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## Tobacco control in the State of Himachal Pradesh, India: A review

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### Abstract

There is a huge cultural acceptance of different forms of tobacco in different states of India and different part of world. With this background we aim to study some best practices in the state of Himachal Pradesh in tobacco control. This is based upon the challenges in the state which will enhance cross cultural competencies among various states of India towards the global tobacco endgame. This sharing and replication of best practices leads to focused and tailor-made approach in targeting areas and region with shared and overlapping needs. The state of Himachal Pradesh is considered as role model for the effective implementation of tobacco control among various states of India. This achievement was well accomplished by the multistakeholder engagement and integration in tobacco control. The challenge now lies in maintaining, sustaining and scaling tobacco control efforts. Effective monitoring through compliance studies from time to time still remains the best and practical solution for global tobacco endgame.

**Keywords:** Tobacco control, civil society organization, multi-stakeholder engagement.

### Introduction

Tobacco kills up to half of its users and more than 8 million people annually. 7 million due to direct tobacco use and 1.2 million due to exposure to second hand smoke. Nearly 148.6 million Disability adjusted Life Years (DALYs) is lost due to smoking and 2.5 million DALYs is lost due to smokeless tobacco use. Nearly two-third of world smokers are in just 10 countries and more than 40% of smokers live in China and India [1]. Tobacco is a risk factor for six of the World's 8 leading causes of death [2]. Tobacco use claims 1.6 million lives in South East Asian Region (SEAR) and the prevalence among adults is 29%. South East Asian Region accounts for 81% of smokeless tobacco users, 22% of global adult smokers and 34% of the world children (13-15years) using various forms of tobacco [3]. Overall prevalence of tobacco use in India among adult is 28.6% (266.8 million) consuming tobacco products in different forms. Smoking accounts for 10.7% (99.5million) of all adults with males (19%) and females (2%) and smokeless tobacco (SLT) accounts for 29.6% in males and 12.8% in females [4]. Among school students in 13-15years, it is 14.6% with boys (19%) and in girls (8.3%) [5].

Tobacco use cost our health, economy, environment and health of workers. Total economic cost attributable to tobacco use from all diseases and death in India in the year 2017-18 for person 35years and older amount to INR 1773.4 billion (US \$ 27.5 billion) of which 22% is direct and 78% is indirect cost. Smoking contributed 74% and smokeless tobacco use contributed 26% of the cost. Tobacco crop is fertilizer and insecticide intensive polluting soil and water. Tobacco curing requires wood leading to deforestation. Plastic pouches of smokeless tobacco (SLT) products and cigarette butt generates huge non-biodegradable solid waste. Tobacco growers and workers suffer from Green tobacco sickness due to handling of tobacco leaves. These workers are poorly paid much below minimum wage. The Direct medical cost alone amounts to 5.3% of total health expenditure [6].

There is a huge cultural acceptance of different forms of tobacco in different states of India and different part of world. With this background we aim to study some best practices in the state of Himachal Pradesh in tobacco control. This is based upon the challenges in the state which will enhance cross cultural competencies among various states of India towards the

global tobacco endgame. This sharing and replication of best practices leads to focused and tailor-made approach in targeting areas and region with shared and overlapping needs.

### Burden of Tobacco use practices in Himachal Pradesh

Prevalence of current tobacco use (smoking and/or smokeless) in the state was 16.1% (6th lowest prevalence among states and UTs). Prevalence of current tobacco smoking was 14.2% (24th rank among states & UTs). Prevalence of current smokeless tobacco was 3.1% (lowest among states & UTs). Goa (7.8%), Kerala (9.1%) and Himachal Pradesh (11.9%) had the least burden of any tobacco usage<sup>[8]</sup>. To achieve the global monitoring framework for NCDs target that requires a 30% reduction in tobacco prevalence since 2010, before 2025, among population aged 15 years and over. At the national level, the target has been achieved only for females (36.5%), while among males (14.6%) the progress is just half way through.<sup>[9]</sup> Out of the 29 states considered, only seven, namely Chhattisgarh (74.8%), Bihar (58.8%), Sikkim (54.7%), Kerala (47.9%), Andhra Pradesh (36.3%), Delhi (34.9%) and Himachal Pradesh (32.5%), have achieved the target<sup>[8]</sup>.

The Global Adult Tobacco Survey (GATS) is a global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators. GATS is a nationally representative survey, consistent with standard protocol across countries including India. GATS is important in designing, implementation and evaluation tobacco control programs under the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) to generate comparable data within and across countries. WHO developed MPOWER which is an evidence based tool in this direction. The comparison of GATS 2009-10 and GATS 2016-17 helps to understand the reduction in this direction as shown in table 1<sup>[4]</sup>.

**Table 1:** Tobacco control in Himachal Pradesh from Global Adult Tobacco Survey 1 to 2<sup>[8,9]</sup>

Category	GATS 1	GATS 2
Tobacco use	21.2%	16.1%
Smoking	18.3%	14.2%
Smokeless tobacco use	4.5%	3.1%
Second Hand Smoking Exposure at home	82.9%	32.5%
Second Hand Smoking Exposure at public places	33.3%	12%
Cigarette promotion noticed by adults	6.3%	4.3%
Adults who thought of quitting cigarettes due to warning levels	33.9%	79.9%

The prevalence of current tobacco use in the state of Himachal Pradesh was 16.1% which was reduced by 5% from 21.1% reported in GATS 1<sup>[10]</sup>. The use of SLT has reduced by 1.4% from GATS 1 to GATS 2 which was reported less than smoked tobacco which was reduced by 4.1% from GATS 1 to GATS 2. The mean age of initiation of tobacco use was increased by 0.3% from GATS 1 to GATS 2. This increase is not sufficient as studies report that starting the tobacco use at early age leads to more dependence to nicotine. Youth are sensitive to nicotine and can feel dependent earlier than adult. Because of nicotine addiction, about three out of four teen smokers end up smoking into adulthood, even if they intend to quit after a few years. This is also the reason the tobacco industries are targeting the youth who see youth as their life long customer. The prevalence of tobacco use both smoking and SLT among 15-24 years of age has reduced by 0.1%. Bidi

is the most commonly used smoked product and khaini is most commonly used SLT in Himachal Pradesh. Second hand smoke exposure is higher among males and more in urban area<sup>[4, 10]</sup>. Enforcement of tobacco laws has reduced the SHS from GATS 1 to GATS 2. It was reduced from 82.5% (GATS 1) to 32.9% (GATS 2).

According to Global Youth Tobacco Survey (GYTS) 2019 the prevalence of tobacco use among youth in Himachal Pradesh was lower among the states and it was reported highest in the state of Mizoram<sup>[11]</sup>. This is the continued efforts by the state government to control tobacco use. GYTS 2019 reports main reason for quitting was health problem which clearly indicates increased awareness about the tobacco harm on the overall health. Lack of money as a reason for quitting was higher for SLT which indicates that SLT is more price elastic and certainly increasing the price will the demand of SLT products. Therefore, the increased prices of tobacco will reduce the affordability and accessibility of SLT. This is line with demand reduction measures of Article 6 of FCTC. Cigarette demand is not price elastic which is evident from GYTS 2019 report which was reasoned less for quitting smoked products than smokeless products. Only 16% had heard of tobacco quit line according to GYTS 2019<sup>[11]</sup>. This was higher among boys and in urban areas. Only 4.5% had called tobacco quit line according to GYTS 2019 which is alarming. Thus, heard of tobacco quit line has not sufficiently been translated in an attempt to seek help for stopping the tobacco use. Those respondents who have heard of tobacco quit line could be motivated to create awareness to enhance the tobacco quit attempts. Such motivation can come a long way in quit attempts among tobacco user.

### Burden of Non-Communicable diseases (NCD's) attributable to tobacco as health impact in the state of Himachal Pradesh

Proportion of total disease burden from premature death was 59.0% and disability or morbidity was 41.0% in HP, 2016<sup>[12]</sup>. Proportion of total disease burden from NCDs was 64.5%. Cancers, cardiovascular diseases and chronic respiratory diseases are the major NCD's causing death in both genders in Himachal Pradesh. Among 15–39 years of population (9.2% of total deaths) cancers, cardiovascular diseases and chronic respiratory diseases contributes 8.2%, 11.8%, 3% respectively. Among 40–69 years of population (35.5% of total deaths) cancers, cardiovascular diseases and chronic respiratory diseases contributes 16.4%, 30.4%, 16.2% respectively. Among 70+ years of population (49.3% of total deaths) cancers, cardiovascular diseases and chronic respiratory diseases contributes 7.7%, 28.4%, 25.8% respectively<sup>[13]</sup>.

Among top 15 causes of DALYs among population, ischemic heart disease (8.7%) and COPD (7.7%) was reported to be the main causes in 2016, which doubled from 1990. Among contribution of top ten risks to DALYs number in population, tobacco use still hold same 5<sup>th</sup> position from 1990 (4.9%) to 2016 (6.5%) in Himachal Pradesh. High blood pressure (4.7%) which was sixth major risk factor in 1990, is now second major risk factor (8.7%) in 2016. This possible increase is also attributable to tobacco among other risk factor. These interactions among various risk factors is the reason for increase of NCD's in Himachal Pradesh similar to the increasing global burden of NCD's. The percent of total DALYs attributable to tobacco use among top 10 attributable risks in female is more by 2.5 DALYs and 9 DALYs in males<sup>[12, 14]</sup>.

### **Smoke free Himachal Pradesh through Multi-stakeholder Engagement and Integration**

Himachal Pradesh was not covered under the NTCP (National tobacco Control Program 2007) till 2014 despite of the fact that as per the National Family Health Survey-3 (NFHS 2005–2006) the smoking prevalence in State was 33.2% more than the country (32.7%). According to Global Adult Tobacco Survey, smoking prevalence in Himachal Pradesh is lower than the national average, but exposure from SHS is high<sup>[8]</sup>. The strategic, collaborative, intersect oral partnership and coordination between the state health officials & various departments mainly police, excise, and taxation, education, rural development, media, and civil society organization (CSO) to develop the action plan for implementation of the tobacco control laws, programs and the MPOWER package in the state was initiated in 2009<sup>[8]</sup>. Based on the compliance study, Shimla, the capital city of the state was declared a “Smoke-Free City” on October 2, 2010, by then Chief Minister. A compliance of greater than 80% was taken as “Smoke Free”<sup>[1]</sup>. GATS, 2016–2017 show a significant decline (21.2%–16.1%) in tobacco use and passive smoking at homes (82.5%–32.9%) in the state. Tobacco Industry was closed within 6 months of its inception in District Hamirpur of the state in 2011. 109181 violators had been penalized and US\$ 197225 has been collected as fine for financing tobacco control since 2010 which were utilized in creating awareness about the tobacco use, well addressing the challenge mentioned above. The study confirmed that signage display was currently inadequate and that more efforts are needed to cover public places within the districts of the state of HP. Public places like eateries (restaurants and bars) and accommodation facilities (hotels and lodges) had very high violations in nearly all indicators<sup>[9]</sup>.

On 3<sup>rd</sup> July 2013 the state was declared as “Smoke Free”. Efforts started from 1<sup>st</sup> May 2011 to 30<sup>th</sup> April 2013. Department of Community Medicine, Indira Gandhi Medical College, Shimla & Population Research Center, Himachal Pradesh University, Shimla conducted End line Compliance Survey independently. This was replicated in 12 district headquarters and 40 block headquarters. Activities included cluster level initiation at panchayat level, activation of flying squads, official training and sensitization, smoke free gram Sabha agenda, steering & monitoring committee’s meetings, removal of promotional boards, initiation against hookah bars, media coverage and violations reported under COTPA. Bilaspur, Shimla and Mandi districts of Himachal Pradesh had the highest level of compliance<sup>[15]</sup>.

The Government of Himachal Pradesh had enacted new legislation named Himachal Pradesh Prohibition of Sales of Loose Cigarettes and Biddies and Regulation of Retail Business of Cigarettes and Other Tobacco Products Act in the year 2016 which was effective from July 30, 2018. This law in other state is at the state level orders or municipal level orders. This law will reduce the number and density of tobacco vendors with ban on specific venues like supermarket, groceries and in specific location like schools<sup>[16]</sup>.

### **Role of Civil Society Organization (CSO) in tobacco control in Himachal Pradesh**

Article 12.e and Article 23.5.e is legally within the preview of the Convention for NGOs to be actively involved in FCTC implementation<sup>[17]</sup>. Article 12.e states that Parties to the Convention should promote awareness and participation of public and private agencies and nongovernmental

organizations not affiliated with the tobacco industry in developing and implementing intersect oral programmers and strategies for tobacco control<sup>[18]</sup>. Article 23, Section 5(g) states the Conference of the Parties shall request, where appropriate, the services and cooperation of, and information provided by, competent and relevant organizations and bodies of the United Nations system and other international and regional intergovernmental organizations and non-governmental organizations and bodies as a means of strengthening the implementation of the Convention<sup>[18]</sup>.

Himachal Pradesh Voluntary Health Association (HPVHA) is the federation of among 20 leading NGOs of the state and is the state chapter of Voluntary Health Association of India (VHAI). It is working since 1987 on health & development issues in the state. The objective of the organization is “Making Health a Reality for the people of Himachal Pradesh”. There are various General Body Members in various district of Himachal Pradesh contributing to the tobacco control like Lok Vikas Mandal in Sujampur Tihra, Dist. Hamirpur, Society for Rural Development Action (SRDA) Thaltukhore, Dist Mandi and Sunrise Education Society, District UNA. Many more though not mentioned here have contributed immensely in tobacco control. Their constant efforts, in regards to policy advocacy Tobacco Control Act, 2003 was amended in the state. These concerted efforts initiated for effective implementation, a state and district steering committees was formed. Continuous technical support and capacity building trainings of NGOs and civil society organization contributed in the state in its true spirit to the society. Advocacy on important social concerns, HPVHA was part of about 15 government committees to provide policy inputs. Analysis of research like Community Need Assessment Analysis done by them, the government made few changes in its programmer and policies with regard to health. HPVHA has received an award for its outstanding contributions in tobacco control efforts including support to declare Shimla as “Smoke Free” by WHO at New Delhi on 23<sup>rd</sup> August 2011. The award was presented by the representative of WHO Dr. Nata to Mr. P.R Ramesh President, HPVHA and the Executive Director Mr. Narender Sharma, HPVHA<sup>[19]</sup>. HPVHA created and disseminated evidence through research studies & conducting surveys.

Earned media is one of the strategies under article 12 of FCTC guidelines on education, communication, training and public awareness. Earned media is defined as any publicity which has not been paid and that is owned and created by a third party<sup>[20, 21]</sup>. Traditionally, the term ‘earned media’ has been used when publicity is generated through public relations invested in targeting influencers to increase awareness about a brand, online and/ or offline<sup>[22, 23]</sup>. Union-BI (Bloomberg Initiative) tobacco control project in Himachal Pradesh was implemented between 2011 and 2014 through a civil society partnership of Himachal Pradesh Voluntary Health Association (HPVHA). Between July 2007 and March 2011, there was only technical support and very limited funding support (about US\$10,000 in 2010). An excellent collaboration between HPVHA and the State Department of Health and Family Welfare, Government of Himachal Pradesh was instrumental in implementing the project work plan with regular onsite and offsite technical support from The Union<sup>[20]</sup>. Sharma, *et al.*<sup>[21]</sup>. Study was one of its kind that systematically analyze all earned print media associated with a tobacco control project, and the way in which the scale of this earned print media was described in the form of hypothetical costs saved was unique<sup>[20, 21]</sup>.

Tashi Jong village of Tehsil Baijnath in Kangra district has been declared as first tobacco free village of the state. It is here that the 8<sup>th</sup> Rimpoche, founded the Khampagar Monastery in 1968. It is home to 300 monks, who live within the premises of the monastery and approximately 500 people who live in the settlement around the monastery. The Tashi Jong Settlement Officers, Tashi Jong Youth Association and the Khampagar Monastery monks actively led the campaign and the local shopkeepers volunteered to stop selling cigarettes and other tobacco products to the locals as well as to visiting tourists. On a particular day, the villagers burnt cigarettes and tobacco products, worth Rs 60,000/-, purchased from the local shops, at the main square of the village <sup>[24]</sup>. Thus these are some best practices in tobacco control in Himachal Pradesh to be considered and shared for enhancing cross cultural competencies in tobacco control measures. Four main challenges of civil society organizations are representation of intended beneficiaries, conflicts of interest, accountability and transparency <sup>[25]</sup>. It is important here to address and overcome the above challenges of CSO for effective tobacco control.

1. Alignments of mission of the collaborating CSOs with the needs of the community rather than the donors.
2. Considering local elected governments while engaging CSO's.
3. Avoiding conflict of interest.
4. Working with more accountable and transparent CSOs so as to avoid unwanted government harassment and scrutiny.
5. More representation of CSO in the formal process of generating new health research for improving and enhancing health equity.
6. Harnessing local knowledge through collaborative research between academicians & CSO for creation of baseline information for the implementation of the knowledge generated by research.
7. Rebuilding and restructuring academic research capacity weakened by the chronic underfunding <sup>[26, 27]</sup>.

Thus, CSOs are a community interface between researchers and communities illuminating socio-cultural beliefs and practices in tobacco control.

### Conclusion

The state of Himachal Pradesh is considered as role model for the effective implementation of tobacco control among various states of India. This achievement was well accomplished by the multistakeholder engagement and integration in tobacco control. The challenge now lies in maintaining, sustaining and scaling tobacco control efforts. Effective monitoring through compliance studies from time to time still remains the best and practical solution for global tobacco endgame.

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