



Editorial

Global challenges in smokeless tobacco control

Smokeless tobacco (SLT) products are consumed without combustion or pyrolysis at the time of use¹. SLT use has now become a significant part of the global tobacco problem and over 90 per cent of users live in low- and low-middle-income countries². SLT use has been reported in over 140 countries^{3,4}. It has been estimated that there are around 357 million adult SLT users globally, with 83 per cent of them living in South-East Asia³. SLT use amongst adolescents in over 100 countries is a matter of concern and poses a global challenge⁴.

Health effects of SLT use have been documented by several groups^{2,5-9}. The International Agency for Research on Cancer (IARC) confirmed the association of SLT use with oral, oesophageal and pancreatic cancers in humans⁵⁻⁷. In addition, it has a significant association with all-cause mortality and cancers of the upper aerodigestive tract, stomach and cervix, along with ischaemic heart disease and stroke^{8,9}.

The SLT products are largely unregulated and underreported². Limited data are available on the properties, production, ingredients and health hazards of these preparations. Many of these products are consumed with areca nut (a Group I human carcinogen) and are culturally acceptable².

Tobacco manufacturers regularly try to introduce newer SLT products, increasing consumer appeal by adding attractive flavouring, newer delivery methods and brand mimicking². This is complemented by targeted marketing (towards vulnerable population groups such as youth as well as existing consumers with 'intention to quit', *etc.*), producing an impact on tobacco use behaviour. Awareness of the hazards of smoke tobacco use is also exploited by the tobacco industry, proposing SLT use as a harm reduction measure. The industry advertises SLT products as a safer alternative to cigarettes and advocates switching¹⁰.

The prevention and control of SLT use is a complex public health challenge and has so far received limited attention from researchers and policymakers worldwide. In 2014, at the sixth session of Conference of the Parties, the Parties agreed to accelerate research activities on various tobacco products including SLT and agreed for strict regulation of new and existing products¹¹. This was a landmark step towards global SLT control. Another important development was the release of the National Cancer Institute (NCI) monograph in the same year². In subsequent years, there has been a considerable push by the WHO Secretariat to give adequate coverage of SLT in all guidelines and reporting instruments¹².

There have been continuous efforts by several organizations and stakeholders to generate information on SLT, but still, there is a dearth of adequate research in this area. Three-quarters of the Parties (72% of the countries ratifying WHO Framework Convention on Tobacco Control) have data on SLT use among adults at the national level, nearly 60 per cent of the Parties have adolescent SLT use data, and among them, only a few have recent data. Periodic data to report trends are meagre. Some information is also available on health (10 parties) and economic (32 parties) consequences of SLT use¹³.

Policy analysis by the WHO Framework Convention on Tobacco Control (FCTC) Global Knowledge Hub on SLT (GKH-SLT) has shown that there is a wide gap between cigarettes and SLT policies. Only a few Parties have adopted policies related to different articles of FCTC¹⁴. Of the 179 Parties, only 112 have categorically defined SLT under 'Tobacco Products'. A total of 120 (67%) Parties have implemented the provisions of Article 16 for SLT products¹³. Pictorial health warnings (PHWs) are one of the most effective tobacco control measures. High SLT burden parties such as India (85%) and Nepal (90%)

have implemented large and multiple PHWs. However, many high-burden countries such as Bangladesh are in different stages of its full implementation¹⁵. In 2016, 36 per cent of Parties had conducted at least one national mass media campaign¹⁶; however, inclusion of an SLT component in these campaigns was not known. Four Parties from Asia used different media strategies including print and social media for raising awareness on harmful effects of SLT use. India is the only Party to have implemented a comprehensive mass media campaign against SLT use¹⁴. Nearly one-third (31%) of the parties have a national quit line¹³. However, only a few parties (2%) have experience in SLT cessation. India has started a national quit line with varying success rates. SLT cessation practices by healthcare providers have only been studied in three Parties, namely India, Bangladesh and Kenya. With regard to Article 6, a key demand reduction measure requires data on price and taxation of SLT. This information is only available for 32 parties¹³.

Based on the decision of the sixth session of Conference of Parties of WHO FCTC, the Secretariat proposed a dedicated knowledge hub on SLT to serve as a repository of information, product-specific SLT burden and research needs, as well as to help member countries in SLT control including sharing of best practices with member countries through inter-country meetings and implementation challenges concerning SLT¹³. In 2016, the ICMR-National Institute of Cancer Prevention and Research, Noida, India, was designated as the WHO FCTC GKH on SLT¹⁴.

The primary responsibility of the hub is to analyze, synthesize and disseminate knowledge relating to SLT control in collaboration with various national and international stakeholders, non-governmental organizations, as well as partners of the Convention Secretariat. The Hub also has a dedicated platform <http://untobaccocontrol.org/kh/smokeless-tobacco>, for dissemination of gathered information.

Several best practices have been implemented by countries, for example, India, Maldives and Thailand have raised taxes on SLT products; Nepal and India have the largest PHWs on SLT packages, and Nepal has also prohibited the use of SLT products in public places¹⁵. The decreasing trend of SLT in India as shown by the second round of Global Adult Tobacco Survey (GATS)¹⁷ is a proof of success of those interventions.

This special issue of IJMR is timely, pertinent, informative and an example of Hub's commitment.

Hopefully, it will lead to increased awareness and give a boost to research in this neglected area to battle this dreadful scourge.

Conflicts of Interest: None.

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