CATCH Approach for Smokeless Tobacco Cessation in the South-East Asia Region

A technical report on gaps, challenges and opportunities for smokeless tobacco cessation in five countries of the South-East Asia Region
Acknowledgements

Under the aegis of Dr Thaksaphon Thamarangsi, Director, Department of Noncommunicable Diseases and Environmental Health (NDE), this document was prepared by the Tobacco Free Initiative (TFI).

Dr Jagdish Kaur, Regional Adviser, TFI/NDE, conceptualized and developed this report with inputs from Dr Vinayak Prasad, Programme Manager, TFI, WHO headquarters and Dr Dongbo Fu, Medical Officer, Department for Prevention of Noncommunicable Diseases, WHO headquarters.

Dr Arvind Vashishta Rinkoo coordinated the technical content of this report.

We also extend sincere thanks to Member States for their contributions towards the development of this report.
Contents

Abbreviations ............................................................................................................................................. v

Introduction .................................................................................................................................................. 1

Methodology ............................................................................................................................................... 3

Need/demand analysis ................................................................................................................................. 5
The need ....................................................................................................................................................... 5
The demand .................................................................................................................................................. 6
The need–demand interplay .......................................................................................................................... 7

The supply-side scenario .............................................................................................................................. 10
Existing health capacities ............................................................................................................................. 10
Regional good practices ............................................................................................................................... 13

Challenges and opportunities .................................................................................................................... 17
Limited number of good practices on SLT cessation in the Region ............................................................... 17
Resource crunch .......................................................................................................................................... 18
Inadequate training and capacity building on SLT cessation ..................................................................... 19
Lack of an enabling environment ............................................................................................................... 20
Absence of multi stakeholder engagement and partnership ........................................................................ 20

Conclusion and recommendations ............................................................................................................. 22

Bibliography ................................................................................................................................................ 27
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAM</td>
<td>complementary and alternative medicine</td>
</tr>
<tr>
<td>COP</td>
<td>Conference of the Parties</td>
</tr>
<tr>
<td>CSO</td>
<td>civil society organization</td>
</tr>
<tr>
<td>CSR</td>
<td>corporate social responsibility</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
</tr>
<tr>
<td>GATS</td>
<td>Global Adult Tobacco Survey</td>
</tr>
<tr>
<td>GoI</td>
<td>Government of India</td>
</tr>
<tr>
<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>ITU</td>
<td>International Telecommunication Union</td>
</tr>
<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Programme</td>
</tr>
<tr>
<td>SLT</td>
<td>smokeless tobacco</td>
</tr>
<tr>
<td>STEPS</td>
<td>WHO STEPwise approach to surveillance</td>
</tr>
<tr>
<td>TFI</td>
<td>tobacco-free initiative</td>
</tr>
<tr>
<td>TSNA</td>
<td>tobacco-specific nitrosamine</td>
</tr>
<tr>
<td>WATI</td>
<td>web-assisted tobacco intervention</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Introduction

Tobacco is one of the greatest threats to global health today. Use of both smoking and smokeless tobacco (SLT) is associated with increased risk of chronic and terminal diseases. These encompass periodontal diseases, oral and pharyngeal cancers, myocardial infarction, stroke, erectile dysfunction and problems in pregnancy, including stillbirth and low birth weight. SLT is an addiction for millions of people worldwide, and research indicates increasing use by young individuals in many countries. SLT consumption involves chewing tobacco, often along with betel quid (betel leaf, arecanut, lime and catechu), and this is one of the most common addictions globally, particularly in the South-East Asia Region. The 11 countries in the South-East Asia Region have over 290 million SLT users, which is nearly 80% of the global figure. SLT users outnumber the estimated number of smokers in the Region. In many countries, while the prevalence of smoking is decreasing, the use of SLT is on the rise. The heterogeneity of custom-made and traditional SLT products in the Region poses an additional challenge to their regulation and testing. SLT consumption has the potential of becoming a global threat of massive proportions based on its aggressive marketing strategy, attractive packaging, flavouring and affordability.

At its fourth session in November 2010, the Conference of the Parties (COP) to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) adopted guidelines for implementation of Article 14 of the Convention on "Demand reduction measures concerning tobacco dependence and cessation" (decision FCTC/COP4[8]).

These guidelines encourage countries to:

- strengthen or create a sustainable infrastructure which motivates attempts to quit usage of tobacco, ensure wide access to support for tobacco users who wish to quit, and provide sustainable resources to ensure that such support is available;
identify the key, effective measures needed to promote tobacco cessation and to incorporate tobacco dependence treatment into national tobacco control programmes and health-care systems;

urge parties to share experiences and collaborate in order to facilitate the development or strengthening of support for tobacco cessation and tobacco dependence treatment.

Unfortunately, tobacco cessation remains a weak point in tobacco control in the South-East Asia Region. Though there is clear scientific evidence that tobacco cessation interventions are highly cost-effective public health measures, countries of the Region have failed to optimally prioritize this issue so far. This assumes greater importance in case of SLT cessation initiatives that ought to take into account a complex set of factors in the Region such as culture, religion, gender, age, educational background, socioeconomic status and the special cessation needs of SLT users.

This study aims to understand the needs and challenges of SLT cessation in five identified countries of the South-East Asia Region – Bangladesh, Bhutan, India, Myanmar and Nepal – that have high prevalence of SLT consumption among adults and youth. The study strives to identify opportunities for taking this public health agenda forward in these five countries and to lay down specific priorities for action and intervention.
**Methodology**

An initial review of the literature was done to assess the need/demand for quitting SLT use among SLT users in the five South-East Asia Region countries and to evaluate the existing capacities of the health systems in these countries to provide cessation support to SLT users. The need/demand for quitting among SLT users in the five South-East Asia Region countries—Bangladesh, Bhutan, India, Myanmar and Nepal—were primarily identified from various surveys such as Global Adult Tobacco Survey, Global Youth Tobacco Survey and national level surveys. The evaluation of the existing capacities of the health systems in these countries to provide cessation support to SLT users, including current practices and methods of SLT cessation used by health-care providers and the challenges therein, was based on information and data available with the Tobacco Free Initiative of the WHO Regional Office for South-East Asia (TFI WHO SEARO) and on the published literature.

The next phase of the review of the literate was focused on identifying the global best practices in smoking and SLT cessation. Based on the reviewed literature and the current regional practices and capacities of the health systems, future opportunities and priorities for action for the Region were identified, including those aimed at building capacity for training on SLT cessation (Fig. 1).

The study lays out specific recommendations on how the countries of the South-East Asia Region can customize and adopt the global best practices in tobacco cessation to address the special needs of SLT cessation in the Region, and on how these countries can create sustainable enabling environments to support implementation of these practices.
Fig. 1. Study methodology (centred on five identified countries of the South-East Asia Region)

- Review of the literature
  - Need/demand for SLT cessation
  - Global best practices in smoking & SLT
- Demand-supply analysis
  - Supply scenario (incl. methods & good practices)
  - Existing capacities of the health systems (incl. challenges therein)
- Gap analysis (to identify opportunities & priorities in SLT cessation)
- Recommendations
- The “CATCH” Approach (Fig. 3)
Need/demand analysis

Need is different from demand and supply. Put simply, need is what people might benefit from; demand is what people would be willing to pay for in a market or might wish to use in a system of free healthcare; and supply is what is actually provided by the health systems. Although this distinction is uncontroversial, the difficulty of measuring need makes it tempting to measure supply and demand as surrogates for need. This chapter deals with an analysis of need–demand for SLT cessation among SLT users in the five identified countries of the Region.

The need

The need for SLT cessation in the Region can hardly be overstated. Primarily, this is on account of the two factors discussed below.

Firstly, the adverse health effects of SLT are well documented. SLT causes oral cancer, oesophageal cancer and pancreatic cancer in humans. More than 30 carcinogens have been identified in SLT products, including tobacco-specific nitrosamines (TSNAs), which cause tumours affecting the nasal cavity, lungs, trachea, pancreas, liver and oesophagus in animal models. SLT use causes adverse oral health outcomes including oral mucosal lesions, leukoplakia and periodontal disease. SLT products are also associated with adverse reproductive and developmental effects including stillbirth, preterm birth and low birth weight. Many SLT products are associated with increased risk of fatal ischaemic heart disease, type 2 diabetes and fatal stroke. Additionally, SLT products contain nicotine, and users of SLT products demonstrate signs of dependence similar to those of cigarette smokers, including tolerance with repeated use and symptoms of withdrawal upon cessation of use. Notably, the proportion of cases of cancers of the oral cavity, oesophagus and pancreas that can be attributed to SLT use, i.e. the attributable fraction, is greater in countries where SLT use is highly prevalent.
Secondly, the Region is home to over 290 million SLT users, which is nearly 80% of the global number. SLT users outnumber the estimated number of smokers in the Region. Markedly, there has been increasing use of SLT products by the youth and teenagers in many countries across the Region. As per the Global Youth Tobacco Survey (GYTS), a significant increase in the prevalence of current SLT use among youth aged 13–15 years was noted in Bhutan (from 7.4% in 2004 to 21.6% in 2013) and in Nepal (from 6.1% in 2007 to 16.2% in 2011). In Myanmar, among youth, there had been a significant reduction of cigarette use (from 7.1% to 6.8%) during the 2004–2011 period. However, SLT consumption among the youth has increased during the same period from 6.5% to 9.8%. In Bangladesh and India, SLT is consumed by 4.5% (GYTS-2013) and 9% (GYTS-2009) of youth, respectively. In Bangladesh, as per the Global Adult Tobacco Survey (GATS)-2009 conducted for adults aged above 15 years, 26.4% of men, 27.9% of women and 27.2% overall (25.9 million adults) used SLT. GATS-2010 in India revealed that more than one-third (35%) of adults in India used tobacco in one form or the other. Among them, 21% adults used only SLT, 9% only smoking tobacco and 5% used smoking tobacco as well as SLT. The extent of use of SLT products was 33% among men and 18% among women. Among both sexes, the prevalence of SLT use was higher than the prevalence of smoking in India, which was 24% among men and 3% among women. Notably, this difference was more pronounced for women than for men. Also, in general, across the Region, the prevalence of SLT use was higher in rural areas than in urban areas. Similarly, SLT use was more pronounced among the low socioeconomic strata and less educated adults.

**The demand**

Unfortunately, there is a paucity of data in the South-East Asia Region on the actual demand for quitting SLT use among SLT users. In fact, tobacco cessation questions in most of the nationally representative surveys, such as GATS, GYTS, WHO STEPwise approach to surveillance (STEPS), Demographic & Health Survey (DHS), etc. conducted so far in the countries of the Region are limited to smoking cessation. However, GATS-2010 conducted in India included specific questions on SLT cessation.
The relevant findings from this survey are discussed below and can be reasonably extrapolated across the five identified countries of the Region, given the similarity in socioeconomic and other determinants of SLT use among the populations in these countries.

As per GATS-2010, 35% users of SLT in India made an attempt to quit SLT use in the 12-month period prior to the survey (the corresponding percentage among smokers was higher at 38%). Among SLT users, fewer women (29%) made a quit attempt compared to men (39%). Among the users of SLT, 8% used counselling to quit SLT and 22% used other methods. Among 47% of users of SLT who visited a healthcare provider in the 12 months prior to the survey, little more than one-third (34%) were asked by the health-care provider whether they used SLT and only 27% were advised to stop such use. In contrast, among 47% of smokers who had visited a healthcare provider in the past 12 months, a little more than half (53%) were asked by the healthcare provider if they smoked and 46% were advised to stop smoking.

Though SLT use is a greater public health problem in the Region than smoking, limited available evidence suggests that the actual demand for quitting SLT might be lower than that for quitting smoking. Moreover, the demand for quitting SLT is lower among women than among men. Besides, the health system seems to be less sensitized on the issue of SLT use and the enormous public health gains associated with SLT cessation. The fact that SLT use is deeply embedded in the cultural milieu of the countries of the Region and is more prevalent in low socioeconomic strata, uneducated individuals and the rural population further complicates the scenario.

The need–demand interplay

In the interest of public well-being, efforts should be made to aggressively convert passive public health needs into active demands. This is even more vital in the case of SLT cessation in the South-East Asia Region where the passive needs are huge, but the active demands from the community seem to be deficient. Once more and more SLT cessation needs are converted into demands which are actively sought by SLT
users, this would eventually put the much-needed sustained pressure on policy-makers and implementers to prioritize SLT cessation for action across the Region. Till SLT users in the countries of the Region start demanding quality SLT cessation services, this important public health issue may remain on the back burner for a while. Fig. 2 shows how this useful opportunity can be tapped and the barriers between need and demand can be broken in the context of SLT cessation in the countries of the South-East Asia Region.
Fig. 2. The need-demand interplay

Maximize the enablers

- High prevalence of SLT use in South-East Asia Region
- Enormous need for SLT cessation

Conversion of needs into demands for SLT cessation

Increased demand for SLT cessation

Break the barriers

- Health benefits of SLT cessation
- Decreased prevalence of SLT use in South-East Asia Region
- Increased supply of quality SLT cessation services
- Better health outcomes

1. Increase awareness of negative health impacts of SLT use in the community
2. Educate the community on feasibility of quitting SLT use with the right approach
3. Market the non-health benefits (socioeconomic, cosmetic, etc.) of quitting
4. Take steps to decrease accessibility and affordability (regulatory measures, tax, etc.)

1. Regulate aggressive marketing strategy, attractive packaging and flavouring of SLT products
2. Address the special barriers (cultural & gender-linked barriers) in the Region
3. Reach out to disadvantaged groups (rural, illiterate, poor)
The supply-side scenario

Though all the five countries of the South-East Asia Region identified for this study are parties to the WHO FCTC, none of these countries have optimally prioritized the implementation of Article 14 of the Convention related to demand reduction measures concerning tobacco dependence and cessation. In fact, the entire Region is lacking behind in the implementation of this Article. This is even more pronounced for SLT cessation vis-à-vis smoking cessation, especially in countries with high prevalence of SLT use, as additional barriers such as culture, religion, gender, age, educational background, socioeconomic status and special cessation needs of SLT users come into play. As advocated in the previous chapter, it is imperative that any increase in demand for SLT cessation in the future be met by a corresponding increase in supply of quality SLT cessation services. Until and unless this issue is prioritized for action, this appears to be a daunting task as even the existing level of supply of SLT cessation services in the South-East Asia Region is grossly insufficient to meet the current demands of those SLT users who want to quit. This chapter delves into the existing capacities of the health systems in the five identified countries to provide cessation support to SLT users, including current practices and methods of SLT cessation used by health-care providers in these countries.

Existing health capacities

The existing health capacities in all the five countries are insufficient to meet the current demands of tobacco cessation. The gap is even more pronounced if we exclusively consider the demand–supply dynamics of SLT cessation. In order to address the barriers of SLT cessation service delivery to the last mile in the Region, primary healthcare has to play a decisive role. However, the current practices and methods of SLT cessation used by healthcare providers are not in sync with the global best practices. Despite these shortcomings, several countries in the Region have initiated pilot projects to explore means and methods to address the unmet demands of SLT cessation. Some of these are cost-effective, scalable and replicable.
Bangladesh, Myanmar and Nepal do not have national technical guidelines for management of tobacco dependence. Tobacco cessation services are not offered by the public health systems in these countries. Nicotine replacement therapy is not offered under their public health programmes. No institutionalized attempts have been made to integrate tobacco cessation services into primary healthcare. There is minimal effort at the national or the sub-national level to engage civil society organizations (CSOs) in tobacco cessation. Integrating tobacco cessation with other disease control and preventive health programmes is of utmost importance for mainstreaming this issue. However, there is no policy decision in any of these countries on a formal coordination mechanism between tobacco control and any major public health programme. Tobacco cessation is not formally included in the routine training for any level of staff of any other public health programme. There is no mechanism to routinely collect tobacco related data (screening for tobacco use along with addiction level, counselling for quitting, referral for care and initiation of tobacco cessation, outcome of tobacco cessation, etc.) among registered patients from the existing reporting system of other major public health programmes. However, in Bangladesh, health staff provide counselling to tuberculosis patients for tobacco cessation, if found to be smokers or SLT users. Even then, there is no provision of referring these patients to pharmacotherapy to assist in quitting.

Bhutan has national technical guidelines for management of tobacco dependence. Limited tobacco cessation services are offered by the public health system. Nicotine replacement therapy and cessation counselling are offered under the public health programme. To an extent, tobacco cessation services including SLT cessation have been integrated into primary healthcare. Efforts have been made to impart training on community-based tobacco cessation programmes, including SLT cessation to primary health-care workers. However, there is minimal effort to engage CSOs in tobacco cessation. There is no formal policy in Bhutan on any coordination mechanism between tobacco control and any major public health programme. Tobacco cessation is not formally included in the routine training for any level of staff of any other public health programme. Health staff do provide counselling to tuberculosis patients for tobacco cessation, if found to be smokers or SLT users. However, there is no provision of referring these patients to pharmacotherapy to assist in quitting. Recently, a
tobacco quit line has been established in Bhutan to assist smokers and SLT users in quitting.

In India, elaborate national technical guidelines for management of tobacco dependence are in place. Tobacco cessation services are offered by the public health system under the National Tobacco Control Programme. Nicotine replacement therapy and cessation counselling are offered under the public health programme. To an extent, tobacco cessation services including SLT cessation have been integrated into primary healthcare. Training programmes for health-care workers on tobacco cessation are regularly organized at state and district levels under the National Tobacco Control Programme. Training manuals for doctors, counsellors and health workers are in place. Efforts have been made at the national and the sub-national levels to engage CSOs in tobacco cessation. Efforts have also been initiated to develop coordination mechanisms between tobacco control and other major public health programmes. For example, a formal coordination mechanism exists between the technical working groups of the Revised National Tuberculosis Control Programme and the National Tobacco Control Programme. There is a policy of integrating tobacco control related information in the routine tuberculosis control training for all levels of staff. A mechanism is in place to routinely collect tobacco related data among registered tuberculosis patients from the existing reporting system in the Revised National Tuberculosis Control Programme. Combined information, education and communication (IEC) materials exist on tuberculosis and tobacco. Health staff provide counselling to tuberculosis patients for tobacco cessation, if found to be smokers or SLT users. Provisions are in place for referring these patients to pharmacotherapy to assist in quitting. However, still there is no policy for joint supervisory activities under the Revised National Tuberculosis Control Programme and the National Tobacco Control Programme. Lately, innovative cost-effective initiatives such as mTobaccoCessation and tobacco quitline have been taken in India to assist smokers and SLT users in quitting.
Regional good practices

India has taken two major initiatives to provide effective tobacco cessation services to tobacco users who want to quit. The Ministry of Health & Family Welfare (MoHFW), Government of India (GoI) partnered with WHO and the International Telecommunications Union (ITU) to launch a pan-India “mTobaccoCessation” initiative, leveraging mobile technology for offering tobacco cessation services (Box 1). Besides, a national tobacco quit line has been established in India with the aim of providing cost-effective tobacco cessation services to the community (Box 2).

Box 1: A pan-India mTobaccoCessation intervention – a collaborative initiative of the GoI, WHO and ITU

This initiative strives to reach out to tobacco users of all categories who are willing to quit tobacco use and to support them towards successful quitting through text messaging via mobile phones. Any tobacco user including an SLT user willing to quit tobacco may give a missed call to 011-22901701 for registration, or else can also e-register through http://www.nhp.gov.in/quit-tobacco/registration. An overall package of nearly 150 SMSs is sent over a period of six months to support those who get registered for the programme to quit tobacco. A dedicated sender ID has been created for sending bulk SMSs for promotional purposes. Besides, a dedicated email ID quit_tobacco@gov.in has been created for sending mailers at regular intervals for promotion of the project and for informing people at large about the ill-effects of tobacco use. Launched on 15 January 2016, the initiative was an instant hit among tobacco users in India with approximately 1.60 million registrations within the first few days of launch. WHO-ITU is committed to scaling-up the intervention in India and in the remaining countries of the Region in a phased manner.
The national tobacco cessation quitline (1800-11-2356) is managed by the Vallabhbhai Patel Chest Institute, New Delhi on behalf of MoHFW, GoI. The quit line is presently available in two languages – English and Hindi. To start with, the caller is registered with the quitline. Subsequently, the caller is asked to set a quit date, which would be within the next 7–10 days. A comprehensive “Tobacco quit pack” is sent to the caller by email. The actual sequence of calls is: Call 1 (call made by any person willing to quit tobacco); Call 2 (pre-quit date call made by a counsellor 3–4 days before the planned quit date); Call 3 (quit date call made by a counsellor on the planned quit date or 1–3 days after the planned quit date); Call 4 (quit date follow-up call made by a counsellor 3–7 days after the planned quit date); and Call 5 (ongoing support call made by a counsellor about 1–3 weeks after the quit date follow-up call). The quitline will be scaled-up in a phased manner in order to provision tobacco cessation services in various local/vernacular languages across the country.

Both these initiatives cater to smokers as well as SLT users. Further, MoHFW, GoI is planning to undertake a feasibility study on how to do a back-end integration of these two services through a single integrated platform to effectively address the needs of the community. Providing both these services through a single window would prove more efficient and effective in addressing the tobacco cessation needs of the community.

India is also a pioneer in the Region in integrating “brief advice” for tobacco cessation in the treatment of tuberculosis patients who register under the Revised National Tuberculosis Control Programme (RNTCP) and are tobacco users (Box 3).
In Bangladesh, a study was undertaken in a hypertension clinic located in village Ekhlaspur, which corroborated the success of simple tobacco cessation counselling in hypertensive patients who were tobacco users, including SLT users (Box 4).

Box 3: Promoting tobacco cessation in India by integrating “brief advice” in the RNTCP

This intervention study was undertaken in district Vadodara, Gujarat to promote tobacco cessation by integrating “brief advice” for tobacco cessation in treatment of tuberculosis patients who were tobacco users, including SLT users, and registered under the RNTCP. Brief advice on tobacco cessation takes less than 3 minutes and consists of five A’s: asking if the patient uses tobacco in any form; advice on quitting tobacco; accessing readiness to quit tobacco use; assisting with counselling and appropriate treatment; and arranging for follow up. At the end of 6 months, 67.3% of patients who were offered brief advice during this intervention study had quit tobacco. The study shows that with careful monitoring, it is feasible to introduce the brief advice strategy as a cost-effective intervention for SLT cessation in tubercular patients.
Box 4: Hypertension clinic service is a good opportunity for tobacco cessation among villagers in Bangladesh

Tobacco use and hypertension are common and co-existent in Bangladesh. This study was done to assess whether a brief counselling by non-medical counsellors during check-up visits for hypertension treatment could reduce prevalence of tobacco use in adults living in a remote village of Bangladesh. Tobacco users were counseled for 5 minutes to quit tobacco use at each of the five visits (entry visit plus four follow-up visits) as per a cessation booklet in Bangla. Data on tobacco use, both smoking and smokeless, were recorded at all visits. Women formed 75% of all respondents. The prevalence of tobacco use on the first visit was 40.5%, which declined to 1.9% by the fifth visit. The major decline was observed due to SLT quitting; its prevalence dropped from 33.2% to 0.4%. This study shows that hypertension screening is a good opportunity for tobacco cessation, especially SLT cessation in community level healthcare settings in Bangladesh.

Limited evidence in the form of pilot projects conducted in the Region suggests that brief advice from a health-care worker, face-to-face behavioural support, telephone helplines and automated text messaging are affordable health-care interventions to address the demand for SLT cessation among SLT users in the Region.
Challenges and opportunities

The existing health capacities of the countries of the Region are grossly inadequate to meet the current demands of SLT cessation. All the countries of the South-East Asia Region are lagging behind in the implementation of Article 14 of the WHO-FCTC related to tobacco cessation. Unfortunately, and understandably so, in comparison to smoking cessation, the demand–supply gap appears to be wider in case of SLT cessation. In order to realistically drive this agenda forward, it is imperative that the countries of the Region with high prevalence of SLT consumption such as Bangladesh, Bhutan, India, Myanmar and Nepal thoroughly understand the complexities and challenges involved in provisioning effective SLT cessation services and prudently identify opportunities for future action.

Challenges and opportunities therein, in the context of SLT cessation in the five identified countries of the South-East Asia Region, can be broadly classified into the following interdependent categories.

Limited number of good practices on SLT cessation in the Region

At present, there are limited numbers of good practices on SLT cessation in the Region. In contrast, a large number of global best practices on smoking cessation are available. However, it is well known that SLT cessation needs are different from smoking cessation needs. For example, during SLT cessation, there is often a stronger need to have something in the mouth (an oral substitute) to take the place of the chew, snuff or pouch. Any successful SLT cessation initiative in the Region should also take into account special barriers in the Region related to culture, religion, gender, age, educational background and socioeconomic status. Notably, SLT use is deeply embedded in the cultural milieu of the countries of the Region and is more prevalent among people from low socioeconomic strata, uneducated individuals and the rural population. Heterogeneity of custom-made and traditional SLT products in
the Region poses additional challenges. A plethora of SLT products are available in the market across the Region. Many of these are manufactured in the informal sector and are completely out of the regulatory framework. Many of these products are perceived to be relatively harmless by a large number of SLT users. In short, an SLT cessation strategy that may work in one country of the Region may not be a success in a different country or even in a different geography of the same country. Thus, customization holds the key for SLT cessation in the Region. Till new evidence and best practices on SLT cessation emerge from the Region, customization of the existing global best practices on smoking cessation to suit the special SLT cessation needs of the Region need to be prioritized. For example, smoking cessation quitlines have been extremely effective in developed countries. Based on these best practices, the establishment of tobacco cessation quitlines in Bhutan and India, which also cater to the demands of SLT users, is the correct way forward. Similarly, the mTobaccoCessation initiative in India has been customized to suit the special needs of SLT users. However, this momentum needs to be carried forward, and scaling-up and further customization of these services are needed to make a real impact at the population level in these countries.

**Resource crunch**

Tobacco cessation is not a priority public health agenda in any of these five countries. This is even truer for SLT cessation – though, ironically, SLT is a greater public health problem than smoking in these countries. Thus, limited funding is available for SLT cessation initiatives. It is crucial that no opportunity be missed to highlight SLT cessation as a priority health agenda. For example, specific questions on SLT cessation could be included in all the nationally representative surveys such as GATS, GYTS, STEPS, DHS, etc. conducted in these countries. Another way for the countries of the Region to deal with this challenge is exemplified in Fig. 2 – passive needs for SLT cessation in the Region are huge, but active demands for these services from the community seem to be deficient. Thus, efforts should be made to aggressively convert passive public health needs for SLT cessation into active demands, which would eventually put the much-needed sustained pressure on policy-makers and
implementers to prioritize SLT cessation for action. Simultaneously, given the huge public health benefits of SLT cessation in these countries, efforts should be made to mobilize resources through fundraising from local as well as international donors. Fundraising through getting corporates to fulfil their corporate social responsibility (CSR) is a huge opportunity for countries such as India.

Inadequate training and capacity building on SLT cessation

Health professionals and workers in these countries involved in tobacco cessation are not adequately trained. As SLT cessation needs are different from smoking cessation needs, adequate SLT cessation training would be the cornerstone of future success of SLT cessation initiatives. At the outset, all countries should have national technical guidelines for management of tobacco dependence. Currently, these guidelines are absent in Bangladesh, Myanmar and Nepal. Ideally, as in the United States of America, a dedicated guide to quitting SLT should be available in each of these countries. This should be followed by development of training modules on SLT cessation for different categories of health professionals and workers. As is the practice in developed countries, while dealing with smoking cessation, an all-inclusive approach holds the key. Separate training manuals on SLT cessation should be developed for all categories of professionals and workers who can meaningfully contribute towards the goal of SLT cessation – including, but not limited to, medical and dental practitioners, teachers and complementary and alternative medicine (CAM) practitioners. Emphasis should be on brief advice from a health-care worker or a professional, and on face-to-face behavioural support. SLT cessation should be included in the curricula of medical, dental and nursing colleges across the Region. Use of web-assisted tobacco interventions (WATIs) and app-based training modules for smartphone users, both well-documented in the published literature, should be explored for training professionals and workers on SLT cessation. Emerging evidence shows that these new modalities could be extremely cost-effective for training health workers in primary care settings and could contribute to last mile delivery of SLT cessation services in the Region. Moreover, SLT cessation should be formally included
in the routine training for any level of staff of all other major public health programmes, at least in countries with high prevalence of SLT consumption.

**Lack of an enabling environment**

For SLT cessation initiatives to succeed and sustain, it is important to create an enabling environment as well as to disable different barriers. Enabling individuals to make healthy choices and to engage in safe behaviour is a core function of public health law. In the context of SLT cessation in the Region, the countries should try to denormalize SLT use by exploring and enforcing strong legislative and tax measures to decrease accessibility and affordability of SLT and processed arecanut products. Aggressive marketing strategy, attractive packaging and flavouring of a plethora of these products should be effectively regulated. An improved regulatory environment would increase demand for quality SLT cessation services. Simultaneously, it is important to aggressively market SLT cessation services among the community. Cost-effective innovative marketing strategies hold the key—use social media, print the quitline number on packages of all SLT products, mention the quitline number in all tobacco control media campaigns, etc.

**Absence of multistakeholder engagement and partnership**

Successful implementation of SLT cessation initiatives calls for multistakeholder engagement and partnership. Support of all the stakeholders is vital. First and foremost is community support and participation. This is a prerequisite if we want to break the gender and culture linked barriers to SLT cessation in the Region. It is important to reach out to disadvantaged population groups – the poor, illiterate, rural and marginalized sections of society. As there is limited evidence on what works best for SLT cessation in the Region, support of researchers and academia is crucial to generate new evidence and best practices, e.g. role of yogic exercises in SLT cessation. Role of CSOs is equally vital. Within the health sector, formal coordination mechanisms should be established between tobacco control and all other major public
health programmes on the issue of SLT cessation. This would facilitate in mainstreaming the issue of SLT cessation. Brief advice (five As) on SLT cessation should be integrated into the interventions of these programmes. Institutionalized mechanisms need to be in place to routinely collect SLT-related data to include screening for SLT use along with addiction level, counselling for quitting, referral for care and initiation of SLT cessation, outcome of SLT cessation, etc. among registered patients from the existing reporting system of other major public health programmes. The telecommunications sector is an important actor in provisioning mTobaccoCessation and tobacco cessation quitline facilities. Ideally, both these services should be provided through a single window for maximizing efficiency and effectiveness. As SLT products are becoming increasingly popular among the youth, the Department of Education becomes an important stakeholder. SLT cessation should be included in school and college curricula at appropriate levels. Information technology (IT) support would be vital to leverage WATIs to provide training on and social support for SLT cessation. Mobile app development companies could be roped in to develop app-based SLT cessation programmes for smartphone users, factoring in web access in remote areas, ethnic factors, literacy levels and cost–benefit ratios.
Conclusion and recommendations

The existing health capacities of Bangladesh, Bhutan, India, Myanmar and Nepal are inadequate to meet the current demands for SLT cessation in these countries.

This study lays down specific priorities for action for these countries to take the agenda of SLT cessation forward. These priorities have been discussed in detail in the preceding chapters and can broadly be classified under the following five interdependent categories, called the CATCH approach. See Fig. 3.

1. **Customize and adopt the global best practices in smoking cessation to suit the special SLT cessation needs, factoring in regional barriers, i.e. develop cost-effective, gender-friendly, culturally and linguistically appropriate SLT cessation interventions based on global best practices:**
   a. Till new evidence and best practices in SLT cessation emerge from the Region, customize the existing global best practices in smoking cessation based on the special SLT cessation needs of the Region including establishing mTobaccoCessation and tobacco cessation quitlines in Bangladesh, Myanmar and Nepal; establishing mTobaccoCessation in Bhutan; and prioritizing back-end integration, scaling-up and further customization of mTobaccoCessation and tobacco cessation quitline in India.

2. **Acquire resources:**
   a. Highlight SLT cessation as a priority public health agenda. In particular, include specific questions on SLT cessation in all the nationally representative surveys such as GATS, GYTS, STEPS, DHS, etc. to underscore the demand for SLT cessation.
   b. Take measures to convert passive public health needs for SLT cessation into active demands from SLT users for quality SLT cessation services, e.g. improve health literacy by educating the community about the benefits, both health and non-health, and
feasibility of quitting SLT use to exert sustained pressure on policymakers and implementers to prioritize SLT cessation for resource allocation.

c. Given the huge public health benefits of SLT cessation, mobilize resources through fundraising from local as well as international donors, e.g. fundraising through CSR in India.

3. **Train and build capacities of professionals and workers:**

   a. Develop national technical guidelines for management of tobacco dependence (absent in Bangladesh, Myanmar and Nepal).

   b. Develop dedicated guidelines for quitting SLT.

   c. Develop training modules on SLT cessation for:

      i. different categories of public health professionals and workers;

      ii. all categories of professionals and workers who can meaningfully contribute towards the goal of SLT cessation, including, but not limited to, medical and dental practitioners, teachers and CAM practitioners;

      These training modules should follow an all-inclusive approach; the emphasis should be on brief advice from a health-care worker or a professional, and on face-to-face support.

   d. Include SLT cessation in the curricula of medical, dental and nursing colleges.

   e. Use app-based training modules for smartphone users or WATIs for training professionals and workers on SLT cessation. These new modalities can be extremely cost-effective for training health workers in primary care settings and can contribute to delivery of SLT cessation services to the last mile.

   f. Formally include SLT cessation in the routine training for any level of staff of all other major public health programmes.

4. **Create an enabling environment:**

   a. Improve the regulatory environment (to increase demand for quality SLT cessation services):
i. Denormalize SLT use by exploring and enforcing strong legislative and tax measures to decrease accessibility and affordability of SLT and processed arecanut products;

ii. Effectively regulate aggressive marketing strategy, attractive packaging and flavouring of plethora of SLT and processed arecanut products.

b. Aggressively market SLT cessation services among the community by using cost-effective and innovative marketing strategies. Use social media; print quitline numbers on packages of all SLT products; mention the quitline number in all tobacco control media campaigns, etc.

5. Harness support from all stakeholders:

a. Ensure community participation and support (to break the gender- and culture-linked barriers to SLT cessation). In particular, reach out to disadvantaged population groups – the poor, illiterate, rural and marginalized sections of society.

b. Involve CSOs.

c. Take the support of researchers and academia to generate new evidence and best practices, e.g. role of yogic exercises in SLT cessation.

d. Within the health sector, establish formal coordination mechanisms between tobacco control and all other major public health programmes on the issue of SLT cessation (mainstream the issue of SLT cessation).

i. Integrate brief advise (five As) on SLT cessation with the interventions of these programmes;

ii. Routinely collect SLT cessation data among registered patients from the existing reporting system of these programmes.

e. Beyond the health sector:

i. Involve the telecommunications sector to provision mTobaccoCessation and tobacco cessation quitline facilities. Ideally, both these services should be provided through a single window for maximizing efficiency and effectiveness.
ii. Engage the Department of Education and include SLT cessation in school and college curricula at appropriate levels;

iii. Seek IT support to leverage WATIs for providing training on and social support for SLT cessation;

iv. Rope in app development companies to develop app-based SLT cessation programmes for smartphone users, factoring in web access in remote areas, ethnic factors, literacy levels and cost–benefit ratios.
Fig. 3. The CATCH approach to SLT cessation in South-East Asia Region

C: Customize and Adopt global best practices
- Consider special SLT cessation needs
- Factor in regional barriers to SLT cessation (develop cost-effective, gender-friendly, culturally and linguistically appropriate SLT cessation interventions)

A: Acquire resources
- Highlight SLT cessation as a priority public health agenda, e.g. include specific questions on SLT cessation in all the nationally representative surveys to underscore demand for SLT cessation
- Take measures to convert passive public health needs for SLT cessation into active demands, (e.g. improve health literacy) to exert pressure on policy-makers to prioritize SLT cessation for resource allocation
- Mobilize resources through fundraising

T: Train and build capacity
- Develop national technical guidelines and training modules for all (all-inclusive approach), including teachers and CAM practitioners
- Include SLT cessation in medical, dental and nursing curricula and in routine training of other public health programmes
- Leverage app-based training modules and WATIs for training of professionals and workers on SLT cessation

H: Create an enabling environment
- Improve regulatory environment to increase demand for quality SLT cessation services
- Aggressively market SLT cessation services among the community by using cost-effective innovative marketing strategies (use social media; print quit line number on packages of all SLT products; mention quit line number in all tobacco control media campaigns)

S: Harness support from all stakeholders
- Ensure community participation and support [reach out to disadvantaged population groups (poor, illiterate, rural and marginalized)]
- Involve CSOs
- Engage researchers to generate new evidence (e.g., role of yoga in SLT cessation)
- Mainstream SLT cessation within the health sector by establishing formal coordination with other major public health programmes (e.g., integrate brief advice on SLT cessation – the five As)
- Think beyond the health sector (Departments of Education, Telecom, IT, app developers, etc.)


31. Mukherjea A, Modayil MV, Tong EK. Paan (pan) and paan (pan) masala should be considered tobacco products. Tob Control. 2015 Dec;24(e4):e280-4..


Tobacco cessation remains a weak point in tobacco control in the South-East Asia Region (SEAR). Though there is clear scientific evidence that tobacco cessation interventions are highly cost-effective public health measures, countries of the Region have failed to optimally prioritize this issue so far. This assumes greater importance in case of smokeless tobacco (SLT) cessation initiatives that ought to take into account a complex set of factors in the Region such as culture, religion, gender, age, educational background, socioeconomic status and the special cessation needs of SLT users. This document aims to understand the needs and challenges of SLT cessation in five identified countries of the SEAR—Bangladesh, Bhutan, India, Myanmar and Nepal—that have high prevalence of SLT consumption among adults and youth. The document strives to identify opportunities for taking this public health agenda forward in these five countries and to lay down specific priorities for action and intervention.