Tobacco Cessation Services in India: Strategies, Level of Implementation and Recommendations

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Background

The chapter shall provide insights into the existing strategies for tobacco cessation with level of their implementation and finally recommendations for MoH, State Govt. and other departments for advancing the tobacco cessation services in India.

Introduction

Tobacco is one of the most addictive substances known to humans. Nicotine is the principal psychoactive component in tobacco which triggers the release of neurotransmitters such as dopamine, which is associated with pleasure, reward and relaxation. This dopamine release reinforces the behavior of smoking or tobacco chewing, eventually leading to the development of dependence. Nicotine withdrawal symptoms such as cravings, irritability, and anxiety, further contribute to its addiction making quitting difficult. Furthermore, factors such as social and environmental cues, genetic predisposition, and stress also influence this addiction. (1,2).

Diagnosis of tobacco dependence typically involves assessin the criteria outlined in standardized diagnostic criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-11). These criteria broadly include factors such as unsuccessful attempts to quit or cut down on tobacco use, spending a significant amount of time obtaining or using tobacco, and experiencing withdrawal symptoms while attempting to quit (3).

The severity of tobacco dependence can be assessed using instrument such as the Fagerström Test for Nicotine Dependence (FTND) for cigarette smoking and smokeless tobacco which assesses factors such as the frequency of tobacco use, the urgency of tobacco use upon waking, and the amount of tobacco consumed to measure the severity of dependence. Scores on the FTND help classify individuals into different levels of dependence, ranging from low to high, guiding treatment strategies and interventions (4,5). Additionally, healthcare professionals may consider other factors, such as the frequency and duration of tobacco use, unsuccessful quit attempts, willingness/ desire to quit and the presence of withdrawal symptoms when diagnosing tobacco dependence and assessing its severity to provide a tailored tobacco cessation counselling.

Establishment of Tobacco Cessation Clinics/Services in India was an initiative by the Ministry of Health, and Family Welfare (MoHFW), Government of India and World Health Organization (WHO). Initially, 13 tobacco cessation clinics were established in Anand, Bhopal, Bangalore, Chandigarh, Chennai, Cuttack, Delhi (2), Goa, Jaipur, Lucknow, Mumbai, and Patna in 2002 which were further expanded to 18 centers in 2005. The services offered at these clinics included individual intervention in the form of behavioral counseling and pharmacotherapy. The centers also intended to create awareness among the general public about the harmful effects of tobacco and about the desirability of tobacco cessation through awareness programs, exhibitions training programs on tobacco cessation for various professionals, and educational materials i.e. booklets, pamphlets and manuals etc. aimed at specific groups of the population. The Tobacco Cessation Clinic Resource Center (TCCRC) at National Institute of Mental Health and Neurosciences, (NIMHANS), Bangalore, was the national coordinating center for all the TCCs (6).

Existing Strategies for Tobacco Cessation

1. Behavioral strategies for Tobacco cessation [7-11]

    i. Brief Intervention (5As) for tobacco users willing to Quit

    The 5As (Ask, Advise, Assess, Assist, Arrange) of a brief intervention summarize all the

activities that a healthcare providers (HCPs) can do to help a tobacco user within 3 - 5 minutes, specifically in a primary care setting or busy practice.

a. The first step is Ask which involves identifying and documenting tobacco use for every patient/ individual. Asking about tobacco use should be done in friendly manner and should be part of the all-medical notes.

b. Advise all current tobacco users to quit: All HCPs should advise their patients to quit tobacco. Simple advice to quit by the physician has been shown to increase the quit rate (OR 1.3 95% CI 1.1-1.6) compared to placebo or no intervention (8) (Fiore, et al, 2008). The advice should be strong, relevant and personalized. It has been seen that specific advice linked to the patient's clinical condition works best. Also, it has been found that the timing of the "ask" has a significant impact. The key step of Advise starts with a good and inquisitive listening.

c. Assess for willingness: It is important to understand that addiction is a brain disease, and craving and withdrawal symptoms are part of this illness. You should assess the user in willing to quit at this time.

d. Assist by Providing Brief Counseling: Making sure that help is available in case of any difficulty increases the person's confidence. Counselling also includes fixing a quit date, making environmental manipulations, tackling withdrawal symptoms and handling relapses.

e. Assist by Offering Medications: Evidence is accumulating that providing medications improves the outcome even in the person who is not contemplating complete quitting.

f. Arrange Follow up: It is important to have regular contact with the person. The first contact should be within first week of the quit date, preferably on 3rd day itself (after 48 hours). Studies have shown that spending just about 3 to 5 minutes during these follow-ups increases overall abstinence rates significantly. However, spending more time is associated with better outcomes (9). Preliminary experience of the TCC clinics in India have shown that retention in follow-up increases the chances of quitting (2).

Table 1 demonstrate the effectiveness of various counselling interventions in tobacco cessation with Brief advice and brief counselling being effective for achieving quit outcomes as compared to no treatment.

Table 1: Effectiveness of counselling **(Fiore, *et al*, 2008; Rigotti, 2012) [9]**		
Type of intervention *Smoking cessation counselling*	**Strength of evidence**	**Risk ratio (95% CI)** **(Placebo or no treatment: 1)**
Individual	**A**	1.39 (1.24-1.57)
Group	**B**	1.98 (1.60-2.46)
Telephone quit line	**B**	1.37 (1.26-1.50)
Physician intervention Brief advice to quit	**A**	1.66 (1.42-1.94)
Brief counseling	**A**	1.84 (1.60-2.13)

Relapse Prevention:

Just like any other chronic disease which is prone to remissions and relapses, it is highly likely that persons addicted to tobacco may relapse i.e. returning to the use of tobacco product after a period of abstinence. It is important to educate patients about the likelihood of relapses and how to deal with them positively. Some common types of relapse triggers are emotional (stress, anxiety, happiness etc.), life- pattern (work break, before going to bed, finishing meals etc.), social (going to party, bar, concert, being with friends) and/or withdrawal (craving for taste/smell of cigarettes, need to do something with hands/mouth etc).

Identifying triggers for relapse in advance and discussing alternate ways of dealing with such triggers, particularly urges and craving, developing a healthy lifestyle, learning how to deal effectively with tension or mood changes and engaging the support of family and friends in addition to support provided by the health provider are all important components of relapse prevention counselling. Further, smoke free environment (workplace, public place and household) can reduce the frequency of relapse among smokers.

ii. **Enhancing Motivation to quit to those NOT willing to quit (5Rs):**

In patients still not willing to quit or reduce tobacco use, 5R intervention is used to tilt the balance towards quitting. This can be achieved by discussing the advantages/ disadvantages of using versus stopping tobacco. Developing discrepancy, eliciting motivational statements i.e. why should you quit? expressing empathy, avoiding argumentation and supporting self-efficacy are important strategies.

The 5 R's are (1) Relevance (how quitting is relevant personally), (2) Risks (potential negative consequences of tobacco use that are relevant to tobacco user), (3) Rewards (potential relevant benefits of quitting tobacco use), (4) Roadblocks (identify barriers or impediments to quitting like craving at present), and (5) Repetition (If tobacco user still not ready to quit repeat intervention at a later date). Addressing these in motivational interviewing mode to get their own answers will help many of these to be ready to quit. It may need more than one interaction. Therefore, keeping the door open as and when they can decide to quit is very useful. The aim is to convert the denial into a readiness to quit. Using educational material may be helpful.

Key takeaways for Behavioral Counselling

- Counselling of any nature for tobacco cessation is effective
- Brief intervention even lasting for a few minutes is effective
- Brief advice to quit by a physician increases quit rates
- Proactive telephonic counselling is better than the reactive one
- Tailor-made web-based counselling might be helpful
- In persons not very keen to quit, an extended intervention with motivation enhancement components like 5Rs may be useful
- Combined pharmacotherapy and behavioral support doubles the quit rate

2. Pharmacological Strategies for Tobacco Cessation [12]

Pharmacotherapy plays a crucial role in tobacco cessation, significantly enhancing quit rates when combined with behavioral support. Healthcare providers should tailor treatments to individual needs, balancing efficacy and safety to maximize the chances of successful cessation. following is its brief description:

I. Nicotine Replacement Therapy (NRT): Nicotine Replacement Therapy (NRT) aims to alleviate withdrawal symptoms. Currently nicotine gums, lozenges, patches and nasal sprays are available; the first two in 2 mg and 4 mg formulations. Combination NRT (e.g., patch plus gum) may be useful for some individuals.

NRT provides medicinal nicotine in a lower dose. It helps in minimizing withdrawal symptoms, cravings mostly. The patients should be advised to self-titrate the use of gums/lozenges as necessary. It should be chewed /suck until the satisfaction achieved matches the use of tobacco in the past; and, nothing should be ingested by mouth for next 15 minutes.

NRT is generally safe in view of its toxic limit of 40 mg/ 24 hours for an adult. It should be used with caution in patients with uncontrolled hypertension. Its use is contra-indicated in patients with recent myocardial infarction (nicotine is vasoconstrictive), minors, pregnant women and lactating women.

ii. Bupropion: Bupropion is a non-nicotine medication originally developed as an antidepressant. It has proven effective for smoking cessation due to its impact on neurotransmitters involved in addiction. Bupropion inhibits the reuptake of norepinephrine and dopamine, reducing withdrawal symptoms and the rewarding effects of nicotine. Bupropion is usually taken as 150 mg OD for 3 days followed by 150 mg BD for 7-12 weeks.

Bupropion is contraindicated in individuals with history of seizure or hepatic disorders (cirrhosis liver), eating disorders, and those undergoing abrupt discontinuation of alcohol or sedatives. Common side effects include insomnia and dry mouth.

iii. Varenicline: Varenicline is a partial agonist-antagonist at the α4β2 nicotinic acetylcholine

receptor, which mediates the addictive properties of nicotine. Varenicline binds to nicotinic receptors, providing partial stimulation to reduce withdrawal symptoms while also blocking nicotine from binding, thus decreasing the rewarding effects of smoking. It should be started initially as 0.5 mg once daily for three days, increased to 0.5 mg twice daily for next 4 days and then increased to 1 mg twice daily for 12 weeks. It may be used as a stand-alone therapy or in combination with NRT.

Varenicline has been associated with neuropsychiatric symptoms in some patients, including changes in mood and behavior (suicidal tendencies). gastrointestinal disturbances, particularly nausea.

iv. Combination Pharmacotherapy: Combining different pharmacotherapies may enhance cessation success rates, e.g. using NRT with bupropion or combining different forms of NRT (patch and gum) has shown superior results compared to monotherapy (9). However, careful monitoring for any side effects is required.

v. Second-Line Therapies: These include nortriptyline (tricyclic antidepressant) and clonidine (alpha- 2 adrenergic agonist). Both have shown some efficacy in smoking cessation. Further, Cytisine, a partial agonist of nicotinic acetylcholine receptors. Although it has been found to be effective in smoking cessation in a recent systematic review, it is not used in India due to its non-availability (13) (Puljević C 2024).

It should be noted that while 2 mg NRT gum or logenzes are the OTC drugs, the rest need a doctor's advice and prescription.

Tobacco Cessation services in India

1. Population Level strategies (National Tobacco Quitline Services and m-Cessation) [14-17]

i. National Tobacco Quitline Services (NTQLS), started on 30th May 2016 at VPCI, Delhi NTQLS is a sponsored scheme of Ministry of Health and Family Welfare, Government of India. This is a confidential, non-judgmental telephone-based tobacco cessation counselling and referral service for anyone seeking help for himself/herself or another person to quit tobacco. It can be accessed through a toll-free number 1800-11-2356 between 8 AM to 8 PM on all days, except Monday. The main objective is to help tobacco users to quit through counselling, referrals, mailed materials, training to healthcare providers, web-based services. Initially the services were offered in two languages Hindi and English. Now 3 more Centres have been established at Guwahati (Dr. Bhubaneswer Barooah Cancer Institute), Bangalore (National Institute of Mental Health And Neuro Sciences) and Mumbai (Tata Memorial Center) for giving counselling in total 15 different languages.

NTQLS works in reactive and proactive ways. The tobacco users initiate the call and the counselors or quit coaches sitting in the Quit-line office responds to the callers. The quit coaches register the callers, assess them and apply the intervention strategies. Intervention strategies include 5As (Ask, Advise, Assess, Assist and Arrange), or 5Rs (Relevance, Risks, Rewards, Roadblocks, Repetition), depending on the level of nicotine dependence and intention to quit. Overall, the NTQLS population-level strategy seeks to create a comprehensive approach to tobacco control that addresses the social, economic, and environmental factors that influence tobacco use. The Delhi-based NTQLS has

reported a quit rate of ~40% at the end of 1-year. Further it reported that while the cost per quitter was ~Rs. 1630, the cost per successful quitter was ~Rs. 5,100 (17).

ii. m-Cessation (18), is a unique program started in January 2016, to reach out to those willing to quit tobacco use and support them towards successful quitting through text messages sent via mobile phones. The initiative is fully supported by the Government of India. In this strategy, those desirous of quitting give a missed call to a toll-free number (011-22901701).

m-Cessation uses two-way messaging between the individual seeking to quit tobacco use and programme specialists providing them dynamic support. The National Tobacco Control Programme (19), and the Union Ministry of Health and Family Welfare, with support from the WHO and the International Telecommunication Union's 'Be He@lthy, Be mobile' initiative have implemented this programme in colaboration.

Till date, the programme has over 2.1 million self-registered users and an average quitting rate of 7 per cent for both smokers and users of smokeless tobacco at six months after enrolment.

(20) (WHO Global Tobacco Epidemic Report, 2019)

2. Community Level tobacco cessation services (Tobacco Cessation Centers and Community Cessation Approaches):

i. Tobacco Cessation Centers: National Tobacco Control Program (NTCP) is currently implemented across all the state and UTs covering more than 740 districts. It aims to create awareness about harmful effects of tobacco consumption" and "help people to quit tobacco". Further, Setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at district level is one of the key thrust areas under NTCP. (21).

At national level, National Tobacco Control Cell, MoHFW has released modules/ guidelines viz. Tobacco Dependence Treatment guidelines, Training manual for doctors and health worker guide to advance tobacco cessation in India. Recently, on WNTD 2024, Operational Guidelines for establishment of TCCs at Medical Institutions was also released by MoHFW. (22).

At state level, a STCC is required to focus on raising profile of tobacco cessation with dedicated training and capacity building sessions for the NTCP staff and health care providers and further pushing for establishment of TCCs at health care facilities.

At district level, a separate budget head is provisioned (INR 15000) for training on tobacco cessation. A DTCCs should advance the tobacco cessation at district level in following steps:

1. Identify an appropriate place in the respective local district-, medical college-, dental college- hospital/s and/or tertiary care center (under NCD programs), deaddiction clinics/ TB Units/ PHCs/ CHCs etc. and
2. Train their Medical Officers/ ANMs as well as those working at CHCs/ PHCs, so that these latter health facilities too function as satellite centers (22).

Human Resource and financial provisions: A provision should be made for at least one counsellor/ psychologist for each TCC. A TCC is provided a non-recurring grant of INR 2,50,000 under the budget for procuring the equipment such as CO analyzer

and running it under the NTCP. Further, there is separate provision of INR 2,00,000 per year for pharmacological treatment which can be used to buy Nicotine gums, Patches etc based upon state preferences (21).

Currently in India, 600+ TCCs are functional under NTCP at District Hospital and 650+ TCCs have been established other than NTCP i.e. at Dental Hospitals/ Medical Institutions/ sub district hospitals/ rural district hospitals/ NCD clinics/ NOHP clinics etc. and provided counseling to more than 13.5 lakhs tobacco users (23).

ii. Community Cessation Approach (Brief Advice): Community based counselling is an established strategy for preventing initiation of tobacco use and enabling the tobacco users to quit. The primary health workers including ASHA, ANMs/ Multi-Purpose Health Workers (MPWs) and other health workers play an important role (due to vicinity and accessibility to the community) in creating awareness, identifying tobacco users, documentation of tobacco use, increasing coverage of brief advice and referral to the nearest tobacco cessation center if required. The health workers should identify and list the tobacco users in the community and provide brief advice and regular follow up for enabling quitting by the user.

Health workers should also be trained for providing brief advice and further sensitized about the existing tobacco cessation services at national level (NTQLS/ m-cessation), State (state level health helplines and quit lines, if any) and district level (TCCs under NTCP/ Other than NTCP) for efficient referral system. Operational guidelines under NTCP emphasizes on community-based counselling and household follow ups to encourage tobacco users to quit. Various modules released under national health mission (ASHA NCD module, Multi-Purpose Workers(MPW)-on Prevention, Screening & Control of NCD, Health workers guide) have explicitly mentioned about role of health workers in providing brief advice for tobacco cessation (24-26). However, studies have reported that only 1/4th of the ANMs reported that they have been provided prior training for tobacco cessation (27) [Panda R et al. 2015]

3. Integration of Tobacco Cessation Services with other national level programs

Tobacco Cessation has a primary role in achieving Universal Health Coverage (UHC). With respect to NCDs, tobacco smokers have 2-3 folds higher relative risk of coronary heart disease (CHD), 1.5 times for stroke, 1.4 times for chronic obstructive pulmonary disease (COPD) and 12-fold risks for lung cancer. Tobacco contributes to around 40% of mortality from TB which is a cause for great concern. The prevalence of TB is three times higher among ever-smokers as compared to that of never smokers. Tobacco use in any form causes poor oral health outcomes like oral cancer, oral mucosal lesions, periodontal disease, implant failure, salivary gland hypofunction, dental caries among many other oral diseases and conditions (28-34).

Thus, convergence of tobacco cessation services within National Health Programs such as National Programme for Non Communicable Diseases (NP NCD previously NPCDCS), National Mental Health Programme (NMHP), National Programme for Health Care of the Elderly (NPHCE), National Oral Health Programme (NOHP), Drug De-Addiction Programme (DDAP), and National Tuberculosis Elimination Program (NTEP) (Figure 1), will assist in expanding the coverage of cessation services (at least Brief advice) and thus enhancing quit rates significantly. Brief advice if delivered regularly and ubiquitously within a healthcare delivery system, has the potential to reach over 80% of tobacco users in a nation annually and thus excelling to achieve SDG 3.3 by 2030.

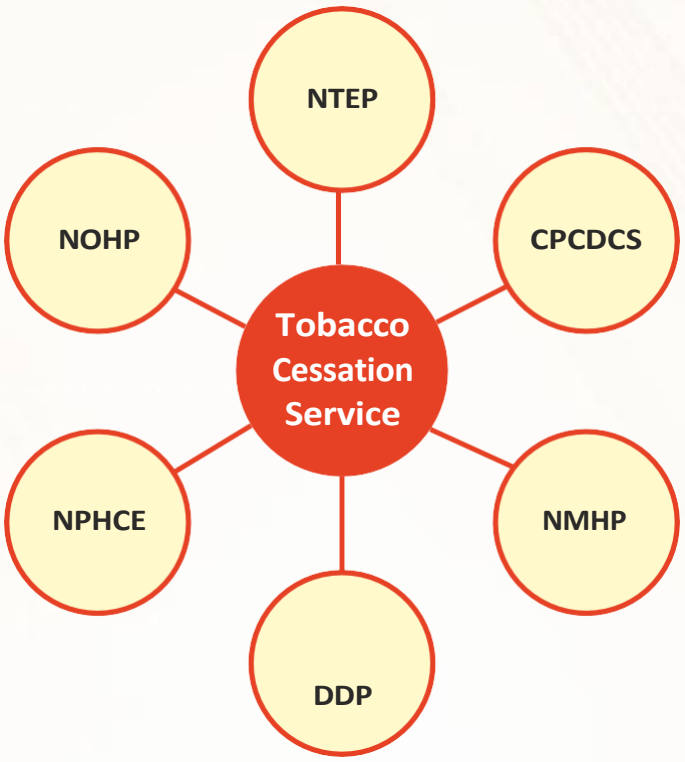

Figure 1: Integration of TCC services with National Health Programs

Integrating national health programs with tobacco cessation services has many challenges including stigma and misconception about tobacco use, various cultural and socioeconomic factors, dearth of awareness about linkage of tobacco use with other morbidities, lack of willingness and coordination among Community Healthcare Workers, deficiency of skilled and trained tobacco cessation experts, constraint on account of time, human resource, suboptimal participation of healthcare professionals, inadequate coordination among various stakeholder, data management, regularity in monitoring and evaluation, fragmented healthcare systems, lack of vertical and lateral integration with other Health programs and Policies, and lack of political leadership and commitment (Figure 2).

Figure 2: Challenges in Integrating National Health Programs with tobacco cessation services

However, there are several opportunities for integration of tobacco cessation services with National Health Programs which are as follows (Figure 3):

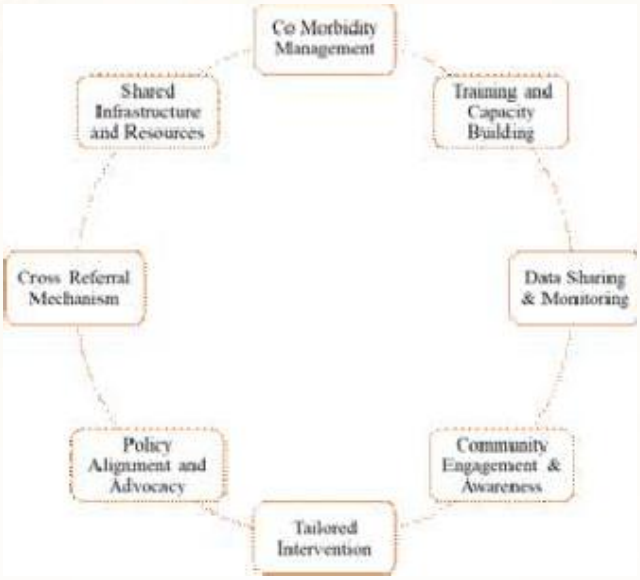

Figure 3: Opportunities of integrating tobacco cessation services with National Health Programs

a. Comorbidity Management: Integration allows for the identification and management of tobacco users and can improve treatment adherence, reduce relapse rates and enhance overall co morbidities control efforts.

b. Shared infrastructure and Resources: lead to cost savings, increased efficiency and improved access to tobacco cessation services for individuals accessing other healthcare services.

c. Training and Capacity Building: Integrating tobacco cessation services with NTEP, NOHP and NCD programs provides common opportunities for training and capacity building among healthcare providers.

d. Cross Referral Mechanism: Healthcare providers within NTEP, NOHP or NCD programs can refer individuals who use tobacco to specialized cessation services, while tobacco cessation providers can refer patients with TB, Oral health, or NCDs for appropriate care.

e. Policy Alignment and Advocacy: Advocating for comprehensive tobacco control policies within the National Health Programs can help strengthen tobacco cessation efforts and promote a supportive environment for tobacco users trying to quit.

f. Data Sharing and Monitoring: Enables comprehensive evaluation of effectiveness of cessation interventions, as well as tracking progress in reducing tobacco use prevalence among population accessing different healthcare services.

g. Community Engagement and Awareness: Community- based interventions across various programs can raise awareness about the link between tobacco use and various health conditions, encourage health behaviour change and promote utilization of cessation services.

4. Integration of Tobacco Cessation services in Medical/ Dental colleges/ Nursing colleges/ AYUSH/ Private hospital Settings India has a vast network of medical, dental, nursing and public health

institutions. Countrywide, it has 757 medical colleges,312+ dental colleges, 2,400 plus pharmacy colleges and over 2694 nursing colleges with affiliations to their respective councils (35-37).

Integration of tobacco cessation delivery through these is of paramount importance interest and shall make the cessation services more affordable, accessible and thus increase the coverage to tobacco users being provided counselling & pharmacotherapy. The MoHFW has already released guidelines for establishing TCCs under dental (2018) and medical colleges (2024) countrywide. At the State-level, an administrative lead by the department of medical education shall be vital for these institutes to have optimally trained staff that will provide the quality services on a regular basis.

Besides abiding to the WHO recommendations under MPOWER for its "O (Offer to Quit)" component, (38). TCCs under medical institutes have significant utility in view of: (1) their position as apex healthcare institutes in their respective locales, (2) a relatively high footfall of the patients and their care givers in these institutions, (3) the proven competence and capabilities of the staff working there, (4) the ease with which they accept and adapt to the newer undertakings overcoming the challenges howsoever daunting and, above all, (5) a setup that can sustain such services with meager resources (39).

The Institutions/ hospital administrations will find it easy if these accept to work through the Systems Approach that comprises of: (1) Screening of all patients (above the age of 10 years) attending their hospitals for current or former use of any type of tobacco; (2) Delivery of treatment through counseling and pharmacotherapy; and (3) proactive follow-up of the treated patients for at least six months to assess their quit status and the support many patients need in the interim.

The medical institutions/ public hospitals should participate in data capturing, reporting and management in collaboration with state cell to quantify the coverage and evaluate the performance of the TCCs. This step will be of the prime value to monitor and evaluate the functioning of the TCCs as well overall efficacy of the tobacco-free cessation delivery services through these medical institutes. It will be very useful to make suitable provisions to integrate their results on the MIS dashboard on the NTCP portal (23)

While the preceding paras refer mostly to the institutes run through the Government health sector, now is the time to mandate participation of the private health sector holistically and by all its health facilities countrywide along with a foolproof integration of a useful insurance program, preferably at no- or minimal (affordable)- cost. The private health sector should know that besides its ethical professional conduct to provide treatment of tobacco abuse and nicotine addiction to all the needy attending it in a timely manner, the delivery of tobacco cessation through its varied portals is a useful business model and a win-win scenario of all the stakeholders, the hospitals, HCPs and above all their tobacco using patients and their families. The delivery of this additional preventive service will not only assist their HCPs to optimally treat tobacco addiction as a stand-alone disease but will also contribute significantly towards management of tobacco-related illnesses as comorbidities.

Also, it will be timely to implement solutions that are appropriate and optimal to the prevailing challenges and done as a package deal instead of a piece-meal approach. The foremost will be a prompt utilization of the resources backed-up in a sustained manner for each and every institute

as the variations in their current status of delivering tobacco cessation are vast. Secondly, it will be critical to have an accountability established for those assigned to the cessation delivery- no tobacco using patients should go unattended and provided at least brief advice. Thirdly, a high visibility of the existence of the cessation services and its accessible location in the institutional premises will be very useful (40-41).

Emerging disruptive Tobacco Harm Reduction (THR) approaches (ENDS/HTPs/ synthetic nicotine/ Nicotine pouches) for tobacco cessation

Harm reduction generally means a reduction of harm at an individual as well as community level. A product that harms a community cannot be called a harm reduction product. The term harm reduction was initially used to reduce the harm from addictive drugs but now the tobacco or e-cigarette industry is using the term to promote e-cigarettes as are supposedly less harmful and may help in cessation. The tobacco/vaping industry wants people to continue to be addicted to nicotine through continuous use of HTPs, ENDS or Nicotine pouches rather than their false notion of 'Harm Reduction' or quitting tobacco use.

The public health community aims for and supports that tobacco cessation does not mean addiction to another addictive substance present in HTPs/ENDS. Since these have Nicotine in chemical form, it is time to talk about 'Harm Elimination' (41-47) The details of the harms caused by ENDS and like products are discussed in another chapter.

Capacity Building for tobacco cessation

As per GATS2, the current tobacco cessation landscape reveals significant gaps -Only 37.4% of smokeless tobacco (SLT) and 54.5% of smokers are asked about their tobacco usage by HCPs. Additionally, merely 31.7% of SLT and 48.8% of smokers receive advice to quit from HCPs (48) A Cochrane Review highlights the critical role of interventions, noting only a 21% success rate in quitting without support. Yet, a significant majority, 71.7% of smokers and 74.9% of SMT users attempt to quit on their own without HCP assistance.

Despite diverse advertisements and promotion strategies highlighting benefits of quitting tobacco and motivation of the users of tobacco to quit, the best opportunity for tobacco users to quit promptly and effectively is when a tobacco-user is reaching out to a health facility at any level of healthcare. The HCPs besides helping to set a social norm for tobacco-free life, should be participating in tobacco cessation delivery due to: (1) Their position to play a prominent role as a messenger, promoter and clinician treating tobacco dependence; (2) The opportunity they have for their every tobacco-using patient to ask, advise and assist in quitting.

In an ideal scenario, every HCP should deliver tobacco cessation to every tobacco using patient at every clinical encounter on every visit to a health facility regardless of the healthcare level- Primary to Tertiary!

At present, the majority of HCPs do not participate in tobacco cessation delivery due to following reasons: (a) their ignorance as the subject is not included under their curriculum; (b) their being the tobacco users currently; (c) limited time to serve for patients reporting under their own specialty; (d) the technology used to register patients (Hospital Information System- HIS) is not utilized for identifying tobacco users; (e) the delivery of tobacco cessation service lacks financial incentive; (f) consideration that counseling is not my job! It should be done by the counselors; (g)

unable to reform and, thus perform as a clinician rather than public health approach; and, lastly, (h) misunderstanding among them about the efficacy of treatment of tobacco use. Further, limited scope of tobacco cessation services in health insurance schemes and low demand of services from patients presents inherent challenges (49-50).

Training HCPs help: (a) Improve quit rates; (b) Protect youth; (c) Reduce prevalence of tobacco-related illnesses: NCDs, TB, mental illnesses, HIV AIDS, etc. (d) Reduce burden of tobacco-related deaths; (e) Prevent economic loss due to premature loss of lives; and (f) Eliminate environmental destruction- Pollution, Fires, etc (51).

But, undoubtedly, capacity building of the HCPs should be prioritized under NTCP and beyond the government sector, for all those working in the private health sector, both in urban and rural geographies. At the outset, it should preferably be done at the state-level as ToTs (Sessions to Train the Trainers) through classroom teaching along with role-plays as these bring a higher and focused participation and learning. Therefore, it should be followed by their interactive empowerment sessions to serve the Master Trainers for training HCPs at the district to primary levels of healthcare. The trainers should stay aware of the need to provide training that is interactive and result-oriented; and, has the desired quality. Monitoring and evaluating trainings', and reporting on their outcomes either dynamically through the NTCP MIS Dashboard or through the state-specific software can be very useful.

Their representative professional bodies or their respective councils at the State- or National-level may be entrusted with the task that every HCPs has been trained in the given timeline. Setting their accountability enabling these to do so effectively will be necessary and useful (50).

MoH released various guidelines for capacity building of HCPs including starting tobacco cessation services (2009), Training Manual for Doctors- NTCP (2011), Tobacco Dependence Treatment Guidelines (2011), Health worker guide (2010) and recently, Tobacco Cessation in dental settings- reference manual for dental professionals (2022) etc. since the launch of NTCP in 2008-09. NIMHANS have used various initiatives for capacity building of health care professionals in tobacco cessation with their on-site and online comprehensive tobacco cessation certificate courses via ECHO platform. (52-53).

Non-Government sector have also contributed in exploring and strenthening the tobacco cessation services in India. Few of the initiatives are mentioned below:

- Technical Support and Capacity Building (Tobacco Intervention Initiative by IDA for capacity building of dentist in tobacco cessation, SIPHER, ICanCaRe capacity building through e learning platform, Toxin Taxation, Rajasthan Cancer Foundation (RCF), SCCoPE Strengthening Cessation Capacity of Primary Care Professionals by PHFI)
- Model of TCC at private hospital (RCF and ICanCaRe Intervention Models, mobile application/ Private Quitline and Virtual clinics) etc.

Setting up of Tobacco Cessation Centre: [54]

A TCC is defined as fixed premises where qualified health professionals/ counsellors provide tobacco (smoke and smokeless form) cessation therapy to help patients in their attempts to quit the habit. The therapy can involve individual or group counselling and may include the dispensing of pharmacological aids if the center is registered and equipped to do so.

The objectives of an effective tobacco cessation center/clinic are to focus on patient care and community-based services. The Patient care services may include behavioural interventions along with pharmacotherapy relapse prevention strategies as well as a integrated referral policies to higher centers. A clear patient protocol must be drawn and necessary follow-ups should be scheduled. The pharmacy in the hospital should have adequate supply of various medications like bupropion and nicotine replacement therapy like nicotine gums, nicotine patches and nicotine lozenges along with other supplementary drugs. The healthcare professionals need to undergo relevant and regular training programs in tobacco cessation, some of which has been enumerated in the chapter

Health Awareness posters and educational materials which are locally relevant and culturally acceptable should be designed and displayed in different mediums like print, audio-video etc. There should be efforts made to use technology tools and social media to propagate information regarding tobacco cessation strategies.

A TCC in a hospital setting may be planned in such a manner that it has a minimum area of 120 to 150 square foot with dedicated space for Health Education in the waiting area as well as space for group counselling too. The location of the TCC may be identified as per availability and accessibility within the hospital premises. There has to be appropriate space for digital displays as well as display of other health education materials. A detailed patient care protocol in tobacco cessation clinic should be laid down along with its scope of services.

The TCC should preferably have clinical diagnostic instruments like stethoscope, BP apparatus, breath analyzers, spirometer along with measuring tape and stadiometer along with cotinine strips for urine analysis, which is optional. The TCC data should be integrated with the electronic hospital information management system and inter-departmental referrals may be made accordingly. There has to be a team approach wherein specialist from various departments like general medicine, psychiatry, oncology and other allied departments like medical social work etc could coordinate with the nodal officer of the tobacco cessation clinic. Further the National Tobacco Quitline- 1800-11-2356 Services should be displayed at various locations of the hospital.

Regular monthly data should be recorded and maintained. Monitoring and evaluation have to be an integral part of the continuous quality improvement of the patient care services in the tobacco cessation clinic. Tobacco Cessation Clinics in Hospitals should work systematically in collaboration with various departments within as well as in the communities from where the patients can be referred and provided counselling and / or pharmacotherapy treatment.

Bibliography

1. Benowitz NL. Nicotine addiction. N Engl J Med. 2010 Jun 17;362(24):2295-303. doi: 10.1056/NEJMra0809890. PMID: 20554984; PMCID: PMC2928221.
2. Mentis AF. Social determinants of tobacco use: towards an equity lens approach. Tobacco Prevention & Cessation. 2017;3.
3. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
4. Heatherton TF, Kozlowski LT, Frecker RC, Fagerström KO. The Fagerström Test for Nicotine Dependence: a revision of the Fagerström Tolerance Questionnaire. Br J Addict. 1991 Sep;86(9):1119-27. doi: 10.1111/j.1360-0443.1991.tb01879.x. PMID: 1932883.
5. Ebbert JO, Patten CA, Schroeder DR. The Fagerström Test for Nicotine Dependence-Smokeless Tobacco (FTND-ST). Addict Behav. 2006;31(9):1716-1721. doi:10.1016/j.addbeh.2005.12.015.
6. Varghese C, Kaur J, Desai NG, Murthy P, Malhotra S, Subbakrishna DK, Prasad VM, Munish VG. Initiating tobacco cessation services in India: challenges and opportunities. WHO South-East Asia Journal of Public Health. 2012 Apr 1;1(2):159-68.
7. Chand P & Murthy P. Clinical Practice Guidelines (CPG) for the management of Tobacco Use Disorders. In Clinical Practice Guidelines on the assessment and management of Substance Use Disorders (eds D. Basu & P. Dalal), pp. 345-382. Indian Psychiatry Society; India: 2014.
8. World Health Organization. "Toolkit for delivering the 5A's and 5R's brief tobacco interventions in primary care." (2014).
9. Fiore M, Jaen C, Baker T et al. Treating tobacco use and dependence: 2008 update. In US Dept of Health and Human Services. Rockville 2008
10. A guide for tobacco users to quit. Available from: https://iris.who.int/handle/10665/112833
11. Murthy P, Mohan B & Hiremath S. Helping People Quit Tobacco: A manual for doctors and dentists. New Delhi WHO, Regional Office South East Asia 2010. Free download from http://apps.searo.who.int/PDS_DOCS/B4611.pdf
12. Tobacco Dependence Treatment guidelines, MoHFW. Available from: https://ntcp. mohfw.gov.in/assets/document/Guideline-manuals/Tobacco-Dependence-Treatment-Guidelines.pdf
13. Puljević C, Stjepanović D, Meciar I, Kang H, Chan G, Morphett K, Bendotti H, Kunwar G, Gartner C. Systematic review and meta-analyses of cytisine to support tobacco cessation. Addiction. 2024 Jul 4.
14. Kumar R, Prasad R. (2014). Smoking cessation: An update. Indian J Chest Dis Allied Sky; 56(3):159-167.
15. Thankappan, KR (April 2014). "Tobacco cessation in India: a priority health intervention". The Indian Journal of Medical Research. 139 (4): 484–6. PMC 4078486. PMID 25055394.
16. Kumar, Raj, Manoj Kumar, Sukriti Raj, Dileep Kumar Arisham, Anil Kumar Mavi, and Kamal Singh. 2023. "Smoking Cessation and Its Significant Role in the Indian Scenario". Monaldi Archives for Chest Disease, December.
17. Kumar R, Saroj SK. Is tobacco Quitline cost effective in India?. Monaldi Archives for Chest Disease. 2020 Nov 9;90(4).
18. M-cessation, Govt. of India. Available from:https://ntcp.mohfw.gov.in/mcessation
19. National Health Mission, Government of India. National Tobacco Control Programme (NTCP). Available at https://ntcp.mohfw.gov.in/
20. World Health Organization. WHO report on the global tobacco epidemic, 2019: offer help to quit tobaccouse.World Health Organization; 2019. Available from: https://www.who.int/publications/i/item/9789241516204#:~:text=The%20%22WHO%20report%20on%20the,bans%20to%20no%20smoking%20areas.
21. Operational Guidelines, National Tobacco Control Programme 2015, NTCC, Ministry of Health and Family Welfare, Government of India, New Delhi. Available from: https://nhm.gov.in/NTCP/Manuals_Guidelines/Operational_Guidelines-NTCP.pdf
22. Operational guidelines for establishing Tobacco Cessation Centres in Medical Institutions. Available from: https://ntcp.mohfw.gov.in/assets/document/Guideline- manuals/ Operational%20Guidelines%20for%20Establishing%20Tobacco%20Cessation%20Centres

%20in%20Medical%20Institutions.pdf

23. NTCP. MIS Dashboard. National Tobacco Control Program. Ministry of Health and Family Welfare. Government of India. New Delhi. Available from https://ntcp.mohfw.gov.in/dashboard. Accessed on 29 August 2024.
24. Module for ASHA on Non-Communicable Diseases. Available from: https://npcbvi.mohfw.gov.in/Douments/Training_Manuals/Expanded_services_HWC_non_Eye/NCD/NCD_Module_for_ASHA.pdf
25. Module for Multi-Purpose Workers (MPW) - Female/Male on Prevention, Screening and Control of CommonNon - Communicable Diseases. Available from: https:// ab- hwc. nhp. gov. in/ download/ document/ b09f1edf31a9165aebf486a55bbe54f5.pdf
26. Health Workers Guide. Available from: https://ntcp.mohfw.gov.in/assets/document/Guideline- manuals/National-Tobacco-Control-Programme-Health-Worker-Guide.pdf.
27. Panda R, Srivastava S, Persai D, Mathur MR, Modi B, Dave P, Arora M. Preparedness of frontline health workers for tobacco cessation: An exploratory study from two states of India. Journal of family medicine and primary care. 2015 Jul 1;4(3):298-304.
28. Peto R, Lopez AD, Boreham J, Thun M, Heath C Jr Mortality from smoking in Developed Countries 1950-2000. Indirect estimates from National Vital Statistics. 1994 Oxford Oxford University Press
29. Parish S, Collins R, Peto R, Youngman L, Barton J, Jayne K, et al Cigarette smoking, tar yields, and non-fatal myocardial infarction: 14000 cases and 32000 controls in the United Kingdom Br M J. 1995;311:471–7
30. Rosenberg L, Kaufman DW, Helmrich SP, Shapiro S. The risk of myocardial infarction after quitting smoking in men under 55 years of age N Engl J Med. 1985;313:1511–4
31. Kassebaum NJ, Smith AGC, Bernabé E, Fleming TD, Reynolds AE, Vos T, et al. Global, Regional, and National Prevalence, Incidence, and Disability-Adjusted Life Years for Oral Conditions for 195 Countries, 1990-2015: A Systematic Analysis for the Global Burden of Diseases, Injuries, and Risk Factors. J Dent Res. 2017; 96:380-7
32. GBD 2017 Oral Disorders Collaborators, Bernabe E, Marcenes W, et al. Global, Regional, and National Levels and Trends in Burden of Oral Conditions from 1990 to 2017: A Systematic Analysis for the Global Burden of Disease 2017 Study. J Dent Res. 2020;99(4):362-373.)
33. Jha P, Jacob B, Gajalakshmi V, Gupta PC, Dhingra N, Kumar R, et al A nationally representative case-control study of smoking and death in India N Engl J Med. 2008;358:1137–47
34. Slama K, Chiang CY, Enarson DA, Hassmiller K, Fanning A, Gupta P, et al Tobacco and tuberculosis: A qualitative systematic review and meta-analysis Int JTuberc Lung Dis. 2007;11:1049–61.
35. Shiksha. Total number of medical colleges in India. Available at https://www.shiksha.com/ medicine-health- sciences/ colleges/ mbbs- colleges- india#: ~: text= A%3 A, best%20 medical%20 colleges%20in%20India.&text=NEET%2C%20KEAM%2C% 20Kerala%20NEET%2C%20MP%20NEET%2C%20Andhra%20Pradesh, NEET%2C%20Maharashtra% 20NEET%2C%20etc. Accessed on 6th March 2024
36. Shiksha. Total number of pharmacy colleges in India. Available at https://www.shiksha.com/ medicine-health-sciences/pharmacy/colleges/colleges- india#:~:text= BITS%20Palani%2C%20PGIMER%2C-,There% 20 are% 20 around% 204 %2 C000 %2B% 20 best% 20 Pharmac y% 20 colleges% 20 in% 20 India% 20out,Pharm%20D%20colleges%20in%20India. Accessed on 6th March 2024.
37. Shiksha. Total number of nursing colleges in India. Available at https:// www. shiksha. com /nursing/colleges/b-sc-colleges- india#:~:text=There%20are%2 0over%202% 2C680%20BSc,get% 20admitted%20in%20these%20col leges. Accessed on 6 March 2024.
38. WHO. MPOWER groups: o Offer help toquit tobacco use. Available at https://www.who.int /data /gho/indicator-metadata- registr y/ imr- details/ 343 # : ~: tex t=The% 20 l etter% 20 O% 20 in% 20 MPOWER, each% 20country%27s%20health%2D care%20system. Accessed on 6th March 2024.
39. Gupta R and Narake S. Systems Approach in Tobacco Dependence Treatment through Hospitals. Journal of Health Management. 2018;20(4):453-464. doi:10.1177/0972063418799216. Available at https://www.researchgate.net/publication/328491262_Systems_Approach _in_Tobacco_Depend ence_Treatment_through_Hospitals. Accessed on 6th March 2024.

40. Gupta R, Agarwal K and Gupta GN."Tobacco Cessation Delivery by the HCPs-Status Quo Report of a Private Hospital in India". EC Psychology and Psychiatry 8.9 (2019): 1003-1009.

41. Gupta R. Healthcare Professionals' (HCPs) Engagement in Tobacco Cessation in India. EC Psychology and Psychiatry 9.4(2020): 08-10.

42.E-Cigarette. Available from What's in an E-Cigarette? | American Lung Association

43. Harm Reduction. Available from Harm Reduction - TobaccoTactics

44. Simonavicius E, McNeill A, Shahab L, et al Heat-not-burn tobacco products: a systematic literature reviewTobacco Control 2019;28:582-594.

45. Hahn J, Monakhova YB, Hengen J, Kohl-Himmelseher M, Schüssler J, Hahn H, Kuballa T, Lachenmeier DW. Electronic cigarettes: overview of chemical composition and exposure estimation. Tob Induc Dis. 2014 Dec 9;12(1):23. doi: 10.1186/s12971-014-0023-6. PMID: 25620905; PMCID: PMC4304610

46. Statement on E-Cigarettes, WHO 2021 available from https://cdn.who.int/media/docs/default- source/thailand/ncds/who-thailand-statement-on-electronic-cigarettes-as-of-20-october-2021.pdf?sfvrsn=97f44cf_5

47. PECA 2019. Available from https://ntcp.mohfw.gov.in/assets/document/The-Prohibition-of- Electronic-Cigarettes-Production-Manufacture-Import-Export-Transport-Sale-Distribution-Storage-and-Advertisement)-Act-2019.pdf

48. Tata Institute of Social Sciences (TISS), Mumbai and Ministry of Health and Family Welfare, Government of India. Global Adult Tobacco Survey GATS 2 India 2016-17. Available from: https://ntcp.mohfw.gov.in/assets/document/surveys-reports-publications/Global-Adult-Tobacco- Survey-Second-Round-India-2016-2017.pdf

49. Gupta R, Pednekar M, Kumar R and Goel S. Tobacco cessation in India: Current status, challenges, barriers and solutions. Indian Journal of Tuberculosis. https://doi.org/10.1016/j.ijtb.2021.08.027. 2021. Availablef r o m https://www.sciencedirect.com/ science/article/ abs/pii/S0019570721001694?via%3Dihub. Accessed on 15th March 2024.

50. Gupta R, Aghi MB, Gupta A, Bhatt G, Goel S. Strategic initiatives to improve tobacco cessation delivery in India. Indian J Community Med 2022;47:328-31. 2022. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9693939/. Accessed on 15th March 2024.

51. WHO. Eastern Mediterranean Region. Health professionals against tobacco. 2005. Available at https://www.emro.who.int/tfi-campaigns/2005/index.html. Accessed on 14th March 2024.

52. Primer on Tobacco Cessation Certificate Module: A Self learn e-module on Tobacco Cessation from NIMHANS. Available from: https://nimhanselearning.org/courses/primer-on-tobacco-cessation/

53. Primer on Motivational Interviewing self-learn Certificate Module: A Self learn e-module on Tobacco Cessation from NIMHANS. Available from: https://nimhanselearning.org/ courses/ primer-on-motivational-interviewing/

54. Operational Guidelines for Establishment of Tobacco Cessation Centers in Dental Colleges. 2018 Availablefrom: https://dciindia.gov.in/Rule_Regulation/ Finaloperation alguidelines TCCindentalcolleges.pdf

RECOMMENDATIONS

5.7. Tobacco Cessation

5.7.1. Recommendation for the MoHFW:

a) Constitutions of a national expert group/ advisory group for advancing tobacco cessation in India with half yearly review of existing services.

b) Drafting of National Strategic Action Plan for advancing tobacco cessation at all levels of healthcare in India in both governmental and private health care sectors along with suitable provisions for adequate and sustained financial support for human resource availability and suitable infrastructure.

c) Updating and/ or revising the existing guidelines (Health worker guides/ tobacco dependence treatment guidelines, guidelines for doctors etc.) on

tobacco cessation and dependence for health care workers and professionals (Medical/ Dental/ Nursing/ AYUSH).

d) Drafting of guidelines with focus on product specific intervention models/ youth and adolescent, women and vulnerable population (elderly, tribals, slums etc.) to ensure equal opportunities to these for availing cessation services.

e) Dedicated IEC/ mass media Campaigns in all regional languages besides Hindi and English for enhancing awareness about harms of tobacco and availability of tobacco cessation services across various states in India.

f) Integration of National Tobacco Quit Line Services (NTQLS) with m-cessation to address the unattended calls and exploring use of IVRS/ Chatbot/WhatsApp/ AI along with Public Private Partnership (PPP) models to scale up Quitline services.

g) Training/ capacity building program specific to tobacco cessation via cascade training approach should be developed by MoHFW and implemented by state and UT governments.

h) Integration of cessation indicators from all levels (NTQLS/ m-cessation, TCCs, Brief advice at primary level, other program like NTEP, NOHP) into existing Management Information System (MIS platform) under NTCP to dynamically assess the overall coverage of cessation services at all levels of healthcare.

i) Involvement of private bodies/ national associations of health professionals (IDA/IMA/ associations of Nurses, Pharmacists etc.) for promotion of cessation services in India.

j) Ensuring the quality of the delivery of tobacco cessation service through accreditation of all TCCs under Indian Public Health Standards (IPHS) through NABH and other accreditation agencies.

k) ICMR and other funding agencies should have a specific call to research to promote multi-center high quality evidence/ operational research for tobacco cessation in India with sustainable funding support. Further, opportunities for collaborative research with existing national institutes of eminence working in tobacco control. (Resource Centre for Tobacco Control, PGIMER/ NICPR, National Resource centre for oral health and tobacco cessation/ NIMHANS etc.) should be promoted with further involvement of AIIMS and state medical institutes.

l) Insurance Regulatory and Development Authority of India (IRDAI) and PMJAY Ayushman Bharat and other state health insurance schemes should be mandated to reimburse the entire cost of tobacco dependence treatment for all tobacco users registering with any health/ Life insurance.

m) Nicotine replacement therapy should be readily and sufficiently available at TCCs at district hospitals under NTCP till primary health care level.

n) Continuing with the Over-The-Counter (OTC) access to Nicotine Gum/Lozenges up to 2 mg (as per schedule K of drugs and cosmetic act, 1945) to ease its access and its optimal utilization by the tobacco users who are willing to quit. Further, global literature suggests limited evidence of its abuse/ dual use/ use by teens or non-smokers.

o) Establish an accrediting body to ensure all tobacco treatment courses meet standardized practices.

5.7.2. Recommendations for State Government and relevant departments

a) Focus and expansion of brief cessation services/ community cessation services up to the primary health care level with training of ASHAs, ANMs for providing brief advice.

b) Further, establishing an integrated reporting mechanism into Community Based Assessment Checklist (CBAC) form for brief tobacco cessation services, outcome and referrals to TCCs.

c) Leveraging on State health helplines with existing resources to include tobacco cessation services and serve as subsidiaries to the NTQLS for mutual support and efficacy.

d) The State NHMs should be enabled to integrate tobacco cessation services into all national health programs under its umbrage such as NTEP, NOHP, NP-NCD, RBSK, NMHP, HIV AIDS, etc.

e) Exploring PPP model to further promote and expand coverage of cessation services at all levels of health care.

f) All health institutions (Medical/Dental/AYUSH/ Nursing/ private hospitals with OPDs) should establish TCCs with adequate training to the staff for efficient cessation services.

g) Satellite TCCs should be established as an extension of the existing TCCs at district hospitals/ medical colleges/ dental colleges/ private hospitals etc.

h) A TCC should be part of the Inspection proforma under regular inspection/ renewal/establishment/ evaluation under NMC/ DCI/ Other governing/ professional regulatory bodies such as NABH.

i) Geotagging of the TCCs (Public/ private) in the state should be prioritized for ease of tobacco users to locate the tobacco cessation services available nearby.

j) Medical/ Dental/ AYUSH/ Nursing colleges should have provision of tobacco cessation skill certification for the students as part of the internship program.

k) State NTCP cells should establish a mechanism for integrated reporting and monitoring/evaluation of cessation services from all levels and connecting district tobacco control cells (DTCC) to TCCs in the districts.

l) Workplace cessation- All workplaces (Govt. or private) should motivate their employees with tobacco use to quit and should have provision to offer aid for tobacco cessation services to existing users in collaboration with private/ govt. tobacco cessation centers.

m) Further, State Govt. and other institutions/ private offices should have protocol to have a declaration about no tobacco use while hiring employees with any false declaration leading to legal proceedings.

n) Public sector undertakings (PSUs) and corporate offices declare themselves as smoke- free to protect employees from second-, third- and fourth-hand smoke as well use of any other kind of tobacco and/or nicotine product.