with the wonderful Ganesh Vandana Dance performance by students of Salaaam Bombay Foundation's Arts Academy. The performance was followed by the official announcement of opening of the 4th National Conference on Tobacco or Health 2019 at Tata Memorial Hospital, Mumbai, India. The Ganesh Vanada Dance Performance was followed by the address of dignitaries on the dais.

Dr. Pankaj Chaturvedi, Deputy Director, Tata Memorial Centre, Mumbai, gave the welcome address for the event. He started by informing the audience about India's performance in tobacco control and how its efforts have kept it in the forefront of the global anti-tobacco movement. According to him the Global Adult Tobacco Survey (GATS) data for India represents a 17% relative decrease and 6% absolute decrease in tobacco use by individuals.

He added that in India tobacco control has become part of the government agenda. It has been an objective of various laws being implemented by the government like the Cigarettes and Other Tobacco Products Act, 2003 (COTPA), Juvenile Justice (Care and Protection of Children) Act, 2015 (JJAct), and the Consumer Protection Act, 1986 and the people who are part of the anti-tobacco movement are acting as civil society who are supporting the government. This has also led to achieving milestones in a short span of time. The government has been able to make huge changes within 5 years, changes which were not possible in the previous 15 years. Moreover, in the country, states like Maharashtra have been among the first to ban pan masala and gutka, such bans also illustrate the commitment of the government towards curbing tobacco usage. The government has also taken up enforcement which adds to the efficacy of the laws and policies which it has introduced. He also spoke about how laws have been implemented innovatively in order to decrease tobacco usage amongst individuals. For example, Maharashtra has the lowest levels of smoking, however most tobacco usage in Maharashtra comes from smokeless tobacco

consumption. It is laws like COTPA which have sections about the need for licenses in restaurants that also provide hookah services (Section 4: No smoking in any public place).

Dr. Chaturvedi gave examples of holistic tobacco awareness drives. For instance where when 2 crore patients were screened for oral cancer in 2 months by front line health workers all over Maharashtra, the patients were also provided with tobacco awareness sessions.

He spoke about how conducting the campaign for giving voice to tobacco victims made a huge impact on tobacco control in India. He also gave the example of Deepak Kumar and how his case against the Indian Tobacco Corporation (ITC) in the consumer court was a huge step for tobacco control. Many such others have played a huge part in the tobacco control mission in the country. Dr. Chaturvedi ended his note by stating that tobacco control is a very serious cause and there is a need to accelerate efforts towards it.

Dr. Prakash C. Gupta, President of 4th NCTOH, Director, Healis - Sekhsaria Institute for Public Health spoke about the motivation which was gained by winning the bidding for the world conference. He also recapitulated events from past NCTOHs.
At the second NCTOH, stakeholders within the tobacco control movement were identified. It was also recognised that the power which the victims of tobacco had within the movement for tobacco control. At the third NCTOH, the Global report on smokeless tobacco was released. Dr. Gupta said that for the first time smokeless tobacco was projected as a global problem, not centred in just a few countries.

Dr. L. Swasticharan, Chief Medical Officer, Ministry of Health and Family Welfare, India, spoke about the importance of increasing awareness of the dangers of tobacco and of encouraging non-consumption and quitting. He also spoke about how the government has been supporting this initiative by means of funding the National Health Mission to strengthen public health services throughout the entire country. We have seen changes in the last few years in which partners and individuals whom we work with do not retire and stay on for the activities of tobacco control.

He also talked about the government's initiative to expand four quit line centres in different languages that would cater to 75% of the cessation attempts. Efforts of collaboration have also helped in initiatives of tobacco control. For example, there is the TB tobacco collaboration where patients being screened for TB are also asked about their history of tobacco use. The government is also mapping government dental medical colleges where there would be cessation centres in order to engage with the challenges of tobacco use at every level of health care.

Within the NCD programmes, there is an effort to support the grassroots training centres doing cancer screening with higher level centres. In order to make the grassroots centres perform

better, training modules have been developed by District Nodal Officers (DNOs) and State Nodal Officer (SNOs) for comprehensive tobacco control. Dr. Swasticharan also spoke about the advisory of the MoH against electronic cigarettes.

India has also been part of many working groups on the ban on tobacco advertising under the WHO Framework Convention on Tobacco Control(FCTC). India has also been working towards implementation of Articles 14 and 20 of the WHO FCTCand has participated in the Expert Group on Articles 9 and 10.Dr. Swasticharan ended by saying that there were various changes which everyone saw between GATS-1 and GATS-2.

Dr. Pallavi Darade,FDA Commissioner, Maharashtra,began by saying that Maharashtra is at the forefront of banning tobacco. It was also one of the first states to ban gutka in 2012. However, she said, what was unique in Maharashtra was that they also banned six more products along with gutka. Such a ban is not seen in any other state. Maharashtra is vulnerable to transportation of gutka and other products from neighbouring states even though production is banned within the state. Since 2012, about Rs. 176 crores of gutka have been seized in Maharashtra. Further, as the commissioner FDA, she states that she collaborated with the Transport Commissioner and she highlighted that as per the Transport Act, only bonafide goods can be transported and the tobacco products which have been banned would not qualify as such, thus when vehicles are caught transporting these products, the licenses of the drivers as well as the vehicle registration should be cancelled. The Commissioner then took out a Government Regulation (GR) for the same.

Dr. Darade also spoke about a notification of a GR dated 9th January 2018, which is the first of its kind, in which selling of Fast-Moving Consumer Goods (FMCG) products like chocolates and chips along with tobacco was prohibited. She spoke about her role as the FDA Commissioner towards spreading awareness about this GR for sellers and then only eventually taking action against them if the GR is not adhered to, in order to protect many from unemployment due to a rule which has been newly introduced. Maharashtra, being in the forefront for tobacco control has been able to have about 500 actions taken. Dr. Daradeconcluded by stating that in any state where there is social equality, social security and education, anti-tobacco activities get good results. Thus, Maharashtra is doing well in tobacco control.

Ms. Tshering Doma Bhutia, Vice President, Salaam Bombay Foundation, gave the vote of thanks at the end of inauguration ceremony.

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OPENING PLENARY: TOBACCO FREE GENERATION

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

3:30 PM TO 5:00 PM

Moderator:
Dr. Pankaj Chaturvedi, Deputy Director, Tata Memorial Centre, Mumbai

Panelists:
Dr. L. SwasticharaN, Chief Medical Officer, Ministry of Health and Family Wselfare, India
Ms. Vineet Gill Munish, National Professional Officer, World Health Organization, India
Ms. Nandina Ramachandran, CEO, Salaam Bombay Foundation, Mumbai
Dr. Gan Quan, Director of Tobacco Control Department, The Union
Dr. P.C. Gupta, Director, Healis- Sekhsaria Institute of Public Health
Dr. K Vishwanath, Professor of Health Communication, Harvard T. H. Chan School of Public Health, Boston, Massachusetts, USA
Dr. Monika Arora, Director, Health Promotion & Tobacco Control PHFI, Gurgaon & HRIDAY-SHAN
Dr. Rajesh Dikshit, Director Center for Cancer Epidemiology, Quitline, TMH, Mumbai

Dr. Pankaj Chaturvedi, Deputy Director, Tata Memorial Centre, Mumbai began the session by introducing the panellists and announcing the format for moderating the session, wherein he directed the questions from the audience to a particular panellist and afterwards gave the audience an opportunity to ask more questions on the topic under discussion.

TOPIC 1: E-CIGARETTES

What is the policy in the USA on electronic cigarettes?

Dr. K.Vishwanath answered that the USA FDA has allowed e-cigarettes, stating they are less harmful than cigarettes and are regulated. Then youth were found using them. He said,"E-cigarettes have become contentious in America, even doctors are confused.There is immense confusion among the tobacco control community in the USA over e-cigarettes. The FDA is waking up and is paying a price for e-cigarettes."

Current studies show that Doctors in the UK are prescribing e-cigarette for cessation and claim it is twice as effective as NRT

in a controlled environment for cigarette smokers. Do you think this could influence policy in India?

Dr. Gan Quan responded by saying that talking in the local context, the potential harm from e-cigarettes is really limited for adults. However the potential benefit of e-cigarette for cessation in adults is also limited compared to the potential damage for youth.

Do we have evidence that e-cigarettes help in cessation?

Dr.P.C. Gupta began to answer by saying that firstly it is wrong to call it e-cigarette; it just looks like a cigarette. It is actually a drug delivery device for nicotine. It is also at times referred to as a cessation device. NRT products have to pass through regulatory tests; e-cigarettes have never been submitted for regulatory testing. The vast majority of people who start using e-cigarettes continue using them. It is just a device which keeps people hooked on to nicotine.

Why do you not recommend e-cigarettes for harm reduction?

Ms. Vineet Gill responded saying that young people are comfortable today smoking e-cigarettes in front of their parents and siblings at the dining table. Their availability is attracting youth, which is dangerous.

Is e-cigarette a cessation device or a gateway product?

Dr. Monika Arora said thate-cigarettes are prolonging cessation. They are also bringing in non-susceptible youth who have never used any tobacco product. The attraction to e-cigarettes brings in youth who are less susceptible to tobacco smoking and then they move on to use conventional cigarettes. In Delhi, children call e-cigarettes “Bijliwali Cigarette” which is available at many stationary shops. The product has percolated to lower socioeconomic groups. The shopkeepers tell them to come in civil clothes and not in school uniforms if they want to buy e-cigarettes as they are not to be sold to minors. It is a versatile product and youth are aware of it.

Is the fight over for e-cigarettes in India?

Dr. L. Swasticharan suggested that looking at it from a de-addiction cycle point of view, it is important to consider

how we approach people for tobacco cessation (quitting the use of tobacco). The body needs to withstand the withdrawal symptoms. With the use of e-cigarettes the whole cycle is being disturbed and defeated. E-cigarettes are thus counterproductive for cessation. We need to strengthen the 'O' component – offer cessation – to help people quit.

TOPIC 2: THE HOOKAH

The hookah is becoming popular among kids. Educatedchildren from good schools and of high socio-economic status use hookahseven after being educated by their parents on the harmful effects of tobacco. What have been your observations?

Ms. Nandina Ramachandran replied that children have witnessed adults using hookahs. For kids it is a cool thing to get together and smoke a hookah. Salaam Bombay Foundation (SBF) works with children and has found they use the JUUL brand e-cigarette which is available in varied flavours, such as supari.

From the audience, Dr. Amit Yadav, advocate, shared that the legal position of hookah smoking (in commercial establishments) is that it is banned (under the Narinder S Chadha Judgement of 2014), but enforcement is the issue. Look at the Juvenile Justice Act, Section 77. Under this, the one who provides the tobacco product to the child or causes the child to come to that situation, like that of the father sending the child to the shop to buy tobacco products, shall be liable to a fine extending up to 1 lakh rupees. Earlier it was that you could get the apparatus to smoke hookah in any public smoking zone. Now as per the change in the rule in May 2017, you can't smoke hookah in any public smoking zone, according to an amendment made to the rules pertaining to smoking in public. Also, hotels, restaurants and airports will have to display a board (60x30 cm) outside the smoking zones mentioning that smoking is injurious to the health of both smokers and non-smokers.

Dr. Pankaj Chaturvedi added that a hookah can only be served in a separate room where food or drink is not served.

The flavoured hookahs available in the market – do they contain tobacco or they are just flavoured?

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In response, Dr. Arora said that when hookah molasses samples have been lab tested, the tests show the presence of nicotine. There are many

misperceptions and myths on hookah, for example that tobacco smoke going through water is harmless.

Dr. Vishwanath added that there is glamour attached to using hookahs. A number of myths need to be broken on their use. He said he has seen young people smoke a hookah on the streets of Boston outside a restaurant (as smoking is not allowed inside) when the temperature is – 28 degrees!

Dr. Swasticharan added that some people think there are non-tobacco hookah mixtures. We have the National Tobacco Testing Laboratory that recently came up in Noida that can check that. Ms. Gill said, 'we need a campaign against hookahs.'

From the audience, Dr. Raman of the National Tobacco Testing Laboratory shared that we should come up with a campaign soon to break the myths on the use of hookah and e-cigarettes. Tobacco Testing Laboratories will also open up soon in Mumbai and Guwahati.

TOPIC 3: QUITLINE

What has been your experience on the recent launch of Quitline service numbers made available on cigarette packets?

Dr. Rajesh Dixit replied thatit was surprising that we received 200 calls on the first day when we opened the Quitline Service, and the calls kept increasing. We have seen that there is will power within people to quit the use of tobacco. We follow-up people who want to quit tobaccowith calls for 6 months to almost 1 year. We look at quit rates for smoking, we also need to find outwhich SLT products are easy to quit.

Can we ban use of tobacco just the way Bhutan has done it?

Ms. Gill responded saying that the prevalence of tobacco users in Bhutan is very low and the possibility of banning also depends on the supply and demand for tobacco.

Dr. Chaturvedi intervened and asked Dr. Pratima Murthy to talk about the Quitline as she has designed it.

Dr. Murthy answered saying, people are desperate to quit. The Quitline started in Delhi and now covers the whole of India. Graphic warnings take 85% of the package.Only 15% of the space was left for the tobacco industry to do the branding. Now with the Quitline number coming on the packets, the tobacco industry feels we have taken away their 15% space too.

TOPIC 4: WOMEN AND TOBACCO USE

We see many women today smoking cigarettes, what do you think is the reason behind this new trend in woman using cigarettes?

Ms. Ramachandran answered saying that for women cigarettes smoking is symbol of equality. It is glamourized through marketing. There is no peer pressure as such, but it is just offering the cigarette to a woman. It is becoming a social norm, so a girl smoking in public is normalized. The cigarettes marketed for women in the '90s called "Ms.", something similar to Virginia Slims, failed because women wanted to use cigarette brands which men used, like Marlboro.

Dr. Gupta added that the cigarette industry is spending money on glamorizing cigarette smoking by women. Offices, call centres, and films have women smokers.

Dr. Dikshit said that health risks for women are much higher. Awareness needs to be built in terms of the use of tobacco having an effect on pregnancy.

Dr. Vishwanath said thatthe issue of body image is high, which puts women under a lot of pressure. Basically smoking is one way of controlling weight; however it is also harmful to the body.

Dr. Arora added that we have not yet done targeted campaigning for women or youth.

TOPIC 5: TOBACCO INDUSTRY INTERFERENCE

Dr. Chaturvedi raised a question:

The Health Ministry has sent Article 5.3 of the FCTC (protect tobacco control policies from commercial and other vested interests of the tobacco industry) to

other ministries for their comments: can this policy be implemented in a holistic manner in the country?

Dr. Swasticharan responded that Article 5.3 of FCTC should be implemented strongly. Delegations which went for CoP 8 had to sign the Declaration of Interest that they did not have anything to do with any tobacco company.

Dr. Quan asked a question:

What is global best practice for the FCTC Article 5.3?

From the audience, Dr. Upendra Bhojani shared his experience saying the only one who did not respond to the Right to Information (RTI) petition he filed to find out about this aspect was the Ministry of Commerceand Industry.

Dr. Chaturvedi added thatthe Ministry of Commerce is the most powerful ministry.

Dr. Swasticharan said that many will say that implementation of FCTC Article 5.3 starts from the Ministry of Health; however for now we can say that it is Work in Progress (WIP).

Dr. Gupta added that we are also working towards stopping the sale of tobacco in the shops that sell chips and other snacks. Here is where children are vulnerable to initiating the use of tobacco. So we need to identify such measures that can support tobacco control work and avoid tobacco industry interference.

Dr. Swasticharan said that the advisory sent (on licensing the sale of tobacco products and disallowing the sale of other items, like snacks, by licensed tobacco vendors) disturbs the other party (tobacco industry).

From the audience, Dr. Jane Ralte added thatMizoramenforces COTPA strongly with the support of the Police Force. She said we havetrained the police on how to best implement COTPA.

Dr. Chaturvedi concluded the panel discussion thanking all the panellists and the audience.

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SYMPOSIUM 1: TREATMENTS FOR TOBACCO CESSATION AND THEIR SUCCESS RATES

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

5:00 PM TO 6:30 PM

Chairs:

Dr. L. Swasticharan
Chief Medical Officer
Ministry of Health & Family Welfare
Government of India

Dr. Pratima Murthy
Professor, Dept. of Psychiatry, & Chief, De-addiction Services National Institute Of Mental Health And Neuro Sciences (NIMHANS), Bangalore

Speakers:

Speaker	Topic
Mr. Ranjit Singh Legal Expert (Supreme Court of India), Member Bar Council of Delhi	Gol Quit Line Policy, Intervention and Implementation
Dr. Gauravi Mishra Professor Oncology, Tata Memorial Centre, Mumbai	Multi-dimensional approach: Importance and solutions offered by practitioners in sensitising patients to quit tobacco, for recovery of overall health
Dr. Anil Kumar Singhal Chief Medical Officer, BEST, Mumbai	Implementation of NRT at the work place
Dr. Biman Natung Nodal officer TCC- Arunachal Pradesh	Challenges and Practical Considerations at North East TCC's

Speaker 1: Mr. Ranjit Singh

Topic: Gol Quit Line Policy, Intervention and Implementation

Mr. Ranjit Singh spoke about Government of India policy initiatives under the National Tobacco Control Programme (NTCP), launched in the year 2007-2008. At the beginning he spoke on tobacco use in India, the prevalence of tobacco use based on GATS-2 results (28.6% of adults ≥ 15 years) and the burden of tobacco related diseases. Over 400 tobacco cessation centres were set up in District Hospitals under the NTCP and provision for free NRT services at District level. National cessation guidelines have been developed and disseminated. The counsellors appointed under the Non Communicable Diseases (NCD) Programme provide tobacco cessation services at primary level. M-cessation services (on mobile phones) have been launched at http://www.nhp.gov.in/quit-tobacco and one can give missed call at 011-22901701. A toll free number was also introduced on May 03, 2016 and it runs 24/7 in shifts. Initially it was from 8 am to 8pm on all days except Mondays. The toll free no. is -1800112356. The Government of India supports the establishment of Tobacco Cessation Centres (TCCs) in each district. The mandate for these is to provide cessation services as well as training to those who can augment the cessation activity in the district. The staff in each TCC consists of one counsellor/psychologist under the NTCP and it is supported with basic equipment. He also spoke about the Quitline services as an effective means of delivering evidence based treatment. He mentioned that at least 30% of the total number of people who called the government's national quit-line services quit smoking or chewing tobacco after they received telephonic counselling four times. The entire counselling is done by trained psychologists. The toll free services are a good way to reach people who are reluctant to come forward due to the fear of being judged. He said we are going to expand the services and increase the no. of counsellors. Also, he said according to the WHO Framework Convention on Tobacco Control quit line counselling is very effective and should be used in tobacco cessation interventions. Phone counselling has been shown to double the chances of quitting, reaching a large number of tobacco users in a cost effective way and serves as a gateway to other cessation resources. Implementation of the Quit line number on the tobacco packs from Sep 1st, 2018 has been in place. The Supreme Court of India on August 14th and the Karnataka High Court on August 31st through separate orders paved the way for implementation of (larger) graphic health warnings (GHW) from Sep 1st, 2019. Mr. Singh ended his talk by saying that the quit line services have been expanded to regional satellite centres in 2018 and counselling is now available in regional languages at Bhubaneshwar Borooah Cancer Institute (BBCI), the National Institute of Mental Health and Neuro Sciences (NIMHANS), in Bangalore and Guwahati as well as the Tata Memorial Centre (TMC), Mumbai.

Speaker 2: Dr. Gauravi Mishra

Topic: Multi-dimensional approach: Importance and solutions offered by practitioners in sensitising patients to quit tobacco, for recovery of overall health

Dr. Gauravi Mishra presented on many studies which TMH has undertaken, one of which was on a community based tobacco cessation programme among women in Mumbai, in which they have

performed personal interviews, games for rapport building, education sessions and many cultural activities. She said that in the current study tobacco is used by 15% of the women and the mean age at the initiation of tobacco is 17.3 years. Reasons for initiation are mainly tobacco use among family members and in the community. Then she spoke about the tobacco cessation programme among employees in the chemical industry: they started with the introductory lecture, collection of pre-intervention data available about varioussocio-demographic and risk factors. In the intervention the employees were screened for oral neoplasms where it was found that 48% employees consumed tobacco, predominately in non-smoking forms and 40% of tobacco users had oral precancerous lesions. After that they conducted workplace cancer awareness and screening programmes with banks, DAE, BMC hospitals, sales tax employees reserve police, BPOs, the state and many other employers. Besides this they have done one study with auto rickshaw drivers. The result was that out of 550 auto rickshaw drivers were benefited from the session and 55 came for screening. Then there was one study on tobacco free cabs: the total number of cab drivers who participated was 400 and of these 64% were found to be tobacco users (80% using smokeless forms) and 112 cab drivers had oral precancerous lesions. There was a community based cancer awareness programme in urban and rural populations in which surveys of tobacco users were done, heath education was provided, and screening was done. Dr. Mishra made the following conclusions:

- Tobacco cessation programmes are feasible and can be successfully implemented in varied occupational and community settings
- Population based tobacco cessation programmes are needed to assist users to quit
- Tobacco quit rates improve with the intensity of the intervention used; e.g. from single session of awareness, to multiple sessions of behavioural therapy
- Pharmacotherapy further improves the tobacco quit rates and should be used whenever feasible.

Speaker 3: Dr. Anil Kumar Singhal

Topic: Implementation of NRT at the work place

Dr. Anil Kumar Singhal spoke about the tobacco free BEST – workplace policy – From Recruitment to Retirement. The BEST is a subsidiary of India's oldest civic body, the MCGM. Every day BEST supplies electric power to 10.55 lakh consumers and transport services to around 30 lakh commuters for their daily needs. Dr. Singhal said that more than 50% of BEST employees had been addicted to tobacco, out of which 90% used to use smokeless tobacco. He showed a

documentary on the Tumbakhu Mukt BEST Campaign of 2017-18, in which many BEST employees shared their views about their initiation to tobacco and experiences of using it. He acknowledged all the contributors/sponsors, Ganga Charitable Trust, CPAA, RUSAN Pharma Ltd, SBF, ICS and others. He spoke about the reduction in cardio vascular disease (CVD) cases during the yearsfrom 2013-14 to 2017-18 treated by angioplasty and by-passes and said that cases of stroke /TB/ back pain hyper acidity had also been significantly reduced. He shared that a positive environment has been created amongst the employees against the tobacco habit. Almost 5000 tobacco addicted employees have given up their tobacco habit and there is significant reduction in tobacco related diseases and their cost. He also discussed about tobacco cessation programme assessment and rating (nicotine patches) and spoke about parameters like the efficacy and effectiveness of 2baconil patch therapy, confidence/ motivation of participants to quit tobacco, adherence to the programme, morning cravings, and the urge to chew tobacco. He said among BEST employees they have found 81% quit rate and after 1 year only one employee relapsed. Out of 1400 highly dependent employees, the following used NRT treatments: 100 patients used patches, 760 gums and 540 lozenges. Around 40,000 BEST employees were aware and celebrated World No Tobacco Day, more than 500 attended awareness camps, many were enrolled on the mobile app, and attended official functions for the felicitation of quitters. Some 15,000 employees received counselling through focus group discussions, family member participation, annual health check-ups, and de-addiction centres. Some 10,500 employees received oral screening during which 1096 suspected cancer cases were found and 1 patient was diagnosed with cancer. Dr. Singhal then summed up by saying that that the main pillars of the tobacco free BEST campaigns are awareness creation, cessation and treatment.

Speaker 4: Dr. Biman Natung

Topic: Challenges and Practical Considerations at North East TCC's

Dr. Natung spoke about the challenges faced in TCCs of the North East and particularly in Arunachal Pradesh. In his presentation he spoke about how tobacco is a socially accepted traditional crop in some parts of the state and a commonly used day to day product. He also spoke about the high prevalence and acceptability of smoking and smokeless use of tobacco. He explained about the treatments used for tobacco cessation (medication with health supplements), and focus group discussions (FGDs) for tobacco users to encourage them to quit smoking.He

highlighted the strong determination of the patients and the appreciation certificate that was provided to those who had already quit. He spoke about the various treatments used for tobacco cessation: magnetic resonance body screening for nicotine level. He also shared that relapse occurs time and again among quitters even after repeated rounds of counselling and NRT. He showed many anti-tobacco hoardings and wall painting in various districts. He shared many activities undertaken for enforcing the COTPA ACT 2003 including the enforcement squad and the sensitization meetings at the DTCC in many districts. He shared his experiences about community level awareness campaigns and showed various pictures from the events covered under NTCP in Arunachal Pradesh. He spoke about oral screenings on the special occasion of Independence Day and various other occasions and showed related pictures. He said current prevalence of tobacco for Arunachal Pradesh from the GATS-2 was 45.5% of adults aged ≥15 years and he discussed the burden of tobacco related diseases in the state. He also said that currently the NTCP is working in 20 districts of the state. At the end of his presentation, Dr. Natung shared a video which they use in the state on the ill effects of tobacco use.

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SYMPOSIUM 2: TOBACCO ECONOMICS AND TAXATION

LECTURE HALL, GOLDEN JUBILEE BLOCK

5:00 PM TO 6:30 PM

Chairs:

Ms. Vineet Munish Gill
National Professional Officer, World Health Organization India

Mr. Praveen Sinha
National Professional Officer, World Health Organization India

Speakers:

Speaker	Topic
Mr. Mark Goodchild Technical Officer, Tobacco Control Economics Unit, Department of Prevention of Non-communicable Diseases, WHO, Geneva	Affordability of Tobacco Products in India
Mr. Sharadchandra Shrivastav Director Anti-Smuggling Unit, Ministry of Finance, New Delhi	Illicit Trade Protocol-Current Status and Next Steps
Dr. Gaurang Nazar Director-Research, HRIDAY, New Delhi	Bidi Industry in India-Output, Employment & Wages
Ms. Nandini Verma India Central Policy Director, Campaign for Tobacco-Free Kids, New Delhi	GST and Civil Society Advocacy

Introduction to the Session – Key Points

- Article 6 of WHO FCTC talks about price and tax measures but tobacco economics doesn't stop there. It straddles several other provisions like article 15 (illicit trade), articles17 and 18 (alternatives for tobacco workers).
- In India, tobacco alone drains out over Rs. 100,000 crore every year (equivalent to $22.4 billion) due to tobacco related diseases, according to a report released by the Ministry of Health conducted by PHFI and WHO in 2014. Calculations are currently being redone with latest numbers from GATS and Consumer Survey.
- The Government pours a little over 1% GDP into health, but tobacco pours out 12% or more for treating these diseases.

Speaker 1: Mr.Mark Goodchild

Topic: Affordability of Tobacco Products in India

Mr. Mark Goodchild spoke about the evolution of the concept of tobacco taxation for tobacco control. He said that in the past, the World Health Organization has only focused on the share of tax in the price of cigarettes. However with time, it's been seen that price increases in cigarettes can't be the only measure, it can be diluted by an increase in consumer incomes, which is especially the case in developing countries. He said that the WHO has therefore had to change its affordability measure to one

which reflects the computation of two behavioural economic factors: Price Elasticity of Demand and Income Elasticity of Demand. Focussing only on price elasticity leads to the simple idea that if prices are raised, consumption will go down. But income elasticity works the other way - growing incomes means people also look forward to buying more disposable goods. Like every other country, in India there is evidence that consumers respond to both: higher goods prices by reducing consumption and higher incomes by increasing consumption. However, unique to India, the larger socioeconomic groups (SEGs), the poorer ones, are the most responsive to price changes. Overall in India, the data suggests that there has been an increase in cigarette prices, which continue to increase. This is similar to WHO findings that cigarettes all over the world have become less affordable, even in the price range that the large SEG consumes. However, the data also suggests, that in India there's been little to no change in prices of other tobacco products. In India, according to data taken from the GATS 2016-17 and Reserve Bank statistics, tobacco use prevalence in the lower income states is at a high of around 30% or more. Even in comparison to the GATS 2009-10, the data confirms that tobacco use prevalence has become more concentrated in the lower income states over time. Even though cigarette prices have increased due to higher taxes on tobacco products in the States and at the Central level, these taxes haven't yet effectively been applied to bidis and smokeless products which are generally cheaper. On one hand, the government has been focusing on various development policy changes like in health and poverty alleviation in the lower income states, but on the other hand, the lower taxes on tobacco products also increase tobacco use in these areas, creating a policy disconnect, where a lot of people are dying from tobacco related diseases. This calls for an increase in taxes on all tobacco products at a much faster pace to promote public health. Mr. Goodchild recommended India should also improve its control over the production and supply of bidis and other tobacco products that are mostly made in the informal sector, so that tax measures imposed can become more effective through a two-pronged approach, affecting both demand and supply.

Speaker 2: Mr. Sharad Chandra Shrivastav
Topic: Illicit Trade Protocol-Current Status and Next Steps

Mr. Sharad Chandra Shrivastav began by stating that the protocol to eliminate illicit trade of tobacco products stems from Article 15 of the WHO FCTC and was adopted by India on 5th June, 2018. He said that the Central Board of Indirect Taxes and Customs (CBIC), which is the nodal agency for the protocol, has been following up on the treaty and the commitment to the protocol since the inception of the FCTC. Since India's accession to the protocol, it has set up an inter-Ministerial Group, which consists of representatives from the Department of Industrial Policy and Promotion, the Ministry

of Commerce, the Ministry of Agriculture, and the Ministry of Health, among others. Besides that, there is also a steering group that has been formed since 15th October, 2018, which is overseen by the new chairman of the CBIC, Mr. PK Das (since 1 January 2019).

The track and trace system, a protocol requirement, is now a part of the duties of the CBIC's Central Excise wing. The system, a non-tax measure to control the consumption of tobacco, should be implemented within 5 years for cigarettes and 10 years for other products as stipulated by the protocol. Some of these non-tax measures include labelling and uniform marking for which principles have been defined and every kind of tobacco product should contain. Kenya's track and trace system which is strong and has been effective is being studied for its implementation in India. So far, the assignment has taken a very fast pace and the chairperson has been volunteering on a regular basis towards its development.

In the year 2017-18, the ministry has booked 933 cases of smuggling cigarettes, both branded and non-branded, which amounted to the recovery of Rs. 80 crores in customs duty. In the current year, there have been more than 1000 cases that have generated Rs. 160 crores.

An important measure taken while committing to the protocol was that seized cigarettes, instead of being sold on auction and recycled back into the market for consumption, as used to happen earlier, they are now to be destroyed. This has been in accordance with the consent of Ministry of Health. This circular was issued in February 2017, and we have already noticed a decrease in consumption on those accounts.

Through the Inter-ministerial group meetings, there are many proposals being suggested that will help contain the consumption of tobacco. It was proposed that the Ministry of Health would issue prohibitory orders in certain cases like in the case of cigarettes, which falls under COTPA. Other proposals like the duty free shops being brought under the ambit of tobacco licenses and the ban on e-sale of tobacco in any form are among others. The Ministry of Environment and Forest is also being requested to issue notifications to destroy seized tobacco and give their clearances.

While complying with the protocol, the main hurdle is controlling the supply chain because it requires proper licensing, due diligence, record keeping, security and preventive measures especially in the free trade zones. Control of delivery and its misuse in free-trade zones and SEZs is being attempted to be addressed through the inter-ministerial and steering groups and guidelines are being framed to deter the misuse of tobacco and the sale of tobacco especially in these areas.Based on the WHO FCTC, every officer is being sensitized at the field level to be observant and vigilant about the menace of tobacco consumption and tobacco smuggling.

When taxes are raised as per capita income rises, raised taxes possibly have no impact. The normative downward sloping demand function when prices are raised and demand goes down doesn't happen in developing countries like it does in European and other countries. Therefore non-price measures are being placed on a very serious platform. Mr. Shrivastav concluded by saying that the entire FCTC is not merely a social movement but also a moral forum due to the adverse health effects of tobacco and it is the ethical responsibility of every citizen to contain the consumption of tobacco.

Speaker 3: Dr. Gaurang Nazar

Topic: Bidi Industry in India-Output, Employment & Wages

Dr. Gaurang Nazar informed the audience that the study he was going to speak about was done in partnership with WHO and Public Health Foundation of India (PHFI).

He gave some background on the subject: Bidi is the most popular tobacco product in India, though health risks are significantly higher in bidi smokers as compared to cigarette smokers. Not just the smokers, but also the workers in manufacturing units, which happen to be mostly women and children, are prone to respiratory illness. In comparison to cigarettes which are taxed at the rate of around 53% or more, bidis are severely under-taxed at only 22% (now 28%). The economic cost towards health-related diseases and deaths from bidi smoking in 2017 amounted to Rs. 805.5 billion whereas the excise tax revenue from bidi was only Rs. 4.2 billion (0.5% of cost). Increase in taxes on bidis has been almost negligible over time.

On the production side, the Bidi Industry, because it is part of the informal sector, it is highly unregulated but labour intensive. A study in Andhra Pradesh has even shown that despite poor working conditions, due to lack of alternative sustainable means of livelihood, bidi rollers have no option but to continue working in the industry. Bidis being considered the poor man's pleasure and apparently contributing significantly to the national economy and employment, has always managed to evade regulation.

Therefore this study, using secondary analysis of existing government sources of data, was conducted to study the contribution of the bidi to the economy, manufacturing units and employment patterns. Datasets from of Annual Survey of Industries, Enterprise Survey and Employment and Unemployment Survey from NSSO, CSO and MoSPI were used for this study. The following outcomes were part of the study: Gross Value Outcome (i.e. measure of good and services produced by any sector in the economy), share of profit in the total outcome, nature and type of employment and wages and trends in the indicators across the years 2000-01, 2005-06 and 2010-11 and comparisons were drawn between the registered and unregistered sectors.

Dr. Nazar described the findings of the study:

- Of the entire manufacturing industry, 12.8% of the manufacturing units are from the bidi industry, and though it might seem like a big number, it contributes only 0.65% of the total Gross Value Added (GVA), amounting to Rs. 48.2 billion. Through the industry, it employs 3.32 million workers, i.e. 7% of the entire manufacturing industry.
- Looking further into the composition of the bidi industry, 99.9% of the manufacturing units are in the unregistered sector, which means that 89% of the employment within the manufacturing units is also in the unregistered sector. From those that are in the registered sector, 70% of the employees are contractual. Therefore the majority of the bidi workforce

remains devoid of employment benefits, social protection and rights available to workers in the formal sector.

- The GVA contributions by the registered bidi sector have increased between 2000-01 and 2010-11 whereas that of the unregistered sector has decreased within that same time period.
- Within the registered sector, the industry is moving towards smaller production units i.e. units with 51-100 employees. However, the contributions to GVA are a lot higher from units that employ more workers.
- Data presents that the profits of the bidi industry have increased over the years from 05%-06% to 10%-11% - but in comparison to the workers' wages, both that of the direct employees and contractual workers have declined over the same period. The contractual workers earn the least wages within the industry. However, the wages of those in managerial positions/supervisory staff have increased, which is consistent in the rise in profits, pointing to a huge pay gap for the workers.
- There are disparities even amongst the bidi workers with regard to gender, which has been consistent over the years. The bidi industry over the years has always employed more women than men, nearly 80% of the workforce. However, women continue to earn much lower wages than men, with male workers earning an average of Rs. 6610.7 annually more than women in 2010-11.

On the basis of these findings, Dr. Nazar presented some recommendations:

- Formalise the industry by registering all manufacturing units for administration of better welfare of bidi rollers. This will ensure access to welfare schemes for bidi workers and monitoring of employment and wages by the Ministry of Labour and Employment. It would also lead to better administration of taxes by the Ministry of Finance as currently there's a huge loss in revenue because of the unregistered sector.
- Amend the Bidi and Cigar Workers (Conditions of Employment) Act , 1966, section 4.2 to prohibit small sized manufacturing units (<20 workers) so that these employees can avail of the same benefits directly as employees or workers in other manufacturing sectors have access to.
- Also amend section 9.2 of the Bidi and Cigar Workers (Conditions of Employment) Act, 1966 to remove the allowance for home-based workers so as to protect women and children from exposure to tobacco.
- Amend the 1st schedule of the Factories (Amendment) Act 1987, section 2[cb] to include bidi manufacturing as a hazardous process
- Establish a national programme focused on relocation and capacity building for bidi rollers for alternative livelihoods, better income, employment benefits and environment; which can be considered under the Skill India Initiative of the Ministry of Skill Development and Entrepreneurship.
- The Government should revisit the fiscal benefits and exemptions given to the bidi industry, as its contribution to the economy is insignificant against the health hazards that it causes. It should levy cess along with GST, just like in the case of cigarettes and SLT, on bidis as well. The tax exemption given to manufacturers with < Rs. 40,00,000 annual turnover should be reconsidered in the case of bidi manufacturers.

Speaker 4: Ms. Nandini Verma

Topic: GST and Civil Society Advocacy

Ms.Nandini Verma talked about her success story of a collaborative process of political and media advocacy to get the highest taxation on tobacco products, including bidis under GST. The story began in 2016, and was met with an aggressive campaign, carried out at national and state levels. Even though the advocacy campaign was met with challenges, especially on the bidi-front, farmers and the bidi rollers lobbied against the taxation of the 'poor man's pleasure'. Ms. Verma said the story is a testament to what the power of what a collaborative campaign and strong follow-ups can achieve. There are still, however, many challenges like excise on cigarettes which is higher than cess on bidi that still need to be addressed but can be jointly tackled by civil society. s

Questions and Answers:

MNC cigarette companies could be complicit in smuggling because they benefit from this for tax evasion - are there such cases in India?

Mr. Shrivastav answered that this is not true in India. MNCs have legal channels and other alternative ways of operating, e.g. by way of transfer pricing (under invoicing exports and over invoicing imports), and would not go through the menace of concealment. The cases we have booked are clear cases of smuggling by concealment or misbranded goods and none of these have been done by MNCs.

There were two associations made - a)Richer Indian states where tobacco consumption is low, e.g. Goa, that has a high net domestic product and low tobacco consumption; b)States with lowest consumption e.g. Goa also had a higher affordability in the case of bidi (not all tobacco products); therefore the association between affordability and actual consumption seems to be a lot more complicated than usually assumed. Is that correct?

Mr. Goodchild said that along with the price measures to control tobacco consumption, there have been a lot of non-price measures also. Therefore, it's not just price influences, but media warnings and health warnings that also influence consumers. Income elasticity is another big factor to be considered. For example, in most developing nations tobacco is considered a normal good, and therefore with an increase in income, people purchase more. However, in high income nations, tobacco is not considered a normal good; rather it's more of a demerit good. The more educated people are, the higher their incomes, the more awareness they have of the ill-effects of tobacco and the less they consume. This is probably happening in India too, which is why the concentration of tobacco consumption is in the poorer regions where they're less educated.

With regard to bidis in India, like for all tobacco products, there are limitations to using just price measures, but if prices are raised, then the poorer people can't afford them and therefore tax measures seem to go hand-in-hand with regulation of the supply chain and with the continuation of other price measures. People with high incomes don't respond much to price

changes but the poor respond very well. Which is what makes the poorer people continue using bidis and chewing tobacco as opposed to cigarettes and hence there should be more focus on those products.

Has there been any change in affordability since GST came into effect? Do the state differences in the pricings go away with GST?

Ms. Verma said it did seem like GST impacted the price of bidis more than that of other tobacco products because GST raised the tax burden from what it originally was for bidis. Earlier the central tax, VAT, was different in different states and the expectation was that the price difference in the states would be quite wide; and with the one tax, GST, it was expected that price differences in the states would narrow. However, the opposite has happened.For cigarettes and bidis, looking at the standard deviation, we see that prices across the states has widened. For example, in Karnataka, a state where the ITC has some operations, would have had a high VAT, and if the tax got lower, prices of the product wouldn't change, only the excess money would go into pockets. This would be interesting to study further.

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DAY 2: SATURDAY, FEBRUARY 9, 2019

9:00 am to 7:00 pm

SYMPOSIUM 3: BIDI: POOR MAN'S DISPLEASURE

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

9:00 AM TO 10:30 AM

Chairs:

Ms. Radhika Khajuria
Senior Policy Advisor, India,
Campaign for Tobacco-Free Kids

Ms. Nandini Verma
India Central Policy Director
Campaign for Tobacco-Free Kids

Speakers:

Speaker	Topic
Dr. P.C. Gupta	Epidemiology and Health Effects of Bidi

Ms. Munni Begum	Exploitation of Bidi Workers: Struggles for a Better Life *(in Hindi)*
Mr. Subrat Saha	Alternate Livelihood Programme for Bidi Workers by the Union Ministry of Labour & Employment
Mr. Ditthi Bhattacharya	Bidi Industry: Addressing Accountability to Develop Worker Led Strategies
Mr. Pradeep Narayanan	Bidi-Political Nexus: Emerging Trends from an Ongoing Mapping Study

Ms. Radhika Khajuria opened the symposium by welcoming all the presenters and attendees.She mentioned that this symposium is the first ever session which includes perspectives of both the bidi workers and the bidi users. The session gives insights about how the tobacco industry has been using the bidi workers for their own benefit as well as perspectives from governance, researchers and doctors.

Speaker 1: Dr. P.C. Gupta, Director, Healis Sekhsaria Institute of Public Health
Topic: Epidemiology and Health Effects of Bidi

Dr. P.C. Gupta began by saying that the bidi is the most single most common tobacco product in India. As many as 71.8 million smoke bidis in India. Dr. Gupta emphasized that the control policies are not working well, as there has been only 13% decrease in the use of bidis. The highest proportion of bidi smokers belong to lowest educational group.He also mentioned that the highest increase (103%) in bidi smoking has been among students. He said that the adverse health effects of bidi smoking should be looked at. Accurate health data comes from all-cause mortality. The all-cause mortality among bidi smokers is higher than average.

The Mumbai Cohort Study shows 64% higher all-cause mortality among bidi smokers. More people in India are dying from tuberculosis. Studies show that bidi smoking contributes a lot to tuberculosis mortality.

Dr. Gupta informed the audience about the ill effects of bidi smoking on the human body. He said that bidi smoking causes similar health effects as cigarette smoking, apparently with higher risk. Intervention policies are influencing bidi smoking less than cigarette smoking. Bidis are getting more and more affordable. This is because income levels are increasing in India and therefore price increases on tobacco products are not adequate to compensate for themed.

Gupta pointed out that younger persons and people having a low level of education are the most important groups in terms of bidi smoking. He showed concern regarding the younger lower socio economic group and said that this is the target group which is the most difficult to reach with any kind of intervention. Dr. Gupta expressed the need to think about bidi workers and the health problems caused by rolling bidis. Several studies show that bidi rolling causes occupational health problems. Some studies also show that bidi workers absorb nicotine in their blood. However, he said that there are no systematic studies which show health effects of bidi rolling and he concluded the presentation by saying that such studies are urgently needed.

Speaker 2: Ms. Munni Begum
Topic: Exploitation of Bidi Workers: Struggles for a Better Life *(in Hindi)*

Munni Begum narrated her struggles as a bidi worker and her fight against the bidi industry. She said that she was introduced to this industry because of her condition back then. She started working to earn money. While working she never liked the smell of bidis. Her father used to smoke bidis and she never liked it. During this period, one day she decided that she did not want to work for the bidi industry. She said that her father died because of bidi smoking and so she decided to work for the benefit of bidi workers and smokers. She mentioned that more females than males are involved in bidi rolling: approximately 90% workers are females. She said that in Uttar Pradesh, where she works, 80% of the workers are females and 70% are Muslims.

They had no option but to work for the bidi industry and their health conditions also worsened as they used to work at home where the tobacco. When women roll bidis at home three categories of people are affected: her children, herself and her entire family. This is because the smell of bidis affects all of them. When she spoke to a few of the other female bidi workers most of them wanted to quit working but had no other option. Munni Begum said that she formed an association of female bidi workers in Jaunpur.

She said she also spoke to the Welfare Commissioner, Allahabad, to ask for some sort of other occupational training of female bidi workers. All the women involved in bidi making were uneducated but they still wanted to work doing things likestitching. These women were willing to undergo training. She also informed the audience that the daughters of these female workers, less than 14 years of age, were also involved. We are trying to create awareness among them and their daughters of the hazards of bidi rolling. Munni Begum requested each and every one to work for these bidi workers and help them.

She said that it is our responsibility to support them. It is necessary to work on their health and education. Female bidi workers are forming associations and collecting money for themselves. She brought to our notice that female bidi workers don't even have any worker registration card (under the Labour Department)and therefore receive no benefits from rolling bidis. In Jaunpur

district, 20000 workers have registered but do not receive any benefits.At end Munni Begum again requested everyone to fight for and support the bidi workers.

Speaker 3: Mr. Subrat Saha

Topic: Alternate Livelihood Programme for Bidi Workers by the Union Ministry of Labour & Employment

Mr. Subrat Saha started his session by saying that until 2017 he was unaware about the harmful effects of tobacco and nicotine on the human body. He had never been told about tobacco at school, college level or even in the MBBS course. Others also must be in this situation. Thus he urged that the education system should have one chapter on tobacco and its ill effects to human body and requested WHO to work with the education system and incorporate this in the system. He mentioned that during his tenure as Welfare Commissioner, West Bengal, he asked the medical doctors to conduct at least one session on tobacco in the schools. Mr. Subrat Saha described the occupational profile of the bidi workers and the working conditions in the bidi industry. He said that bidi work started in factories but due to the Bidi Workers Welfare Cess required from 1971 and other reasons, the employer did not want the workers to work in factories and therefore the work was moved to workers' households at village level.

There, the work is unregulated and the working conditions are unregulated. The names of the workers are not registered with the government. He said that this was highly unrecommended. The social welfare of the bidi workers, e.g., their provident fund, is not monitored. He also informed the listeners that the women bidi workers are not recognized as workers and therefore are deprived of benefits like provident fund, maternity leave, etc.The industry registers only males to avoid providing benefits to the majority of workers, who are women. The women workers are paid less than minimum wages. Apart from this, they experience various diseases like TB, asthma, skin diseases, gynecological problems, bronchitis, anemia, and eye problems.He briefly spoke about the profile of bidi workers of Murshidabad and also stated that the bidi workers stay 50-60 km away from their dispensaries and therefore they were not able to reach them and that their dependents, especially girls also joined this industry.

Next,Mr. Saha spoke about skill development for bidi workers – the Government of India initiative. Due to the harsh conditions of the bidi industry, need for remedial measures were felt and due to the pressure from tobacco control a need was felt to provide a viable source of employment or source of livelihood for the workers. Therefore, to build the capacity of the bidi workers the Skill Development Programme was started. As this was a new area, an Expert Committee was set up on September 1st 2017 to work on alternate vocations for bidi workers. The committee constituted experts from WHO, ILO, UNDP, the Minister of Skill Development, the Minister of Health, and the Welfare Commissioner of Bhubaneshwar, Raipur.A pilot project in West Bengal, Orissa and Chattisgarh was started. Under this programme, it was decided that the GOI will pay a stipend to the bidi workers equal to minimum wages to registered workers

during the training, support for lodging and boarding, and give certification. Later, the programme was expanded to 4 other states and then to all the states of India. A road map was prepared and MIS formats introduced for monthly reporting. At the state level, formation of sub committees, and sensitization of the medical officers on the bidi issue was done. Awareness was created among the bidi workers about the harmful effects of bidi so that they would get motivated to leave the industry. Voluntary Training Partners (VTPs) and medical officers arranged motivational campaigns. However, it was difficult to get training partners for very remote villages. Officials from the dispensary keep in constant follow-up with VTPs. Mr. Saha defined the role of VTPs. They are part of National Skill Development Corporation (NSDC) and support the programme.Various promotional activities are conducted with the cottage industries, etc. Placements are offered to the bidi workers post the training and they earn the double of their earlier income.

Mr. Saha shared a few case studies from Murshidabad regarding skill training. The bidi workers were given computer hardware training, etc. He also shared the success story of one female bidi worker after joining the programme, who now earned Rs. 7000 by working in the hospital.Challenges of the programme:the training modulethe National Skill Development Corporation (NSDC) is not suited to most of our bidi workers, due to time constraints, and training having to be conducted at remote places, with the lack of safe transport facilities. He said that through this programmethey are also trying to formalize the bidi industry. Id cards are issued to bidi rollers through this programme. Mr. Subrat Saha concluded the session by saying that substantial improvements have been seen in the bidi workers.

Speaker 4: Ms. Dithhi Bhattacharya
Topic: Bidi Industry: Addressing Accountability to Develop Worker Led Strategies

Ms. Dithhi Bhattacharya started off by describing the current situation of the bidi industry in India, which consists of as many as 85 lakh workers. She mentioned that the biggest challenge for India is that across the world, cigarette smoking is much more common than poor man's pleasure. While tobacco control is trying to regulate work for the bidi workers, the bidi industry uses the bidi workers as their facade.

She said that bidi making started in factories and then the industry modified itself and became a home-based industry with women, to avoid regulation. They broke themselves into a large number of tiny unregulated units. It is difficult to monitor these units door to door. To counter this difficulty, the bidi manufacturers created various levels of intermediaries. The bidi manufacturers give the raw materials to the contractors and then contractors would pass them to the home based workers. She mentioned that the industry also keeps the daily wages lower by blurring the employer-employee relationship.Except in Tamil Nadu, none of the bidi workers received anywhere close to minimum wages. Bidi is the only employment in India which works on a "Piece rate" basis – a certain daily wage is fixed for rolling 1000 bidis. Ms. Bhattacharya emphasized that minimum wage was not supposed to be set on piece rate but it has to be set on

8 hours of work,not on number of bidis rolled. Apart from this, she said, what was observed was that the contractor was paid the minimum amount by the industry, like Rs. 5 (*sic*) for 1000 bidis. She expressed concern about the workers' survival. Due to this, an extractive relationship develops between the contractor and the bidi workers. She also spoke about the rejection of bidis that occurs. A worker rolls 1000 bidis but gets paid only for 700-800 bidis depending upon the relationship between the contractor and the bidi worker. She explained further about the relationship between the contractor and the worker and how the industry exploits the bidi worker. In addition, the bidi industries' other strategy to fool others is through taxation. She said that taxation did not affect the industry, but the burden is on the consumer. The GST rule states that if you pay GST then you don't have to pay worker's welfare cess. Nowcess no longer goes to the government's welfare fund. The welfare fund that was supposed to provide social security for the workers was now no longer available! It is believed that taxation reduces consumption and then in turn reduces production, but in the bidi industry, taxation will not reduce the number of bidi workers, as the workers do not have any other livelihood. There is nothing else today in rural development which can provide employment to the bidi workers. She said that women bidi workers across the country want to quit this work and will do anything to get away from the bidi industry. She said that they received and heard bidi workers saying that if MGNREGA had worked, we would not be in such a condition. She spoke about the skill training programme for the bidi workers – the workers are willing to learn new skills and have applied for the same. But the numbers trained are small.She said that the number of workers registered for the skill training programme is very much higher than the number trained and placed. The budget allocated to training programme was Rs. 220 lakh and the budget utilized was only Rs. 42 lakh. Ms. Dithhi Bhattacharya concluded by sharing the demands of the bidi workers – regulation of the industry, bringing the work outside the home so that the legal department cannot run away from their responsibilities, and integrated production.She also said that self-employment is not the solution; the bidi workers need a holistic employment option.

Speaker 5: Mr. Pradeep Narayanan

Topic: Bidi-Political Nexus: Emerging Trends from an Ongoing Mapping Study

Mr. Pradeep Narayanan shared insights from the ongoing mapping study of Partners in Change.He informed the audience of the National Voluntary Guidelines for Responsible Business. Many companies started publishing the Business Responsibility reports which were available in the public domain as a part of the national guidelines. The study's methodology was to collect and analyse the information from the Business Responsibility Reports which were available in the public domain. From these reports, the researchers tried to analyse the relationship between the companies, the government and various other bodies which could be classified as "nexus". Mr. Narayanan briefly shared the study about the pharmaceutical company and informed the listeners that the study was able to find the doctor-pharma company nexus.

This study also helped to find out how the government was engaging the pharmaceutical companies. While studying the tobacco industry, it was found that the tobacco industry hugely influences the government. Mr. Narayanan stated that the tobacco industry derails the efforts of the government for tobacco control and he shared few examples of tobacco industry tactics – delaying package warnings, taxation, and producing counter narratives. He explained the term "Modus Operandi" – two poor men – one is poor man's pleasure and the other is women's poor working conditions. He explained how the bidi barons are doing well in occupying political positions and said that the most of the bidi companies are making profits.

Despite the companies earning huge profits, the bidi workers are compromised and many of them do not receive social security benefits. The study tried to see how this industry is trying to influence policies. They found that in 1970s, the bidi barons wanted to enter the political space. The study also mapped some of the front groups like spokespersons of the bidi industry, and action oriented support groups. Mr. Narayanan shared two recommendations: 1. We should find out how bidi pricing is decided; 2. We should move towards the tax aspect. Any cess that the company would be expected to pay, should be paid by them, so that it will affect the companies, not just the consumer.

Comments from the co-chair

The co- chair summarized the entire session and said that bidi barons and political leaders were stumbling blocks and these are the people with power. Tobacco control is facing huge challenges because of them.

Questions and Answers:

What are the challenges in training the entire bidi worker population and how can we overcome them?

Mr. Saha responded saying we are facing a lot of problems in terms of Voluntary Training Partners (VTPs) because NSDC is not able to establish VTPs at bidi workerconcentrated villages. We are unable to provide them training and also the workers are not willing to come out.The second challenge is to provide employability. We have to find alternate employability for them and find the market for them. The next challenge is the manpower and funding. The government should try to reach the remotest village and provide them facilities.

Who was responsible for minimum wages approved by the government not being paid to bidi workers?What are we doing about thewelfare of the unregistered bidi workers?

Mr. Saha said that bidi worker ID cards will be issued to register the unregistered workers.

Ms. Bhattacharya added thatregistration is the problem. The men are registered and not the women and therefore the women do not receive training. Thus firstly there is a problem in the structure and process of registration. The second problem with registration is that if the unregistered bidi worker now goes for registration, the government official says that bidi work is a bad kind of employment and that they should not register. The bidi worker is stuck in this

...kers in case of queries about

...he issue of sexual harassment is ... Internal Complaints Committees ...al area should have ICCs, but the problem is that most of the workers are not aware of them. We should put this into the framework of the Labour Department and with the organizations who are working with the bidi workers.

Regarding the lack of accredited NSDC centres, is there any possibility for integrating (this project) with other ministries?

Mr. Saha responded that in West Bengal it has been difficult to work with the government. But in Orissa, the Department of Rural Development and the Department of Labour Resources are working together. But so far in West Bengal, we have not been able to succeed in this area.

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PROFFERED PAPER 1: REVEAL THE BURDEN AND IMPACT OF TOBACCO USE

PROFFERED PAPER 1: REVEAL THE BURDEN AND IMPACT OF TOBACCO USE
LECTURE HALL, GOLDEN JUBILEE BLOCK
9:00 AM TO 10:30 AM

Chairs:
Dr. Dhirendra Sinha
Dr. Gopal Chauhan

Presenters:

Presenter	Topic
Dr. Rohini Ruhil	Socio-demographic Determinants of Tobacco Use - An Analysis of the Global Adult Tobacco Survey (GATS) India 2016-17
Dr. Rashmi Mehra	Estimating the Usage of Gul among Adults Visiting Delhi Government Dispensaries
Dr. Prashant Kumar Singh	Regional and Socioeconomic Disparity in Dual Burden of Tobacco Use in India during 2009-2017: Analysis Based on Global Adult Tobacco Survey
Dr. Manisha Pathak	Intergenerational Transmission of Tobacco Habits Among Third Generation Indians: Findings from the 2012-13 TCP India Survey
Dr. Lazarous M'bulo	Tobacco Use and Exposure to Second-hand Smoke among Older Adults in India
Dr. Diptajjit Das	Prevalence of Tobacco Use among the Juang Tribe – A Particularly Vulnerable Tribal Group Residing in Northern Odisha

Presenter 1: Dr. Rohini Ruhil

Topic: Socio-demographic Determinants of Tobacco Use - An Analysis of the Global Adult Tobacco Survey (GATS) India 2016-17

Dr. Rohini Ruhil presented an analysis of GATS with specific focus on gender, education, material deprivation index and caste. She said being a man showed the strongest association with tobacco use. Since there is a cultural taboo on women smoking, they choose to use smokeless tobacco. Tobacco industries are based upon gender norms in our country. Tobacco use was inversely proportional to education level. Material deprivation index level was shown to be inversely proportional to smokeless tobacco use; however it was almost proportional in the case of smoking. With regard to caste, being a member of a scheduled tribe (ST) has the highest odds of using tobacco, followed by being of a scheduled caste (SC), and then followed by being of other backward castes (OBC). Poverty was shown to be the strongest determinant of tobacco use. Dr. Ruhil said that so far, we have focused on primary determinants of tobacco use; however we need to move the focus onto secondary issues like employment, poverty and development as well to promote wellbeing.

Presenter 2: Dr. Rashmi Mehra

Topic: Estimating the Usage of Gul among Adults Visiting Delhi Government Dispensaries

Dr. Rashmi Mehra said that use of smokeless tobacco had increased from 0.3% to 1.6% in Delhi. So far there was no published data on exclusive gul users. There were two parts of the study: questionnaire and clinical examination. A gul-specific proforma was used, which included the WHO oral health assessment, the tooth wear index and social demographic questions. Most gul users where recorded from north east district of Delhi but mainly from Uttar Pradesh. Most were unskilled, uneducated and belonging to lower castes. Some 45% of respondents did not know that gul had tobacco in it. Therefore,Dr. Mehra said awareness aboutsmokeless tobacco products needs to be improved. Both population-based oral screening and the scaling up of the National Oral Health Programmelaunched during 2014-15 are very much needed.

Presenter 3: Dr. Prashant Kumar Singh

Topic: Regional and Socioeconomic Disparity in Dual Burden of Tobacco Use in India during 2009-2017: Analysis Based on Global Adult Tobacco Survey

Dr. Prashant Kumar Singh said the objective of this research was to study trends and patterns among dual tobacco users, whose prevalence has decreased from about 5% in GATS-1 to approximately 3% in GATS-2. Age, gender, education, occupation, awareness are significantly associated with dual tobacco use. Dual tobacco use is higher among people living in rural areas, the self-employed, persons with less than primary education, and those over 65 years.Geographically, dual use is more prevalent in the north-eastern states and in Uttar Pradesh. Dr. Singh saidthese factors should be explored further.

Presenter 4: Dr. Manisha Pathak

Topic: Intergenerational Transmission of Tobacco Habits Among Third Generation Indians: Findings from the 2012-13 TCP India Survey

Dr. Manisha Pathak began by saying that many of the risk factors associated with tobacco use in young adults are well established, particularly the influence of parental smoking. Knowing that parental tobacco use behaviour influences tobacco use in the offspring and comprises both familial and environmental influences, it seems reasonable to assume that this generational link will be replicated across multiple generations.She said the objective of this study was to assess if grandparents' tobacco use influences their grandchildren's tobacco use behaviour and to assess if grandparents' tobacco use behaviour is mediated through parental tobacco use. For smokeless tobacco user grandchildren, Dr. Pathak said the results indicated a strong association when father and grandfather both were ever tobacco users (OR=1.78; 95% CI= 1.15-2.76),father and grandmother were ever users (OR=2.25; 95% CI=1.18-4.29) andespecially if mother and grandmother were ever users (OR=2.78; 95% CI= 1.51-5.11). For grandchildren who smoked, results indicated a strong influence of father and grandfather (OR=1.92; 95% CI=1.35-2.71) and father and grandmother (OR=3.17; 95% CI= 1.31-7.68). This study provides evidence that regardless of the generation, parental tobacco use influences children's tobacco use behaviour. Parents also play a mediating role across generations influencing tobacco habits. The study underscores the role of grandparents and parents in prevention of adolescent tobacco use. Thus, culture and family factors need special attention during implementation of tobacco control policies and behavioural intervention programmes.

Presenter 5: Dr. Lazarous Mbulo

Topic: Tobacco Use and Exposure to Second-hand Smoke among Older Adults in India

Dr. Lazarous Mbulo explained thatsince tobacco use and second hand smoke exposure increases the risk of NCDs, especially in the elderly, thus the objective of this study was to explore patterns and identify risk factors for tobacco use and second hand smoke(SHS) using data from the two waves of GATS, in the population in general and then among the elderly. SHS could be at home, and/or in public places during the last days. Using multilevel logistic regression, correlates found for smoking were male gender, low socioeconomic status, belonging to rural areas and having less education. Those for second hand smoke at home were tobacco use, rural residence, having less education, self-employment and retired status. Adults of 65 years or older had a similar likelihood of exposure to SHS at home as the other age groups, but were less likely than youngerpeople to be exposed to SHS in public places.There was a decline in exposure of older adults to SHS between the two waves of GATS. Dr. Mbulo said that still there is a need to create awareness about the harmfulness of exposure to SHS for the elderly, targeting these interventions to reduce disparities among social groups.

Presenter 6: Dr. Diptajit Das

Topic: Prevalence of Tobacco Use among the Juang Tribe – A Particularly Vulnerable Tribal Group Residing in Northern Odisha

Dr. Diptajit Das informed the audience that India has 635 tribal communities out of which 75 are particularly vulnerable tribal groups (PVTG'S) and Odisha has the largest number of PVTG'S

which is 13.The Juang tribes are one of the primitive tribes of Odisha and they mainly depend on the forest for their primary sustenance. There is no reported literature or baseline information available regarding the prevalence of tobacco consumption in this community. Dr. Das said this study was to evaluate the impact of tobacco use on the oral health of the Juang tribes in Banspal Taluk of northern Odisha. He said a sample of 1416 individuals was analysed which was obtained from census data and the Statistical Wing of The Scheduled Caste and Scheduled Tribes Research and Training Institute. Data was collected using the WHO oral health assessment form. A 1997 type III clinical examination was carried out as per ADA specifications. Individualsbelonging to the age group of 60 years and above showed a very high prevalence of tobacco use: 72%. The entire study population was characterized by high prevalence of tobacco use and associated tobacco product consumption by the younger population is an issue of significant concern.

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PROFFERED PAPER 2: MONITORING COMPLIANCE AND OVERCOMING OBSTACLES IN IMPLEMENTING TOBACCO CONTROL LAW

Chairs:
Mr. Sanjay Seth
Dr. Jane Ralte
Ms. Leni Chaudhuri

Presenters:

Presenter	Topic
Mr. Deepak Mishra	How to Prioritize Tobacco Control in the Agenda of the Challenges-Ridden State – A Case Study from State of Bihar in India
Mr. Govind Kumar Tripathi	Multi Stakeholder Engagement Accelerated System and Shown Model of Elimination of Tobacco by Achieving High Compliance of Legislative Provisions in Bhatinda, India
Dr. Rakesh Kumar Gupta	Need toTackle Menace of Smokeless Tobacco in Punjab by Strict Implementation of Food Safety and Standards Act FSSA
Dr. Vasundhara Kulkarni	Compliance of Cab Drivers and Reactions of the Commuters to the Smoke Free Cab Policy

Presenter 1: Mr. Deepak Mishra

Topic: How to Prioritize Tobacco Control in the Agenda of the Challenges-Ridden State – A Case Study from State of Bihar in India

Mr. Deepak Mishra began by noting that Bihar has a very high growth in population and a poor economic base. He said the prevalence of tobacco consumption in Bihar, particularly smokeless

tobacco is very high and it is socially acceptable. When the Socio Economic and Educational Development Society or SEEDS started its work in Bihar, tobacco control was the least priority for the government. Bihar has a long history of cultivation and production of tobacco, starting from the British period. MOHFW included two districts, Munger and Patna, under the NTCP in 2009. The State Tobacco Control Cell (STCC) was established in 2010. SEEDS in partnership with HRIDAY started tobacco control activities in 7 districts (including Patna) in April 2010, in collaboration with the Bihar STCC. More districts have continued to be added, up to March 2018. The process of institutionalization of the tobacco control program at state and district levels continued with the support from SEEDS and The Union. The District Tobacco Control Cell (DTCC) was formed in all districts, under the District Health Society (DHS). Several Public Notices were issued for implementation of Sections 4, 5, 6A and 6B of COTPA in the State, in various state departments: Health, Education, Home, Tourism, Transport, Panchayati Raj, Labour and Employment. In November 2014, production, storage, transportation, distribution, sale and purchase of all forms of smokeless tobaccowere bannedby the Department of Food Safety. The Agriculture Dept. also issued instructions to the Joint Director / Deputy Director and District Agriculture Officer to curb tobacco cultivation and promote alternative cropping. Tobacco control is reviewed periodically at state and district levels. Other key outcomes of this partnership between NGOs and government bodies since 2010 are as follows: 13 out of 19 focused districts have achieved high compliance to various provisions of COTPA 2003; 13 districts have been declared smoke-free; two districts have been declared TAPS-free at point of sale; Bihar became the 3rd state in the country to ban gutka in May 2012; all smokeless tobacco products were banned there in November 2014. Patna was the first city in India to implement 85% pack warnings.The government of Bihar has banned the sale of loose cigarettes and e-cigarettes; the state health department has increased coverage of tobacco cessation services by integrating it with the de-addiction programme.Awareness about tobacco control issues has been generated among the common people through aggressive electronic, print and social media campaigns.Guidelines for FCTC Article 5.3 have been developed and are in the process of implementation.

Presenter 2: Mr. Govind Kumar Tripathi

Topic: Multi Stakeholder Engagement Accelerated System and Shown Model of Elimination of Tobacco by Achieving High Compliance of Legislative Provisions in Bhatinda, India

Mr. Govind Kumar Tripathi described a cross sectional study that was conducted in the Bathinda District of Punjab to assess compliance with Sections 4, 5, 6 and 7, 8 and 9 of COTPA, 2003, as a result of robust enforcement through multi stakeholder engagement. He said that for Section 4, public places were divided into 5 categories: a. Restaurants, bars, and shopping malls, b. Government buildings (banks, court, public offices etc.), c. Educational institutions (school and colleges) d. Health care facilities (public and private); and e.Transit stations (railway stations, bus stations, and airports). As many as 340 public places in urban and rural areas were studied. For Sections 5, 6 and 7, information was collected from 377 tobacco vendors (points of sale or PoS) in urban and rural areas in Bathinda District. For assessing enforcement of Section 6B, 150 educational institutions were observed.

The overall compliance with Section 4 was 88.3%; For Section 5, No advertisement of tobacco products was found in 91.3% of the PoS. The compliance to selling of loose cigarette was low, i.e., 67%. Regarding Section 6, the sale of tobacco products to minors (urban 1.5% and rural 5.2%) and by minors (urban 0.8% and rural 5.9%) was less in urban areas as compared to rural areas. Mr. Tripathi said that campuses appeared free of tobacco use internally, while they found some cigarette or bidi butts and empty gutka pouches at 1.4% of the educational institutions.Compliance to Section was good. Due to continuous efforts by many stakeholders, the overall compliance to law provisions was good. However there is a need for sustainability.

Presenter 3: Dr. Rakesh Kumar Gupta
Topic: Need toTackle Menace of Smokeless Tobacco in Punjab by Strict Implementation of Food Safety and Standards Act FSSA

Dr. Rakesh Gupta began by stating that about 25 lakh adults in Punjab use tobacco in some form.There has been an increase in SLT use since GATS1. Provisions to curb the epidemic of SLT exist under which smokeless tobacco products can be banned by states. These include the Regulation 2.3.4 of the Food Safety and Standards (Prohibition and Restrictions on Sales) Regulations (FSSR), 2011 under the Food Safety and Standards Act (FSSA), 2006. Penalties provided under FSSA, 2006 are for unsafe (Section 59), substandard (Section 51) or misbranded food (Section 52). He said that there is also provision of a penalty for contravening a provision of this act or the rules made under it, not separately specified, of up to Rs. 2 lakhs (Section 58). The latter is the case for violating regulation 2.3.4 under FSSR 2011. Dr. Gupta spoke about six issues related to the Food Safety Act and Rules.

Issue 1: What should be done if any banned food product (including scented/ flavoured tobacco) is recovered? As discussed in a meeting of Commissioner, Food and Drug Administration (C-FDA) with Food Safety Officers (FSOs), it was clarified that samples of chewable tobacco products in which additives are mentioned should be taken and sent to a Public Analyst as food products, since flavoured and scented tobacco is banned under FSSA Rules.

Issue 2: There was a circular from C-FDA regarding mandatory five samples per month to be taken by each FSO. The Assistant Commissioner (AC), Food should personally ensure that regular sampling is done by FSOs and a monthly report sent to C-FDA with cc to tobaccocontrocellpunjab@yahoo.com.

Issue 3: In the case of seizure of flavoured and scented tobacco, the public analyst should clearly statein the report that the item found was flavoured or scented tobacco so that a case may be launched in the court of ADC (as in the Patiala case in 2015).

Issue 4: A circular was issued by C-FDA regarding cancellation of the food license of a premise if there is storage/ selling of tobacco products. FSOs need to proactively check and ensure that all commercial establishments selling food products get a food license. In case they sell tobacco products, cancel the food licenses.

Issue 5: Disposal of banned food products, including flavoured/scented tobacco, should be as prescribed by the FSSAI. In some of the States these items are disposed of in deep pits.

Issue 6: Ban on Pan Masala without Tobacco in Maharashtra and Himachal Pradesh. Under Section 3.1.7 of the Food Safety and Standards (Food Products Standards and Food Additives) Regulations, 2011, there is a restriction on use of anti-caking agents in any food except where their use is specifically permitted. Pan Masala is an article of food which contains anti-caking

agents like Magnesium Carbonate in excess of the legal level and thus contravenes Regulation 3.1.7. Dr. Rakesh Gupta concluded by saying that multi-sectoral efforts are required to implement the laws and it is important to take strict punitive action against violators.

Presenter 4: Dr. Vasundhara Kulkarni
Topic: Compliance of Cab Drivers and Reactions of the Commuters to the Smoke Free Cab Policy

Dr. Vasundhara Kulkarni said that cab drivers are at a very high risk of cancer of the oral cavity and lungs because of high stress due to odd working hours, uncertainty of income and traffic jams, colleagues using tobacco, and constant exposure to second hand smoke from commuters. With this study, Dr. Kulkarni said, they wanted to measure the compliance and perceptions of cab drivers to the implementation of smoke free cab policy and also study those of commuters with regards to the policy. Methods used included: meeting with union leaders, the informed consent procedure before data collection, oral visual examination at taxi stands, registration of post observation files at TMH, and examination of the screen positive drivers at TMH. The researchers found that 100% of cab drivers pre and post intervention wanted their cabs to be smoke free. Some 18% were aware about passive smoking in the pre intervention round; 16% were aware of the fact that passive smoking is hazardous to health. Almost all (98%) cab drivers were aware of the existing law that bans smoking in public places. Smoke free laws are essential to reduce exposure of cab drivers and commuters to second hand smoke. The study demonstrates good compliance by both cab drivers and commuters to the smoke free cab policy in Mumbai.

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PLENARY 2: CONTROL OF SMOKELESS TOBACCO AND ARECA NUT

Chairs:

Shri. Vikas Sheel
Joint Secretary,
Ministry of Health & Family Welfare
Government of India

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

Speakers:

Speaker	Topic
Dr. Prakash Gupta	Colossal Burden of SLT Use in India: the Problem of Plenty
Dr. Dhirendra N Sinha	Need For Data Driven Policy Priorities: Understanding SLT Monitoring and Surveillance
Dr. Irina Stepanov	Chemical Analysis of SLT and Areca Nut
Mr. Ranjit Singh	Areca Nut and SLT Control Policies
Shri Vikas Sheel	Addressing SLT under NTCP Umbrella Efforts: Enforcement is the Key

Speaker 1: Dr. Prakash C. Gupta

Topic: Colossal Burden of SLT Use in India: the Problem of Plenty

Dr. Prakash Gupta began by saying that the burden of smokeless tobacco (SLT) use is very high in India and smokeless tobacco is inexorably linked with betel quid/areca nut. The most reliable information on smokeless tobacco use is available from GATS, India. In the recent GATS-2 results, the number of SLT users is estimated as close to 200 million. He said that, however, a satisfying statistic in GATS shows that the prevalence of SLT use has decreased from 25.9% to 21.4%. A less satisfying statistic is that the relative decrease in SLT use is just 17% as compared to 24% for smoking tobacco.Among men, prevalence in GATS-2 decreased (29.6%) compared to GATS-1 (32.9%). Among women, it decreased to 12.8% from 18.4%. The relative decrease was 10% among men and 30% among women.Data show that health education on tobacco use and policy intervention through COTPA are working towards reducing tobacco use in India but not equally well for different categories of tobacco use or different segments of the society. Information on betel quid or areca nut use has generally been subsumed under the category of smokeless tobacco use.This exactly was the situation in GATS-1. A deeper analysis of the individual level data from GATS-1 however, showed little difference between dependence and initiation characteristics of areca nut users, regardless of whether used with tobacco or without tobacco.

GATS-2 provided information on betel quid and areca nut use without tobacco. A module was created with questions on the three most common categories of areca nut products. This module was administered to all participants, irrespective of their responses about SLT use. From this module, the prevalence of betel quid without tobacco was 8.7%; areca nut, 8%; and pan masala without tobacco, 4.8%. These prevalence values, however, cannot be added together as they are not mutually exclusive. Also, many of the respondents could have reported use of other

smokeless and smoking products also. Thus an in-depth analysis of unit level GATS-2 data was carried out. In the population, 11.0% use areca nut products without using any tobacco. Prevalence of SLT+areca nut use is 21.4% + 11.0% = 32.5%. The total estimated number of SLT users (19.94 Cr) + areca nut users (10.27 Cr) is 30.21 Cr. Adding smokers (9.95 Cr), the number of tobacco+areca users in India is 40.16 Cr.Just like tobacco, areca nut is also a class 1 carcinogen and has several adverse systemic health effects. Dr. P.C. Gupta concluded that this gives us the idea that we need control policies for areca nut products like those for tobacco products in COTPA.

Speaker 2: Dr. Dhirendra N. Sinha

Topic: Need For Data Driven Policy Priorities: Understanding SLT Monitoring and Surveillance

Dr. Dhirendra Sinha said that the Ministry of Health and Family Welfare initiated the National Tobacco Control Program in 2007-08.This is relevant to Article 14 of the FCTC which requires demand reduction measures regardingtobacco dependence and cessation.

Tobacco Control Services include the following:

1. Population based: a. Mass communication; b. Brief advice; c. Quitline
2. Individual based: a. Tobacco Cessation Clinics (TCCs); b. Specialized tobacco dependence treatment services; c. Making medicines available

Preventive efforts include raising/creating awareness;promotive efforts include counselling, while curative efforts include providing pharmacological interventions. Pharmaceutical treatment includes using nicotine such as nicotine replacement therapy (NRT) and non-nicotine measures like bupoprion and varenicline. Combination therapy includes NRT with counselling. However, the amount of therapy/drugs required for SLT dependence treatment is still unknown.

For the general public, the National Quitline and the Mobile (m)Cessation number are available. Dr. Sinha said India's NTCP isalso in the process of introducing tobacco cessation clinics (TCCs) at dental and medical colleges. Utilising nursing and pharmacy colleges also for TCCs is currently under exploration.As an integrative approach, NTCP is teaming up with ASHAs and ANMs for screenings. An E-DantSeva portal, providing locations of TCCs at dental clinics via the Quitline is in process.

Speaker 3: Dr. Irina Stepanov

Topic: Chemical Analysis of SLT and Areca Nut

Dr. Irina Stepanov started by saying there is a range of SLT products, which is still expanding, that collectively causes a range of diseases. She said that, because chemical constituents play a key role in causing SLT-associated

diseases, understanding the chemical composition of SLT is important for tobacco control.

Nicotine is a major addictive component found in all SLT products. Other chemicals that may be involved in addiction include minor alkaloids and beta-carbolines. The levels of total nicotine do not differ as much among products as the levels of free base or unprotonated nicotine which is readily available in the body. In India, there is at least a 300 fold variation in free base nicotine levels across SLT products. Tobacco specific nitrosamines (TSNAs) are systemic organ specific carcinogens, among which NNN is most important for SLT. Levels of these carcinogens play an important role in DNA mutations leading to cancer. It was found that 100% of animals developed tumours when exposed to NNN. A 700 fold variation was observed in a few varieties of SLT products and consumers are not aware of this. Some of the factors affecting chemical composition include cultivation, processing, formulation and packing. However, these are also the ways to control variations. Under the University of Minnesota's New Product Watch (NPW) project, a national tobacco monitoring network in the USA, tobacco products were purchased in 3 rounds over 3 years. Lots of variations were observed in round 1 which later decreased in subsequent rounds. This indicates that the companies were test marketing these products. Also, the way some products are stored at point of sale also leads to variations in NNN and NNK. Biomarker-based research shows that, independent of the patterns and the amount of use, levels of chemical constituents in SLT determine the levels of exposure in users of these products. Risk of SLT-associated cancer is relatively increased in countries with elevated levels of chemical carcinogens in SLT products.

Dr. Stepanov summed up the benefits of chemical analysis of smokeless tobacco products:

1. Chemical analyses of smokeless tobacco products can
a. Provide critical information on the variation of key harmful constituents across products
b. Help to detect tobacco industry's marketing practices
c. Result in development of important biomarkers that can be further applied in human clinical trials.
2. Chemical analysis of products is a crucial resource for creating a solid science base for tobacco control policies and interventions.

Speaker 4: Mr. Ranjit Singh
Topic: Areca Nut and SLT Control Policies

At the beginning of his talk, Mr. Ranjit Singh reminded the audience that habitual chewers of betel leaf and areca nut have a greatly increased risk of developing a range of serious diseases, including cancers of the mouth and esophagus.The first legal case on areca nut products was reported in December 2010 in the Ankur Gutkha case.

Mr. Singh said some of the applicable laws on areca nut include the following:

1. Food Safety and Standard (FSS) Act, 2006 where different sections deal with general/guiding principles, responsibilities and functions which primarily focus on providing safe and wholesome food for the health of individuals.
2. Currently 2-3 regulations under FSS, 2006 that deal with it that came out in 2011. Both pan masala and areca nut are food products and as such they should not contain tobacco/nicotine.
3. Packing/labelling should include FSSAI mandated health warnings (e.g., "chewing of supari/pan masala is injurious to health") and should not include anti-caking agents like magnesium carbonate.
4. There have also been cases of misbranding where the packets state that the contents include 0% tobacco/nicotine but on testing in a government lab in Ghaziabad, they were found to contain nicotine.

He listed some of the applications of laws to smokeless tobacco and areca nut products as follows:

1. Maharashtra, Bihar and Himachal Pradesh have banned pan masala and flavoured scented supari.
2. In 1992, tobacco toothpaste and tooth powder were banned under an Amendment to the Drugs and Cosmetics Act (1940). This ban was upheld by the Supreme Court.
3. Also, as per the Rule under the FSS Act, almost all states have banned gutkha. Enforcement of this ban is weak but we do have relevant IPC Sections (272 and 273 on adulteration of food and drink intended for sale) to penalize the non-compliant.
4. Another law exists under Environment Protection Act, 1986 which bans packing of gutkha in plastic pouches (Plastic Waste Management Rules, 2016).

Mr. Ranjit Singh suggested that some ideas for the way forward, based on lessons learntcould include:

1. Ban food additives in tobacco products. Food additives in the form of scent/flavouring, are extensively used as ingredients in the manufacture/ preparation of chewing tobacco/areca nut
2. Section 30 of COTPA, empowers the Central Government to add any tobacco product tothe schedule of COTPA after a 3 month notice, which gives it the power to regulatethe product. This has weakened the case to ban it under FSSA rules. Thus these products, e.g. gutka and chewing tobacco, should be deleted from the COTPA Schedule.
3. Pan masala should be tested for nicotine, tobacco, and magnesium carbonate; SLT should also be tested for food additives.
4. An advertisement ban is needed on injurious foods such as pan masala and supari

Speaker 5: Shri Vikas Sheel
Topic: Addressing SLT under NTCP Umbrella Efforts: Enforcement is the Key

Shri Vikas Sheel did not have a presentation but asked for suggestions from the audience as to how the government can improve.There was a question from the audience:

How can the NTCP budget be protected and what are the ways to move forward?

Shri Sheel answered by suggesting that the NTCP can't provide for complete tobacco control but the best way is for it to collaborate and integrate with other systems. Resource allocation should move towards integration with good civil society groups and NGOs.

Some of the action points as suggested by Shri Sheel included the following:

1. Work on signages to be implemented specifically for SLTs
2. Work on proper guidelines for tobacco cessation clinics in medical colleges
3. Work on linkages with other programs
4. Improve lab conditions to build capacity for analysis of SLT products

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MEET THE EXPERTS SESSION

This time a new session format named "Meet the Experts" was introduced in the. It was a 60-minute informal session, led by the experts in tobacco control. In this formal session, delegates were able to join in conversation with the experts during lunch session.

Dr. Irina Stepanov, PhD in Chemistry, Associate Professor, School of Public Health at University of Minnesota and Dr. Suchitra Krishnan-Sarin, Professor of Psychiatry at Yale School of Medicine were the experts invited in the session.

Dr. Stepanov is known for application of the fundamental concepts of science and analytical technologies to incorporate biochemical measurements into epidemiological and community-based studies and intervention trials.Tobacco research is one of the many areas of her expertise and her primary focus is on tobacco carcinogenesis and the mechanisms underlying inter-individual differences in cancer risk due to tobacco use. For her contribution in the field of Public Health, she received recognition from Delta Omega Public Health Honorary Society in 2013.

Dr. Krishan-Sarin's research is focused on developing a bio-behavioral understanding of substance use behaviors in adult and adolescent substance users, with the goal of developing optimal prevention and cessation interventions.

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SYMPOSIUM 4: VENDORS LICENSING: THE NEXT FRONTIER IN TOBACCO CONTROL

Chairs:
Narendra Kumar
Gaurav Gupta

Speakers:

Speaker	Topic
Mr. Ashish Pandey	Introduction with the Tobacco Epidemic in India: 27 Crores of People Addicted to Tobacco
Mr. Ramesh Bhaiyya	Implementing Vendors Licensing: Experiences from the Ground
Mr. Ranjit Singh	Legal Basis for Tobacco Vendor Licensing in India

Speaker 1: Mr. Ashish Pandey

Topic: Introduction with the Tobacco Epidemic in India: 27 Crores of People Addicted to Tobacco

Mr. Ashish Pandey began by saying that Indian government initiatives already include the COTPA of 2003, the Juvenile Justice (JJ) Act revised in 2015 and theNTCPwhich is now covering over 620 districts. The global initiative of WHO is the FCTC with MPOWER: M: Monitor; P: Protect; O: Offer help to quit; W: Warn; E: Enforce; R: Raise Taxes – all of which he explained as shown below:

- Monitoring is required for policy makers to know the prevalence of tobacco use, compliance with the tobacco control law, to assess the number of tobacco selling units, and to know the volume of sale. Challenges include the unregulated sale of tobacco products.

- Protection includes protecting non-smokers from tobacco smoke and non-users from initiation to tobacco use. Challenges include smoking in the public places and sale to/by minors.
- Offer help to quit: The government is providing cessation services, trying to make tobacco products less accessible and less affordable. Challenges include the fact that 75% of Cigarette sales are in the form of single/loose cigarettes.
- Warning about the dangers of tobacco: current requirements include warningabout the dangers of tobacco: through legally mandated pictorial and textual health warnings, through mandatory signage at the point of sale andthroughmass media. Challenges includeblurred/smudged/coloured pictorial warnings,stretched images,outdated warningsand no warnings on some tobacco products; illicit/counterfeit products.
- Enforce bans on tobacco advertising, promotion and sponsorship under COTPA, 2003. Challenges includelack of enforcement.
- Raise taxes on tobacco: higher taxes reduce consumption, induce quitting.Challenges:sale of loose cigarettes,which in turn affects the tax revenue generation for the government.An estimated 30% of India's potential excise revenues from all cigarettes does not get captured through tax and thus an informal economy prevails.

Mr. Pandey proposed the following solutions for some of the challenges:

Regulate the sale of tobacco:provide exclusive licenses for the sale of tobacco products; map and define the number of points of sale; regulate points of sale.

Terms and conditions for grants/cancellation of permission/licenses to sell tobacco**:**strict compliance with COTPA, Section 77 of JJ Act, 2015, Section 2.3.4 of FSSA Regulations, 2011, no sale of single cigarettes/bidis or sale of loose tobacco, no sale of single cigarettes or sale of any loose tobacco, waste (litter) management around the shop, enforce opening and closing timings, prohibition on sale any food items from thelicensed premises.

Opportunity: The Central Government's advisory issued by the Ministry of Health & Family Welfare to the State Governments (Sept 2017). The advisory mandates developing a mechanism to provide permission/ authorization through Municipal/ Local Authorities to sell tobacco products and to restrict sale of any non-tobacco products such as toffees, candies, chips, biscuits, soft drinks in the same shops.

State Government Initiatives: Legislation: Himachal Pradesh has already followed the advisory and has come up with the Prohibition of Sale of Loose Cigarettes and Beedis and Regulation of Retail Business of Cigarettes and Other Tobacco Products Act, 2016. Mr. Ashish Pandey said other States in the process of following the advisory by drawing up legislation include West Bengal, Rajasthan, Madhya Pradesh and others. He said some municipal corporations are following the advisory under their respective state acts: e.g., Lucknow and Ayodhya (in Uttar Pradesh), Ranchi, and Chas (in Jharkhand) and Patna (in Bihar).

Speaker 2: Mr. Ramesh Bhaiyya
Topic: Implementing Vendors Licensing: Experiences from the Ground

Mr. Ramesh Bhaiyya spoke about the experience of Lucknow in achieving tobacco vendor licensing. Lucknow is thecapital of Uttar Pradesh, the "City of Nawabs." It has 110 Wards, a high prevalence of tobacco use, in a population of around 50 lakhs.

Networking for Vendor Licensing: The Governor, Shree Ram Naikji was involved. However, as there are chances for the government to change within two years, the Urban Development Minister Shee Suresh Khanna was also approached for the help. The Mayor was involved and convinced to make a tobacco free Lucknow. Vendor organizations in Lucknow were also approached and a network was formed with the aim for a tobacco free city. Councillors in the city were convinced and a written consent was taken from all the 110 Councillors for them to be a part of the program for a tobacco free city. On 3rd February, 2018 the Municipal Commissioner passed an order for vendor licensing. A Rajpatra (Gazette Document) is going to be issued by the State Government so no other government can challenge or amend it.

Why Vendor Licensing? Addiction among youth to tobacco products is high; vendor licensing will help in reduction in the number of vendors selling tobacco products; development of Lucknow can be promoted with the revenue generated from the licensing money from each vendor.

Stakeholders in the Process of Vendor Licensing: These include the State Tobacco Control Cell & District Tobacco Control Cell, Tambakhu Mukt Doot, Vendor Mitra, Vendor Sangh, Avasiya Kalyan Sangh, Adhyapak Abhivabak Sangh.

Procedure for Vendor Licensing:Nagar Nigam was convinced that sections 437 and 438 of the Uttar Pradesh Municipal Corporation Act, 1959 (437: regulation of offensive trade, 438: licence required for any trade hazardous to health) give the power for vendor licensing and regulation. The Additional Commissioner was made responsible for Vendor Licensing; he then distributed work to the Zonal Officer through training; after that screening for licensing was done along with Tobacco Free Lucknow team.

Activities during the awareness programme for vendor licensing: an awareness rally, a rath yatra for awareness, a bike-athon, a bike rally, and sensitisation in schools, a selfie zone and oral health camps.

Criteria for the License**:** The Vendor should be a citizen of India, over18 years of age, and pay a fee of Rs.1000/- per year.There should be only one tobacco shop for every 1000 people, the distance from one shop to another must be more than 200 metres; no shop is allowed within 100 yards of any educational institution.

Challenges:alowannual feeis charged for licensing (due to politics), engaging the government, delay due to elections, establishing vending zonesfor tobacco vendors.

Speaker 3: Mr Ranjit Singh
Topic: Legal Basis for Tobacco Vendor Licensing in India

Mr. Ranjit Singh said vendor licensing can be a way to regulate tobacco sale. Up till now we have failed to map the tobacco shops and vendors as tobacco sale happens in general stores, bakeries, stationary shops, cosmetic shops, and grocery shops. In 2017 a central government advisory

came out in the form of a letter from the Ministry of Health & Family Welfare, Government of India to state governments, dated 21st September 2017, requestingthem to develop a mechanism to provide permission/ authorization through Municipal/ Local Authorities to the retail shops who are selling tobacco products. Also,a condition to be added in the authorization was that the shops authorized for selling tobacco products cannot sell any non-tobacco products such as toffees, candies, chips, biscuits, or soft drinks.

Use of Local Municipal Laws can be explored for reduction in tobacco sale. The first state to explore these was Bihar: the Bihar Municipal Act, 2007 states in Section 342 that a residential premise cannot be used for non-residential purposes (as listed in the Schedule) without a license or permit, including for tobacco storing, packing, pressing, cleansing, preparing or manufacturing by any process (in the Schedule, entry 324). Penalties for contravening this law include a fine up to Rs. 5000 and imprisonment up to six months.

The Jharkhand Municipal Act, 2011 is fairly similar, as it requires a municipal license or written permission to be obtained before one can use a residence to be used for non-residential purposes. Jharkhand also has Jharkhand Municipal Trade License Regulations, 2017, which require a license to set up a shop or business. The licensee may carry out only that trade for which the license was granted. If the inspector finds otherwise, the license may be cancelled. In Himachal Pradeshnow there is a lawstating that registration is compulsoryfor selling tobacco products.

Mr. Ranjit Singh suggested that the way forward includes incorporating the following terms and conditions in the license for sale of tobacco: Compliance with COTPA, 2003, Sections 4/6(a)6(b)/5 & 7, Section 77 of the JJ Act, 2015, the FSSA, 2006 and Rules, the MoH Advisory dated 21st September 2017 and display of the license certificate at a conspicuous place in the premises. Noncompliance would lead to the cancellation of the license.

Questions and Answers:

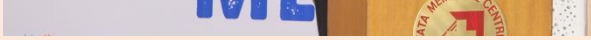
Were the challenges in the implementation not anticipated earlier? Also were pan vendors considered for vendor licensing?

Mr. Ranjit Singh said yes, the challenges were anticipated and the way forward was only to involve the politicians. The order for vendors licensing is going to be a Gazette Order so it will remain as an order and no new politician or an officer can change or challenge it.

The eligibility criteria for vendor licensing in Lucknow are kept stringent. The structure of the shop is taken into consideration and only those vendors who have shops and do not sell tobacco products on a cycle can apply for the license. Screening will be done by a zonal officer. Then the license will be issued.Right now applications are invited from all the vendors including the pan vendors.

Why doesn't current vendor licensing talk about controlling of vendors?

Mr. Ranjit Singh answered saying that at this point we have this as a challenge. But surely we can explore something like Lucknow's order which says the distance between 2 shops should be at least 200 metres; a license will be issued only to those who comply with COTPA,to those who




have a structured shop with the proofs for credibility like rent agreement and electricity bill.Inspection of the shop is also one of the steps.Documents to be shown by the vendor include the PAN card and Aadhar card; these eligibility criteria can substantially reduce the number of vendors.

Why get new laws for tobacco control when we already have existing laws?

Mr. Ranjit Singh replied saying thatthere are no new laws passed: the orders passed are just facilitative instruments for the already existing laws (supportive laws).

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PROFFERED PAPER 3: EMERGING YOUNG VOICES IN TOBACCO CONTROL

Chairs:
Dr. Monika Arora
Mr. Nirmalya Mukherjee
Ms. Vaishakhi Mallik

Presenters:

Presenter	Topic
Mr. Sanjay Seth	Mobilizing National Service Scheme (NSS) Volunteers for Tobacco Control in India
Dr. Vikrant Mohanty	Vape under the Cape: Youth Perspectives on Electronic Vaporizing Products
Ms. Gauri Mandal	"Pen-hookah" (E–cigarette) Use among Adolescent School Students from Urban Slums of Mumbai
Dr. Charu Khurana	Exploring Behavioural Factors and Perception towards Hookah Smoking among Youth Smokers
Dr. Karan Mehra	Youth Against Tobacco Campaign: A Model for Awareness Generation among the Youth
Mr. Ajay Ghangale	Capacity Building of Youth for Advocacy with Stakeholders in Tobacco Control
Dr. Puneet Chahar	ENDS Social Media Marketing: Content Analysis of Indian Facebook Pages
Dr. Krishna M. Palipudi	Monitoring Disparities in Tobacco Use and Exposure to Secondhand Smoke among Young Adults in India

Presenter 1: Mr. Sanjay Seth

Topic: Mobilizing National Service Scheme (NSS) Volunteers for Tobacco Control in India

Mr. Sanjay Seth spoke about the Sambandh Health Foundation's (SHF's) initiative, "Pledge for Life," that strives to mobilize youth and engage them in tobacco control. SHF wanted to work with an organisation that harnesses the power of youth for social change. Among the many existing ones, the National Service Scheme or NSS, is an Indian government-sponsored public service program conducted by the Ministry of Youth Affairs and Sports, in schools (Stds. 11 & 12) and colleges (years 1& 2) all over India. NSS volunteers (students) are supposed to put in 240 hours of work over a period of two years in order to receive a certificate.To get NSS volunteers to work with it in Assam, SHF ran a series of workshops for NSS Programme Officers (POs) and told them about the tobacco problem prevalent in society, using a video to communicate the message. SHF had made a video with doctors from the Voice of Tobacco Victims and their patients. After watching the video, NSS POs were moved and they came forward asking how they could contribute towards solving this problem. Their suggestions and initiatives were far bolder and aggressive than Sambandh Health Foundation people had thought of. The NSS POs who had attended our workshops went back to their schools/colleges/universities and started engaging their NSS youth units to conduct workshops at the community level. First of all, a pilot intervention was carried out in three universities. From August to December 2018 these 67 NSS units with 6500 volunteers completed 258 events on their own. To begin the initiative, NSS cadets have pledged not to use any kind of tobacco product before going to colleges with the message. SHS offered them our support by helping them with videos and providing them scripts to organise a pledge ceremony with students and people in the community. Many of these NSS youth also go back to their schools with the message after completing their schooling. NSS youth have gone beyond the pledge ceremony and organised street plays and poster competitions which were never suggested by SHS. These NSS youth have reached out to 39,000 schools with the program. SHS has created a website and a mobile app so that youth can report all the initiatives taken by them. For organising activities, SHS offersspecial badges. SHS personnel also attend the camps organised by these students which are often in villages in remote areas. Mr. Seth ended by saying that SHS is expanding the program to other schools in Assam and planning to introduce it in other states also.

Presenter 2: Dr. Vikrant Mohanty
Topic: Vape under the Cape: Youth Perspectives on Electronic Vaporizing Products

Dr. Vikrant Mohanty began by informing the audience that Cape is a superhero who has an image of saving people and solving their problems.He said vaping has been camouflaged in a super hero image (Cape) to glamorise and market it to youth and make them see the e-cigarette as a cessation tool. Youth are the target for vaping companies as they are prospective customers, which may give the companies consistent profits. Dr. Vikrant Mohanty discussed a study

done on e-cigarette use in colleges across Delhi by the Public Health Dentistry Dept. at Maulana Azad Institute of Dental Sciences. It studied prevalence, knowledge, attitudes and practices in a sample of 1000 students. They were all about 19 years of age (63% male), through 26 questions. Some 65%of these youth were aware of e-cigarettes, around 61% of them knew that e-cigarettes are harmful, i.e. 85% of those awareof the product.; the rest considered them beneficial for quitting smoking. Around 80% of the youth were non tobacco users. Some 2.6% were exclusive e-cigarette users, suggesting they had no history of tobacco use.

E-cigarette users were asked how they started. A significant number claimed that they had started using them because their friends were doing it. Some 31% of respondents started because the e-cigarette was promoted as cessation tool. Another 32% were unaware about the contents and whether e-cigarettes contained nicotine or not. Some 39.5% of the subjects had their own vaping devices. Such users had spent an average of Rs 1,523 to purchase and sustain these products. Many claimed to have spent around Rs 12,500 on them. These products are easily available in retail stores, stationary stores, and online. Many users claimed to have requested their relatives and friends travelling from abroad to bring e-cigarettes. GATs data puts Delhi second in prevalence of e-cigarette use in India, only behind Sikkim. Users are also increasing among the employed. The industry claims that working people find them a remedy for stress. People who have smoked cigarettes more than 10 times a day were more prone than others to start using e-cigarettes. An article by Kennedy et al. (2017) discusses how 68 countries have regulated e-cigarettes. India is yet to regulate them. Dr. Mohanty concluded by saying that, while e-cigarettes entered the market as a style statement or as an escape from regular smoking, we need to target youth to stop themfrom falling for this bad practice in a similar fashion as vaping or cigarette companies have been targeting them to use it.

Presenter 3: Ms. Gauri Mandal
Topic: "Pen-hookah" (E–cigarette) use among Adolescent School Students from Urban Slums of Mumbai

Ms. Gauri Mandal informed the audience that Salaam Bombay Foundation (SBF) is implementing a program called “LifeFirst”, which offers cessation services for tobacco and areca nut use in various settings, including schools. She spoke about a study done among adolescent students in 40 schools based in urban slums of Mumbai where the LifeFirst programme is being conducted. SBF aimed to find out about e-cigarettes use. At the outset in each school, they conducted an orientation session with all the students of the seventh, eighth and ninth standards, informing them about the ill-effects of tobacco and areca nut through a small animated video. After the video, the students were told about the counselling services available for those addicted to such products. All registrations for counselling services would be voluntary. A series of sessions is offered as a part of the counselling. Group counselling services involve videos, presentations and various other activities. These counselling services focus on developing coping mechanisms and refusal skills in students so they can say ‘no’ to tobacco. In the 40 schools, LifeFirst reached out to over 4,000 students. Among these, 34% students (who were consuming any areca nut or tobacco product) registered for cessation services. During registration, they were interviewed with the help of questionnaires to collect data on demographics, current use of areca nut, tobacco and ever use of e-cigarettes. Among those registered, 12% students claimed to have used e-cigarettes at least once. The study found that 47% of those who were using smoking products also used e-cigarettes, while 32% of smokeless

product users also used them. After the cessation services, the outcomes were measured through self-reports. While the overall cessation outcome stood at 70%, those who smoked e-cigarettes had a lower cessation rate of 55%. Ms. Mandal concluded by saying that e-cigarettes are easily accessible and commonly used among adolescents in Mumbai slums. Salaam Bombay believes it is very important to increase their knowledge about the potential harms of e-cigarettes.

Presenter 4: Dr. Charu Khurana

Topic: Exploring Behavioral Factors and Perception towards Hookah Smoking among Youth Smokers

Dr. Charu Khurana began by saying that the hookah originated in India around 400 years ago and now is an instrument of smoking flavoured tobacco, a recent trend. He said that compared to cigarette smoking, hookah smoking requires a higher frequency of puffs, higher inhaled smoke volume, as well as a burning temperature. The target market for the hookah has been young adults between 18-24 years and it is easily available for them in bars, cafes, and lounges without any regulations. Haryana has a long history of consumption of the hookah and it is common in families where hookahs have been smoked for generations. Dr. Khurana said this study was conducted to understand the behaviours and perceptions that surround the hookah phenomenon amongst student youth in Gurgaon, Haryana in order to counter it. A descriptive cross sectional survey of university students < 35 years of age who smoked hookah was conducted over three months using snowball sampling. The total sample size was 215 students in Gurgaon, Haryana, in health professional and engineeringstreams. In this study, the mean age for starting hookah smoking was 17.3 years and most hookah smokers were between 15 to 20 years of age. The questionnaire also asked information on the use of other tobacco products and found that the majority smoke hookah only. Pleasurable experience and adding intimacy to social gatherings came out as important factors in hookah smoking, followed by curiosity, dealing with boredom and peer pressure. A total of 37.7% smoked daily, frequented cafes and lounges with friends and shared hookahs. When asked if are they were addicted to hookah, they denied it, claiming that they could leave it whenever they desired. Hookah was easily accessible to them and it took them less than 30mins to get their hookah. The respondents considered hookah less harmful, less addictive and producing less pungent smell than other smoking products. Limitations of the study included that information presented is subjective, from self-reports, without reliability checks. No physiological exam was conducted. Dr. Khurana concluded that students in health professional and engineering streams in Gurgaon were commonly using hookahs and that the study highlights the lack of awareness regarding the harmful effects of hookahs even among the highly educated.

Presenter 5: Dr. Karan Mehra

Topic: Youth Against Tobacco Campaign: A Model for Awareness Generation among the Youth

Dr. Karan Mehra said youth in Punjab are facing a lot more problems due to addictions in many forms including tobacco. The aim of the State of Punjab is to sensitize youth about the ill-effects of tobacco. He said the State is taking timely action on hookah bars, e-cigarettes and other tobacco products and declares college campuses and universities tobacco free. A model is needed for reaching the youth of the marginalised sections of society in slum areas and in rural areas. In Punjab, the sale and distribution of chewable flavoured and scented tobacco products have already been banned. Sale of e-cigarettes is also already banned under the amended Drug

and Cosmetics Act, 1940. Hookah bars are banned in the state under an amendment of section four of the COTPA. To enforce a more integrated approach, the state has authorised head constables at the lowest level to issue challans - or tickets - for violations under COTPA.

Dr. Mehra said a study was conducted in the month of March 2018, and during the state meeting, brainstorming was done among the 30 members of the stakeholders. After thata campaign called Youth against Tobacco was conducted at various places. The campaign was divided into five phases to last until World No Tobacco Day on 31st May. During the first phase, meetings were held at the district and block levels under the chairmanship of District Collectors (DCs) and (Sub Divisional Magistrates (SDMs) to discuss the various projects on tobacco awareness that need to be adopted for targeting youth.

An earlier study conducted in 2017 found that prevalence of tobacco among the people in slum areas in Punjab is around 58%; around 41% of them had oral lesions. The state campaigns in slum areas were organised on the basis of these studies, using Nukkad Nataks (street plays), distribution of IEC materials and screening of videos and films, to spread awareness about the ill-effects of tobacco. In the last phase of the campaign, law enforcement was carried out after sensitising the people and the vendors.

In rural areas, meetings were held under the chairmanship of Sarpanches (village heads) and committee was established to work towards making the village tobacco free. Sarpanches involved local people along with the youth in their committee. They conducted various awareness activities in the village. Following their footsteps, new villages joined the committee. Today, a total 729 villages in Punjab are tobacco free.

To disseminate the message among children Punjab organised writing, drawing and painting competitions in schools and colleges on the theme of ill-effects of tobacco. On 1st Nov 2018, observed as Punjab State “No Tobacco Day”, a Yellow Line Campaign was started covering 448 schools and 2.46 lakhs of students. Under this, a yellow line is marked to demarcate the 'tobacco free zone' at 100 yards from the schools and colleges. Dr. Karan Mehra said the Campaign was targeting youth to create awareness about the issues and health problems associated with tobacco use along with the relevant rules and regulations.

Presenter 6: Mr. Ajay Ghangale
Topic: Capacity Building of Youth for Advocacy with Stakeholders in Tobacco Control

Mr. Ajay Ghangale began by saying that we all know that in our nation tobacco is a serious problem, today. India has a huge population of 1.35 billion, which is mostly represented by youth. More and more youth are falling for tobacco use.

He said that according to the Global Youth Tobacco Survey, 2009, more than 24% boys and more than 13% girls believe that they attract more friends by smoking. Simultaneously, another study found that more than 21% boys and more than 15% girls believe that smoking accentuates their attractiveness. This reflects their knowledge and perception of tobacco and in turn it shapes their attitude. An estimated 14.6% youth in India are using some form of tobacco.

Mr. Ghangale wanted to describe the work of Salaam Bombay Foundation(SBF) over the years. He affirmed that SBF believes that “A Child in School Has a Future”. As we know, a school plays

an integral role in the education of a child, and a Tobacco Free School plays crucial role for the right kind of education of a child. SBF is running an in-school leadership tobacco control program in more than 350 schools in Mumbai. Through awareness programs and activities, students are being sensitised about the ill-effects of tobacco along with the development of refusal skills, interpersonal skills and confidence. More than six lakh students have been impacted by the program.

The students are also given a platform to discuss the tobacco problems in their schools and society. The "Balparishad", is a platform where all the "Balpanchayat" members from across BMC schools in Mumbai come together to discuss their problems related to tobacco and health with stakeholders for tobacco control such as police officials, education officials, and MLAs. Tobacco awareness activities are major part of the program to spread the message among students, but advocacy with stakeholders, who are responsible for tobacco control, is of immense importance. "Balpanchayat" is a committee of 4-5 students formed in every school to discuss the tobacco problems in their schools. Members of Balpanchayats represent their schools in "Balparishad".

In cities like Mumbai, police officials are major stakeholders for the tobacco control mission, because implementation of COTPA Act 2003 rests on their shoulders. Mr. Ghangale said that during the awareness activities by the students with police authorities, SBF found that many police officials were unaware about any law enforcing tobacco control. Post the activity conducted by students of SBF these police officials took pledges to stay away from any kind of tobacco product and ensure the implementation of COTPA for a tobacco free next generation. More than 1,00,000 police officials were sensitised through the programs.

SBF has also conducted this awareness activity with the staff of BEST bus transport in Mumbai. The effects of these activities were clearly visible as the BEST has almost stopped carrying tobacco advertisements on their buses –BEST has a fleet of more than 4600 buses. Earlier these buses regularly carried tobacco advertisements, which were in violation of the tobacco control law according to COTPA Section 5. The Juvenile Justice Act 2015 and COTPA Sections 6A and 6B were enforced in the city with the help of the Mumbai Police department under the leadership of former Police Commissioner Dattatray Padsalgikar and strict actions were taken on more than 6500 tobacco vendors within the 100 yards of school premises. These vendors had to pay a fine of Rs 200 for violating the law and selling tobacco products within 100 yards of school premises. The police department is also keeping an eye on implementation of the JJ Act.

Mr. Ghangale concluded by saying that these are a few of many significant and crucial milestones achieved by persistent efforts of SBF Balpanchayat leaders, over a span of 16 years, by their intervention and awareness activities with various stakeholders' in the city.

Prsenter 7: Dr. Puneet Chahar
Topic: ENDS Social Media Marketing: Content Analysis of Indian Facebook Pages

Dr. Puneet Chahar said he was going to talk about the rise in the electronic cigarettes market. According to a study, the global current market size of e-cigarettes stands at around $409 million in 2017 which is expected to increase to $22.7 billion by 2022. He said when we talk about the Indian context, one of the recent studies by Mohanthy shows evidence of an online

retail market in which 34 brands are available on various online platforms. This suggests a strong e-cigarette market in India. So, how are digital platforms changing the retail landscape in India? Social media has emerged as an important strategic marketing tool which aids the promotion of small business enterprises. It leads to a better understanding of consumer behaviour, allows early corrective measures, if any, and users are constantly engaged with the brand by "liking", and commenting. Talking about the social networking sites in India, the popularity of Facebook is much greater when compared with other social media platforms, which puts it top on the list for our study. Use of social media marketing is not new when we talk about e-cigarettes in the world. Different authors have done different studies on Twitter, Instagram and Facebook to show that these platforms have been used regularly to promote electronic cigarettes. Ultimately, so much buzz around e-cigarettes creates social influence by kindling curiosity that leads people to try them and become users. Thus, all our efforts through COTPA and other regulations seem to have been going backwards.

Regarding the effectiveness of ENDS as a cessation tool, there are divided opinions and only two randomized control trials have been done in this regard. E-cigarette companies have been using online platforms to promote their products. These promotions can be used by health researchers to study public behaviour towards these products. Massive focus groups are present on these platforms. The aim of our study was to access the pattern of posts about electronic nicotine delivery systems on an Indian social networking website, Facebook. It was an "infodemiological" cross sectional study, run between October and November 2018. Data was collected by a single researcher. No ethical clearance was required as the data is presented publically. Facebook was searched for key words such as e-cigarettes, e-cig, and vaping, with the key word India in all searches. All the pages taken for the study had Indian data. A total of 10 pages were taken for the study. The selection criteria were that the page has to be of Indian origin, discussion about vaping and recent posts (within 24hrs) on pages. Age criteria on the page, number of members and date of creation of the page, large member base, number of posts (photos & videos) in the last month and the number of new members added in the last month, all were taken into account for the study. Ultimately two pages were further searched for posts regarding e-cigarettes and 40 posts from each page were identified.

Coming to the results, Dr. Chaharsaid the first two websites with the largest number of members were taken for the study. There were a total of 6471 members and 129 were added in the last thirty days. Photos and videos were constantly shared online to generate curiosity and attract new members. Posts regarding the parts and accessories of ENDS were the most common posts on these pages followed by e-cigarettes, vapes, etc. One of the most amazing findings was that, even though e-nicotine delivery systems were banned in many states, the warnings on the posts stating "not to be sold to minors" were only present on 13 out of 80 posts on the page. There were five links on these pages that could take you directly to the online selling portals. Only three posts were related to cessation, which suggests that the prime objective of these posts was marketing for regular use. Around 49% people were asking about the products and suggestions for the online purchase followed by the posts of the agents of the product manufacturing companies giving them info about the product and purchase. Legal issues were also discussed and offers were given on various products.

Dr. Chahar said only 40% of pages had age restrictions or were closed groups. The remaining 60% can be accessed by any individual irrespective of their age group or whether they use e-

cigarettes or not. Around 70% members of these pages were less than two-years-old to the platform and this put them at risk of trying these products out of curiosity for the first time. Various parts sold on these platforms, put the novice first time buyers at risk as they could try to fit large power batteries to comparatively smaller machines which could result in causing fire. Also, many flavours of these products can be obtained through these platforms. These platforms were also posting information about the law and regulations about vaping that was giving it an overall positive outlook among its members. Thestudy was limited by its small size, and cross sectional nature. Dr. Chaharconcluded that a more comprehensive understanding of the content shared in the platforms is required.

Presenter 8: Dr. Krishna M. Palipudi
Topic: Monitoring Disparities in Tobacco Use and Exposure to Secondhand Smoke among Young Adults in India

Dr. Krishna Palipudi began by saying that fortunately or unfortunately, the last time the Global Youth Tobacco Survey (GYTS) was conducted in India was in 2009, well before the two rounds of the Global Adult Tobacco Survey (GATS) (in 2009-10 and 2016-17). Data from GATS has demonstrated that tobacco use is a major burden in India like in many other countries around the world. He said he hoped that we are going to have data from GYTS this year.

There has been a sharp decline in overall tobacco use according to the two rounds of GATS. The aim was to find out if this decline is an overall phenomenon or if it is happening only among various sub-groups such as urban, rural residents, or demographic, educational, occupational, and economic categories, to understand how successfully this tobacco problem is being curbed. In this study, both rounds of GATS (2009-10 and 2016-17) were used to understand the pattern. In each round, there were close to 70,000 respondents interviewed from over 76,000 sampled households. Current tobacco use was defined as using smoking and smokeless tobacco on a daily basis or less than daily. For secondhand smoking, two indicators were taken: monthly smoking exposure at home and exposure at any public places during the last 30 days. A disparity index was calculated, which is the absolute range between the highest and lowest prevalence for each socioeconomic and demographic sub-group. Logistic regression was applied to understand predictors of tobacco use after controlling several selected demographic and socioeconomic variables.

He said it was observed that current tobacco use has declined between the age group of 15-24 years. This gives a very good picture about the success of the tobacco control program. Looking at the state wise differences, in most states prevalence of tobacco use declined from the first round to the second round. Overall disparity went down from 43% to 39% but not within all states. Now looking at the public place exposure to second hand smoke, the disparity rate (using the disparity index as described), has gone down from 58.2% to 32.8%. This shows a high impact. Data also demonstrate that even though we are observing an overall decline in tobacco use prevalence, still tobacco advertising, promotion and sponsorship (TAPS) are active.

Dr. Palipudi concluded that there is an overall decline between 2009 and 2016 in current tobacco use and second hand smoke exposure, which is evident across various selected demographic and socioeconomic variables. Exposure to TAPS has a role in explaining tobacco use disparities and second hand smoking exposure. These findings suggest that efforts to reduce

pro-tobacco marketing among young adults might be important to further reduce their current tobacco use and exposure to second hand smoke.

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PROFFERED PAPER 4: CREATIVE ANTI-TOBACCO CAMPAIGNS AND INTERVENTIONS IN INDIA

Chairs:
Dr. L. Swasticharan
Mr. Deepak Mishra

Presenters:

Presenter	Topic
Mr. Vivek Awasthi	Freedom from Tobacco in Uttar Pradesh through the "Yellow Line Campaign"
Ms. Premalatha L.	Green Line Campaign – Tobacco Free Schools – A Study aiming for Tobacco Free Academic Year 2018-19
Mr. Prabhakara	Rose Campaign
Mr. Rajeev Kumar Chaudhary	E-Resource Centre for Tobacco Control: One - Stop Solution
Ms. Kalpana Phawde	Balparishad: An Assembly of Young Tobacco Control Advocates Demanding a Tobacco Free Environment for Youth
Ms. Ashima Sarin	How a Volunteer Force of 23 Doctors was increased to 400 Doctors in 8 years and the Voice of Tobacco Victims (VoTV) Campaign Brought about Major Policy Changes in Tobacco Control in India
Dr. Subhadra Gupta	Tobacco use among Taxi Drivers: Prevalence and Predictors
Mr. Binoy Mathew	Exposing Tobacco Industry Tactics in Implementation of 85% GHW's Through Media Advocacy
Dr. Stuti Bhargava	Evaluation of Impact of Ongoing Anti-Tobacco Campaigns on Central Indian Population

Presenter 1: Mr. Vivek Awasthi
Topic: Freedom from Tobacco in Uttar Pradesh through the "Yellow Line Campaign"

Mr. Vivek Awasthi said that as per GATS-2 data released in 2017 (2016-17), in Uttar Pradesh, 35.5% of adults (15 years and above) used tobacco. Over the entire state, nearly 35.7% adults are exposed to second-hand smoke at public places, in public transport and work places. Under the aegis of the Uttar Pradesh Voluntary Health Association (UPVHA), the Yellow Line Campaign was started in Uttar Pradesh, mainly focusing on educational institutions and school students to check for compliance of sections 4 and 6 of COTPA. The theme for this campaign was Freedom from Tobacco through the Yellow Line campaign and it was started on 15th August, 2018. Mr. Awasthi concluded by saying that so far more than 3500 educational institutions and 2500 other government offices have been declared tobacco free through the Yellow Line Campaign. He also said work is currently on-going to include the 'Yellow Line Campaign' under NTCP.

Presenter 2: Ms. Premalatha L.
Topic: Green Line Campaign – Tobacco Free Schools – A Study aiming for Tobacco Free Academic Year 2018-19

Ms. Premlatha spoke about the Green Line campaign that was started with the aim of making tobacco free schools in Tamil Nadu. It is being carried out in collaboration with the Mary Anne Trust. Tobacco vendors and points of sale are marked using geolocations on using software designed especially for this campaign called Tobacco Monitors. This mapping activity helped identify proximity of vendors to educational institutions. Many enforcement agencies were approached to see that no tobacco is sold around educational institutions and COTPA is implemented. This campaign found that within 100 yards of all the schools surveyed, tobacco products were sold in shops. Geo Location through Tobacco Monitor application clearly indicates the presence of violations within the 100 yards of the Educational Institutions. Ms. Premlatha said that in light of the findings seen from this campaign, many enforcement agencies were approached to see that no tobacco is sold around educational institutions and COTPA is implemented and to render educational institutions 'Tobacco-Free Zones.'

Presenter 3: Mr. Prabhakara
Topic: Rose Campaign

Mr. Prabhakara said that according to GATS-2,theprevalence of tobacco use in Karnataka is 22.8% and the average age of initiation is 19.8 years. In collaboration with the Education Department, the State Tobacco Control Cell, under the Department of Health and Family Welfare,along with the district administrations conducted a campaign called 'Rose Campaign' to sensitize tobacco sellers around all education institutions. In this campaign, all POS owners, teachers and local political leaders were identified and sensitized about tobacco sale around institutions. Around 1200 schools were selected for this intervention. Tobacco sellers were identified and handed a red rose by school students with an appeal to stop the sale of tobacco

within 100 yards of schools and other educational institutions. Mr. Prabhakarasaid the impact of the campaign has been so great as to achieve more than 80% compliance across more than 1000 of the selected 1200 educational institutions. Looking at the success rate, the Government of Karnataka has decided to expand this to the entire state.

Presenter 4: Mr. Rajeev Kumar Chaudhary
Topic: E-Resource Centre for Tobacco Control: One - Stop Solution

Mr. Rajeev Kumar began by noting that a number of tobacco control activities are taking place across India under the able guidance of many tobacco control experts. He said policies are being framed and amended accordingly based on the work being carried out pan-India under tobacco control. The existing information on tobacco control is lying scattered at different sources, due to absence of a common platform. PGIMER Chandigarh has taken the lead to develop a common platform and formulate a resource centre for collection of all tobacco control information and resources at one point. The information from key stakeholders was collected via the Delphi technique where their opinion about tobacco control was collected. An advisory board was then set up to collate information regarding tobacco control activities and updates across India and provide it to the resource centre.Mr. Rajeev Kumarended by saying said that a virtual resource centre (www.rctcpgi.org) has been created which holds information about all tobacco control activities and updates from all over India. This centre was launched at the Asia Pacific Conference on Tobacco or Health at Bali, Indonesia and has had multitudinous visits since then.

Presenter 5: Ms. Kalpana Phawde
Topic: Balparishad: An Assembly of Young Tobacco Control Advocates Demanding a Tobacco Free Environment for Youth

Ms. Kalpana Phawde described how Salaam Bombay Foundation, under its tobacco control programme, organized an annual health assembly of young tobacco control advocates called ‘BalParishad’. There is a class level Balpanchayat formed consisting of students working in the field of tobacco control. Eight students from this class level Balpanchyat are then elected to the School Level Balpanchayat. These children lead all tobacco control activities at the school level throughout the year. At the end of the year, two members from this school level Balpanchayat are invited to participate in city level children's Health Assembly called city Balparishad. Representatives from the Health Department, the Educational Department, and the Food and Drug Administration were invited as panellists. Ms. Phawde said that due to the activity of these school children, the Municipal Corporation of Greater Mumbai (MCGM) has passed a circular to ban the advertising of tobacco products and surrogate advertising at Ganeshotsav Pandals. Additionally, Ms. Phawde said tobacco advertisements have been removed from more than 4000 BEST buses as a result of the activities of these Balparishad tobacco control advocates.

Presenter 6: Ms. Ashima Sarin
Topic: How a Volunteer Force of 23 Doctors was increasedto 400 Doctors in 8 years and the Voice of Tobacco Victims (VoTV) Campaign Brought about Major Policy Changes in Tobacco Control in India

Ms. Ashima Sarin talked about how the Voice of Tobacco Victims campaign, a brainchild of Dr. Pankaj Chaturvedi, is a doctor’s led initiative to sensitize policy makers about the harms of

tobacco use and the condition of victims of tobacco use. She said this campaign aimed to make cancer survivors and their relatives, the face of anti-tobacco campaigns in India. When it was launched in the year 2011, the campaign had around 20 doctors who volunteered. Currently it has over 400 doctors across 25 states in India. This campaign has been successful in driving many policy changes over the years. Some of these changes where the VoTV campaign played a major role were in the increase in VAT in many states, the twin-packet smokeless tobacco ban, amendments in the Juvenile Justice Act and the ban on sale of loose cigarettes under the Legal Metrology Act. Ms. Sarin said the campaign had been running successfully across various states in India owing to the connect that it has shown amongst the policy makers and the general public due to the involvement of patients and their relatives in this campaign.

Presenter 7: Dr. Subhadra Gupta

Topic: Tobacco use among Taxi Drivers: Prevalence and Predictors

Dr. Subhadra Gupta said that in oder to identify prevalence and patterns of tobacco use in Maharashtra, doctors from Tata Memorial Hospital interviewed around 400 taxi drivers. A structured questionnaire about their attitudes and practices regarding tobacco use was used to collect information. This was then followed by educating the drivers about the hazards of tobacco use. From the 400 taxi drivers who were surveyed, khaini use was the most prevalent. The mean age of initiation was around 25 years with the chief reason for initiation being curiosity. According to the logistic regression analysis that was done it was found that drivers who were graduates and non-users of alcohol were less likely to use tobacco. Dr. Subhadra Gupta said that around 64% of the 400 individuals surveyed reported that they had made previous attempts to quit tobacco use. However, they claimed that some support/assistance would definitely help in quitting.

Presenter 8: Mr. Binoy Mathew

Topic: Exposing Tobacco Industry Tactics in Implementation of 85% GHW's Through Media Advocacy

Mr. Binoy Mathew began by reiterating that Graphic health warnings (GHW) on tobacco packages are an effective measure to warn the public of the harms of tobacco use. Graphical warnings covering 85% of tobacco packaging were notified on 15th October, 2014 and became effective from 1st April, 2015. However, the notification was kept in abeyance in March 2015, due to pressure form the tobacco industry. Mr. Mathew said that to increase awareness among the masses regarding the harms of tobacco use, the Voluntary Health Association of India (VHAI) came up with a strategy to involve the media through one-to-one interactions, press meets, press releases and combating industry pressure. By involving the media, the VHAI managed to get 1200 earned media stories about 85% graphic health warnings and around 100 hours of time on news channels. Mr. Mathew concluded by saying that with this persistent effort of constant media involvement to highlight the harms of tobacco use, India implemented 85% graphic health warnings on tobacco products packages from 1st April 2016.

Presenter 9: Dr. Stuti Bhargava

Topic: Evaluation of Impact of Ongoing Anti-Tobacco Campaigns on Central Indian Population

Dr. Stuti Bhargava presented a study that was done in the city of Nagpur in Maharashtra toassess the impact of an anti-tobacco campaign on a central Indian population and to identify the reasons for non-participation of tobacco users in tobacco de-addiction programmes. She said around 1010 tobacco users were surveyed using a structured questionnaire. The study stated that the prevalence of use of 'kharra' is very high in this belt of the population in this city:kharra contains tobacco, areca nut and other ingredients. The survey highlighted that most of the participants felt that the public discourses were mere publicity stunts. In addition to this, the people felt that warnings on tobacco packages only highlight the harms of tobacco use. There is no mention of any advice on de-addiction. Only around 11% of the sample who had surveyed had temporarily altered their habits somewhat owing to the warnings on tobacco packages. They also highlighted that there is absolute unawareness about tobacco cessation activities, which needs to be highlighted more. Dr. Bhargava said this study gave an insight into what the current anti-tobacco campaigns lack from the point of view of the general population. She said this study also suggests that more information should be available to the general masses about tobacco de-addiction and cessation activities.

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PROFFERED PAPER 5: TOBACCO CESSATION: EXISTING TREATMENT MODALITIES AND INNOVATIONS

Chairs:
Dr. Dinesh K. Daftary
Dr. Pratima Murthy
Dr. Jane Ralte

Presenter	Topic
Dr. Bhavya K Bairy	Competence and Self-efficacy of Dentists in Tobacco Cessation Enrolled in a Tobacco Cessation Training Programme in NIMHANS ECHO (Extension for Community Healthcare Outcomes).
Dr. R. Venkitachalam	Barriers for Giving Tobacco Cessation Advice among Clinical Students Of Dentistry: A Cross Sectional Study.
Dr. Neetu Grewal	Effectiveness of Behavioural Counselling with Nicotine Gum Versus Behavioural Counselling by Itself among Patients Visiting a Tobacco Cessation Clinic in Delhi: A Randomized Controlled Clinical Trial.
Ms. Priyanka Dhawan	Effectiveness of Hospital Initiated Intervention for Tobacco Cessation
Dr. Himanshu Gupte	Hookah Use and Its Cessation among Adolescent School Students from Urban Slums of Mumbai.
Dr. Suzanne Tanya Nethan	Behavioural Interventions for Smokeless Tobacco Cessation: Results of a Systematic Review and Meta- Analysis.

Presenter 1: Dr. Bhavya K Bairy

Topic: Competence and Self-efficacy of Dentists in Tobacco Cessation Enrolled in a Tobacco Cessation Training Programme in NIMHANS ECHO (Extension for Community Healthcare Outcomes).

Dr. Bhavya Bairy said the Hub and Spoke model is being used for creating a virtual knowledge network by NIMHANS to link clinicians (spokes) with specialists at NIMHANS (Hub) who mentor and train them to treat complex conditions like Addiction and Mental Health. For this, video conferencing technology is accessed on smart phones or tablets (4G).It was noted that there was a lack of awareness of tobacco related counselling among dentists – thus digital training programme at NIMHANS was started in November 2018, using the hub and spoke model. Best practices in tobacco cessation counselling to dentists in 12 weekly sessions. Initially, a need based pre-assessment of the dentists registered for the course was carried out. The instructors then used the 5a model to teach tobacco cessation counselling: ASK, ADVISE, ASSESS, ASSIST, and ARRANGE. Participants were tested after the course in knowledge and practices in tobacco cessation (Average score 6.6/10). Dr. Bairy concluded saying that this programme shows that digital/social media platforms can be used to complement the conventional mode of training.

Presenter 2: Dr. R. Venkitachalam

Topic: Barriers for Giving Tobacco Cessation Advice among Clinical Students Of Dentistry: A Cross Sectional Study.

Dr. R. Venkitachalam said that a cross sectional questionnaire based census survey was conducted among 180 third year and final year students and house surgeons of a dental school to explore the perceived barriers for giving tobacco cessation advice to patients. Nearly 90% of the respondents asked their patients about tobacco use and 80% reported providing some advice to patients. Barriers faced by the students included a lack of a formal system for follow-up as well as resistance from patients. Patient education materials and information about quit lines are also needed.Dr. Venkitachalam concluded that providing these materials and establishing formal training in tobacco cessation in all dental colleges would ensure better advice given by dentists.

Presenter 3: Dr. Neetu Grewal

Topic: Effectiveness of Behavioural Counselling with Nicotine Gum Versus Behavioural Counselling by Itself among Patients Visiting a Tobacco Cessation Clinic in Delhi: A Randomized Controlled Clinical Trial.

Dr. Neetu Grewal said that in this study, tobacco users were randomly assigned into two groups: 1) the behavioural counselling only group and 2) the behavioural counselling with nicotine gum group. The Fagerstrom test was used to determine initial nicotine addiction level. A flow chart of the study design was shown. Six follow-ups were made to assess quit status. At the end of six months, quit status was verified by biochemical testing. The quit rate was higher in the group with nicotine gum prescribed in addition to counselling, but the difference was not statistically significant after the 3rd and 6th month. Both interventions showed satisfactory results. Dr. Grewal concluded that effective tobacco cessation intervention is possible in good dental care surroundings.

Presenter 4: Ms. Priyanka Dhawan

Topic: Effectiveness of Hospital Initiated Intervention for Tobacco Cessation

Ms. Priyanka Dhawan began by saying that thestudy objective was to review and assess the successfulness of tobacco cessation interventionsfor hospital patients. A PUBMED search for systematic reviews and meta-analyses for tobacco cessation interventions (behavioural, pharmacological or mixed) in hospital settings with at least six months of follow-up was done. An AMSTAR (Assessing the Methodological Quality of Systematic Reviews) rating table was used as a measurement tool to assess the quality of systematic reviews. Out of 18 systematic reviews and meta-analyses found, only there met the inclusion criteria. Ms. Dhawan said they found that highly intensive smoking cessation counselling given in hospital that was continued with supportive contacts for one month after discharge increased cessation rates. Adding nicotine replacement increased the effectiveness further.

Presenter 5: Dr.Himanshu Gupte

Topic: Hookah Use and Its Cessation among Adolescent School Students from Urban Slums of Mumbai.

Dr. Himanshu Gupte called attention to the fact that hookah smoking was becoming popular among school-going adolescents who live in the slums of Mumbai. He drew special attention to the fact that various flavours of hookah were available on e-commerce platforms. Although many users are under the impression that hookah smoking is less harmful than cigarette smoking, it actually has similar health threats. He explained that LifeFirst is a programme that holds group awareness sessions among 7th to 9th Std. students about tobacco products and their ill-effects and teaches tobacco refusal skills. It also and holds an interactive tobacco and areca-nut cessation programme with. students for which registration is required. Held over six months, five interactive theme-based group sessions plus one final session are conducted. Dr. Gupte said that during 2017-18, the LifeFirst cessation programme was implemented in 40 schools in slum areas of Mumbai.After the initial awareness sessions with 4302 students, 1441 students registered for tobacco and areca nut cessation. Of the latter, 6% were current hookah users(more girls than boys). Curiosity and peer influence were the main reasons the youth started smoking hookah. By the sixth session,54% of the students in the cessation programme had quit smoking hookah (compared to 72% of the students who had used other products). He said increased awareness was also noted. Dr. Gupte concluded that school based awareness and cessation programmes are needed to help adolescents quit hookah smoking.

Presenter 6: Dr. Suzanne Tanya Nethan

Topic: Behavioural Interventions for Smokeless Tobacco Cessation: Results of a Systematic Review and Meta- Analysis.

Dr. Suzanne Nethan contextualised the need for effective behavioural interventions for smokeless tobacco in the fact that its use is on the rise globally.She explained the myth that

smokeless tobacco is less harmful to health than smoking cigarettes.She said a systematic review was conducted on cessation studies on smokeless tobacco with a minimum of six months of follow-up using the PICO (Problem, Intervention, Comparison and Outcome) method. Studies on interventions among youth or adults published from 1990 to 2017 were searched using appropriate keywords. This was followed by a meta-analysis of the study outcomes by deriving the pooled estimates by the random effects model. Nineteen studies from around the world with around 25,000 participants, in both developed and developing countries were included. She said that overall efficacy was found in the studies, more so in developing countries, but those on youth did not show efficacy overall. Dr. Nethan concluded that healthcare providers need to be sensitized to provide advice and detailed counsellingfor quitting SLT use and that youth may need interventions tailored to their age groups.

Key Points:

- Patients tend to think: if cancer is in my destiny what can I do about it? (Implied: "nothing").
- Personal communication is important with quitters.
- Mind over matter makes a lot of difference: the message to the mind is an important part of the intervention.
- Behavioural counselling alone often does not work.
- There is a lack of national-level data regarding the current reach of quit lines.
- Sensitization of dentists and health care providers to assess preparedness and willingness of patients to quit using tobaccois also an important factor.
- Health professional associations can be approached.
- Health professionals need to be trained in tobacco cessation counselling. Such counselling needs to be integrated with treatment for chronic diseases, women's health, adolescent health and can be part of health education.
- Links and collaborations among medical practitioners, researchers and health advocates helps spread awareness of tobacco cessation counselling.

Recommendations:

- Make the content of the school based orientation sessions on tobacco different for different classes, i.e. different modules for 7^{th}, 8^{th}& 9^{th} standards, as age groups differ.
- In addition to capacity building, collaborations should be encouraged.
- Tailor-made modules at the workplace to meet specific needs and also training for OPD and IPD staff in hospitals were suggested.

PROFFERED PAPER 6: TOBACCO INDUCED DISEASES: DIAGNOSTICS TECHNIQUES AND TREATMENTS

Chairs:
Dr. Samir Khariwala
Dr. Rakesh Gupta

Presenters:

Presenter	Topic
Dr. Samir Khariwala	Patterns of Use and Cessation Attempts in Smokers Developing Oral/Head and Neck Cancer
Dr. Ulhas Wagh	Fluorescence Imaging of Oral Premalignant Lesions: Effective tool for Screening and Tobacco Cessation
Dr. Garima Bhatt	Potential of Utilization of Non-Communicable Disease Clinics for Tobacco Cessation Services – Opportunities and Challenges
Dr. Gurmandeep Singh	Opportunistic screening for oral cancer and precancerous lesions in dental OPDs of Public hospitals of Punjab, India
Mr. K. Odaiyappan	Awareness on about Tobacco among Cancer Patients

Presenter 1: Dr. Samir Khariwala

Topic: Patterns of Use and Cessation Attempts in Smokers Developing Oral/Head and Neck Cancer

Dr. Samir Khariwala is a research collaborator with Dr. Pankaj Chaturvedi on a study aimed at analysing the constituents of tobacco products in India and their links to cancer. This information will be used for advocacy.

The information Dr. Khariwala presented in this session was on head and neck cancer patients in the USA where doctors were studying patient risk factors and their attempts at smoking cessation prior to diagnosis. He said combustible tobacco is more common use in USA (cigarettes), while smokeless tobacco use prevalence is very high in India. There is also some snuff use in the USA. The USA alone has 46 million smokers and 60,000 cases of HNSCC per year. Smokers, when they come in and are diagnosed with cancer, they still find it difficult to quit; some will smoke after 3-4 days of being asked to go in for a diagnosis; some will stay off smoking during treatment and restart once the treatment is over.

The researchers looked at certain symptoms in patients who were trying to quit. They found most users were likely to report one group of symptoms: Group 1: increased appetite, cravings, depression; Group 2: restlessness, irritability, insomnia, anxiety, and difficulty concentrating. Most of these smokers had already made at least one or more attempt to quit smoking in their lifetime, when around 80% of those who attempted it had been able to quit. They were able to quit for at least one day,a month or more, even for some years. However, later the urge to smoke took over for all of them. Those with Group 2 symptoms tried to quit more often.

The study also looked at the methods used to quit smoking. The researchers asked 130 patients about their prior unsuccessful tobacco cessation techniques, product used, and the maximum time abstained from smoking. For the most part they found the methods used included nicotine patch, nicotine gum, pharmacotherapy,e.g. varenicline, and behavioural therapy. Some had also used cold turkey. In conclusion, among smokers developing HNSCC:

- Most have made one or more attempts to quit
- Symptoms experienced while trying to quit tend to cluster into two groups
- Previous cessation attempts were mostly unassisted.
- Unassisted cessation or cold turkey was associated with the longest abstinence periods

Dr. Khariwala concluded that the data suggest insufficient support being given to patients and education among physicians regarding behavioural and pharmacologic cessation therapies.

At this point the audience asked questions to Dr. Khariwala:

You said 81% in all used the cold turkey method, so was that prior to diagnosis?

Dr. Khariwala clarified that all these people attempted to quit before they were diagnosed with head and neck cancer.

When patients used methods to stop smoking, did they attempt to do this on their own or did they go to cessation clinics?

Dr. Khariwala saidit depends. Nicotine gum can be bought easily, for the nicotine patch you need a prescription. In many cases, the primary care doctor would give patients a nicotine patch. The problem is the local physician is not trained in tobacco cessation counselling or engaged in the full cycle of cessation.

Could that be a reason for the relapsing of the cases?
Dr. Khariwala replied thatit may well be. We don't have a proper cessation programme in place.

Did anyone tell you that they were using E-Cigarettes?
Dr. Khariwala answered that no, none did. He said they did this study at a time when e-cigarettes were still becoming popular.

Presenter 2: Dr. Ulhas Wagh
Topic: Fluorescence Imaging of Oral Premalignant Lesions: Effective tool for Screening and Tobacco Cessation

Dr. Ulhas Wagh introduced his talk by saying that India is the oral cancer capital of the world because of the rampant habit of tobacco chewing. He said it is very important to screen patients for oral cancer and its complications in the early stages, and put in place prevention programs to ensure that these do not develop further, with an effective tobacco cessation program.

Dr. Wagh listed the current challenges to early diagnosis: Patients do not notice early changes or symptoms; sensitivity is low during routine check-up. Even though effective IEC and warning slogans are printed on packets, tobacco users continue the habit. Increasing numbers of youth are being found with oral abnormalities in the context of tobacco habits.

The main objective of the study was to evaluate the value of adding Narrow Band Imaging (NBI) using the VELscope for detection of tissue changes in the oral mucosa not readily seen during routine white light examination in dental patients. The study also aimed to see if the images produced by auto-fluorescence can be a motivating factor for patients to change from risky to healthy behaviour in the context of tobacco habits.

The VELscope was used as an auto-fluorescence imaging device to illuminate oral tissue with bright blue light, along with a standard oral screening procedure. The study was conducted in Thane, north of Mumbai during a period of three years from 2015 to 2018. The sample size was limited to 50 cases having the habit of tobacco in various forms. Quarterly follow-up visits were organized to assess clinical findings and the impact on behavioural modification.

Flavin adenine dinucleotide (FAD) is a natural fluorophore in the oral mucosa fluoresces under bright blue light from the VELscope. Increased metabolism associated with cell turnover and dysplasia causes a decrease in concentration of FAD, resulting in decreased fluorescence. Breakdown of the collagen matrix of the oral mucosa due to dysplasia or malignancy also leads to a decrease in fluorescence, hence grey patches. Five cases were presented with images.

The patients were advised to go for a biopsy for further investigation. Out of 50 subjects 42 came for follow-up visits regularly, after screening.All 50 were subjected to an auto fluorescence imaging study and histological examination was done in 48 of these cases by performing biopsy. The results of the biopsies included 35 cases of leukoplakia, 3 cases of erythroplakia, 2 cases of non-specific ulcerative lesions, 2 cases of cancer in situ, and 8 cases of squamous cell carcinoma. Behavioural change with regard to tobacco use was observed among 42 subjects.

Use of auto-fluorescence with the VELscope enhanced the diagnostic quality of the images of suspicious lesions at early and late stages, which also supports the clinical judgment of dysplasia. Auto-fluorescence also made it possible to visibly show the abnormalities in the oral mucosa to the patients. This was a motivating factor for the patients to quit tobacco use. Dr. Wagh concluded that the addition of fluorescence imaging to conventional screening is certainly supportive for both cancer diagnosis and tobacco cessation programs.

Questions and Answers

What is the cost of the VELscope?
Dr. Wagh replied that it costs Rs. 10 lakhs. He said, one thing he observed, using the VELscope, was that showing the image in the VELscope to the patient was quite a motivating factor, not just for the patients but also the relatives. Follow-up visits by patients scheduled quarterly were more regular.

Do you find that the VELscope helps in seeing things that you would not generally see in regular light, in confirming something that you already suspect?
Dr. Wagh said thatcertainly, wherever he looked, in white light, he could not see the lesions. But with VELscope, he saw them.

What is the sensitivity of the VELscope and how specific is it compared to other sophisticated equipment?
Dr. Wagh informed the audience that the sensitivity is almost 98 percent, specificity is almost 100 percent. This is used in schools and while going for screening camps.

Presenter 3: Dr. Garima Bhatt

Topic: Potential of Utilization of Non-Communicable Disease Clinics for Tobacco Cessation Services – Opportunities and Challenges

Dr. Garima Bhatt introduced her talk by saying that some 60% of all deaths in India are due to NCDs. She said tobacco use is a major risk factor for NCDs which is preventable and modifiable. There is provision for screening for risk factors for NCDs at NCD clinics. The National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched during 2010-11. The NCD clinics are at CHC and DH levels. Manpower in clinics is 1 doctor, 2 nurses, 1 counsellor and 1 data entry operator.

Dr. Bhattexplained that a package has been developed wherein the plan is to use the existing infrastructure and staff of the NCD clinics for tobacco cessation counselling: a booklet for health care providers (HCPs) at NCD clinics that contains information on the burden of non-communicable diseases (NCDs) and tobacco use, brief info about the National Tobacco Control Programme (NTCP) and the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS), complications associated with continued tobacco use among NCD patients, advantages of quittingtobacco and use of behavioural methods for cessation in health care settings. Patients visiting NCD clinics are provided disease specific pamphlets, short message service (SMS), and a tobacco cessation specific intervention package.

She listed that activities that were undertaken for package development: consultation with officials, orientation workshop with NTCP and NPCDCS program managers, discussion, content finalization, consultation meetings with state health department officials, communication with academicians and public health experts for necessary reforms, and promotion of booklets and pamphlets at noticeable government platforms, campaigns and mass media used to share the idea. She said the proposed framework for implementation of the intervention at NCD clinics includes: patient registration, meet doctor, proceed to counsellor, meet nurse, return home, return for follow up. The expected benefits of intervention delivery through NCD clinics include mutually beneficial integration of two national programs for synergistic outcomes, wider outreach of tobacco cessation services, optimization and efficient use of available resources, and potentially better outcomes in this responsive group.

Challenges for intervention delivery through NCD clinics include the following: a large patient load, severity of nicotine dependence, compliance of patients for follow-up, sub-optimal coordination between program managers, and resistance from staff due to perceived additional responsibility. The way forward she suggested wasdelivery of effective, patient centric, disease specific and culturally sensitive care. Dr. Garima Bhatt concluded that tobacco cessation services at the NCD clinic might prove to be an efficient way of reducing complications among NCD patients using tobacco.

Questions and Answers

Does this take the form of teamwork at the NCD clinic?
Dr. Bhatt affirmed thatit does.

Does the Psychiatry Department ideally have to be involved?

Dr. Bhatt responded that ideally, it should be. But the number of counsellors available is very few in India. The existing staff will be trained by experts, so that they can help the patients.

Presenter 4: Dr. Gurmandeep Singh

Topic: Opportunistic screening for oral cancer and precancerous lesions in dental OPDs of Public hospitals of Punjab, India

Dr. Gurmandeep Singh began by giving some background about tobacco usage, death and cancer and the fact tobacco, especially in smokeless forms is implicated in 90% of oral cancer, one of the commonest forms of cancer and causes of cancer-related deaths in the Indian population. He said that oral cancer screening is an important tool for the early detection and prevention of oral cancers. Early detection would not only improve the cure rate, but it would also lower the cost and morbidity associated with treatment. A sensitisation workshop for the Dental Surgeons was organised by State Tobacco Control Cell, Punjab. A questionnaire was prepared by the expert panel for the Oral cancer screening during the meeting. A mechanism was developed to counsel and refer tobacco users to tobacco cessation centres.

A study was conducted in the year 2017-18 in Punjab. Oral cancer screening was done in all the dental clinics of Government hospitals of Punjab during dental fortnights. Each patient was asked to complete a health questionnaire concerning age, gender, and tobacco use. The dental surgeons then examined the oral cavity of the tobacco users and recorded the presence or absence of lesions. The forms were collated and data were analysed to determine the prevalence of lesions and risk factors. The results showed that a total of 1, 36,326 patients were examined, 9.18% were tobacco users. Oral lesions were detected in 6329 tobacco users (50.5%). Fifty five patients (0.43%) had oral cancer.

Dr. Singh said the intervention/treatment/immediate treatment needed was provided to the patients. A total of 15,515 Tobacco users were counselled by the dental surgeons to quit tobacco and referred to Tobacco Cessation Centres. A total of 349 (5.51%) suspected patients were referred to higher centres for comprehensive evaluation and treatment. Dr. Singh concluded that since the patients attending the dental clinics of public hospitals are representative of the general population, opportunistic screening in a general dental practice setting may be a realistic alternative to population based screening.

Presenter 5: Mr. K. Odaiyappan

Topic: Awareness on about Tobacco among Cancer Patients

Mr. K. Odaiyappan began by informing the audience that in India 42% of male and 18% of female cancer deaths were related to tobacco use. He said various studies conducted in different sectors of population have shown different rates of awareness, 40-80% regarding tobacco use and cancer. This study was done to understand the awareness among cancer patients regarding tobacco's effect on cancer. It was a cross-sectional survey performed by Tata Memorial Centre, Mumbai from March 2017onwards. A validated questionnaire is being administered to newly registered patients in the thoracic and colorectal unit. The credibility of the tobacco use habit stated by the patient is being verified with the patient's attendant. Recently a total of 877 patient questionnaires were analysed: Males: 631 (71.1%), Females: 256 (28.9%). Their ages varied from 18 to 85 years. Their residence: Maharashtra – 331 (37.3%), West Bengal – 156 (17.6%);

Literacy: Illiterate: 162 (18.2%). Family income per month: < Rs 5000: 367 (41.3%). The diagnosis of cancer made 247 patients (44.1%) quit tobacco use. A family member's pressure was the second most common reason for quitting tobacco use among patients: 79 (14.1%). The commonest reason for tobacco use was, "It gives a sense of pleasure" (28%). As many as 204 (36.4%) patients who used tobacco had attempted to quit tobacco earlier. They also accepted professional help to quit tobacco as patients at TMH. Mr. Odaiyappan concluded that more than three fourths of cancer patients are aware that tobacco use causes cancer: one fourth of cancer patients need to be sensitized; one third of patients who use tobacco have attempted to quit tobacco earlier in their life. The time in the hospital must be utilized to make these persons quit tobacco.

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PLENARY 3: GLOBAL ADULT TOBACCO SURVEY (GATS): MONITORING THE TOBACCO EPIDEMIC AND CONVERTING DATA TO POLICY FOR A TOBACCO FREE GENERATION

Chairs:
ShriVikas Sheel
Dr. Prakash C. Gupta

Speakers:

Speaker	Topic
Dr. Krishna M Palipudi	Global Perspective on Tobacco Surveillance
Dr. T. Sundararaman	GATS-2 India Survey Key Findings and Policy Perspective
Ms. Vineet Gill Munish	Approaches to Data Dissemination: Learnings from India on Research, Surveillance and Exchange of Information (FCTC, Article 20).
Dr. Manju Rani	GATS – Moving from Data to Policy
Mr. Pranay Lal	Strengthening Communication Activities Utilizing GATS Data for Enhanced Tobacco Control in India

Speaker 1: Dr. Krishna M Palipudi

Topic: Global Perspective on Tobacco Surveillance

Dr. Krishna Palipudi started his presentation discussing tobacco use and non-communicable disease (NCD). Tobacco – the biggest contributing factor to NCD, causes 63% of all deaths globally, NCD causing 86% of premature deaths –the majority of these in the low and middle income countries. He listedthe WHO FCTC tools and said that the WHO FCTC provides a foundation for countries to implement and manage tobacco control. WHO's MPOWER package assists country-level implementation of effective measures to reduce tobacco demand. He also informed the audience about the FCTC monitoring protocol 20.2 that integrates tobacco surveillance programmes into national, regional, and global health surveillance programmes so that the data is comparable and can be analysed at the regional and international levels.

Dr. Palipudi also spoke about the CDC surveillance that is ongoing, systematic collection, analysis and interpretation of data essential to planning, implementation and practice, integrated with timely dissemination. He said the bad news is that the tobacco product landscape is evolving.

He said the GTSS is a set of globally standardized surveys, which systematically monitors youth and adult tobacco use and provides key tobacco control indicators (WHO FCTC and MPOWER). They monitor not only tobacco use, but also tobacco control solutions, enhance capacity to design, implement, monitor and evaluate tobacco control polices. Dr. Palipudi also discussed the GTSS framework for survey implementation: from conducting the survey to data analysis, from data release to action and implementing programmes. The Global Tobacco Surveillance System (GTSS) includes: The Global Youth Tobacco Survey (GYTS), the Global Adult Tobacco Survey (GATS), and tobacco questions for surveys (TQS).

He gave an overview of GATS,its methodology in detail and different rounds of GATS. Between 2008 and 2018, GATS was implemented in 34 countries representing more than 70% of the world's adult population. Dr. Palipudi saidGATS follows a standard, systematic and consistent process to generate comparable data within and among countries, to monitor tobacco use across time and countries. He explained the GATS features and partnerships with various organisations. The GATS is a nationally representative household survey of persons aged 15 years and older, with multi-stage, geographically clustered sample design. The GATS questionnaire topics are prevalence of smoking and smokeless tobacco use, use of emerging products, cessation, second-hand smoke, media, knowledge, attitudes and perception as well as economics. He shared the key findings.

Speaker 2: Dr. T. Sundararaman

Topic: GATS-2 India Survey Key Findings and Policy Perspective

Dr. T. Sundararaman began by speaking about the challenges of using information. The information science hierarchy is: Data, Information, and then Knowledge.The Final GATS2 Report provides much more information than the GATS1 report and more can be extracted from the data sets. Understanding the numbers means having a conversation around the data, comparing values across states, looking for consistencies and inconsistencies across data sets within the same states, looking for patterns in the data, building hypotheses and then testing

and exploring general questions for further studies. But for knowledge one needs interpretation of the data, in context with the purpose.

Knowledge informs action: policy action and implementation. He showed graphs for the distribution of the estimated adult population by tobacco use from GATS India, discussed prevalence rates of various states by any tobacco use, smoking and smokeless tobacco use. Also, he discussed prevalence of tobacco use and change from GATS-1in 2009-2010 to GATS-2 in 2016-17 with respect to smoking, smokeless use and all tobacco use.

Dr. Sundararaman also shared about exposure to second hand smoke: at home, at the workplace, in Govt. offices, health care facilities, restaurants and public transportation. He shared results from both GATS India surveys on tobacco use as well as exposure to second hand smoke among pregnant women from GATS-2 2016-17. Much higher proportions of tobacco users thought about quitting smoking o smokeless tobacco because of health warning labels in the GATS-2, 2016-17 compared to GATS-1, 2009-10 among cigarette, bidi and smokeless tobacco users. He also spoke about current tobacco users who perceived that tobacco use has already done harm to their bodies, from GATS-2in Madhya Pradesh.

Speaker 3: Ms. Vineet Gill Munish

Topic: Approaches to Data Dissemination: Learnings from India on Research, Surveillance and Exchange of Information (FCTC, Article 20).

Ms. Vineet Gill Munish spoke about tobacco surveillance that is a part of the National Tobacco Control Programme for which dedicated funds are available. Three rounds of GYTS were conducted in 2003, 2006 and 2009 and two rounds of GATS were conducted in 2009-10 and 2016-17. Key Tobacco control questions were placed in the National Family Health Survey (on prevalence, SHS and cessation).

She also discussed prevalence of tobacco use and change by states/UTs from GATS-1 to GATS-2 across all states/UTs. She talked about the GATS dissemination strategy and gave the background that the huge investment of GoI in the survey was made to obtain state wise estimates for differences in tobacco use prevalence and type of tobacco use and varying levels of implementation of the national tobacco control programme and law enforcement in the states.

She said the objectives of the dissemination strategy are to engage with the highest level policy makers, provide a platform for tobacco control programme officials at state and districts levels, to review their performance and brainstorm on successes and gaps, sensitize relevant stakeholder departments and sectors, and generate earned media and visibility. She spoke about collaboration for dissemination led by MoH with support from WHO and state tobacco control policy, VHAI, local civil society organisations and the Tata Institute of Social Sciences.

She showed a few press releases with the states for decreases in prevalence and pictures of many internal meetings held with senior officials and policy makers. These states used the GATS 2 data to reflect on their efforts.Results were analysed to identify gaps and revise strategies.

Ms. Gill also mentioned that the states which performed well, shared their strategies and the GATS release event was a learning and self- reflection platform for the NE states. Ms. Gillconcluded saying the main outcomes wereas follows:

- Participation of health ministers provided the political commitment to the NTCP
- More than 2000 stakeholders were sensitized through the state level disseminations
- Over 300 media stories were generated pan-India in national and regional dailies
- The participation of policy makers and officials from diverse sectors has re-kindled the efforts and support for the NTCP.
- The states were energised to plan afresh based on GATS findings and realign tobacco control efforts and strategies.

Speaker 4: Dr. Manju Rani

Topic:GATS – Moving from Data to Policy

Dr. Manju Rani made a brief presentation on moving from data to policy and the pathways followed. First comes data, then comes advocacy and then new policies are adopted, based on the data. In parallel, data is assessed at implementation level, the impact of existing policies is discovered and policy modification takes place. She also discussed the importance of using the data to assess policy implementation.

She discussed some data from GATS-2 and GYTS 2009 relevant to COTPA section 6: no person shall sell, offer for sale, cigarettes or any other products to minors or around educational institutions. She showed and discussed a graphical presentation on knowledge, attitudes and perceptions on smoked and smokeless tobacco use. She showed her analysis on prevalence of tobacco use by state. Later she spoke about changes in prevalence from 2009-2017 and implications for policy – How are the policies in the best performing states different from others? Is it the difference in polices or the level of implementation that differentiates performance, and should the poor performing states change their policies or implement them better? She then presented a few findings state wise. There should be data to advocate for new polices, like data that shows 2/3 of cigarette smokers bought loose cigarettes so a new policy should be to ban single stick sales. Dr. Rani concluded that key prerequisites for data to be used for policy advocacy need to include the following:

- Make the data accessible widely: GATS has such rich data, made publicly accessible
- More analysis – more debate; more visibility – more impact
- Continuous dissemination of the data through simple thematic policy briefs and peer-reviewed journal articles for use in national and global advocacy
- Find the right opportunities and the right people for dissemination.

Speaker 5: Mr.Pranay Lal

Topic: Strengthening Communication Activities Utilizing GATS Data for Enhanced Tobacco Control in India

Mr. Pranay Lal's presentation had two main parts:

- Strengthening communication of GATS-2 results to state level policy makers
- Guiding state initiatives based on GATS-2 findings

He spoke about the planning and structuring use of GATS data and there are three levels of using data

- Assessing the effects of implementation of provisions of COTPA and NTCP
- Correlating data from GATS with data from other disease control programmes
- Continuously using GATS data at national/regional/local levels with other robust surveys
- Use data to predict trends and new polices

He later discussed a research article on 'systematic review of barriers to and facilitators of the use of evidence by policymakers'. The take home message was that the relationship between policymakers and researchers is critical for translating data into policy and action. Also that contact, collaboration and relationship are major facilitators of use of evidence

Lastly he spoke about use of GATS data at the state level

- Use GATS data in designing state level interventions and help state governments/STCC set targets and make campaigns
- Leverage central and state health programmes to incorporate tobacco control interventions or messages

Mr. Lal suggested using GATS results to design new interventions – ban on sale of single cigarettes, vendor licensing and raising the age of customers to 21 years.

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PROFFERED PAPERS 7: PREVALENCE OF TOBACCO USE & BURDEN OF DISEASES

ATTRIBUTABLE TO TOBACCO USE

Chairs:
Dr. Sonu Goel
Dr. Krishna M Palipudi
Dr. Manju Rani

Presenters:

Speaker	Topic
Dr. G. K. Mini	Low Tobacco Consumption among School Teachers in Kerala, India
Dr. Garima Bhatt	Prevalence of Tobacco Use Among Patients Suffering from Non-Communicable Diseases in Two Districts of Punjab: A Cross Sectional Study
Ms.Marina D'Costa	Pathways of Initiation in Tobacco Use among School Going Adolescents in Mumbai
Dr. Shekhar Grover	Prevalence of Tobacco Use among Priests and Their Willingness to Spread Anti-Tobacco Messages among Devotees in Delhi

Presenter 1: Dr. G. K. Mini

Topic: Low Tobacco Consumption among School Teachers in Kerala, India

Dr. G. K. Mini said teachers are role models and as such they can play a major role in influencing lifestyle and habits of students. She described a survey of teachers in Kerala,using the WHO STEPS interview schedule, conducted among 2216 teachers from 100 government schools in Thiruvananthapuram District in 2018. This was part of a cluster randomized controlled trial on hypertension control. The objective was to study their tobacco use pattern and their practices related to tobacco control in the schools. Lifestyle indicators of teachers, genderwise, schoolwise, clusterwise and districtwise, were taken into consideration.Teachers reported very low prevalence of tobacco use compared to the general population, but male teachers were more likely than female teaches to be current smokers or users of SLT. Around 10% noticed the sale of tobacco within 100 yards of their schools. Dr. Mini concluded that if teachers have lower tobacco usage compared to the national or state average then they may influence change through their students. Thus teachers who are tobacco users should try to quit.

Questions and Answers

Dr. Sinha asked Dr. Mini,***What is the prevalence of tobacco use among teachers in most states?***
Dr. G. K. Mini responded that an exclusive study would need to be done among teachers to answer that question.

Presenter 2: Dr. Garima Bhatt

Topic: Prevalence of Tobacco Use Among Patients Suffering from Non- Communicable Diseases in Two Districts of Punjab: A Cross Sectional Study

Dr. Garima Bhatt informed the audience that the objective of the study was to assess tobacco use among NCD patients over 30 years in S.A.S. Nagar and Fategarh district clinics in in Punjab. A sample size of 1002 patients was calculated. Data were segregated in terms of smokers and non-smokers. Tobacco users were divided into distinct categories for clear results in terms of patients suffering from hypertension and those with diabetes. Males in the age group of 40-49 yrs. were most likely to smoke. Data were further segregated between urban, semi urban and rural populations. Hypertension 42 and diabetes 2 were the most common NCDs. There were also small numbers of CVD and COPD. While close to 10% of hypertensives and diabetics were tobacco users, about 92% of COPD patients and 42% of CVD patients were tobacco users. Kerala data were then compared with Punjab data. There were some limitations in the survey on tobacco consumption and intention to quit. Dr. Bhatt concluded saying that the NCD patients who used tobacco presented an opportunity for health care providers to impart a tobacco cessation intervention.

Questions and Answers

It is not very clear and conclusive that diabetes is directly related to tobacco usage what do you think?

Dr. Bhatt replied that tobacco use including smokingis higher in NCD patients in general

Presenter3: Ms.Marina D'Costa

Topic: Pathways of Initiation in Tobacco Use among School Going Adolescents in Mumbai

Ms. D'Costa began by saying that according to surveys, tobacco use has increased in recent years among adolescents students in India. She said that the study she was going to present aimed to understand tobacco use behaviour in school going adolescents in Mumbai. Fourteen focus group discussions were conducted with166 students in grades7,8 and 9 in 15 municipal schools. In-depth interviews were then conducted with 60 of these students. It was found that easy access to tobacco products as well as normalization of tobacco use weremajor factors in initiation. Most adolescents started with sweetened areca nut. Many moved on to gutka. With curiosity, some tried out multiple products before deciding to place their loyalty on one product.She gave elaborate details and datain presenting her paper,which includedkey issues like pathways of initiation to tobacco use.Another important finding Ms. D'Costa mentioned was that emotionally stressful events at home or at school aggravated the use of the adolescents' chosen tobacco product.

Questions and Answers

Co-Chair Dr. Krishna Palipudiasked a question;

Can there be a more in depthfocus group discussions (FGD) to see habits genderwise?

Ms. D'Costa answered that a focus group discussion with girls could be conducted to see their smoking or other tobacco habits andfind measures to be adopted to help them quit.She also mentioned that clear indicators for policy makers can be as follows: 1. Counsellors need to know how to deal with users; 2. Counsellors need to know ways to quit tobacco.

Presenter 4: Dr. Shekhar Grover
Topic: Prevalence of Tobacco Use among Priests and Their Willingness to Spread Anti-Tobacco Messages among Devotees in Delhi

Dr. Shekhar Grover suggested that religious professionals may be helpful in community based cessation programmes. Priests, due to their position in society may be able to influence habits of devotees to a large extent. A community based cross sectional study was conducted among 159 head priests orclerics – among Hindus and Muslims – was conducted in Delhi to find out the knowledge attitudes and practices with regard to tobacco and their willingness to spread anti-tobacco messages among devotees. Some 23% were tobacco users, most of whom used more than one form. Users were less informed than non-users about the harmfulness. Almost all of them expressed willingness to spread the message of the harmfulness of tobacco to the devotees. Mr. Grover concluded that religious leaders should be motivated and trained in tobacco use prevention and cessation activities. He also clarified that since the pattern of tobacco consumption is very region specific and culture specific, so the training would need to be customized.

PROFFERED PAPERS 8: TOBACCO INDUSTRY'S TACTICS AND INTERFERENCE

Chairs:
Mr. Ashish Pandey
Ms. Vineet Gill Munish

Presenters:

Presenter	Topic
Dr. Shekhar Grover	Global Status of Article 13: Ban on Tobacco Advertising, Promotion and Sponsorship (TAPS)
Mr. Vijay Bhasker Yetapu	Social Media for Tobacco Control: A Case Study
Dr. Amit Yadav	Advertisement, Promotion and Sponsorships Related to Smokeless Tobacco in India – The Insidious Interference by the Tobacco Industry to Recruit SLT Users
Mr. S. Cyril Alexander	Tobacco Industry Interference in Schools
Mr. Amit Bhatt	Replacing Tobacco Advertisements with Anti-Tobacco Stories in Print Media"- An Effective Change for Tobacco Control in Rajasthan
Mr. Mangesh Ramachandra Chougule	An Innovative Way to Capitalize on Public Festivals to Spread Tobacco Control Awareness
Ms. Seema Gupta	**Topic:**Exposing TI Tactics in Implementation of 85% GHW's through Policy & Political Advocacy

Presenter 1: Dr. Shekhar Grover
Topic: Global Status of Article 13: Ban on Tobacco Advertising, Promotion and Sponsorship (TAPS)

Dr. Shekhar Grover presented the findings of the WHOGlobal Tobacco Epidemic Report, 2017, on the global status of Article 13 of the FCTC.He began by elaborating on the provisions that are provided under Article 13 – Tobacco advertising, promotion and sponsorship. Then he presented a global review of the policy progress made under Article 13 on Cigarettes (CIG) and Smokeless Tobacco (SLT). The study was conducted on the secondary data available on TAPS from GATS and the data of India were compared to that of few other countries. Mr. Grover shared the following findings:

- Of the 179 countries ratifying FCTC, 135 (75%) have defined/included SLT. Baseline numbers included 179 countries for CIG and 135 countries for SLT.
- The proportions of parties banning tobacco advertisements in the broadcasting media (84% of Parties for CIG and 72% of Parties for SLT) or in the print media (78% of Parties for CIG and 66% of Parties for SLT) are higher than those banning advertisement at point of sale (46% of Parties for CIG and 42% of Parties for SLT).
- As per the India GATS-1 report, the percentage of adults who noticed any SLT advertisement in a store (10.8%) is higher than that of those who noticed any on the internet (1.3%).
- The proportion of parties having a ban on tobacco advertisements in the International Broadcasting Media (70% of Parties for CIG and 59% of Parties for SLT) is greater than that for the International Print Media (53% of Parties for CIG and 44% of Parties for SLT).
- Online purchase of Snus is more prevalent in European countries, Sweden being the primary vendor.
- A complete ban on promotion and sponsorship has been made by 26% of the Parties for CIG and 26% of Parties for SLT.
- Surrogate advertisements: The tobacco companies under the same name, logo, and using similar packaging advertise non tobacco products.
- Billboards or hoardings display ads for the surrogate products, as do ribbons of pan masala at shops.
- Many companies also use deceitful terms in SLT brand names to promote the products: half of the parties who have signed the convention have put a ban on this practice.
- In India exposure to advertisements and promotions other than point of sale have been highest and have deceased the most between GATS-1 and GATS-2.

In conclusion, Dr. Grover said that less than one fifth of parties have a comprehensive TAPS ban for STL. Only India and Bangladesh have developed implementation indicators for SLT.Implementation of TAPS ban policies for CIG and SLT is not good.Monitoring is also needed for proper implementation.

Presenter 2: Mr. Vijay Bhasker Yetapu
Topic: Social Media for Tobacco Control: A Case Study

Mr. Vijay Yetapu focused his presentation on a study aboutthe different aspects of tobacco promotion on social media, mainly on Facebook (FB),as it has the highest number of users across the world. He said that during the study it was observed that events are promoted for the sale of tobacco products by companies, such as Gold Flake. Various FB groups are created by the companies and people are motivated to use their products. As per the policy of FB, blogs or groups connecting people with tobacco-related interests are permitted, as long as the service

does not lead to the sale of tobacco or tobacco-related products.To counter big tobacco tactics, the organization, VChangeU has created multiple social media pages for tobacco control to engage youth in promoting better health and staying away from tobacco products for ever. They provide support and solutions to tobacco addicts to quit their addictions.
VChangeU has developed a Facebook page and post anti-tobacco posts/messages to encourage users to quit smoking. Some of the users have quit smoking because of these initiatives. There are other organizations/FB groups which have been created for anti-tobacco campaigns, such as QuitNet, BecomeAnEx.org, and TobaccoFreeFlorida.com. Mr. Yetapu concluded saying that VChangeU aspires to expand its reach and come up with innovative campaigns and solutions to help people quit smoking.

Presenter 3: Dr. AmitYadav

Topic: Advertisement, Promotion and Sponsorships Related to Smokeless Tobacco in India – The Insidious Interference by the Tobacco Industry to Recruit SLT Users

The presentation had a major focus on Smokeless Tobacco as around 20 crore adults in India are SLT users. Dr. Amit Yadav said that of the 650,000 deaths due to SLT use globally, more than 350,000 occur in India. 13 states of India have a high SLT burden. The extent of SLT TAPS in the country was analysed by reviewing GATS-1 and GATS-2 along with the GYTS India Report.

Among other findings, Mr. Yadav presented the following major findings from GATS2:

- One fifth (20.5%) of adults aged 15 or above, including bothusers and non-users,noticed any SLT product marketing (advertisement or promotion) during the last 30 days at various places, like television, posters, newspapers, free samples, or surrogate advertisements.
- Almost one fourth or (24.3%)of adult SLT usersin India noticed advertisements or promotions.
- The proportion of adults aged 15-24 years who noticed any SLT marketing during the last 30 days in India (23.9%) is higher compared to the proportion of those above 25 years who noticed it (19.3%).

Despite the food safety law designed to prevent the sale of food products containing tobacco or nicotine being adopted by the states, the tobacco industry and vendors continue to flout this law. The flavoured and scented products continue to be marketed – often using surrogate products – and sold. Mr. Yadav ended his talk by noting that several states have takenthe initiative to implement a comprehensive ban on tobacco marketing. These included Maharashtra, Tamil Nadu, Telangana, Bihar, and Jharkand.

Presenter 4: Mr. S. Cyril Alexander

Topic: Tobacco Industry Interference in Schools

The focus of the presentation by Mr. Cyril Alexander was on the corporate social responsibility (CSR) activities carried out by tobacco companies who are actually responsible for the death of lakhs of people. He said tobacco industries target children and young adults through their CSR activities and manipulate them into using their tobacco products. He said this is evasion of COTPA Section 5. The Tobacco Monitor App in Tamil Nadu received a complaint that the

Handwriting Competition Season 7 was sponsored by the Classmate stationery band of the ITC. Representation was sent to the Tamil Nadu School Education Departmentrequesting them to send circulars to all the schools not to participate in the Handwriting Olympiad as it was sponsored by a tobacco company. The School Education Department responded positively and circulars were sent tothe schools.It also sent a responseletter to the National Forum for Tobacco Eradication (NFTE) stating that ITC's Classmate Ltd. had been removed from the position of the title sponsor for the Handwriting Competition Season 8.Mr. Alexander also said that some NGOs also need to stop taking funds from tobacco industries under CSR – something whichhighlights the need to strengthen the implementation of tobacco control laws in the states.

Presenter 5: Mr. Amit Bhatt
Topic: Replacing Tobacco Advertisements with Anti-Tobacco Stories in Print Media"- An Effective Change for Tobacco Control in Rajasthan

Mr. Amit Bhatt pointed out that direct and indirect tobacco advertisements are banned in India but that despite this, tobacco product manufacturesstill use surrogate advertising to indirectly promote theirtobacco products. In fact, between the two GATS waves, in Rajasthan, the tobacco industry was busy promoting its wares through surrogate ads in various media. Mr. Bhatt shared that in view of this situation, in Rajasthan, various initiatives have been taken to make space for anti-tobacco stories in the media.Senior officials representing media management were sensitized by journalists, connected with people through social media campaigns, and success case stories were shared with a human touch in print media. As a result, in the last five years, 3500 news stories were published in Rajasthan on tobacco control issues. Slowly, fewer and fewer tobacco related advertisements were seen. Mr. Bhatt concluded that as a result, GATS2 showed a significant reduction in tobacco use had been achieved.

Presenter 6: Mr. Mangesh Ramachandra Chougule
Topic: An Innovative Way to Capitalize on Public Festivals to Spread Tobacco Control Awareness

Mr. Mangesh Ramachandra Chougule said that among the various interventions a planned by Salaam Bombay Foundation (SBF) for tobacco control, participating in a public festival is one of them. Ganeshotsav is considered to be one of the grand public festivals celebrated in India and it serves as a marketing platform for tobacco companies. With an opportunity to create awareness about the ill-effects of tobacco and advocate for a ban on direct and surrogate advertising of tobacco and supari products and to provide school children huge platform to showcase their skills, SBF collaborated with Ganapati mandals (committees) of Mumbai and conducted anti-tobacco awareness campaigns to sensitize them to not accept advertisements from tobacco companies. On these occasions awareness activities were also conducted like poster exhibitions, rangoli competitions, anti-tobacco Ganpati art, and the snake and ladder game. Illustrating the success of the sensitisation conducted by SBF, Mr. Chougule said each individual marquee has turned down advertisements worth USD 50,000- 75,000 in implementing the law.

Presenter 7: Ms. Seema Gupta
Topic: Exposing TI Tactics in Implementation of 85% GHW's through Policy & Political Advocacy

Ms. Seema Gupta noted that the tobacco industry uses its enormous wealth and influence to market its deadly products. Even as advocacy groups and policy makers work to combat industry influence, new tactics are used by companies and their allies to bypass tobacco control laws. Efforts were made to get 85% pictorial pack warnings on tobacco products, in the face of opposition by the tobacco industry. Ms. Gupta highlighted the efforts made by civil society groups like the Right to Information Act, policy and political advocacy, media advocacy, letters, signature campaigns, social media, legal interventions, and RTIs to counter the tobacco industry's tactics. Shespoke about the challenges faced, the manipulation of the political and legislative process, the creation of front groups to show support for the tobacco industry, influencing and putting additional pressure through a coordinated campaign. Ms. Gupta concluded that a sustained and strategic campaign was successful in countering Tobacco industry interference.

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PROFFERED PAPERS 9: TOBACCO CONTROL LAW: CHALLENGES AND MEASURES FOR EFFECTIVE IMPLEMENTATION

Chairs:
Mr. Praveen Sinha
Mr. Ranjit Singh
Dr. L. Swasticharan

Presenters:

Presenter	Topic
Dr. Jael Thomas	Prohibition of Tobacco Sales near Educational Institutions May Stop Minors from Accessing Tobacco Products – A Cross Sectional Study in Karnataka
Mr. Sameer Narake	AssessingImplementation of Ban on a Smokeless Tobacco Product, Gutka, in Two Large Cities of Maharashtra and Madhya Pradesh States in India
Dr. Gopal Chauhan	What is the Way Forward for Strengthening Tobacco Control in India? Critical Analysis of Tobacco Control Strategies in Relation to GATS-2 report
Dr. Tanu Anand	Awareness about Anti - Smoking Laws and Legislations among the General Population in Slums of Delhi, India
Dr. Pragati Hebbar	Realistic Evaluation of COTPA Implementation
Dr. Nirlep Kaur	Effective Use of the Legal Metrology Act (2009) to Curb the Sale of Smuggled/Illicit Cigarettes – a Case Study from Punjab, India

Ms. Seema Gupta	**Topic:**Exposing TI Tactics in Implementation of 85% GHW's through Policy & Political Advocacy

Presenter 1: Dr. Jael Thomas
Topic: Prohibition of Tobacco Sales near Educational Institutions May Stop Minors from Accessing Tobacco Products – A Cross Sectional Study in Karnataka

Dr. Jael Thomas spoke about Section 6 of the COTPA 2003, which prohibits the sale of tobacco products within hundred yards of educational institutions. Violators are punishable with a fine of INR 200. A cross sectional study conducted in 10 districts of Karnataka conducted in 2013 revealed only 24% of the 3307 public and private primary, secondary, and college educational institutions had a sign stating the ban on sale of tobacco products within 100 yards.In fact, some 40%of the sales occurred within 100 yards of these institutions. In 2015, after regular enforcement, about 69% of the same institutions displayed the signage and only 12% of the sales took place within 100 yards. Dr. Thomas concluded that regular enforcement of COTPA is the only way to reduce and curb the access to tobacco by minors.

Presenter 2: Mr. Sameer Narake
Topic: AssessingImplementation of Ban on a Smokeless Tobacco Product, Gutka, in Two Large Cities of Maharashtra and Madhya Pradesh States in India

After giving some background on how gutka is made and how it has become a major contributor to oral cancer, Mr. Sameer Narake provided specifics on the prevalence of gutka use among adults (8.2%) as per GATS2. He also quoted the FSSA rule of 2011 which prohibits the use of tobacco and nicotine as an ingredient in any food product, adopted by Madhya Pradesh and Maharashtra in 2012. He said a cross sectional study was conducted to evaluate the implementation of the ban in Mumbai and Indore in May-June 2013, in which 40 kiosks were observed and 1003 ever gutka users were surveyed. It revealed the pattern of availability and the vendors' pattern of selling the product. In Mumbai no kiosks displayed gutka, but in Indore, 7 out of 10 kiosks had gutka products on display. In Mumbai 7% and in Indore 85% of ever users said gutka was easily available. In Mumbai only regular customers, while in Indore generally any customer could buy it. Mr. Sameer Narake concluded that enforcement of the law is sub optimal in both states, but that observation suggests that better enforcement was being done in Mumbai compared to Indore.

Presenter 3: Dr. Gopal Chauhan
Topic: What is the Way Forward for Strengthening Tobacco Control in India? Critical Analysis of Tobacco Control Strategies in Relation to GATS-2 report

Observing the change in adult tobacco use prevalence from the two rounds of the GATS,Dr. Gopal Chauhan said that while the prevalence of tobacco has gone down significantly overall

(34.6% to 28.4%), it has increased by over 10 in a few states, including Goa, Punjab, Tripura , Assam and Tamil Nadu.
He elaborated on the partnership of NGOs with state government initiatives and how this helped achieve success in states like Kerala, Sikkimand Bihar. In Kerala adult tobacco use decreased from 21.4% to 12.7%.Dr. Chauhan concluded that based on the results, the Kerala model is most suitable to be replicated throughout India as it has anintermediate population size and has shown a significant decline (40%) in tobacco use.

Presenter 4: Dr. Tanu Anand

Topic: Awareness about Anti - Smoking Laws and Legislations among the General Population in Slums of Delhi, India

Dr. Tanu Anand spoke about thecross sectional study conducted among 708 slum dwellers to access the level of awareness and the status of implementation of regulations amongst slum dwellers in Delhi.She said the study revealed that a majority of male smokers (98.7%) wasalso illiterate. Some 40.9% of current smokers were found to be smoking in public places. Nearly one third of the population under study agreed to have violated the law, by smoking in public places. Only 21.5% of respondents reported having seen anyone punished for smoking in public places. Some 96% also agreed that strict action needs to be taken by the government. Dr. Anand concluded saying that the study reveals a strong case for spreading more awareness regarding COTPA among slum dwellers. It further reiterates the need for better enforcement for effective tobacco control in slum areas.

Presenter 5: Dr. Pragati Hebbar

Topic: Realistic Evaluation of COTPA Implementation

Dr. Pragati Hebbar explained that her study focused on three important parameters, 1) It described COTPA implementation across Indian states,2) It explained facilitators and barriers for COTPA, and 3) It informed implementers and policy makers about best practices for tobacco control policy implementation.
Dr. Hebbar concluded that implementation is better when specific departments are given mandates/strategies for COTPA implementation that are tailored for them

Presenter 6: Dr. Nirlep Kaur

Topic: Effective Use of the Legal Metrology Act (2009) to Curb the Sale of Smuggled/Illicit Cigarettes – a Case Study from Punjab, India

While reflecting on the negative impacts of cigarettes, Dr. Nirlep Kaur highlighted the fact that there has been a spurt in the sale of smuggled or illicit cigarettes without the stipulated 85% health warnings. Also, the products being of suspect quality, manufactured by unknown sources, only adds to the health hazards.
Dr. Kaur explained the specific packaging stipulations as per law (Rule 6 of Legal Metrology of the Packaged Commodities Rules, 2011), relevant to sale of single cigarettes, and also provided detailed insights on the repercussions/ penalties to be borne by the perpetrators. She said this

study was conducted during July to December 2017 in Punjab on enforcement methods of this law. The state government issued a letter to the Controller Legal Metrology to implement the Legal Metrology Act against the sale of smuggled/illegal cigarettes. Special teams were formed at district level under the inspectors for Legal Metrology. These teams conducted regular enforcement drives to nab the violators. A total of 169 challans ortickets were issued and Rs. 6.17 lakhs were collected in fines. Dr. Kaur concluded saying that as a result of these enforcement efforts, the sale of smuggled and illegal cigarettes declined.

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DAY 3: SUNDAY, FEBRUARY 10, 2019

9:00 am to 1:30 pm

SYMPOSIUM 5: TEN YEARS OF INDIA´S NATIONAL TOBACCO CONTROL PROGRAMME: A SUSTAINABLE IMPACT

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

9:00 AM TO 10:30 AM

Chairs:

Dr. L. Swasticharan
Chief Medical Officer
Ministry of Health & Family Welfare
Government of India

Dr. Jamie Tonsing
Regional Director,
The Union
South-East Asia

Speakers:

Speaker	Topic
Mr. Praveen Sinha National Professional Officer, World Health Organization, Government of India	FCTC vis à vis India's Tobacco Control Framework
Ms. Pooja Gupta Consultant, National Tobacco Control Programme, Govt. of India	NTCP – Implementation: Achievements and Challenges
Mr. Nalin Singh Negi Sr. Research Manager, Vital Strategies	Implementation of Film Rules: An Effective Strategy to Stop Tobacco Advertisements
Mr. Ranjit Singh Legal Expert (Supreme Court of India), Member Bar Council of Delhi	Graphical Health Warnings: Progress and Challenges in Implementation

Dr. L Swasticharan Chief Medical Officer Ministry of Health & Family Welfare Government of India	Strengthening Tobacco Cessation and Tobacco Product Testing in India

Speaker1: Mr. Praveen Sinha
Topic:FCTC vis à vis India's Tobacco Control Framework

Mr. Praveen Sinha started out by saying that the FCTC, signed on 5th February 2004, was the first Global Health Treaty. India played a key role in finalizing provisions for it. India had assented to the Cigarettes and Other Tobacco Products Act (COTPA) on 18th May 2003. The content of the articles and how they are being applied in India today is as follows:

- Article 5 (General Obligations) is instrumental in forming policies under various government departments to reduce and restrict tobacco consumption.
- Article 6 (Price and tax measures to reduce demand for tobacco) is one of the most cost effective strategies of tobacco control: The Indian government has recently implemented GST of 28 % on tobacco goods and 18 % on tendu leaves.According to a WHO study, tobacco products were affordable in India even after the implementation of high tax due to the pricing not being indexed as per inflation. WHO recommends that tax levied should be at least 70% of the MRP for effective control. As bidi is an indigenous product, it was not placed in the high tax slab until recently.
- Article 8 (Protection from exposure to Tobacco Smoke): In the definition of public places restaurants and hotels with seating capacity of 30 persons or more, a separate provision for a smoking area or space may be made.
- Articles 9 & 10 (Regulation of the contents of tobacco products and disclosures thereof): Laboratories for tobacco product testing have been recently set up by the Ministry of Health and Family Welfare.
- Article 11 (Packaging and labelling of tobacco products): Tobacco product packages have to carry a warning label along with graphic illustration of patient photographs covering 85% of the package as well as quit line numbers.
- Article 12 (Education, communication, training and public awareness): Multiple short films were presented to audience before movies during the free time available. Training Modules were also developed for NCTP staff.

- Article 13 (Tobacco advertising, promotion and sponsorship): Advertisements at the point of sale reduce effectiveness of the law prohibiting advertisements generally. Limitations of advertising on social media and web content are not well formed.
- Article 14 (Demand reduction measures concerning tobacco dependence and cessation): National quitlines have been set up. As many as 400 tobacco cessation centers are to be developed in district hospitals. Dental colleges are to develop a Tobacco Cessation Centre.
- Article 15 (Illicit trade in tobacco products): An intermissional group has been formed at the Ministry of Finance. Implementation of the same is pending.
- Article 16 (Sale to and by minors): Section 6 of the COTPA(2003) safeguards the rights and health of minors; however the sale of single sticks increases the affordability and accessibility of tobacco products.
- Article 17 (Provision and support for economically viable alternative activities): The Ministry of Labour and Employment initiated the skill development and training programme for bidi rollers.
- Article 20 (Research and Surveillance): GYTS was conducted in 2003, 2006 & 2009; GATS was conducted in 2009-10, 2016-17.

Speaker 2: Ms. Pooja Gupta

Topic: NTCP– Implementation: Achievements and Challenges

Ms. Pooja Gupta informed the listeners that the National Tobacco Control Programme (NTCP) has a hierarchal structure with the National Tobacco Control Cell at the apex and the District Tobacco Control Cell at the base. It was initiated in 9 states and 18 districts but quickly grew and has been implemented in 36 states and UTs and 628 districts within them.

National level activities of the NTCP:

- Support to states through Programme Implementation Plans (PIPs).
- Media awareness campaigns.
- Tobacco testing laboratories have been set up.
- Surveillance using GATS and GYTS.
- Promotion and implementation of graphic warnings on tobacco product packaging.
- Tobacco cessation services in regional languages.

District level activities:

- Establishment of functional TCCs.
- Training and capacity building of all stakeholders.
- School awareness and information, education and communication programs (IECs).

Achievements:

- 17% relative reduction in tobacco use during 2009-10 to 2016-17.
- Nasha Mukti Task Force constituted and dedicated to disease preventive and health promotion strategy for addressing tobacco, alcohol and substance abuse.
- Acceded to the Protocol to Eliminate Illicit Trade under Article 15 of WHO FCTC.
- Issued an advisory for prohibition of e-cigarettes and other devices with a nicotine delivery system.
- MoHFW has advised all states to adopt vendor licensing to protect children from getting exposed to the sale of tobacco products.
- Static and video broadcasting of anti-tobacco messages during movies.
- The Ministry of Labour is partnering to find alternative vocations for bidi rollers.
- The Ministry of Commerce through the Tobacco Board is restricting the usage of land for tobacco cultivation
- The Ministry of Agriculture initiated a crop diversity program in 10 states.
- The Ministry of Finance has included bidis in the 28% tax slab.
- Tobacco Cessation Quitlines have received 3-4 lakh calls; successful quit rate of 38%.
- India was nominated as host country for the WHO FCTC COP for 2 years and has hosted COP 7 and COP 8.

Challenges:

- A plethora of tobacco products are manufactured industrially as well as informally assembled.
- Tobacco use is a part of the socio-cultural fabric in India, thus considered as a norm.
- There are multiple litigations against tobacco control laws.
- Constant dynamic tactics are used by the industry to circumvent rules.

Solutions to overcome the challenges:

- Use existing structures like COTPA which can be modified, instead of forming new ones.
- Police and education are key verticals which must be actively involved.
- Use vertical structures instead of horizontal structures in the government.
- Training of enforcing agencies.

Speaker 3: Mr. Nalin Singh Negi
Topic: Implementation of Film Rules: An Effective Strategy to Stop Tobacco Advertisements

Mr. Nalin Singh Negi talked about Article 5 of the COTPA,which conforms to Article 13 of the FCTC,andprohibits direct and indirect Tobacco Advertising, Promotion and Sponsorship (TAPS). The COTPA extends the prohibition to the portrayal of tobacco use in films and other entertainment content. The Government of India modified the rules for Tobacco Advertising Promotion and Sponsorship (TAPS) and renamed the result the Film Rule. It mandates the screening of pre-approved public service announcements (PSAs) and a disclaimer at the beginning and middle of films and television

programs in which tobacco consumption is depicted. Running scrolls on screen while tobacco use is depicted and strong editorial justification to the Central Board of Film Certification (CBFC) on its necessity are required. They also took measures to produce hard hitting anti-tobacco campaigns to denormalise and discourage tobacco use.

A study was conducted to study the implementation and enforcement of the Film Rule in cinemas across India and on television to understand the gaps in implementation. The results obtained are as follows:

- 99% of films implemented at least 1 of the 3 components of the Film Rule.
- 97% implemented anti-tobacco health spots.
- 79% implemented an audio visual disclaimer.
- 86% implemented static messages.
- 27% implemented all 3 components.

Overall implementation of the Film Rule on television was low, only 4% of the programs observed implemented at least 2 of the 3 elements of the Film Rule. None of the television programs carried the government approved anti-tobacco health spots. Only 1 TV show carried the disclaimer in the same language of the show, as per the Film Rule. Some 65% of the television shows carried health warnings, but they were improper in font, background and placement.

An exit survey was also conducted at cinemas on a sample of 1514 people out of which 25.7% were tobacco users and 74.3% were non tobacco users. It was recorded that 89.2% of the total sample recalled seeing the tobacco scene from the movie. Around 93% of those who recalled the tobacco scene were further interviewed. The results found that:

- 60% recalled seeing the disclaimer.
- 54% recalled seeing the PSA 1and 60% recalled seeing the PSA 2.
- 53% recalled seeing the static message.

Mr. Negi concluded that theFilm Rule is a cost effective strategy implemented by the government to protect the public from tobacco promotion;it also ensures denormalisation of tobacco use. Mr. Negi also made some policyrelated suggestions as follows:

- Strengthen enforcement of the Film Rule on Television.
- Offer guidelines to the CBFC to identify and certify films carrying pro-tobacco content under the provisions of Film Rule.
- Regulate surrogate advertising like pan-masala ads.
- Extend the scope of the Film Rule to web based content.

Speaker 4: Mr. Ranjit Singh

Topic: Graphical Health Warnings: Progress and Challenges in Implementation

Mr. Ranjit Singh stated that the use of Graphic Health Warnings (GHW) is one of the most litigated issues under tobacco control. It started with The Cigarettes (Regulation, Production and

Distribution) Act, 1975. It was followed by COTPA, 2003, the Prohibition of Advertisement and Regulation of Trade and Commerce Protection Supply and Distribution Act, Section 7: Display of pictorial health warning on tobacco product packs in which the word 'pictorial' was added in 2007. Lawyer Ruma Kaushik's PIL for implementation of Specified Health Warnings (SHW) in 2004 was instrumental in implementation of the law. The specified health warning rules of 2008 state that specific health warnings shall be printed, pasted or affixed on every retail package; the warning shall occupy 40% of the principal display area on the front panel of the pack and it shall be rotated every 12 months. After an expert committee reviewed the new SHW rules, they were implemented in 2016. The rules stated that SHW shall cover at least 85% of principal display area in 60% shall be the cover picture and 25% textual health warnings, it also stated that every package shall carry i) the name of the product ii) the names and addresses of the manufacturer, importer and packager iii) the origin of the product (for importers) iv) the quantity and date of manufacture and finally v) a minimum size of packaging was fixed at 3.5 x 4 cm. After the implementation of the law, several tobacco companies that did not affix SHWs were sealed. In January 2018 the Karnataka High Court ruled in favour of public health in several litigations, based on the data released by GATS. Subsequently new GHW rules were enforced in September 2018, under which the new GHW must cover 85% of the principal packaging carrying i) images of patients suffering from oral cancers, ii) the health message 'Tobacco causes cancer' and iii) the Quitline number- 1800112356.

There are challenges that need to be overcome such as:

- Packages with no warning/old warning/inconsistent warning are still in circulation.
- Single sticks, loose sticks of cigarettes and bidis are sold.
- Promotional inserts.

Mr. Singh ended his talk by saying that later on the next step would beimplementation of plain packaging to improve the focus on the GHW carried on the packaging.

Speaker 5: Dr. L Swasticharan
Topic: Strengthening Tobacco Cessation and Tobacco Product Testing in India

Dr. L Swasticharan talked about Article 14 of the WHO FCTC, Demand Reduction Measures Concerning Tobacco Dependence and Cessationthat guides the state to:

- Design and implement effective programs aimed at promoting the cessation of tobacco use.
- Include diagnosis and treatment of tobacco dependence and counselling services for cessation of tobacco use in national health and education programs.
- Establish healthcare facilities and rehabilitation centre programs for diagnosing, preventing, counselling and treating tobacco use.
- Collaborate with other parties to facilitate accessibility and affordability of the treatment of tobacco dependence.

He said key activities of Indian Tobacco Cessation Services include the following:

- Promoting and publicizing tobacco cessation facilities
- Awareness programs
- Community based counselling
- Psychological and pharmacological treatment

The National level activities include:
- Support to the state through programme implementation plans (PIPs)
- Mass media campaigns
- Advocacy and inter-sectoral linkages
- Monitoring and evaluation (GATS & GYTS)
- Tobacco Testing Laboratories (TTLs)- 3 in phase 1
- Expansion of cessation facilities
- National Quitline and Helpline
- M-cessation
- Review and monitoring of NCTP
- Capacity building

State level activities include:
- Seeking support for NCTP from the centre through PIP
- Planning, executing and monitoring implementation of NCTP
- Integration with other programs
- IEC with other programs or individuals
- Capacity building

District level activities include:
- Implementation of NCTP at grass root levels.
- Establishment and functioning of Tobacco Cessation Centers (TCCs)
- Training and capacity building of stakeholders
- Increasing awareness programs through IECs and school awareness programs

Policy relationship - enforcement protocol includes:
- M- Monitor through GATS
- P- Protect from SHS
- O-Offer to help quit
- W- Warn about dangers of tobacco
- E- Enforce bans on tobacco counselling
- R- Raise Taxes

Opportunities for integration to develop TCCs at:
- DOTS providers (providers of Directly Observed Treatment, short-course for TB)
- NOHP
- Dental Colleges
- Medical colleges
- NACO/ICTC

- NCPDCS
- NCPDCS-Ayush Integration

National Tobacco Testing Laboratories (NTTLs) are envisioned as accredited world class laboratories engaged in providing analytical facilities for tobacco and tobacco products to generate scientific information for public health. These are located at the National Tobacco Testing Laboratory (Apex) at the National Institute of Cancer Prevention and Research, Noida;the National Tobacco Testing Laboratory at the Central Drug Testing Laboratory, Mumbai and the National Tobacco Testing Laboratory at the Regional Drug Testing Laboratory at Guwhati.

The mission of the NTTLs includes:

- Undertake analysis of smoking and smokeless tobacco products through latest equipment and experimental facilities.
- Participate in the generation of global testing protocols, round robin tests, method validation and development of analytical method for tobacco products.
- Undertake relevant research to develop new technologies including sensor materials and biomarkers for tobacco analysis as well as safe disposal of tobacco related wastes.
- Provide scientific analytical information to NCTP.
- Share information and knowledge including technical knowledge with others.

Current status of the NTTLs:

- Major sophisticated equipmentis installed.
- Semi major equipment is in progress for procurement.
- Key scientific manpower and support staff is in place.
- Preliminary testing has been initiated in all 3 labs.
- Adaptation of the standard operating procedures (SOPs) is being done.
- Collaboration with research institutes and central government institutes.
- Chemical and biological profiling of tobacco products is planned.

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SYMPOSIUM 6: TOBACCO CONTROL: HEALTH PROFESSIONALS AND AYUSH

LECTURE ROOM-1, HOMI BHABHA BLOCK

9:00 AM TO 10:30 AM

Chairs:
Dr. Dilip Kumar Acharya
Dr. Y.P. Muley

Speakers:

Speaker	Topic
Dr. Dilip Kumar Acharya Chairman IMA National Cancer & Tobacco Control Committee Indore, Madhya Pradesh, India	Health Hazards and Quitting Methods
Dr. Sanjay Dudhat Head, Surgical Oncology, Nanavati Hospital,Mumbai	Role of General Physicians in Tobacco Control
Dr. Vinay Hazarey Secretary, No Tobacco Association	Role of Dentists in Tobacco Control
Dr. Sandhya Shetty Vipassna Research Institute Research Council Member Mumbai, India	Significance of Vipassana in Tobacco Cessation
Ms. Swati Rane Member of Maharashtra Nursing Council	Role of Nurses in Tobacco Control

Speaker1: Dr. Dilip Kumar Acharya, Surgical Specialist, Indore

Topic: Health Hazards and Quitting Methods

Dr. Dilip Kumar said the harmful effects of tobacco are sociological as well as health related. Within health it also affects oral health along with other aspects. He highlighted the continued lack of knowledge of the ill-effects of tobacco by the public despite various efforts by the government.

He also highlighted the need of strengthening the health system as it needs to be supportive and aware of the needs of individuals who either need help in quitting tobacco and/or are affected by tobacco. He said that many

successful cases of quitting are non-pharmacologically assisted where the tobacco users have been able to stay away from tobacco through awareness about the harmful effects of tobacco. Additionally, supportive environments are also helpful to individuals in the process of quitting tobacco.

Dr. Kumar spoke about individuals who are part of oral health care like dentists who need to be trained in advising patients to quit tobacco use as they see the effects of tobacco on their patients. They should also be able to provide support in order to help them stay away from tobacco.

Speaker 2: Dr. Sanjay Dudhat
Topic: Role of General Physicians in Tobacco Control

Dr. Dudhat stated that the impact that tobacco has on individuals makes it a global health hazard. He said that the greatest role which a doctor can play is to speak about the ill-effects of tobacco. The stature which doctors enjoy in society through the trust reposed in them can lead to many leaving tobacco with the doctor's support and guidance. Doctors can be the role models for other professionals as well in spreading awareness about the ill-effects of tobacco. The reason doctors normally do not discuss tobacco with their patients is because not all doctors are involved in tobacco control. There are also challenges of time constraints and the lack of capacities of doctors to engage in effective tobacco control if they are not trained in counselling. Dr. Dudhat added that irrespective of the huge efforts of tobacco control in the country tobacco is still not seen as a serious health issue by many doctors. There is also a lack of training of health professionals at the medical schools about tobacco. Moreover, not all health professionals are aware of the laws and policies related to tobacco. One of the first things which doctors can do, Dr. Dudhat said, is that they should not be tobacco users, they should then be trained, then spread awareness about the ill-effects of tobacco. They need to be patient with patients facing challenges to quit tobacco. They will then become role models who would be able to bring change in society. The media should also hold awareness campaigns which should include print media, social media, various public lectures, through which people can be responsive to tobacco control. At the end also, Dr. Dudhat reiterated that all health professionals including doctors are role models to society and thus they should not be tobacco users.

Speaker 3: Dr. Vinay Hazarey
Topic: Role of Dentists in Tobacco Control

Dr. Hazarey spoke about the three -pronged approach towards tobacco control within oral health:

1) Management of oral pre-cancer, like the oral pre-cancer algorithm for detection

2) Skilful counselling as playing a key part in success rates in quitting tobacco
3)Duties of health professionals as part of tobacco control.

Dr. Hazarey added that dentists should be able to give full support to individuals trying to quit tobacco. He also spoke about the various dental colleges that can become strong centres for advocacy. He also added that there is a dire need to prioritise pre-cancer detection in dentistry as it can be one of the major ways cancer is prevented. Lastly, Dr. Hazarey added that in order to include a holistic approach towards tobacco control one should also include aspects of yoga and Vipassana within the framework and policy of tobacco control.

Speaker 4: Dr. Sandhya Shetty
Topic: Significance of Vipassana in Tobacco Cessation

Dr. Shetty started by stating there is a huge knowledge implementation gap for Vipassana. She stated that through Vipassana one can see the curbing of immediate impulses towards consumption of tobacco. She also explained that there have been scientific studies by NIMHANS, which demonstrate how Vipassana is able to help patients reach psychological wellbeing. Dr. Shetty then gave a demonstration of Vipassana (a breathing exercise) to the audience.

Speaker 5: Ms. Swati Rane
Topic: Role of Nurses in Tobacco Control

Ms. Rane spoke about the lack of knowledge within communities of doctors and nurses about counselling. She stated that there is a need to equip doctors and nurses with the skills of counselling. She also pointed out that there are nurses at all levels from ANMs, ASHA, PHCs workers, many who are consumers of tobacco themselves, and thus there is a need to do an assessment on the ground of training needs of all these categories of nurses in order to gauge the kind of changes which need to be brought. She also spoke about how tobacco cessation can be done at various levels by involving and training nurses who work on the ground, such as Anganwadi Workers, village leaders, and ASHA workers. She also included the importance of including and systematically identifying all tobacco uses in schools and further integrating tobacco control activities with ongoing school health programmes of the State.

A prioritisation also needs to be made for communities which have high tobacco usage in both the rural as well as the urban areas. Ms. Rane also pointed out that various frameworks which need to be included while assisting individuals trying to quit include the Frames Model (Miller and Sanchez 1994), which should also include post cessation interventions to see that patients are not relapsing. She added that nurses are an important part of follow-up for tobacco cessation.

She illustrated the various challenges which nurses face within their role of tobacco control:

- Lack of integration of tobacco cessation treatment into standard nursing practice
- Nurses lack knowledge, skills and confidence in participating in cessation programs
- Nurses lack formal training in smoking cessation and tobacco control has not traditionally been a part of nursing practice

- Smoking status of nurses themselves needs to be assessed

Ms. Swati Rane concluded by saying that nurse counselling training programs should include modules on health education and behaviour modification to improve their competence in helping smokers to quit. Additionally, nursing programs should also include tobacco cessation and behaviour modification, techniques which should be covered specifically within a nursing school curriculum.

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PROFFERED PAPER 10: IMPLEMENTING GOOD GOVERNANCE IN TOBACCO CONTROL THROUGH MULTI-STAKEHOLDER INVOLVEMENT

LECTURE ROOM-1, HOMI BHABHA BLOCK

9:00 AM TO 10:30 AM

Chairs:
Dr. Rakesh Gupta
Deputy Director
Department of Health & Family Welfare
Punjab, India

Dr. Amit Yadav
National Institute of Cancer
Prevention & Research
Noida, India

Presenters:

Presenter	Topic
Dr. Somil Rastogi	A Case Study on Engaging MLAs of West District in Delhi for Tobacco Control Activities
Mr. Binoy Mathew	Media Advocacy for Building Support for Taxation of All Tobacco Products at the Highest Rate under the New Goods & Service Tax (GST) Regime
Ms. Bhavna Mukhopadhyay	Advocacy for Taxation of All Tobacco Products at the Highest Rate under the New Goods & Service Tax (GST) Regime through High Level Political & Policy Advocacy
Dr. Upendra Bhojani	Politics of Tobacco: Elected Leaders' Concerns about Tobacco in India
Mr. Sandeep Gawade	Empowering Teachers to Implement Tobacco Free School Campaign in Schools
Dr. Himanshu Gupte	Training on Evidence-Based Brief Advice for Tobacco Cessation Interventions for Health Care Professionals in Mumbai, India
Mr. Vivek Awasthi	Leadership Development and Building Capacity of Officials for Actions on Tobacco Control
Ms. Sukriti Jain	Building and Activating a Sustainable Enforcement Mechanism of Tobacco Control Laws in Police Department of Uttar Pradesh, India

Presenter 1: Dr. Somil Rastogi

Topic: A Case Study on Engaging MLAs of West District in Delhi for Tobacco Control Activities

Dr. Somil Rastogi began by saying that when found not following the COTPA rules and regulations, tobacco vendors often take the names of political leaders as an escape route from being penalized for not following COTPA rules. He said that to ensure COTPA implementation, community mobilization by MLAs was found to be important. During this survey conducted by Sambandh Foundation, MLAs and DCPs of West District of Delhi were sensitized to help non-users and children to avoid tobacco initiation by informing them of the harmful health effects of tobacco and the current laws that prohibit tobacco sale to minors and the ban on sale of tobacco within 100 yards of educational institutions. The constituencies that were covered included: Tilak Nagar, Hari Nagar, Janakpuri and Vikaspuri. On 25th June 2018 and 2nd July 2018, Police fined violators of Section 4 and 6 of COTPA at prominent public places while MLAs as a gesture of Gandhigiri offered them rose sticks with an appeal to comply with the law. MLAs also placed posters of COTPA in their office to appeal to the masses to comply with it. The people were so motivated with the involvement of MLAs that they supported the MLAs whole heartedly for this social cause. Coordination with the police was also done and instructions were released to ACsP and SHOs for the drive. Enforcement was carried out using the principle of Gandhigiri in the entire West Delhi district. It was found that the MLAs have a huge social media following. They used this platform as well to appeal to the masses to comply with COTPA regulations. The MLAs also took personnel from Sambandh Foundation involved in this survey to the Health Minister to advocate for further tobacco control initiatives. Dr. Somil Rastogi concluded that policy makers can play a crucial role in tobacco control.

Presenter 2: Mr. Binoy Mathew
Topic: Media Advocacy for Building Support for Taxation of All Tobacco Products at the Highest Rate under the New Goods & Service Tax (GST) Regime

Mr. Binoy Mathew said the Voluntary Health Association of India (VHAI) kept the media involved by one-to-one interaction with Sjournalists and their op-eds and press releases highlighting the dangers of tobacco use among the masses. This media intervention strategy resulted in 563 earned media stories on GST generated during the period from March 2016 – June 2017. These included occasionalop-eds in key national dailies on tobacco taxation, media outreach nationwide for higher taxes and taxes on tobacco covered in all the national dailies and 13 vernaculars. Mr. Binoy Mathew concluded that as a result of this effort with the media, tobacco has been taxed at the highest demerit rate of 28%+ cess.

Presenter 3: Ms. Bhavna Mukhopadhyay
Topic: Advocacy for Taxation of All Tobacco Products at the Highest Rate under the New Goods & Service Tax (GST) Regime through High Level Political & Policy Advocacy

Ms. Bhavna Mukhopadhyay narrated how the VHAI team sensitized all senior policy makers in the Finance Ministry including the GST council members:the Finance Minister (FM) and key state FMs, with evidence and research based representations. The strategies that were used included:

1) Stakeholder mapping and engagement
2) Coalition Building
3) Government engagement
4) Monitoring political dynamics
5) Media Advocacy

She said twelve hundred letters were sent and forty one-to-one meetings held to advocate for all tobacco products (including bidi) to be taxed at the highest GST rate. Arguments were modified on the basis of parliamentary sessions, political changes, tracking the GST council meetings and tobacco industry interference. Ms. Mukhopadhyay concluded that as a result of the VHAI sensitization programme, tobacco products have been taxed at the highest demerit rate of 28%+ cess. For cigarettes, cess has been further increased.

Presenter 4: Dr. Upendra Bhojani

Topic: Politics of Tobacco: Elected Leaders' Concerns about Tobacco in India

Dr. Upendra Bhojani described a study on the concerns of elected leaders on tobacco. Questions and debates by parliamentarians in the Lokasabha and the Rajyasabha between July 2014 and March 2018 were searched using the term 'tobacco' while searching the archives. As many as 463 questions and 114 debates were found relevant, of which 242 questions and 66 debates were selected for analysis based on their relevance. He said that after selecting these questions and debates, dominant themes were identified that defined the concerns raised by various political leaders. Five major concerns were identified:

1) Health concerns which included trends in tobacco use; health harms of tobacco; costs/expenses related to tobacco use and illnesses and to provide cessation support.
2) Agricultural concerns which included tobacco yield; alternatives to tobacco farming; and support for tobacco farmers.
3) Trade concerns which included concerns on trade in illicit products; export of tobacco; tobacco units in Special Economic Zones
4) Taxation concerns which included concerns related to Goods and Services Tax; revenue collection and its use and different taxation rates on different products.
5) Tobacco control policies which included concerns on implementation of new policies as well as amendments to the existing ones.

Dr. Bhojani concluded by saying that understanding these concerns is essential for better implementation of tobacco control policies and formulation of new ones.

Presenter 5: Mr. Sandeep Gawade

Topic: Empowering Teachers to Implement Tobacco Free School Campaign in Schools

Mr. Sandeep Gawade described how Salaam Bombay Foundation (SBF) in collaboration with education departments of Mumbai West, Mumbai North, Thane and Pune – the largest municipalities in Maharashtra – introduceda tobacco free school campaign in all government and aided schools in Mumbai, Thane and Pune. He said the campaign included sensitization of education officers. Sensitized education officers announced the 'Tobacco Free School Campaign'

by sending notices to schools under their jurisdiction and called for principals' meetings. The principals were sensitized in ward-wise meetings in the presence of education officers who instructed them to identify a nodal teacher to lead the tobacco free school campaign. The SBF team trained 303 nodal teachers through ward-wise training in implementing tobacco control workshops and implementing eight criteria for tobacco free school (TFS). 109 schools formed Balpanchayats. More than 1,500 children participated in tobacco control activities. Mr. Gawade said that at the end of the campaign, 80schools achieved tobacco free status by fulfilling eight out of eleven 'Tobacco Free School Criteria'.

Presenter 6: Dr. Himanshu Gupte

Topic: Training on Evidence-Based Brief Advice for Tobacco Cessation Interventions for Health Care Professionals in Mumbai, India

Dr. Himanshu Gupte described a study conducted among health care professionals from different settings to explore whether sensitization training leads to their improved capacity to offer brief advice. He said LifeFirst training of one-day duration was offered to health care professionals from public and private hospitals, medical and dental schools, government primary healthcare centres, non-governmental organizations, and private medical practitioners. The training included an overview on smoking and smokeless tobacco, tobacco control policies, tobacco dependence and practical skills for using the 5As framework. Sensitization training sessions were able to increase participants' knowledge, skills, and self-efficacy to deliver brief advice. Dr. Gupte concluded that scaling up tobacco cessation programmes based on findings from this study is possible across various health professional institutions.

Presenter 7: Mr. Vivek Awasthi

Topic: Leadership Development and Building Capacity of Officials for Actions on Tobacco Control

Mr. Vivek Awasthi described how the Uttar Pradesh Voluntary Health Association or UPVHA is a state level network of NGOs working on tobacco control in Uttar Pradesh since 2008 with support of The Union and providing technical support to the State Tobacco Control Cells (STCCs) and District Tobacco Control Cells (DTCCs) in implementation of COTPA and advancing tobacco control activities in the state. He said UPVHA provided technical support in creation of District and Sub-district level institutional frameworks, including creation of DTCCs, nomination of departmental nodal officers, creation of enforcement squads, development of enforcement plans, drafting of notifications, printing and distribution of challans and fine books. UPVHA provided technical support to the STCC in capacity building of enforcement officials in enforcement activities, declaration of tobacco free institutions, Gram Panchayats and depositing of fines. Mr. Awasthi said that as a result of the efforts of UPVHA, the institutional framework for tobacco control was set up across the state, regular enforcement started in 35 districts out of 75. Also more than 300 Gram Panchayats were declared tobacco free by local authorities. In addition, all government offices at district headquarters were declared tobacco free by the district administrations in Faizabad and Rampur districts.

Presenter 8: Ms. Sukriti Jain

Topic: Building and Activating a Sustainable Enforcement Mechanism of Tobacco Control Laws in Police Department of Uttar Pradesh, India

Ms. Sukriti Jain spoke about how state and district level police personnel in Uttar Pradesh were trained and sensitized on COTPA through guidebooks developed by VHAI. She said they were trained for providing technical inputs on monitoring violations and imparting innovative ideas for ensuring designated tobacco free zones such as Police Stations, Hospitals, Schools and Courts as mandated in Section 4 of COTPA. This ensured increased involvement of other stakeholders (Education, Health, FDA, Tourism, Transport and Urban Development) in tobacco control activities in UP. Ms. Jain concluded saying a strong mechanism was developed to review violations that included issuing of circulars by senior police officials at state and district levels, inclusion of COTPA in the training syllabus of newly appointed police officials and the formation of an enforcement squad that also comprised members from other departments.

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PROFFERED PAPER 11: TOBACCO CONTROL AWARENESS AND ADVOCACY: INNOVATVE INTERVENTIONS

BOARD ROOM, GOLDEN JUBILEE BLOCK

9:00 AM TO 10:30 AM

Chairs:

Mr. Pranay Lal
Senior Technical Advisor
The Union

Dr. Kunal Oswal
Public Health Lead
Tata Trusts- Cancer Care Programme

Presenters:

Presenter	Topic
Mr. Narayan Lad	In School Preventive Health Programme: Reducing Tobacco Addictions and Under Nutrition in Underprivileged Children.
Dr. Vijaya Hegde	A Community Based Cross Sectional Study on Second and Third Hand Smoke Exposure among Rural Women: A Neglected Public Health Challenge in India.
Mr. Dipesh Thakker	Digitization of Monitoring Process
Ms. Gauri Mandal	School Based Tobacco and Areca Nut Cessation Programme for Adolescents in Mumbai.
Dr. Prachi Kerkar	Effects of Tobacco Control Intervention on Production Workers at Manufacturing Worksites in Maharashtra.

Presenter 1: Mr. Narayan Lad

Topic: In School Preventive Health Programme: Reducing Tobacco Addictions and Under Nutrition in Underprivileged Children.

Mr. Narayan Lad began by saying that many children in Mumbai slums live in extreme poverty. They are susceptible to undernutrition and infectious diseases. Due to hunger they often turn to addictions, especially tobacco, which is easily available near their homes and schools at low cost. The In-School Preventive Health Programme of Salaam Bombay Foundation, designed for 7th to 9th graders, with tobacco control and life skills was being implemented in 309 municipal schools. He said the

Nutritional Awareness Component, added in 2018, is being piloted in 100 schools with over 12,000 students, along with tobacco control sessions. It begins with teacher sensitization followed by in-school workshops for students and community awareness sessions for parents, followed by more activities at school. Student strained in the nutrition awareness programme become Health Monitors for their schools. The initiatives of the Health Monitors in raising awareness on nutrition and the need to avoid tobacco have made an impact in schools. Nutrition week conducted in schools can equip parents with good health tips to lay a healthy foundation for their children. A food festival was organized by the Health Monitors and their mothers. The mothers very enthusiastically accompanied the Health Monitors to brief the other students about healthy diets and the value of eating the right meal. There was a great influence of the Health Monitor on other children. Mr. Lad concluded that it is very important to train principals and teachers in these concepts of nutrition and tobacco control.

Comment by a Chair

Mr. Pranay Lal commented that innovations can have a wider and more effective impact in weaning children away from tobacco. He also suggested we should transition from policy to action and action back to policy.

Presenter 2: Dr. Vijaya Hegde

Topic: A Community Based Cross Sectional Study on Second and Third Hand Smoke Exposure among Rural Women: A Neglected Public Health Challenge in India.

Dr. Vijaya Hegde said that studies have shown that the use of tobacco is higher in rural areas. Many rural women are exposed to second-hand smoke (SHS) and third hand smoke (THS) at home (smoke particles remaining on surfaces). Restricting smoking at home is a challenge for women.She said people are unaware that it affects the intrauterine environment and there may be growth retardation.A cross sectional study of 753 rural women with children was conducted near Mangalore.Two thirds of them believed SHS was harmful to children and nearly one fourth did not allow anyone to smoke near their children. Rural women were less empowered; their role was only to perform household chores.Exposure to tobacco smoke was not avoided at home.Restricted house spaces where there are no balconies, provide few choices to avoid smoking in front of the children.Dr. Vijaya Hegde concluded thatawareness needs to be created in the whole family; primary health care providers and policy makers need to be involved.

Presenter 3: Mr. Dipesh Thakker

Topic: Digitization of Monitoring Process

Salaam Bombay Foundation (SBF) is working on creating tobacco free schools in Maharashtra and seven other states, including rural areas. Since monitoring over such a wide area is difficult. SBF developed a data system for schools to upload their Tobacco Free School (TFS) status based on 11 criteria, online. An app was created and every school got a unique identification number (UID). Scalability, sustainability and stake holder management were the key buzz words. Mr. Dipesh Thakker said over 2900 schools have been declared tobacco free. In the process, paperwork and travel time were reduced. In addition, district-wise TFS status can also be accessed online.

Comment by a chair

Mr. Pranay Lal added that the Yellow line campaign is effective in to demarcating the tobacco free zone around schools: 100 yards around educational institutions. This ambitious programme can push vendors off and reduce unauthorised surreptitious sales. NGOs implementing this can build in proxy indicators like engaging with the communities. Empowering each other and responsiveness is important.

Presenter4: Ms. Gauri Mandal

Topic: School Based Tobacco and Areca Nut Cessation Programme for Adolescents in Mumbai.

Ms. Gauri Mandal began by saying that in India, around 14.6% of children aged 13-15 years use tobacco. She moved on to describe the LifeFirst School Cessation Programme of SBF, which offers tobacco and supari cessation services in schools catering to children of lower socioeconomic status in Mumbai. She said that in 2017-18, the initial orientation programme in 40 schools was attended by over 4000 students. About one third of these children registered for the full LifeFirst cessation programme. Sessions were conducted through videos, games and role plays over a period of six months on themes including rapport building, the ill effects of tobacco, counselling, use of coping mechanisms and developing refusal skills. Tobacco use in multiple modes, dual use of smokeless tobacco and either supari or smoking was noticed, resulting in reduced cessation outcome. Ms. Mandal concluded by saying that multiple follow-up group sessions reinforced the messages and promoted cessation.

Comment by a chair

Mr. Pranay Lal voiced admiration for the detailed observations by SBF staff during the programme on the tobacco habits of students attempting to quit and the outcomes of the cessation attempts.

Presenter5: Dr. Prachi Kerkar

Topic: Effects of Tobacco Control Intervention on Production Workers at Manufacturing Worksites in Maharashtra.

Dr. Prachi Kerkar introduced her topic saying that a baseline survey of production workers was conducted at 20 manufacturing worksites in 3 districts of Maharashtra to assess use of tobacco. Worksites were randomly assigned to intervention and control groups. The intervention was designed to evaluate the effects of health promotion and health protection activities aimed to create tobacco free worksites. Intervention was both at the management level and at the individual worker level. High prevalence of tobacco use was found among production workers (over 23%). She said the quit rate in the intervention group was double that in the control group. Ms. Kerkar said a follow up survey in both the groups was done at the end of intervention. Afterwards, a delayed intervention was carried out in the control group.

Suggestions by the chairs

The chairs, Dr. Kunal Oswal and Mr. Pranay Lal suggested sharing the findings from the study with the relevant policy makers for better tobacco control policy compliance. Mr. Pranay Lal suggested identifying champions; then pitchingthe idea to the Federation of Indian Chambers of Commerce and Industry.

Evidence can become a policy.He also suggested meeting the National Institute of Occupational Health, Mumbai. He emphasised that empowering each other and responsiveness are important.

CLOSING PLENARY: TOBACCO INDUSTRY INTERFERENCE

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

11:30 AM TO 1:00 PM

Chairs:

Dr. Gan Quan
Director of Tobacco Control Department
The Union

Dr. Monika Arora
Health Promotion & Tobacco Control,
PHFI, Gurgaon
HRIDAY-SHAN, New Delhi

Presenters:

Presenter	Topic
Dr. Sonu Goel Additional Professor, SPH, PGIMER, Chandigarh	What Is Tobacco Industry and TII?
Mr. Pranay Lal Senior Technical Advisor, The Union	Tracking Activities of Foundation for a Smoke Free World (FSFW) and the Need for a National Policy on FCTC Article 5.3
Dr. Amit Yadav National Institute of Cancer Prevention & Research, Noida, India	Tobacco Industry Interference in Control of SLT Use and Policy Response in India
Ms. Vaishakhi Mallik Associate Director, South Asia, Vital Strategies	Policy, Advocacy and Communication Anticipating and Countering Tobacco Industry Arguments
Dr. Upendra Bhojani Faculty and Asst. Director, Institute of Public Health, Bangalore, India	Protecting Public Policies from Industry Interference: Challenges and Opportunities

Speaker 1: Dr. Sonu Goel

Topic: What Is Tobacco Industry and TII?

Dr. Sonu Goel briefly described the tobacco industry and the 8000 year old history of tobacco from the age ofthe Meso-Americans, the gift of tobacco to Christopher Columbus (1492), Portuguese Barter Trade (1600's) and tobacco in the Mughal era. Modern history of tobacco use was discussed from the Civil War in North Carolina in 1865 to the emergence of the big four in 1911.

Tobacco Industry growth was showcased in the Indian

scenario. Tobacco industry interference (TII) was stated as creating barriers in setting and implementing public health policies for tobacco control. In this context, Article 5.3 of the FCTC was highlighted. A scoping study to document evidence on TII (Article 5.3 of FCTC) in India was discussed. Tobacco industry influences policy and administrative decision making by sponsoring government events, political parties and politicians to obtain favourable policy decisions and reversal of proposed legislation. One of the major policy loopholes is that tobacco is not considered an illegal product and no license is required by law for processing, manufacturing or selling of tobacco products, unlike for liquor. Tobacco industry interference that dissuades people from quitting (O component of MPOWER policies) includes hiding facts about the harmfulness of tobacco, fake harm reduction innovations such as filters and light cigarettes, and promotion of e-cigarettes as cessation devices. Tobacco industry inference in tobacco advertising, promotion and sponsorships (TAPS) includes normalizing and glamorizing tobacco, increasing the social acceptability of tobacco, hampering efforts to educate people about the ill effects of tobacco, including efforts to reach the young ones. Rampant TAPS activities include surrogate advertisements, creating new customer bases with attractive offers and supports and bonuses for tobacco shops and vendors. Tobacco industry interference in the R component of MPOWER (Raise taxes on tobacco) includes arguments against high taxes asserting that they lead to massive job losses and that the poor get adversely affected by higher tobacco taxes. There is also increased tax evasion. Besides all thiSs, the industry also interferes with the implementation of COTPA. Dr. Goel ended his talk saying that along with all these efforts, the tobacco industry has been historically undertaking nefarious activities to undermine public health efforts, has been misguiding stakeholders by different means and using 'dilute and delay' tactics for various public health strategies.

Speaker 2: Mr. Pranay Lal

Topic: Tracking Activities of Foundation for a Smoke Free World (FSFW) and the Need for a National Policy on FCTC Article 5.3

Mr. Pranay Lal described the rise of tobacco industry foundations and their progress so far. In India, corporate social responsibility (CSR) contributions by tobacco industries and allied sectors accounted for Rs. 776.54 crore, out of which the ITC had the maximum contribution followed by Godfrey Philips, the DA Group, Miraj, VST, Borsad tobacco, and Sopariwala. Tobacco industry initiatives to make a "smoke free foundation" started in September 2014 through Derek Yach and the Vitality Group. Various publications, news and tactics used by smoke free world were discussed like Yach's year-end blogs, comparisons on the relative safety of snus with gutka in India, their strategic plan for 2019-2021. Ogilvy CommonHealth India, Conrad Foundation, Conrad Challenge and various vaping associations have been advocating harm reduction and new technologies, finding alternatives to bidi rolling and bidi use. These are a few initiatives under the Foundation for a Smoke-Free World in India. Mr. Lal emphasized that the next steps at policy level, national and sub national levelswould be mainly through policy implementation of the FCTC article 5.3 ("Act to protect these policies from commercial and other vested interests of the tobacco industry"), and through using social media alerts.

Speaker 3: Dr. Amit Yadav

Topic: Tobacco Industry Interference in Control of SLT Use and Policy Response in India

Dr. Amit Yadav emphasized the need to focus on smokeless tobacco since two thirds of the global SLT users live in India and one in five Indian adults uses SLT. He said more than 90% of SLT users were living in 13 high burden states. SLT burden in high burden states was discussed,among which Uttar Pradesh, Maharashtra and Bihar had the maximum burden. The speaker analysed expenditure on SLT. He discussed the earliest challenges in SLT control, the polluters pay principle and the ban on sale of SLT in plastic sachets, the ban on surrogate advertisements on buses, the ban on tobacco and nicotine in food under the FSS Act,2006. Further, he said, direction from the Supreme Court on banning the sale of certain SLT products was highlighted. Mr. Yadav concluded by briefly describing some recommendations on increasing the age of access to tobacco, enforcement of COTPA, 2003, enforcement of 2011 regulations under FSSA, 2006, use of the Trademarks Act, 1999 and prevention of direct or indirect advertisements of known hazardous products.

Speaker 4: Ms. Vaishakhi Mallik

Topic: Policy, Advocacy and Communication Anticipating and Countering Tobacco Industry Arguments

Ms. Vaishakhi Mallik talked about typical industry tactics used to block progress at every step namely, research, policy, implementation and adoption. Typical industry tactics include illegal distribution and cross border smuggling to deter policies on raising taxes, global campaigns encouraging youth to be adventurous, take risks and try new things and creating false worries about public support and harms to the local economy by curbing tobacco use.

The tobacco industry playbook includes devising billion dollar marketing budgets, promoting self-regulatory systems, voluntary codes and industry labelling regimes to head off legal regulations, targeting vulnerable populations in developing nations, funding and publishing pseudo and junk science, using front groups and trade associations to make arguments for them, using CSR to win favour, encourage goodwill and discourage legal policy.

Countering tobacco industry interference is required and can be done by using data highlighting harms and putting real stories and faces to the tobacco epidemic. This could be done by social and industrial de-normalization. A formative research study on TI perception was discussed. The #OneTobaccoTax campaign and how TII was countered with it was explained.

Speaker 5: Dr. Upendra Bhojani

Topic: Protecting Public Policies from Industry Interference: Challenges and Opportunities

Dr. Bhojani emphasized the concern about public policies, beyond just health policies, their current state and potential changes. The current major challenges include CSR initiatives which enable the tobacco industry to enhance its image building and create avenues for policy confluence. The ITC Ltd. (cigarette manufacturer) appears as a supporter of the NITI Aayog for the aspirational districts programme. Public Investment in tobacco companies is another challenge along with intimidation by tobacco companies to governments. Retired government servants are observed as current board members of companies which they used to regulate earlier. Political donations by tobacco companies are another challenge. The reforms in finance regulation with the introduction of the election bonds scheme have made addressing it more difficult by removing caps on corporate donations and making the identities of donors anonymous.

Talking about opportunities to protect public health policy, Dr. Bhojani highlightedthe adoption of policies in line with article 5.3 of FCTC (protecting public health policies from tobacco industry interference). Several state governments have already adopted such a policy. While this is encouraging and there is hope that other states would also consider adopting such policies, he said there are other mechanisms we need to consider while thinking of a policy framework to prevent tobacco industry interference. In the past, filing of PILs by concerned citizens has made a difference particularly when the demand is for a new policy measure like this. Other avenues could include service rules for officials, codes of conduct for elected representatives and others, an ongoing discourse on business and human rights, ethical investments as well as voluntary initiatives. Considering the blurring of boundaries of what we define as industry, there is a need for engaging with farmers/workers, and seeing some industry funding going to research and NGOs, Dr. Bhojani made a plea for developing a code of ethics by and for the tobacco control community.

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CLOSING CEREMONY

RUSTOM CHOKSI AUDITORIUM, GOLDEN JUBILEE BLOCK

1:00 PM TO 1:30 PM

The closing plenary was followed by the closing ceremony. The ceremony began with the announcement of winner of bidding for 5th NCTOH. Dr. Sonu Goel from PGIMER, Chandigarh represented his organization that had put and won the bidding to host 5th NCTOH. He made a small presentation on Chandigarh and PGIMER Institute and invited all the delegates to 5th NCTOH which is being organized at PGIMER Chandigarh from 25-27th September 2020.

This was followed by vote of Thanks. Ms. Tshering D. Bhutia, Vice President, Salaam Bombay Foundation gave vote of thanks and thanked all the people, organizations and institutes who took efforts to make this conference successful.

In the end, Dr. P.C.Gupta, President of 4th NCTOH officially announced the closure of 4th National Conference on Tobacco or Health.

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TH NATIONAL CONFERENCE ON TOBACCO OR HEALTH

We, the participants of the 4thNCTOH assembled at Tata Memorial Hospital, Mumbai on 8-10 February 2019 hereby make the following declaration:

17% relative reduction in tobacco use showed India's commitment to curb the tobacco epidemic. Despite such a strong and passionate commitment to reduce tobacco use countrywide, some challenges ineffective enforcement of FCTC and COTPA 2003and interference by tobacco industry still exist.

The 4thNCTOH through its theme ***'Tobacco Free Generation'*** not only provided us the platform to collectively share the vision for a 'Tobacco Free India' but also helped us to develop a concrete multi-sectoral action plan to move ahead to protect upcoming generations from menace of tobacco and achieve the ultimate goal of making India "Tobacco Free".

In order to achieve our goal of "Tobacco Free India" we recommend implementation of following steps:

1. **Focus on:**
(a) Comprehensive mass awareness and education on harms of tobacco use and benefits of quitting; and, Strengthen tobacco cessation delivery countrywide**;**
(b) Amendments in COTPA 2003 to plug all its loop-holes; and, ensure its optimal enforcement for all its notified rules uniformly, specifically by amending the clause on accountability of the enforcers for delay or inaction;
(c) Persuading Central Government to divest from tobacco industry through LIC and other portals;
(d) Creation of alternate crops and jobs for tobacco cultivators and workers (industry and informal bidi sector) respectively;
(e)Elimination of tobacco-specific environment pollution; and,
(f) Preservation of human rights of the users, industry workers and cultivators

2. Augment youth-specific initiatives by:
(a) Prioritizing control of smokeless tobacco, which is often a gateway to smoking, alcohol and other addictions;
(b) Strategizing a full-proof control on emerging new products such as various forms of ENDS, Heat not Burn products, etc. including their online and illegal sale;
(c) Curbing all kinds of tobacco advertisements from the digital media that influence adversely; and,
(d) Deciding on timeline for Tobacco-free Generation in India- We propose 1st January 2025 as the cut-off date.

3. Counter tobacco industry interference by:
(a) Developing a policy for compliance of article 5.3 of FCTC that disallows governmental- and corporate- investments in tobacco industry
(b) Raise tobacco taxes to the levels recommended by WHO which is 75% of the retail price of the tobacco products;
(c) Control illegal trade practices through the introduction of the stringent legal measures.

4. **Link Tobacco Control (TC) with NCDs and SDGs**
Identify critical opportunities to strengthen tobacco control policies within the ambit of NCDs and SDGs.
Evaluate the strategies of National Tobacco Control Programme (NTCP) and align them with the other programmes being implemented for prevention of NCDs
MEDIA IMPRESSIONS

No.	Publication	Type	Date
1	Times of India	Print	10-Feb-2019
2	Times of India	Print	12-Feb-2019
3	Hindustan Times	Print	10-Feb-2019
4	Hindustan Times	Print	12-Feb-2019
5	DNA	Print	9-Feb-2019
6	DNA	Print	10-Feb-2019
7	The Hindu	Print	9-Feb-2019
8	Indian Express	Print	9-Feb-2019
9	Maharashtra Times	Print	9-Feb-2019
10	Maharashtra Times	Print	9-Feb-2019
11	Loksatta	Print	10-Feb-2019
12	Lokmat	Print	9-Feb-2019
13	Lokmat	Print	10-Feb-2019
14	Pudhari	Print	9-Feb-2019
15	Pudhari	Print	10-Feb-2019
16	Sakal	Print	12-Feb-2019
17	Prahaar	Print	11-Feb-2019
18	Apala Mahanagar	Print	9-Feb-2019
19	Tarun Bharat	Print	11-Feb-2019
20	Tarun Bharat	Print	12-Feb-2019
21	Navrashtra	Print	11-Feb-2019
22	Pratakal	Print	9-Feb-2019
23	Navashakti	Print	9-Feb-2019
24	Mumbai Lakshadeep	Print	11-Feb-2019
25	Mumbai Mitra	Print	11-Feb-2019
26	Gujarat Samachar	Print	10-Feb-2019
27	Gujarat Samachar	Print	10-Feb-2019
28	Janmabhoomi	Print	9-Feb-2019
29	Sandesh	Print	9-Feb-2019
30	DD Sahyadri News	Electronic	8-Feb-2019
31	Times of India	Online	9-Feb-2019
32	DNA	Online	9-Feb-2019
33	DNA	Online	12-Feb-2019
34	Mumbai Mirror	Online	12-Feb-2019
35	The Hindu	Online	9-Feb-2019
36	Indian Express	Online	9-Feb-2019
37	Daily Hunt	Online	9-Feb-19
38	Governance Now	Online	11-Feb-2019
39	Maharashtra Times	Print	13-Feb-2019
40	Loksatta	Print	13-Feb-2019

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