

Barriers to Smoking Cessation in Marginalized Communities and the Use of Harm Reduction Products in Islamabad, Pakistan

Submitted
by



List of Acronyms

Burden of Disease	BoD
Framework Convention on Tobacco Control	FCTC
Federal Excise Duty	FED
Gross Domestic Product	GDP
Grounded Theory	GT
Harm Reduction Products	HRPs
Key Informant Interviews	KIIs
Primary Sampling Unit	PSU
Pakistan Tobacco Board	PTB
Pakistan Tobacco Company	PTC
Second-hand Smoke	SHS
Secondary Sampling Unit	SSU
World Health Organization	WHO

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Executive Summary

More than 23.9 million people use tobacco in Pakistan. This makes the country to have one of the largest smoking populations in the world, with grave health consequences, especially for the poor and the marginalized. According to World Health Organization, Pakistan has a heavy burden of disease because of tobacco use. The probability of dying between age 30 and exact 70 from any of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases are higher in Pakistan than in India, Bangladesh and Sri Lanka. The rate of quitting smoking in Pakistan is one of the lowest in the world – 2.6%. The main barriers to quitting smoking in Pakistan are lack of medical and clinical assistance, peer pressure, easy availability of cheap and illicit cigarettes, and low perceived risks of smoking. There is a dearth of literature on smoking cessation in Pakistan. Additionally, almost no work has been done on smoking cessation in the marginalized communities.

This study explores barriers to smoking cessation in the marginalized communities in Islamabad and the possibility of their use of harm reduction products, mainly e-cigarettes. Using primary data collected from KIIs with the members of marginalized communities, the respondents were selected through two-stage sampling. We interviewed 48 KIs, who were selected from eight randomly selected marginalized community areas.

This study has used multiple domains under various indicators to assess barriers to smoking cessation in the marginalized communities by using the inductive technique. These include demographic and socioeconomic background of smokers, smoking and cessation behavior, barriers to smoking cessation, factors that can convince a smoker to stop smoking, the possible use of HRPs for the purpose of smoking cessation besides examining the individual perception regarding smoking cessation policy. In this sample study, respondents have low income and educational levels. Most of the respondents have education below the tenth grade while the average income is Rs11000-Rs30000. With no permanent source income, most of the respondents are self-employed.

Results

In the marginalized communities, there is a likelihood of smoking initiation before 15 years of age. This may be due to presence of elder smokers in the household (fathers, uncles, brothers etc.), no parental guidance or control, lack of knowledge about legal age for initiating smoking, and weak enforcement of tobacco laws. Peer pressure is a major barrier to smoking cessation in the marginalized communities.

Critically, the environment in which smoking is an accepted social behavior works both ways – as an attractive and accepted invitation to initiating smoking and as a strong barrier to giving it up.

The main reason for starting smoking is the company and friendship of smokers in the household, outside the household, and at the workplace. The environment in which smoking is a normal social behavior leads young people to initiating smoking in their teens. The curiosity of trying out smoking just for the fun of it is a major reason for a teen becoming a smoker. In this sample study, most of the smokers have made at least one attempt to quit smoking. However, these attempts have been made without any medical help. Most of the quitting attempts in Pakistan are made without assistance.

The study participants did not know about the presence of smoking cessation clinics in Islamabad or elsewhere in Pakistan. Some of them for the first time in their lives have come to know about a smoking cessation clinic. As the marginalized communities' access to health facilities in Pakistan is limited, their lack of knowledge about the smoking cessation clinics is understandable. Further, lack of knowledge about the health hazards of smoking seems to be the major reason for not seeking medical assistance for quitting smoking. The respondents in the marginalized communities did not consider smoking a health issue and therefore did not feel the need to consult a doctor in this regard.

As none of the respondents has been able to quit smoking despite making many attempts, they try to justify the failure in two diametrically opposed attitudes – helplessness in giving up smoking and the expression of confidence in their will to quit as and when they want. For most of the KIs, increase in the prices of cigarette packs would force them to look for cheaper alternatives. The availability of cheaper and illicit cigarette brands is a major issue in Pakistan. Though none of the respondents has succeeded in quitting smoking, most of them seek help in this regard. They want smoking cessation clinics at health facilities.

Currently the knowledge about HRPs, especially e-cigarettes, in the marginalized communities of Islamabad can be described as vague. None of the respondents has used the HRPs with the intent of smoking cessation. Those who used e-cigarettes did so more out of curiosity than anything else. There was no evidence of any respondent opting for a longer use of e-cigarettes with the intent of harm reduction or smoking cessation. Friends are the main source of knowledge about HRPs. The respondents who said they have used an e-cigarette took it from their friends. Members of the marginalized communities may know about HRPs but they seem uninterested in buying them, largely because of their higher prices. A vaping device in Pakistan costs Rs5000-Rs20000 (30-125 US dollars). Most of the

respondents in this study are smoking local cigarette brands which cost less than Rs2100 (14 US dollars) a month.

Recommendations

- Smoking cessation mechanisms seems to be missing from the tobacco control efforts in Pakistan, especially for the marginalized communities. Evidently, the smokers in the marginalized communities need help in quitting smoking. There is a need for establishing smoking cessation clinics in hospitals and creating buy-in about them through mass awareness.
- Pakistan needs to increase the prices of cigarettes by increasing taxes on them. Easy availability of cheap smoking options is a major barrier to smoking cessation.
- Pakistan also needs to develop durable mechanisms to control illicit trade of cigarettes in order to restrict the options of buying cheap illicit or smuggled cigarette.
- The other demand side barrier is lack of tobacco-control law enforcement, especially in the marginalized areas. Tobacco law enforcement on smoking at the public and private places should be ensured.
- Lack of knowledge about alternatives (HRPs) to combustible smoking and their higher prices in Pakistan are a barrier to adopting them. There is a need for creating an understanding about HRPs, which should be backed by sensible regulation.
- There is a need for more research on HRPs in Pakistan. Currently the use of HRPs, mainly e-cigarettes, is unregulated and limited to the upper and middle classes. The unregulated use of HRPs in a regulatory vacuum may create space for abuse of HRPs in the form of fake products.
- The research on HRPs should be backed by advocacy campaigns in Pakistan and interaction with policy makers in order to highlight the potential of HRPs in smoking cessation. As the use of e-cigarettes are increasing, it will attract more attention, both by the government and the tobacco control stakeholders. In order to present a clear picture about HRPs, there is a need for more work on them.
- As Pakistan is one of the largest tobacco growing countries, there is a need for a transformative study on tobacco farmers in Pakistan, providing them equally profitable alternative crops in line with a local agro-climatic zone.

1 Background

WHO terms the tobacco epidemic a threat killing more than eight million people a year. It estimates that most of the 1.1 billion smokers worldwide are in low- and middle-income countries “where the burden of tobacco-related illness and death is heaviest”.¹ This makes tobacco use a major contributor to health inequalities ([Been et al., 2014](#)). Health is the second major component of human capital after education ([Hameed & Qaiser, 2019](#)). In terms of economic, human productivity and health expenditure globally, the price of tobacco use is heavy as WHO estimates “US\$ 1.4 trillion in healthcare costs and lost productivity each year”. Understandably, world needs a strong and combative monitoring and prevention policies to control smoking use to save the millions of lives ([WHO, 2017](#)).

Historically, the higher income or developed countries have reduced the number of tobacco smokers significantly since the 1970s (see Figure 1.1). Here the important question is how the developed countries have been able to reduce smoking prevalence. This largely happened on the back of public awareness of the importance of health, and the introduction of smoking control measures, including price, legislation and taxation ([GSTHR, 2018](#)).

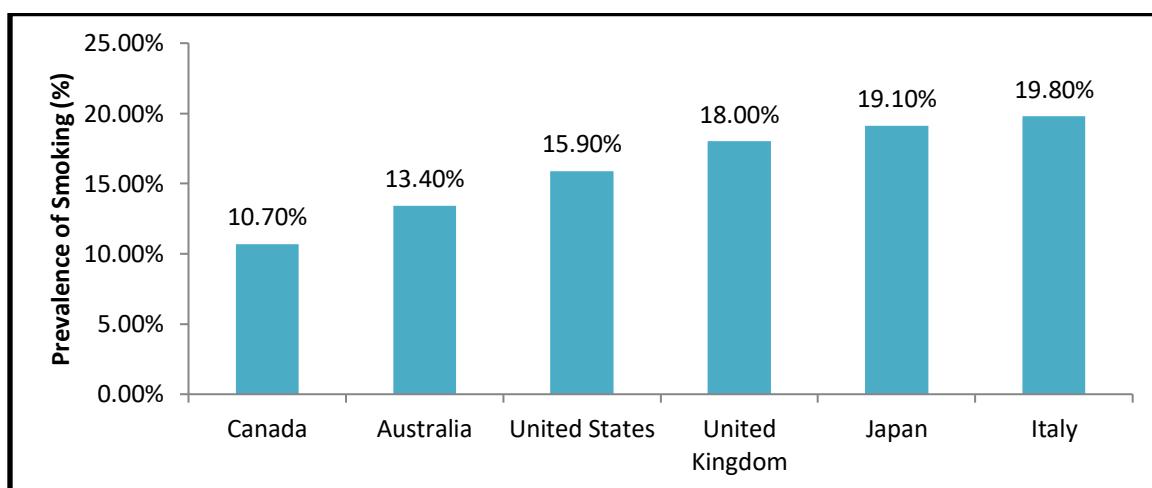


Figure 1.1: Lowest prevalence of smoking in high-income countries (2015)

Source: WHO report on the global tobacco epidemic, 2017, Country profiles http://www.who.int/tobacco/surveillance/policy/country_profile/en/. Note: more recent national surveys may show different figures. Country data available at www.gsthr.org.

Despite reduced number of smokers in many countries, still population growth adds to increase the number of smokers globally. Of this number, around 6 million are dying due to direct consumption of tobacco and 890,000 people are dying as the result of second-hand smoke (SHS). The SHS is also dangerous for those who do not directly consume tobacco. According to the WHO's sub-regional survey data analysis in 2004, the proportion of children and non-smoker exposed by the SHS indicates that 40%

¹ <https://www.who.int/news-room/fact-sheets/detail/tobacco>

children and 33% of male non-smokers, and 35% of female non-smokers were exposed to SHS. The highest prevalence was observed in Southeast Asia, Europe and the western Pacific, where more than 50% different population groups exposed by the SHS (Öberg, Jaakkola, Woodward, Peruga, & Prüss-Ustün, 2011)

Cigarette smoking is the most common as well as one of most important preventable causes of lung, liver, mouth and throat cancer, chronic obstructive pulmonary disease (COPD), heart disease and stroke. According to WHO, between 1999 and 2016 cigarette consumption has decreased in AMRO, EURO and WPRO (excluding China) regions by .29 trillion, .23 trillion and 0.16 trillion respectively. However, the consumption has increased in other all-remaining regions such as China (0.71 trillion), AFRO (0.03 trillion), EMRO (0.09 trillion), SEARO (0.23 trillion). The most burden of cigarette consumption has increased in China and Southeast Asia regions (Ezzati & Lopez, 2004).

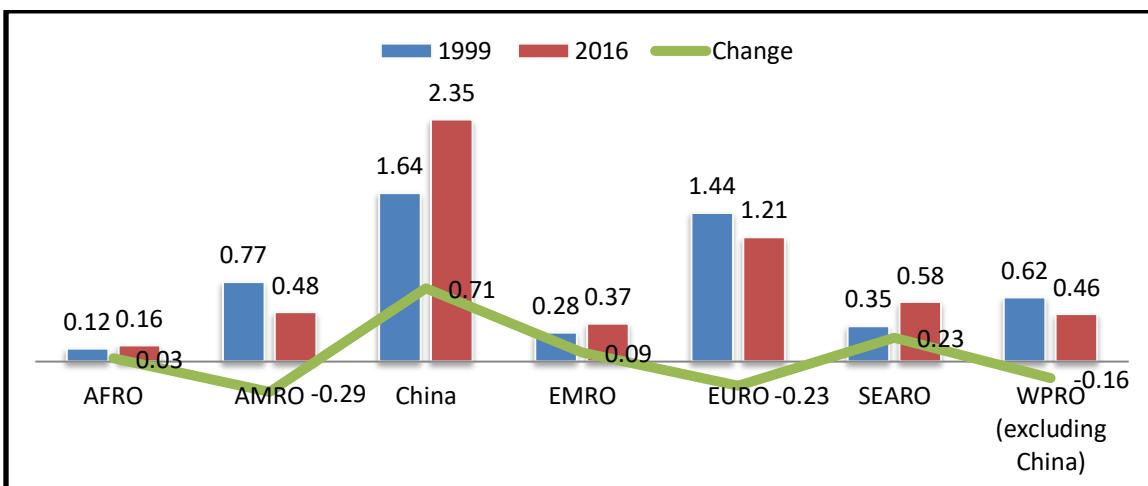


Figure 1.2: Global Cigarette Consumption by WHO Region, 1999-2016, in trillions

The South and Southeast Asian countries are the home to 400 million tobacco users, where 1.2 million individuals die every year (WHO, 2011). Pakistan, India, Bangladesh and Sri Lanka are the most vulnerable countries in Asia where a large number of people used tobacco and combustible cigarettes (Sreeramareddy, Pradhan, Mir, & Sin, 2014). Pakistan and Bangladesh are among nations where a large number of adults 15-65+ years of age people use tobacco smoking (Rafique et al., 2018).

1.1 Tobacco Smoking in Pakistan

Several tobacco products, such as cigarettes, water pipe, shisha, pan, gutka, and niswar are consumed in Pakistan (Khan, 2012). Today Pakistan has around 23.9 million tobacco users². Other estimates put the number at more than 24 million.³

In Pakistan, tobacco is a major cause of diseases such as cardiovascular, lung cancer, emphysema, chronic bronchitis etc. SHS is an equally hazardous for child health and aggravates childhood illness (NIPS & ICF, 2013).

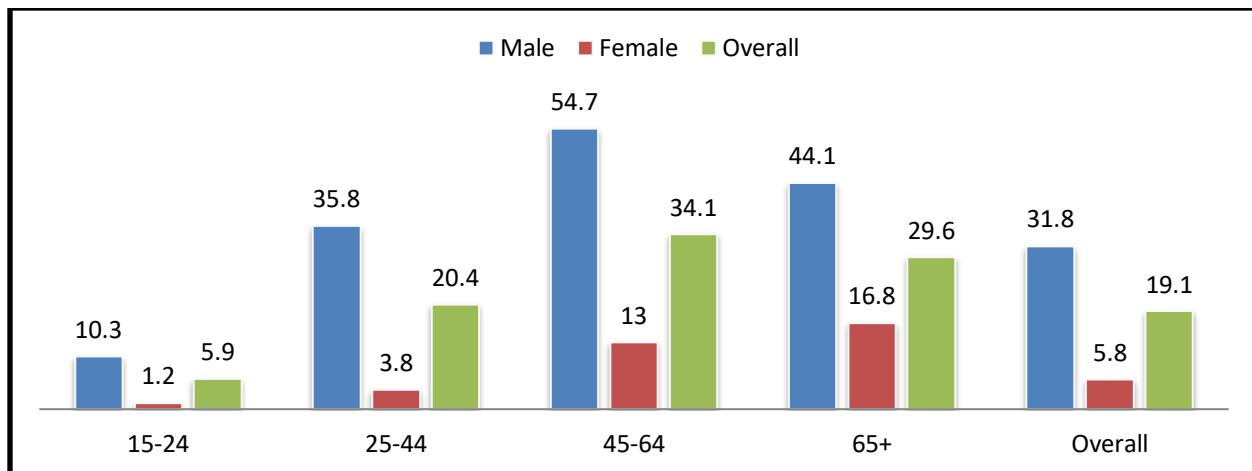


Figure 1.3: Prevalence of tobacco smoking among adults 15-65+ years of age

It is evident (Figure 1.3) that in Pakistan tobacco prevalence percentage expanded with the expansion of age, from 5.9% among 15-24 to 34.1% among 45-64 and diminished among 65 and plus. The greatest incidence of tobacco use is in males between those ages 45-64⁴. According to Pakistan Demographic and Health Survey (PDHS), in 2017-18, 23% males and 5% females are using any type of tobacco product, including cigarettes, hookah, shisha (water pipe), paan, gutka and niswar. PDHS indicates that 22% male and 3% female are currently smoking cigarettes, where 20% male smoke daily and 2% occasionally. The large number of individuals are exposed to the SHS at the government offices/buildings, healthcare facilities, restaurants and public transport (NIPS and ICF, 2019). According to Global Adult Tobacco Survey (GATS) in 2014, 64.6% were exposed to SHS at government institutions, including 69.1% males and 45.1 females. Worryingly 37.6% were exposed to SHS at healthcare facilities, including 42.3% males and 32.8% females. A majority (86%) was exposed to SHS at public places such as restaurants (88.8% males and 55.7%

² Fact Sheet, Pakistan [available at <http://www.tcc.gov.pk/fact.php>]

³ Euromonitor International. 2018. Smokeless Tobacco and Vapour Products in Pakistan. Pp. 11

⁴ <https://extranet.who.int/ncdsmicrodata/index.php/catalog/257/download/2159>

females) and followed by public transportation, where 76.2% were exposed to SHS - 84.6% males and 61.9% females (see Figure 1.4).

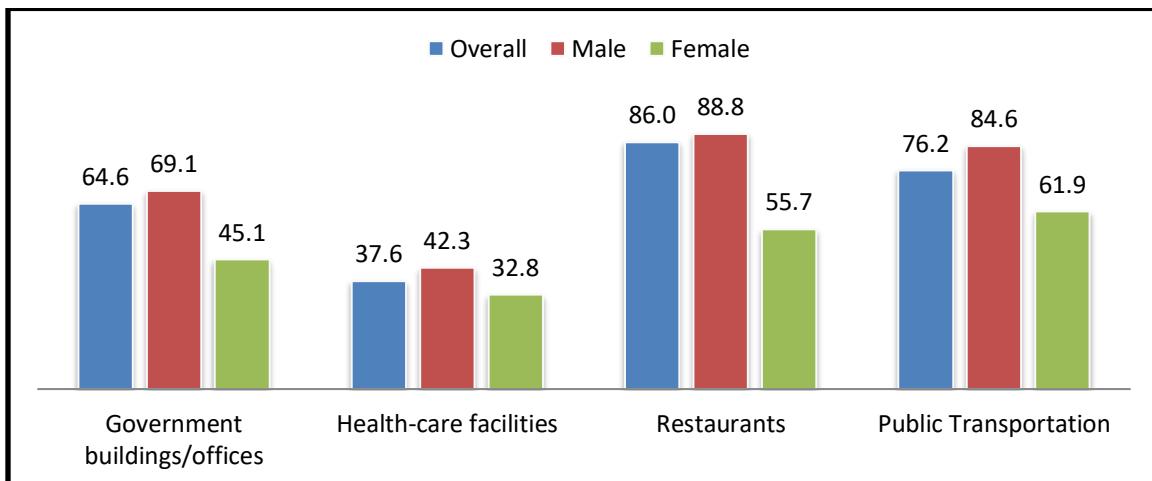


Figure 1.4: Exposed to second-hand smoke in Pakistan, 2014

1.2 Tobacco Economic in Pakistan

Pakistan is one of the top countries producing tobacco after India in South Asia. However, tobacco farming's share in overall irrigated land of Pakistan is 0.25%, with 75,000 growers in the country, most of them in Khyber Pakhtunkhwa province.⁵ Pakistan was ranked ninth in 2016 among top ten countries producing raw tobacco. Overall tobacco produce is 0.42% of total farming produce in Pakistan (SPDC, 2018b). Similarly, the employment in the tobacco is 0.03% (8200) of the employment in agriculture sector.⁶ Almost all 45000 tobacco producers in Khyber Pakhtunkhwa are "producing 95% of Flue Cured Virginia (main ingredient of cigarettes) on an area of 30,000 hectares in the districts of Swabi, Mardan, Charsadda, Buner, and Mansehra".⁷

Table 1-1: Flue Cured Virginia Tobacco Production and Yield in Pakistan

Years	Area (Ha)	Production (Million Kgs)	Yield (Kg/Ha)
2013-14	27413	90.18	3290
2014-15	30765	79.25	2576
2015-16	29061	72.29	2488
2016-17	26121	64.79	2480
2017-18	24527	68.17	2780

⁵ Pakistan Tobacco Board, Economics Significance of Tobacco [available at <http://www.ptb.gov.pk/?q=node/65>]

⁶ Ibid

⁷ Pakistan Tobacco Board, Economics Significance of Tobacco [available at <http://www.ptb.gov.pk/?q=node/65>]

However, the Pakistan Tobacco Board (PTB) says 350000 workers are directly or indirectly related to tobacco industry, which annually generates Rs300 billion and livelihood for 1.2 million people.⁸ According to Federal Board of Revenue (FBR), Rs111 billion revenue was collected in 2015-16 from tobacco sector.

1.3 Health Situation and Tobacco Use in Pakistan

For WHO, Pakistan is “one of the 15 countries worldwide with a heavy burden of tobacco-related ill health” as “31.8 % of men, 5.8 % of women, and 19.1% of Pakistan’s adult population currently use tobacco in one form or another. Of these, 17.9 % of men, 1 % of women and 9.6 % of the adult population overall are daily cigarette smokers, while 4.4 % men, 1 % women and 2.7 % of the adult population are daily water pipe smokers.”⁹ In Pakistan every year 160100 people are killed by tobacco-caused disease as more than 125000 (10-14 years old) and 14122000 adults (15 + years old) use tobacco daily (Drope et al., 2018).

Healthy people not only contribute effectively and efficiently but also dedicate more time to industrious activities (Khaliq & Ahmad, 2018). In Pakistan, health indicators such as life expectancy, infant mortality, and health expenditure are strongly related to economic growth. Ali, Chaudhry, & Farooq (2012) estimated 2.47% Gross Domestic Product (GDP) decline because of 1% increase in infant mortality. Similarly, Akram & Padda, (2008) maintained that health indicators are positively related to economic growth in the long term.

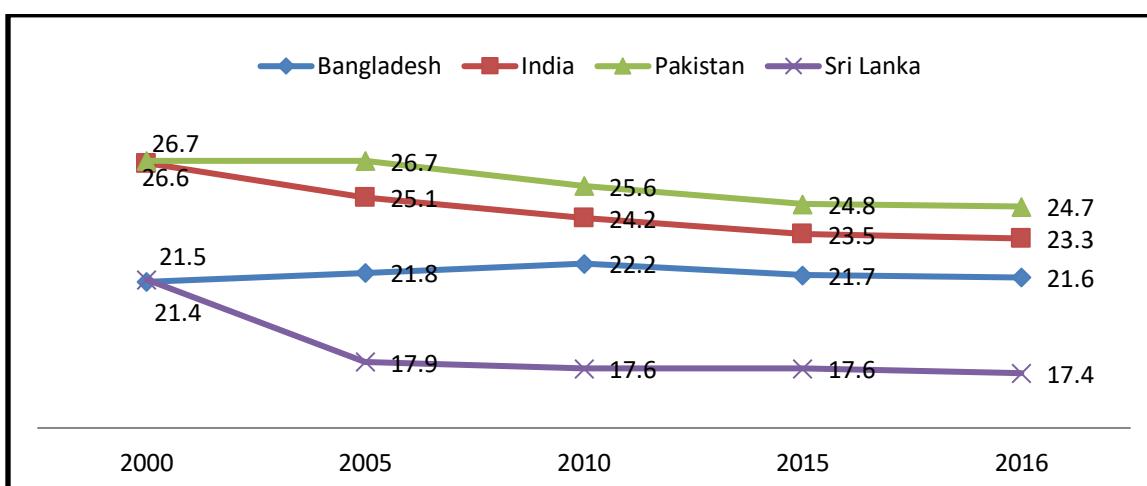


Figure 1.5: Probability (%) of dying between age 30 and exact age 70 from any of cardiovascular disease, cancer, diabetes, or chronic respiratory disease

Source: WHO, 2018

⁸ Ibid

⁹ WHO. Tobacco Control in Pakistan. [available at <https://www.who.int/tobacco/about/partners/bloomberg/pak/en/>]

The probability (%) of dying between age 30 and exact 70 from any of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases is higher in Pakistan than in India, Bangladesh and Sri Lanka. Though overtime the probability (%) has decreased from 26.7% to 24.7% in Pakistan during 2000-2016, it is still higher than India and Bangladesh (see Figure 1.5).

Pakistan is facing a double burden of disease (BoD). The Non Communicable Diseases (NSDs) along with injuries and mental health contributed half in overall BoD. Pakistan is the seventh most diabetic country in the world and one in four adults over 18 years of age is hypertensive, coupled with increased smoking levels. The public health system in Pakistan faces imbalance in numbers, skills and workforce across the country and regional level along with limited resource ([WHO, 2018](#)). As percentage of GDP, Pakistan's health budget was less than most of the countries in 2015-16 (see Figure 1.6).



Figure 1.6: Public health expenditures as % of GDP

Source: World Health Organization Global Health Expenditure database

1.4 Price, Taxation and Legislation for Tobacco Control

Price, tax, and legislation are important policy components for smoking cessation and smoke free environment. These factors are associated with smoking cessation, quitting and switching.

1.4.1 Price

There is an absolute correlation between price and consumption of cigarette even if other factors such as tobacco control programmes, media campaigns, health warnings, attitude, and behavior of smokers remained constant. Studies indicate high smoking prevalence in the developing nations where most of the cigarette smokers live in rural and marginalized areas¹⁰. According to previous study findings, normal

¹⁰ <http://www.actbr.org.br/uploads/arquivo/151ASH-691.pdf>

10% increase in the cost of 20-stick cigarette packet would diminish 4% demand of cigarette among the adult populace ([Abdullah et al., 2013](#)).

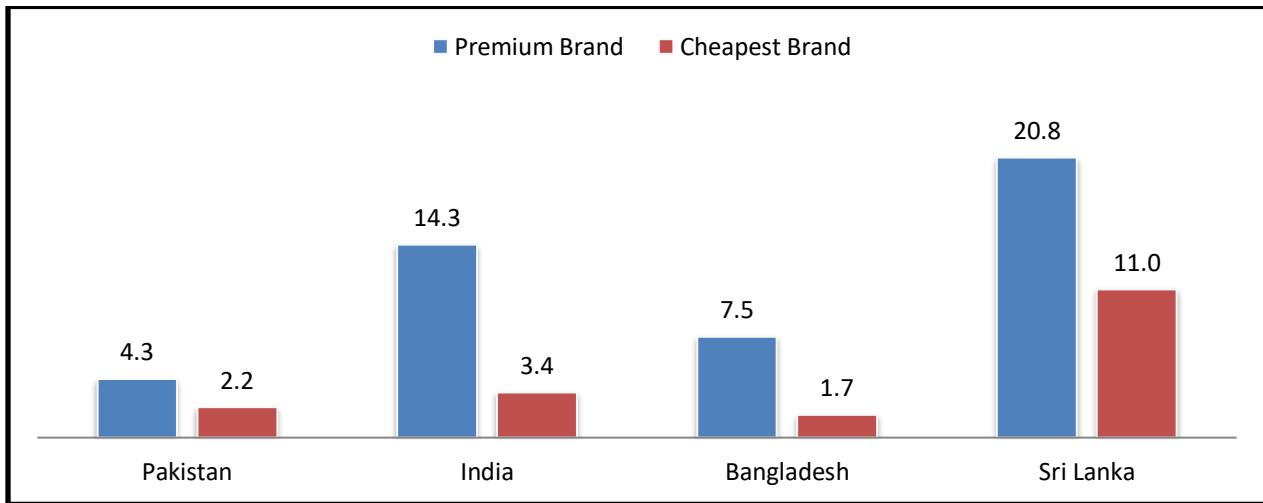


Figure 1.7: Price of 20-piece pack of premium and cheapest brand of cigarette in international dollars, 2016

Source: WHO, 2017

In the developing and low-income nations such as Pakistan, India, Bangladesh, and Sri Lanka high cost premium and cheap low cost cigarette brands area available. A price analysis of 20-piece pack of premium and cheapest brands of cigarette in dollars in 2016 shows the rates in Sri Lanka are higher than in Pakistan, Bangladesh, and India. Evidently, the higher price leads to lower prevalence. The number of cigarette smokers in Sri Lanka and India are less than in Pakistan and Bangladesh (see Figure 1.7).

There are different brand cigarettes are available in Pakistan, including Marlboro, Benson and Hedges, Dunhill, Gold Leaf, Capstan, Gold Flake, Embassy, Morven Gold, Diplomat, K2, Red and White, Gold Street Premium and Kisan. Figure 8 illustrates the price of 20-piece pack of different brands of cigarette in Pakistan at Rs. (\$1=160PKR).

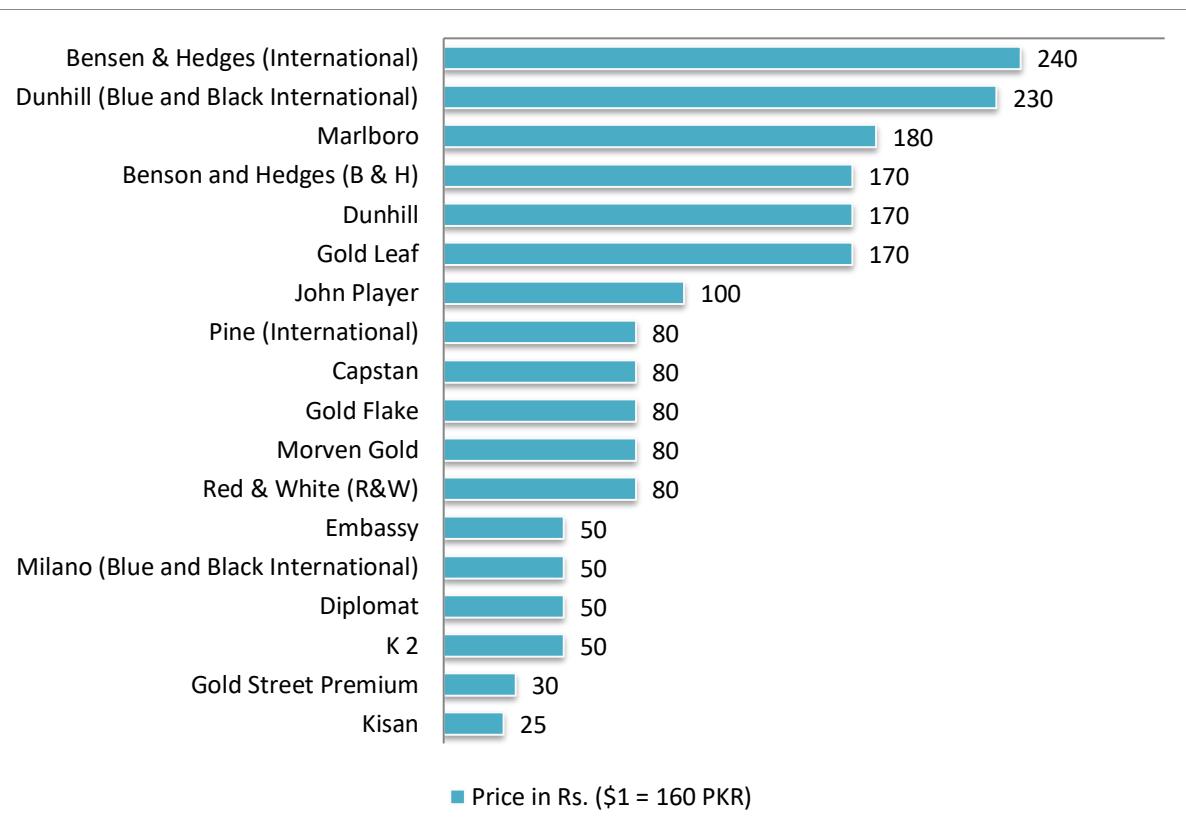


Figure 1.8: Price of 20 piece pack of different brand of cigarette in Pakistan (\$1=160PKR)

WHO supports high taxation on tobacco use in Pakistan. “A uniform specific tax that accounts for 70% of average cigarette price could reduce overall cigarette consumption by 7.5%, increase tax revenues by 27.2 billion rupees, lead to over half a million users quitting and reduce premature deaths among current adult smokers by over 180,000, while also preventing 725,000 youth from taking up smoking” ([Burki et al., 2013](#)).

1.4.2 Taxation

A number of taxes are imposed on cigarettes and tobacco products in Pakistan. These include a provincial tobacco development cess, federal excise duty (FED) on cigarettes, along with general sales tax, and customs and regulatory duties. The main source of revenue is FED, accounting for almost 80% of tax collected from the tobacco industry. The FED on cigarettes has been modified from time to time. The FED structure consists of “a specific tax on low-priced brands, an *ad valorem* tax on high priced brands, and a combined specific and *ad valorem* tax on mid-priced brands”. In 2013, a two-tiered tobacco excise tax system was introduced, as the *ad valorem* tax was withdrawn. Apart from setting tax rates for locally manufactured premium and mid-priced cigarette brands at up to 75% and 57% ([SPDC, 2018](#)), a third tax

tier to a minimum rate of 27% was announced in 2017-18 budget¹¹. The third tier, according to the government, was introduced “to document and curb the menace of illicit trade of sub-standard low-priced cigarettes.”¹²

However, the tobacco control activists opposed the introduction of third-tier, saying it led to increase in gross turnovers/sales volume of Pakistan Tobacco Company (PTC) and Philip Morris Pakistan. “Sales volume of PTC picked up 23% in the 3rd quarter of year 2017 as compared to 2nd quarter. The sale volumes of PMPL also rose during the third quarter of 2017 which are reflected in a profit before tax of Rs. 786 million as compared to loss before tax of Rs881 million during SPLY.”¹³

On the other hand, after the introduction of the third tier, there has been a decrease in the revenue collected from the tobacco industry. The country collected Rs88 billion from tax on cigarettes in 2017-18, down from Rs111 billion in 2015-16. According to the State Bank of Pakistan’s second quarterly report for the financial year 2017-18, “cigarette production witnessed a major turnaround in H1-FY18, with its production expanding sharply by 69.8 per cent compared to a contraction of 30.9 per cent seen during the same period last year. The government’s clampdown on counterfeits, smuggling, and tax evasion helped enhance the share of formal producers in the market¹⁴.” The central bank also attributes slow increase in the overall collection of FED to “a fall in revenue collection from cigarettes by 11.8 per cent, despite a substantial increase in cigarette production. The sudden fall in FED collection from cigarettes was an outcome of a reduction in tax rate on lower tier brands.”¹⁵

In September 2018, the government of Pakistan Tehreek-i-Insaf (PTI) did not abolish the third tier but increased the third tier tax by 46% - a measure cautiously welcomed by the tobacco control stakeholders¹⁶. However, the third tier was finally abolished in June 2019 budget. On the other hand, the government announced but did not impose a sin tax on cigarette packs.

¹¹¹¹ Smokeless Tobacco and Vapour Products in Pakistan, August 2018, Euromonitor

¹² Federal Budget Speech 2017-18, Ministry of Finance, Government of Pakistan.

¹³ SDPI. (2018). Govt Kitty Vs Public Health – The Case of Reduction in Prices of Cigarettes in Pakistan [available at <https://www.sdpi.org/publications/files/Pre-Budget-2018-19-Government-Kitty-vs-Public-Health-The-Case-of-Reduction-in-Prices-of-Cigarettes.pdf>]

¹⁴ The State of Pakistan’s economy, 2018. Second Quarterly Report FY 2018. State Bank of Pakistan, pp21

¹⁵ The State of Pakistan’s economy, 2018. Second Quarterly Report FY 2018. State Bank of Pakistan, pp51

¹⁶ Maqbool, Shahina. Health agencies welcome increase in tobacco taxes, 19 September 2018, The News [<https://www.thenews.com.pk/print/370521-health-agencies-welcome-increase-in-tobacco-taxes>]

1.4.3 Legislation

The first major legislation for tobacco control in Pakistan is the Prohibition of Smoking and Protection of Nonsmokers Ordinance 2002. The ordinance issued by the fourth military government in Pakistan prohibits smoking in public; tobacco advertisement, sale of cigarettes to minors, storage, sale, and distribution of cigarettes in the immediate vicinity of educational institutions, etc. (see Table 1.2). Another ordinance - the Cigarette (Printing of Warning) (Amendment) Ordinance in 2002 – allowed the government to replace the health warning with a sticker and specific warning.

Earlier in 1979, again under the third military government, for the first time, the Cigarettes (Printing of Warning) Ordinance 1979 made health warning a must on all cigarette packs and tobacco ads.

However, it is important to note that no law on tobacco control has been passed by an elected legislature in Pakistan. A bill on tobacco control introduced in the provincial assembly of Khyber Pakhtunkhwa in October 2016 lapsed after the legislature's term expired in 2018. The bill prepared with the technical assistance of WHO was opposed by the cigarette manufacturers and tobacco farmers.

WHO says Pakistan has achieved significant restrictions on tobacco advertisements. These include restrictions on tobacco advertisements on electronic media, newspapers, and magazines. The “ship sized billboards of tobacco advertisements on the roadsides are no more there”.¹⁷

Box-1: Chronology of the Tobacco-Related Legislation in Pakistan

Legislations	Description
Motor Vehicles Ordinance, 1965 (as amended) - July 10, 1965	Sets forth the definition of "public service vehicle." The Prohibition of Smoking in Enclosed Places and Protection of Non-Smokers Health Ordinance, 2002 incorporates this definition with regards to its smoke free provisions. Has been amended several times since.
Cigarettes (Printing of Warning) Ordinance No. LXXIII, 1979 -September 1, 1980:	Requires that health warnings be printed on packets of cigarettes. It prohibits the manufacture, sale, or possession of the packets on which the warning is not printed. Has been amended several times.
Prohibition of Smoking in Enclosed Places and Protection of Non-Smokers Health Ordinance No. LXXIV, 2002 - June 30, 2003	Prohibits the use of tobacco in any place of public work or use and in public service vehicles. It also prohibits: advertisement of tobacco products; sales to minors; and sale or distribution of cigarettes near educational institutions
SRO 655(I)/2003 - June 30, 2003	Establishes the Committee on Tobacco Advertisement Guidelines, names its members, and outlines its functions.
SRO 654(I)/2003 - July 3, 2003	Declares several officials and individuals as persons competent to enforce the 2002 Ordinance.
SRO 653(I)/2003 - July 3, 2003	Declares additional locations as places of public work or use for purposes of the ban on using tobacco products contained in the 2002 Ordinance
SRO 652(I)/2003 - July 3, 2003	Establishes June 30, 2003 as the effective date for the Prohibition of Smoking in Enclosed Places and Protection of Non-Smokers Health Ordinance, 2002.
SRO 1001(1)/2003 - October 27, 2003	Establishes a detailed health warning.
Notification F.13-5/2003 - October 27, 2003	Announces new guidelines issued by the Committee. The new guidelines address a range of issues concerning tobacco advertising, promotion and sponsorship
SRO 22(1)/2004 on Cigarette (Printing of Warning) Rules, 2003 - January 13, 2004	The Rules provide the specifications (text, font, size, color) of the new health warning established by SRO 1001(1)/2003. The Rules also set forth the date when the new health warning will come into force for each of the three types of advertisements.
Federal Excise Rules, 2005 (as amended) - July 1, 2005	For the purpose of tobacco control, the rules include provisions regulating minimum price, excise stamps and banderoles, and some packaging and labelling requirements, among other things.
Federal Excise Act, 2005 (as amended) - July 1, 2005	For purposes of tobacco control, the Federal Excise Act, 2005 establishes the federal excise duties for tobacco and tobacco products
SRO 882(I)/2007 - August 21, 2007	Announces guidelines on tobacco product advertisements in various types of media.
SRO 956 DSA 2008 - September 6, 2008	Allowed establishment of designated smoking areas at all places of public work or use except health, education, and public transport vehicles and flights

¹⁷ Tobacco Legislation –Pakistan, WHO, [available at http://www.emro.who.int/images/stories/tfi/documents/Law_PAK.pdf]

SRO 51(KE)(Withdrawal of DSAs)/2009 - June 15, 2009	Requires all places of public work or use to be 100% smoke free. It rescinded SRO 956(I)/2008, which had permitted owners of places of public work or use to establish designated smoking areas or rooms.
SRO 53(KE)/2009 - July 1, 2009	Amends the advertisement guidelines issued in SRO 882(I)/2007. SRO 53(KE)/2009 inserts new text addressing free goods, cash rebates, free samples, and discount or below market-value goods as a form of tobacco advertising, promotion and sponsorship
SROs 01(KE)/2010 and 02(KE)/2010, Amending the Cigarettes (Printing of Warning) Rules, 2009 - January 11, 2010	Delayed the effective date of pictorial warnings from February 1, 2010 to May 31, 2010
SROs 86(KE)/2009 and 87(KE)/2009 on Cigarettes (Printing of Warning) Rules, 2009 - February 1, 2010	The Rules include the specifications for the new health warning, including size, placement, and rotation requirements. SRO 87(KE)/2009 contains the text and image of the warning to be displayed.
SRO 277(I)/2011 - March 29, 2011	Identifies additional enforcement authorities under the 2002 Ordinance on the Prohibition of Smoking in Enclosed Places and Protection of Non-Smokers Health
SRO 863(I)/2010 on The Prohibition of Sales of Cigarettes to Minors Rules, 2010 - October 1, 2011	The Rules prohibit the manufacture and retailers on the sale of sweets, snacks, or toys in the form of cigarettes that may appeal to minors; as well as packs with fewer than 20 cigarette sticks
SRO 1086(I)/2013 - May 31, 2014	Establishes further restrictions on tobacco advertising, promotion, and sponsorship.
SROs 22(KE)/2015 and 23(KE)/2015 - March 30, 2015	Originally issued to increase the size of the health warnings to 85% of both front and back of cigarette packages. Additionally, the SROs prescribed rules regarding the rotation, manner, look, and design of the single health warning. The original effective date was March 30, 2015, but implementation was delayed several times. Ultimately, the size of the health warnings was amended to require warnings covering 50% of cigarette packs and outer packaging beginning June 1, 2018.
SRO 562 (I)/2018 - April 18, 2018	Raised Federal Excise Duty (FED) on all three tiers of cigarettes that were announced earlier in the finance bill.
SRO 128(KE)/2017 - June 1, 2018	Establishes the warnings required to appear on packs and outer packaging of cigarettes beginning June 1, 2018
SRO 127(KE)/2017 - June 1, 2018	Amends the Cigarettes (Printing of Warnings) Rules, 2009 to require pictorial health warnings on 50% of the front and back surfaces of packs and outer packaging of cigarettes. The size of the warnings will increase to 60% on June 1, 2019

Source: *Economics of tobacco taxation and consumption in Pakistan*: <https://pide.org.pk/Research/Economics-of-Tobacco.pdf>

Under FCTC, Pakistan has taken measures for smoke free environment and completely banned smoking at health care facilities, schools, universities, government offices, public transport, and restaurants. Pakistan also banned tobacco advertising, promotion, and sponsorship along with health warnings on smoking tobacco products (see Table 3).

Box-2: Status of tobacco control policies in Pakistan, India, Bangladesh, and Sri Lanka

	Pakistan	India	Bangladesh	Sri Lanka
Smoke-free environments - complete smoking ban				
Healthcare facilities	Yes	Yes	Yes	Yes
Primary and secondary schools	Yes	Yes	Yes	Yes
Universities	Yes	Yes	Yes	Yes
Governmental facilities	Yes	Yes	Yes	Yes
Private offices	Yes	Yes	Yes	Yes
Public transport	Yes	No	No	Yes
Restaurants	Yes	No	No	No
Bans on tobacco advertising, promotion, and sponsorship				
Domestic TV and radio	Yes	Yes	Yes	Yes
Domestic magazines and newspapers	Yes	Yes	Yes	Yes
Outdoor advertising	Yes	Yes	Yes	Yes
Point-of-sale advertising	No	Yes	Yes	Yes
Retail product display	No	Yes	Yes	Yes
Internet advertising	No	Yes	Yes	Yes
Free distribution	Yes	Yes	Yes	Yes
Promotional discounts	Yes	Yes	Yes	Yes
Non-tobacco products or services with tobacco brand names	No	Yes	No	Yes
Tobacco products with non-tobacco brand names	No	Yes	No	No
Paid placement in media	Yes	Yes	Yes	Yes

Financial sponsorship, including corporate social responsibility	No	No	No	No
Publicity of sponsorships	No	No	Yes	No
Health warnings on smoking tobacco products				
Text warnings describe health impact	Yes	Yes	Yes	Yes
Warnings include a picture or graphic	Yes	Yes	Yes	Yes
Health warnings on smokeless tobacco products	Yes	Yes	Yes	Yes
Warnings are written in the principal language(s)	No	Yes	Yes	No
Ban on misleading packaging and labeling	No	Yes	No	No

Source: Adapted from Tobacco Control (2018), Pakistan - Country Fact Sheets

1.5 Efforts for Tobacco Control and Combustible Smoking Cessation in Pakistan

In order to control tobacco and combustible smoking efforts, Pakistan has taken a number of initiatives, including ratifying FCTC, promulgation of ordinance, prohibition of smoking at public places, creation of National Tobacco Control Cell, etc. The summary of tobacco control efforts is given in Table 4.

Box-3: Tobacco and Combustible smoking control efforts

Prohibition of Smoking and Protection of Non-Smoker's Health Ordinance, 2002	
1.	Ban on smoking in places of public work or use
2.	Ban on smoking in public service vehicles
3.	Regulation of tobacco advertisements
4.	Ban on sale of cigarettes to under-18s
5.	Ban on sale or storage of cigarettes/tobacco products in/near educational institutions.
6.	Mandatory display of "No Smoking" signs at public places.
Cigarette (Printing of Warning) Ordinance, 1979: Amendment in 2002	
1.	Ban on possessing, selling or offering for sale packets of cigarettes without health warning.
3.	Ban on sale of cigarettes in loose form.
4.	Ban on import of Sheesha (tobacco and non-tobacco) and related substances.
5.	Ban on tobacco advertisements in Print, Electronic and Outdoor Media
6.	Ban on manufacturing, importing and selling of cigarette packs having less than 20 cigarette sticks.
7.	Enhancing the size of Pictorial Health Warning to be printed on cigarette packs and outers.
8.	Ban on free samples, cash rebates, discounts and sponsorship of events.
9.	Declaration of places of public work or uses completely smoke-free/ Illegalization of "Designated Smoking Areas".
10.	Increased FED on cigarette packs in 2016-17 and 2015-16.
Infrastructure development / Institutionalization	
1.	Restructuring/Strengthening of National Tobacco Control Cell at Federal Level.
2.	Establishment of Provincial TCC at KPK and Balochistan. Punjab and Sindh committed same.
3.	Formation of National Technical Advisory Group (TAG) at Federal Level.
4.	Formation of Technical Working Group on Tobacco Taxation.
5.	Notified Provincial Implementation & Monitoring Committees / Taskforces.
6.	Notified Districts Implementation & Monitoring Committees.
Awareness / Capacity Building	
1.	Launched 2 national mass media campaigns on tobacco control with the assistance of the World Lung Foundation.
2.	More than 402 capacity-building sessions with law enforcement officers & authorized persons.
3.	Provincial and District Implementation Committee meetings.
4.	Development, printing and direct dissemination to districts of communication materials (1,157,000 units)
5.	Installation of plates / posters carrying "Smoking is an Offense" message in ministries.
6.	Installation of 200 boards with tobacco control messages at public places in Islamabad.
7.	Coordination with PEMRA to air tobacco control messages as mandatory airing of public service messages.
8.	Development and dissemination of advocacy kits on tobacco control (for parliamentarians and journalists).
9.	TV/ Radio Programmes/ Newspapers Articles / City branding.
10.	Production and airing of two documentary films in national and regional languages.
11.	Incorporation of tobacco control messages in curriculum (Punjab has incorporated).
12.	Branding of buses with tobacco control messages in Islamabad/ Rawalpindi.
Enforcement	
1.	Letters to Provincial CMs to enforce tobacco control laws.
2.	Letter to all federal secretaries and provincial chief secretaries to enforce tobacco control laws.
3.	Capacity building of law enforcement officers / authorized persons.
4.	Raids by law enforcement teams.
5.	Penalized Philip Morris Pakistan by Hyderabad Court, on violation of tobacco advertisement guidelines.
6.	Registration of 1396 cases across the country under various sections of 2002 Ordinance.
7.	Directions by provincial IGs for strict enforcement of tobacco control laws.
Monitoring Tobacco Use	
1.	Conducted Global Adult Tobacco Survey (GATS), 2015 first time in Pakistan.
2.	Conducted Pakistan Demographic Health Survey (PDHS), 2012-13.

<p>3. Conducted Global Youth Tobacco Survey (GYTS), 2013.</p>	FCTC Assessment Exercises
<p>1. Conducted FCTC Needs Assessment Exercise (14-17 March 2017).</p>	
<p>2. Conducted FCTC Impact Assessment Exercise (2-5 May 2016).</p>	

Source: Government of Pakistan: <http://www.tcc.gov.pk/achievements.php>

1.6 Challenges for Smoking Cessation in Pakistan

Smoking cessation seems to be a weak link in the fight against tobacco epidemic in Pakistan. The success rate of quitting smoking is less than 3% in Pakistan.¹⁸ According to WHO cessation index, Pakistan offers nicotine replacement therapy and/or some cessation services with at least one cost covered.¹⁹ However, the smoking cessation services in Pakistan are conspicuous by their absence. The smoking cessation clinics established by the Tobacco Control Cell in one of the leading public hospitals in Islamabad turned out to be “ghost” clinics.²⁰ As the information about smoking cessation services is not widely disseminated, hardly anybody knows about them. Even the young educated well-to-do smokers who want to quit do not know about such services.²¹ Because of this lack of knowledge about the smoking cessation services, almost half of the quit attempts are unaided in Pakistan.²² An inadequate healthcare system, lack of smoking cessation policy, a strong influence of tobacco industry, and lack of awareness among people about serious health hazards of smoking are the main barriers to smoking cessation in Pakistan.²³ The primary tobacco law in Pakistan - the Prohibition of Smoking in Enclosed Places and Protection of Non-smokers Health Ordinance, 2002 – does not talk about smoking cessation.

The primary tobacco law in Pakistan - the Prohibition of Smoking in Enclosed Places and Protection of Non-smokers Health Ordinance 2002 – does not talk about smoking cessation. There are many challenges be present for combustible smoking cessation in Pakistan. These challenges consist of;

- Government reliance on tobacco generating revenue.
- General public is not aware of health risk of combustible smoking.
- Lack of combustible smoking cessation clinic in health care institutions at provincial and regional levels.
- Poor implementation of health and cigarette Ordinances at the provincial and regional levels.
- Lack of awareness about harm reduction product and safer nicotine delivery system.
- Lack of scientific research for combustible smoking cessation in academic institutions.

¹⁸ Ibid

¹⁹ <https://tobaccoatlas.org/topic/quitting/>

²⁰ Pakistan Today, PIMS running ghost Tobacco Cessation Clinic, November 1, 2014, [available at <https://www.pakistantoday.com.pk/2014/11/01/pims-running-ghost-tobacco-cessation-clinic/>]

²¹ Kanwal Shaheen, Oyinlola Oyebode and Haleema Masud, (2018). Experiences of young smokers in quitting smoking in twin cities of Pakistan: a phenomenological study, BMC Public Health, pp.4

²² GATS 2014

²³ Abdullah ASM, Husten CG. Promotion of smoking cessation in developing countries: a framework for urgent public health interventions. Thorax. 2004; 59 <https://doi.org/10.1136/thx.2003.018820>.

- Lack of coordination between international and public health organization.
- Poor monitoring combustible smoking use and enforcement among provincial and regional institutions.
- Poor management of illicit cigarette trade controlling.
- Lack of combustible smoking cessation intervention.
- High prevalence of combustible smoking among medical doctors.
- Lack of doctors' training on combustible smoking cessation.
- Poor application of MPOWER measures.

1.7 Study Significance

This study critically provides a perspective on the difficulties of the members of the marginalized communities in Islamabad in quitting smoking. The study also gauges the adult smokers' knowledge and understanding of the health hazards of smoking along with probing the critical question of why the quit attempts remain unsuccessful. It importantly looks into the dichotomy of easy and cheap access to combustible smoking and the non-existent quitting services for the marginalized communities. It also highlights the use of alternatives to combustible cigarette smoking – such as nicotine gums and e-cigarettes - and how their prices are keeping them out of bound of the users in the marginalized communities. Consequently, a comprehensive understanding of the barriers to smoking cessation in marginalized communities will help develop effective interventions, which are indigenous and accessible.

1.8 Limitations

This qualitative study is based on the interviews of the 48 KIs living in the marginalized or poor areas of Islamabad, Pakistan's capital. Therefore, the findings of this study cannot be generalized. This is despite the fact that some of the findings did correspond to national outcomes regarding smoking trends and the cessation efforts. The gender analysis is not part of this study as all the 48 KIs are males.

As the numbers of female smokers are much less than the male counterparts in Pakistan, finding female smokers in the public is a rarity. However, there is a need for an exclusive research on the female smokers in Pakistan.

We planned to interview the tobacco control stakeholders on the barriers to smoking cessation in Pakistan. However, our efforts to meet with the stakeholders were unsuccessful. Our requests for interviews were turned down. The tobacco control stakeholders cited PMI funding for the FSFW as the

reason for not meeting with us. This hampered our investigation into why the smoking cessation has remained a weak link in the fight against tobacco epidemic in Pakistan.

2 Materials and Methods

2.1 Study Area

Pakistan is located in the western part of the Indian subcontinent, with Afghanistan and Iran in the west, Arabian Sea in the south and India in the east. With a population of 207.8 million, Pakistan is the sixth most populous country in the world. Though most of the population (63%) lives in the rural areas, the country's rate of urbanization is highest in South Asia²⁴. The main sources of households' income are based on agriculture and its allied activities (GoP, 2019). Based on the provisional results of the population census, Pakistan Bureau of Statistics (PBS) estimated \$1,641 GDP per capita in 2017-18. In terms of per capita income index in 2018, Pakistan stood 147th in the world²⁵. For this study, KIIs have been carried out with the smokers in the marginalized communities in Islamabad.

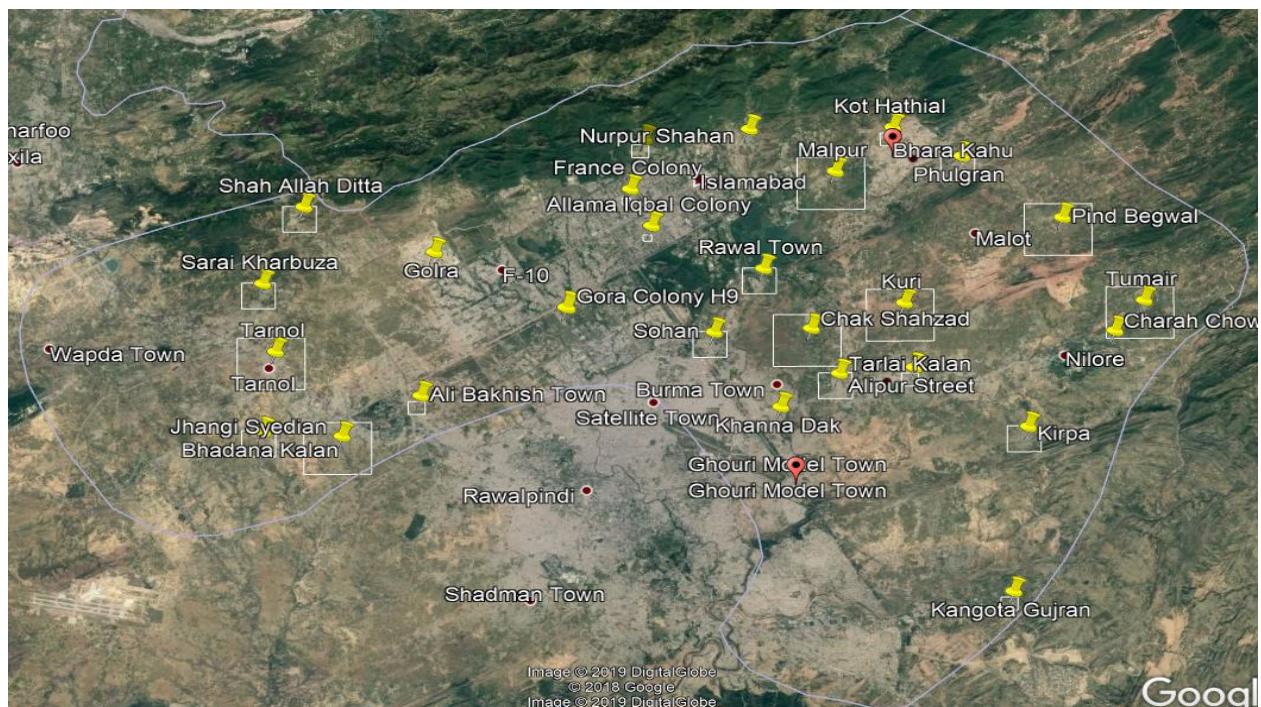


Figure 2.1: Study Area Map (Islamabad-Capital of Pakistan)

2.2 Data

This study has used primary data collected from KIs. Semi-structured questionnaire developed in English was translated into the local language (Urdu) for the understanding of enumerators. For verifying the questionnaire's consistency and flow of questions' reliability, it was re-translated from Urdu to English.

²⁴ <https://dailymail.co.uk/199327/pakistans-urbanisation/>

²⁵ <https://www.ceicdata.com/en/indicator/pakistan/gdp-per-capita>

The selected KIs were initially briefed about the importance of research and questionnaire, which was followed by a verbal consent. The primary data collection questionnaire is based on the local and international literature review on smoking cessation. The questionnaire consists of introduction, respondent's demographic and socioeconomic characteristics, knowledge, and perception about smoking hazards at the individual and community levels, focusing on collecting data on the consumption and smoking quitting pattern in marginalized communities. We have used Pencil and Paper Interview (PAPI) and Digital Voice Recording (DVR) for the primary data collection – a simple but precise technique of collecting data with high quality results and accuracy.

2.3 Sampling Methodology

This study has selected respondents from the marginalized communities to gather qualitative data in Islamabad. Using a self-constructed sampling frame, we employed a two-stage sampling for the selection of respondents.

Sample size and its allocation

Qualitative research needs smaller sample size for the measurement and exploration of objectives and scope compared to the quantitative research. Qualitative sample sizes have to be sufficiently large to obtain enough data to adequately depict the objectives, scope and address the research questions. In other words, the qualitative research is the attainment of saturation at the optimum level. For the grounded theory, [Morse \(1998\)](#) proposed 30 – 50 interviews, while [Creswell \(1998\)](#) suggested only 20 – 30. For this study, we have interviewed 48 KIs, which is enough to obtain saturation. Additionally, KIs were further divided into eight randomly selected marginalized community areas.

Sample selection procedure

The study has used a two-stage sampling to select the primary and secondary sampling units. In the first stage for determining Primary Sampling Units (PSUs), all 14 urban and rural charges²⁶ of district Islamabad were further divided into 28 self-identified marginalized community areas (see Figure 2.1), followed by random selection of eight marginalized areas. In the second stage, the Quick Count listing has been used in each selected PSU for the listing of minimum 40-50 potential individuals target population who have

²⁶ A charge is a census defined geographical area used in the 2017 population census in Pakistan. Each charge has several circles with each circle comprising several census blocks (enumeration areas):

<http://www.statistics.gov.pk/assets/publications/Pakistan%20Population%20and%20Housing%20Census-2017%20National%20Report.pdf>

the first-hand knowledge about barriers to smoking cessation and use of harm reduction products in each selected PSU in line with criteria given below;

- 18 years and above
- Adult smoker residing in the marginalized community area

Further, from each selected PSU and potential individuals' list, the required number of diverse mix of individuals has been selected by using simple random sampling (Secondary Sampling Units) (See Table 2.1).

Table 2-1: Selected PSUs and SSUs

Selected Marginalized Areas	Number of Individuals listed	Selected Individuals
Bhara Kahu	45	6
France Colony F-7	42	6
Ghauri Town	49	6
Golra Sharif	49	6
Gora Colony (Rimsha Colony)	46	6
Saidpur Village	51	6
Tarlai	50	6
Tarnol	50	6
Total	382	48

2.4 Domains & Indicators

This study has used multiple domains to assess barriers to smoking cessation in marginalized communities in Islamabad by using inductive technique. These include demographic and socioeconomic background of smoker, smoking and cessation behavior, barriers to smoking cessation, factors that can convince a smoker to stop smoking, the possible use of HRPs for the purpose of smoking cessation, and gauging individual perception about smoking cessation policy (see Table 2.2). In policy predictors, this study considered four attributes that may impact smoking cessation:

- Individual level control of combustible smoking, for example, use of cigarettes, health related risk, social and family life constrictions, and well-being;
- Community and indoor workplace level control of smoking, for example, prohibited smoking at workplace;
- Smoking control regulation and guidelines; and

- The possibility of use of HRPs to give up smoking.

Table 2-2: Domains and indicators for barrier to smoking cessation

Domains	Indicators
Demographic & Socioeconomic background of Smoker	Age, Gender, Education, Employment Status, Income
Smoking & Cessation Behavior	Use of Cigarettes, History of Smoking and Cessation,
Barriers to Smoking Cessation	Craving, Peer Pressure, Fear of Failure, Fear of Weight Gain
Factors that Can Convince a smoker to stop smoking	Factors related to Health, Monetary value, Social Life, Family Health
Use of E-cigarette	Consumption of e-cigarette, Price of e-cigarette, e-cigarette help in quitting smoking, e-cigarette & health
Policy predictors	Combustible smoking cessation, Health facilities, use of HRP

2.5 Data Analysis

With the help of STATA, qualitative data has been organized and categorized, using grounded theory (GT) under the inductive data presentation and interpretation analysis approach. In the qualitative research, the grounded theory is the most common technique to develop theory on the behalf of grounded data collected ([Corbin & Strauss, 1990](#) & [Lawn, Pols, & Barber, 2002](#)). Furthermore, descriptive and inferential analysis has been employed to assess the barriers to smoking cessation in marginalized communities, including differences in smoking and cessation behaviors, factors that can convince a smoker to stop smoking, and the use of HRPs by sorting demographic and socioeconomic characteristics.

There are three stages for data analysis by using GT methodology.

- **Open Coding:** Using line-coding technique, open-ended questions are coded. In addition, key concepts and statements are moved to subcategories, which are further divided into conceptual components and indicators for understanding and making sense of the collected data.
- **Axial Coding:** At this stage, relationship and causal linkages are constructed between the categories.
- **Selected Coding:** In the last GT is identified by using core categories' relation with other categories.

3 Results and Discussion

3.1 Results

For this cross sectional qualitative study, 48 respondents have been selected from a randomly selected eight marginalized areas of Islamabad. This study has used a semi-structured questionnaire to conduct in-depth interviews of adult smokers (18 years and above) to explore barriers to smoking cessation in marginalized communities in Islamabad and the possibility of using HRPs. Furthermore, the results have been categorized into socioeconomic, combustible smoking use, knowledge about the impact of combustible smoking on health, access to combustible smoking, attitudes towards HRPs use, cessation behavior, and barriers and attitudes towards combustible smoking control. In this study, data analysis is based on the given opinion or response of participants in transcript form under predefined themes. In addition, these textual data have been converted into a numeric number along with participant-coded wordings.

3.1.1 Socioeconomic Background

Socioeconomic factors such as age, education, employment, and income are critical imperatives for any basic social research to understand and assist in making better association of population with study segments and objectives. Age, education level, occupation, and income, as important predictors of cigarette smokers, represent their own causal pathways in explaining inequalities in health and smoking behaviors.

Age in Years:

A distribution of smokers' age, illustrated in figure 1, indicates that out of the 48 respondents, 14.6% were between 18 to 24 years, 54.2% were between 25 to 44 years, and 31.3% were between 45 to 64 years.

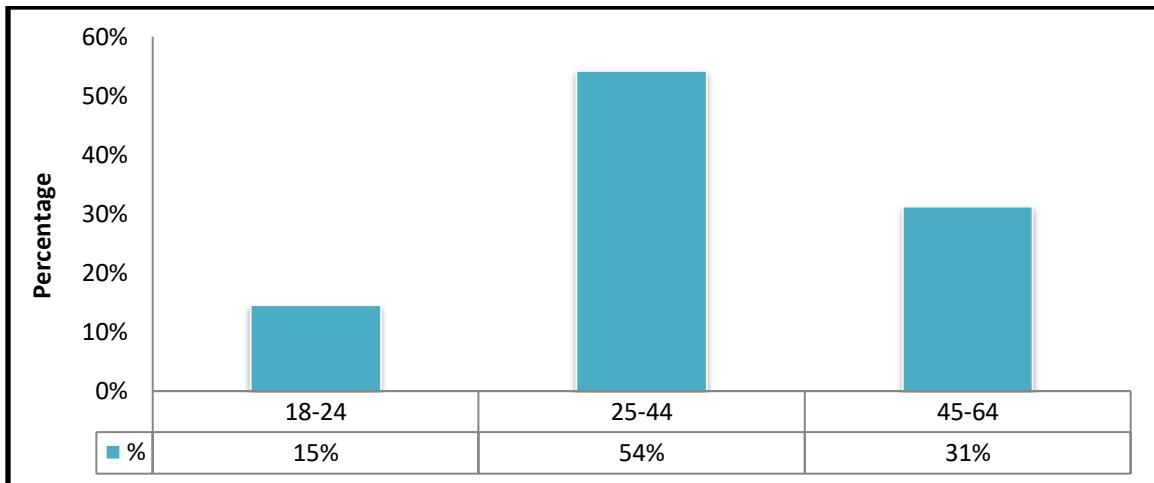


Figure 3.1: Respondents Age in Years

Education:

Populations with lower education or illiteracy have high smoking prevalence as smokers with less education find it more difficult to quit smoking ([Zhuang, Gamst, Cummins, Wolfson, & Zhu, 2015](#)). The education levels (figure 2) have been classified into six groups - bachelors or master's, intermediate (Fsc/FA/A levels/IB/AP), matriculation (tenth grade), middle (eighth grade), primary and illiterate. The majority (68.8%) of respondents have schooling up to matriculation (tenth grade), with only 8.3% going beyond the tenth grade (intermediate, bachelors and master's). At least 14.6% of the respondents are illiterates.

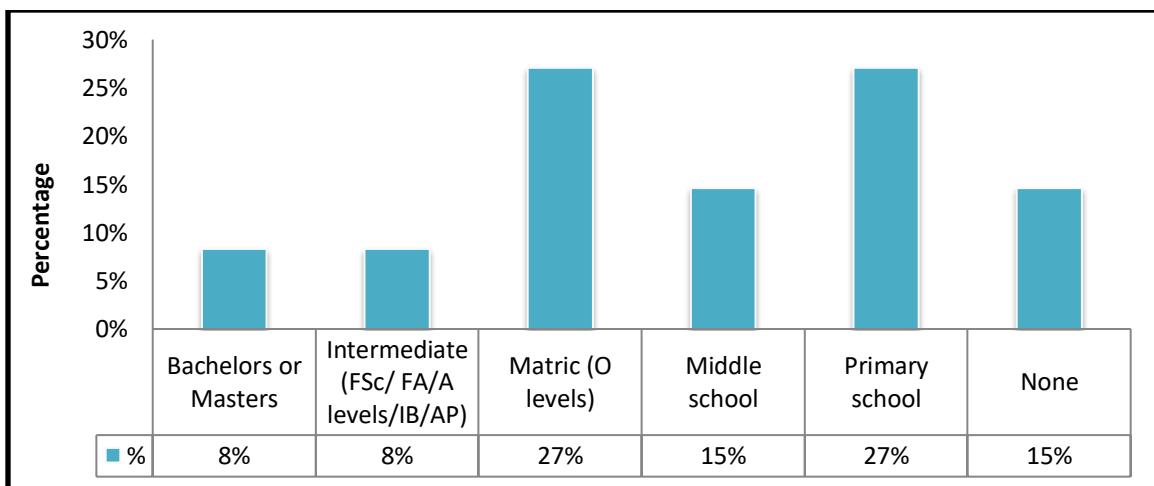


Figure 3.2: Respondents Education

Employment:

Respondents (45.8%) are employed while 47.9% are self-employed and 6.3% are unemployed (figure 3.3). Employment status estimates illustrate that combustible smoking is considerably more common among the self-employed workers compared to those employed and unemployed. However, the proportionate difference between employed and self-employed smokers is insignificant but statistically significant between self-employed and unemployed smokers. Recent studies show lower levels of education, manual occupations, and material disadvantage have also been related to higher rates of smoking ([Leinsalu, Kaposávri, & Kunst, 2011](#)).

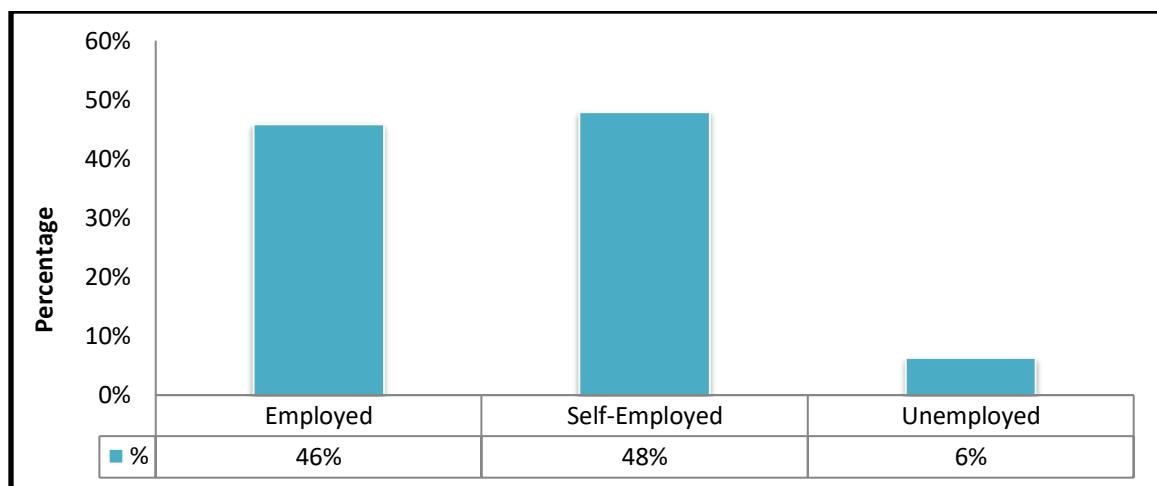


Figure 3.3: Respondents Employment Status

Monthly Personal Income:

The personal income of combustible cigarette smokers (Figure 4) has been classified into four groups – less than and equal to 10k, 11k-20k, 21k-30k and greater than 30k. It indicates that 8.3% combustible cigarette smokers earn a monthly average income less than Rs10000 (67 dollars), 43.8% Rs11000-Rs20000 (73-133 dollars), 33.3% Rs21000-Rs30000 (140-200 dollars) and 14.5% earn a monthly income of more than Rs30000. The average monthly income estimates indicate that the majority of combustible cigarette smokers have average personal income between Rs11000-Rs20000.

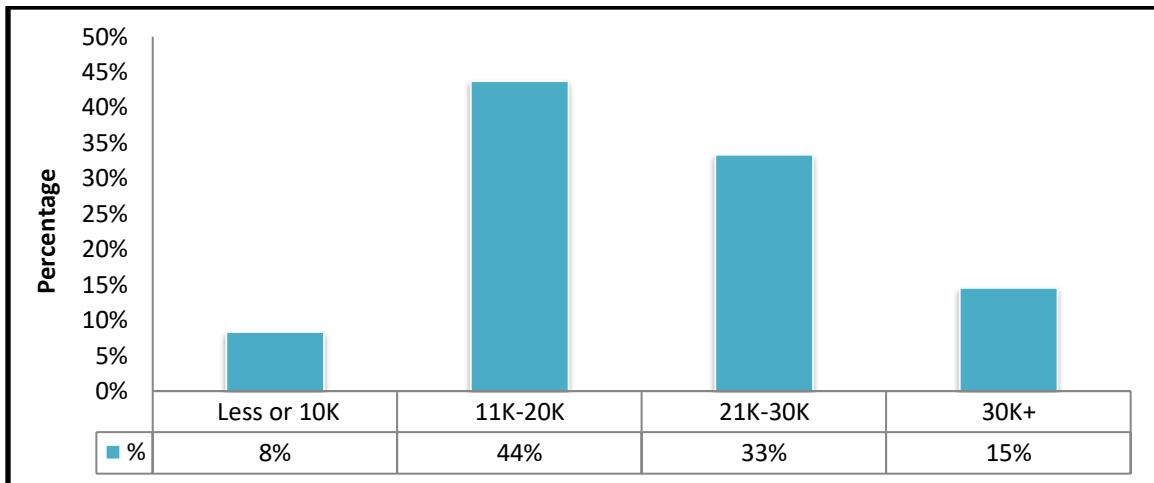


Figure 3.4: Respondents Personal Monthly Income

3.1.2 Smoking Consumption & Cessation Behavior

3.1.2.1 Smoking Consumption Behavior

In the marginalized communities of Islamabad, the chances of males smoking their first cigarette before 18 years are higher than other areas (See Table 3.1). Most of the respondents reported first experience of combustible cigarette smoking between 10-15 years of age. This may be due to presence of elder smokers in the household (fathers, uncles, brothers, etc.), no parental guidance or control, lack of knowledge about legal age for initiating smoking, and its weak enforcement. A respondent reported that he started cigarette smoking when he was *"in the second or third grade"*. As he would play with an older friend who used to smoke, *"we would smoke a bit. Afterwards, I would steal from the cigarette pack of my father one or two sticks. So you can say I started proper smoking, when I was in the fifth grade."* The minimum legal age for buying any tobacco product in Pakistan is 18 years.

Table 3-1: Age at first time smoking of combustible cigarette

Age	%	N
10-15	29.2	14
16-20	33.3	16
21-25	27.1	13
26-30	6.3	3
30 & above	4.2	2
Total	100.0	48

3.1.2.2 Why people start smoking?

The main reason for starting smoking (10-20 years age bracket) is the company and friendship of smokers in the household, outside the household, and at the workplace. The environment in which smoking is seen as normal social behavior by elders and friends leads young people to starting smoking in their teens. It is seen as part of the daily life with no social stigmas attached. Those who have friends and/or parents who smoke are more likely to start smoking than those who do not.

When in their teens the curiosity of trying out smoking just for the fun of it is a major reason for becoming a smoker – 60% smokers attributed their smoking initiation to friends and fun. This indicates that the company of friends who are smokers is a strong pull for initiating smoking. The respondents recalled that when they *saw their friends smoking, they also started smoking*.

The use of a tobacco product in the household as a normal social practice leads to initiation of smoking. A respondent recalled, “*When I was a child, my grandmother used to smoke hukka (water pipe). It was my responsibility after coming from school to fill the water pipe with tobacco. While performing that duty, I would also have one or two puffs of the water pipe. Of course, afterwards I also started smoking cigarettes*”.

At the workplace, the presence of smokers is a major reason for initiating smoking. The combination of economic pressure and the company of smokers is too much to resist. One of the respondents maintained that as he started looking for work after the death of his father, “*most of the people I met with were smokers*”. In the company of smokers, he also took to smoking as a normal social behavior.

In the marginalized communities, smoking is seen as a reliever of stress caused by the constrained economic situation. A respondent said, as he was poor and depressed, he took to smoking to relieve stress. “*Now it is a habit, which is very difficult to give up*”.

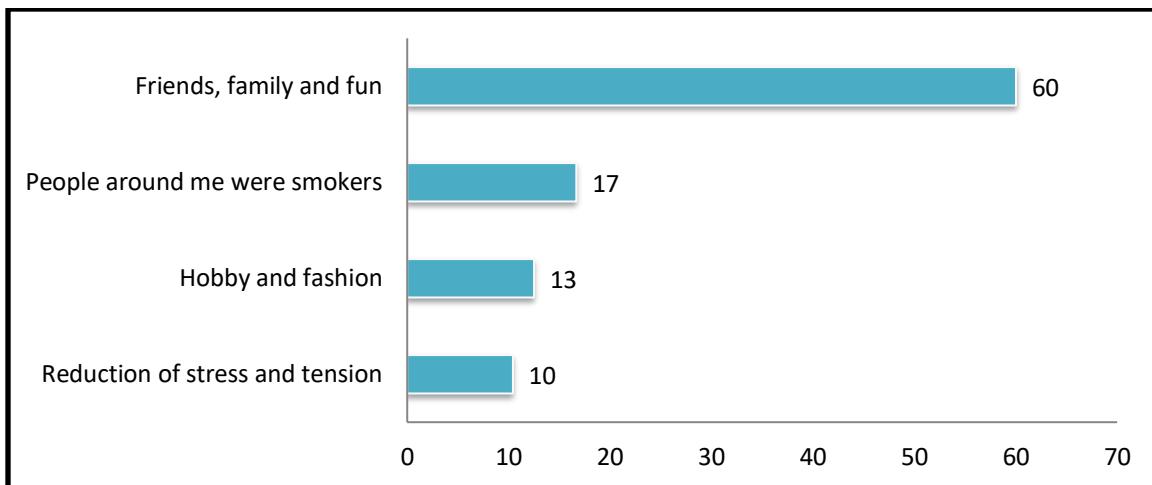


Figure 3.5: Why people start smoking?

Studies indicate strong relationship between health risk and cigarette consumption. In many studies, the lowest cigarette consumption bench was set at 1–9 or 1–15 cigarettes per day, investigating communicable, heart and lungs related diseases (Rosengren et al, 1992; Bjartveit & Tverdal, 2005 and Prescott et al, 2002). However, heavy smoking can lead to schizophrenia (Boksa, 2017). On average, a regular cigarette produces 1 to 2 milligrams of nicotine.²⁷ According to GATS in 2014, on average males consumed 13.7 cigarettes per day in Pakistan.

In the marginalized communities of Islamabad, the smokers are consuming more cigarettes per day than the national level. On average, a regular smoker in marginalized areas in Islamabad smokes 20 cigarettes or a pack per day (See Table 3.2).

Table 3-2: Cigarette Consumption/Per Day

Cigarette consumption/per day	%	N
<10	10.4	5
10-15	18.8	9
16-20	52.1	25
20>	18.8	9
Total	100.0	48

²⁷ <https://www.cancer.org/cancer/cancer-causes/tobacco-and-cancer/why-people-start-using-tobacco.html>

In this study, we asked respondents when and why they smoke more than the usual. More than two-thirds respondents reported smoking more cigarettes than the usual. Tension is the main reason for smokers consuming cigarettes more than their average consumption. Mostly when they are worried, the smokers invariably smoke more. While for others, as smoking becomes habit, it becomes an essential part of the daily life. They may smoke more in the morning and after having lunch. Some said during winters their cigarette consumption increases. Others reported that when they are in the company of friends who are also smokers, they consume more cigarettes than the usual. Similarly, some smokers when busy in a task may smoke more than their usual quota of cigarettes.

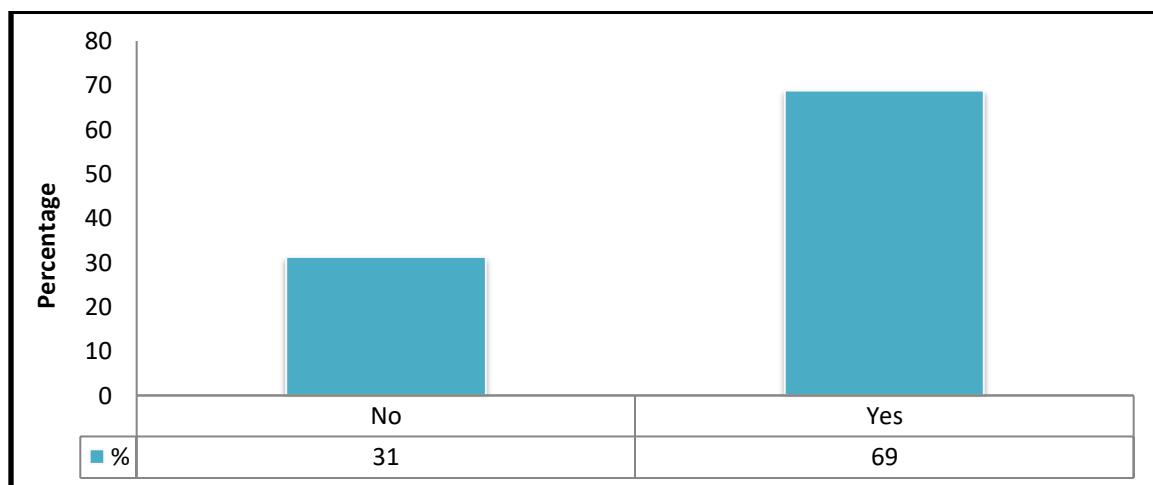


Figure 3.6: Have you ever been more smoking than usual?

For the smokers in the marginalized communities, their choice of cigarette brand is largely driven by affordability (See Figure 3.7). A little more than half of the respondents (54.2%) opted for Capstan, mainly because it is cheap. A pack of Capstan costs less than half a dollar in Pakistan. The possibility of changing brands depending on the income of the respondent in the marginalized communities is frequent. One of the respondents currently using Capstan said earlier he would look for cheaper alternatives. These include locally made unregistered and tax evading cigarette brands. Around 40% of cigarettes sold in Pakistan are smuggled or manufactured by illegal/non-regulated industry.²⁸ As cigarette prices in Pakistan are cheapest in the world(Khan, 2012), the cheaper options for smokers in the marginalized communities are multiple.

²⁸ Senate of Pakistan. (2016). Report of the Senate of Standing Committee on National Health Services, Regulations and Coordination on The Prohibition of Smoking and Protection of Non-Smokers Health (Amendment Bill), 2016, pp. 3 [available at http://www.senate.gov.pk/uploads/documents/1482217221_703.pdf]

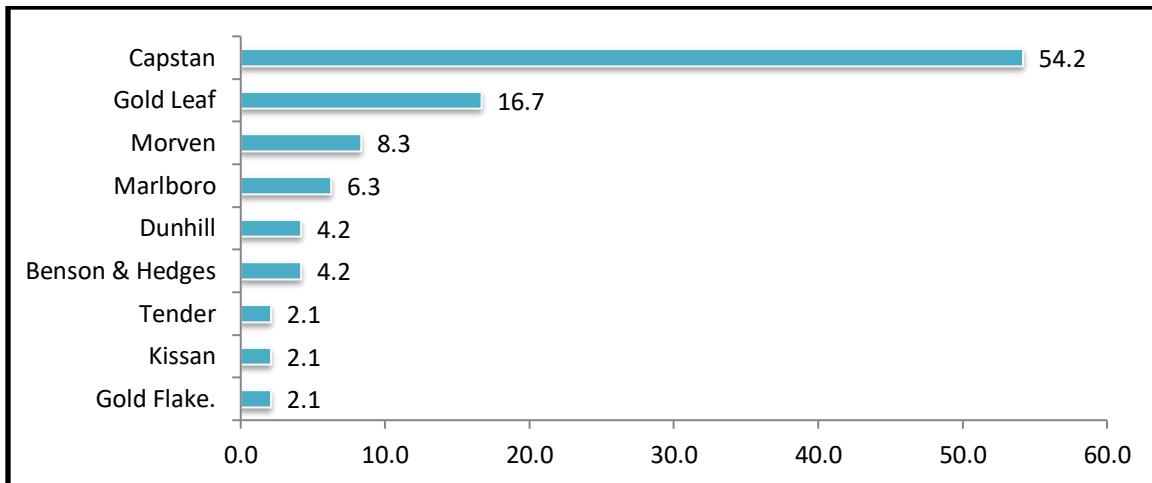


Figure 3.7: Which brand of cigarettes people most like?

3.1.2.3 Smoking Cessation Behavior

For the understanding of smoking cessation behavior, most studies have used daily smoking amount of nicotine or number of cigarettes for assessing quit attempts, quit success, use of cessation assistances ([Fiore et al., 2008](#)). The success rate of quitting smoking in Pakistan is low – 2.6% ([Irfan et al., 2016](#)). Though every year around 25% smokers make an attempt to quit smoking in Pakistan, 97.4% fail to quit ([Shaheen, Oyebode, & Masud, 2018](#)).

In this sample study, most of the smokers (75%) have made at least one attempt to quit smoking. However, these attempts have been made without any medical help. Though respondents made several attempts, they did not succeed in giving up smoking.

Though there is urge to give up smoking, the attempts at quitting are not successful. This fact was highlighted by a respondent who made quit attempt every two months before relapsing into smoking. Numerous experimental studies observed that the main reasons behind the multiple efforts along with high failure rate are lack of clinical and health care delivery systems, effective treatments, practical counseling, and social support ([Fiore et al., 2008](#)).

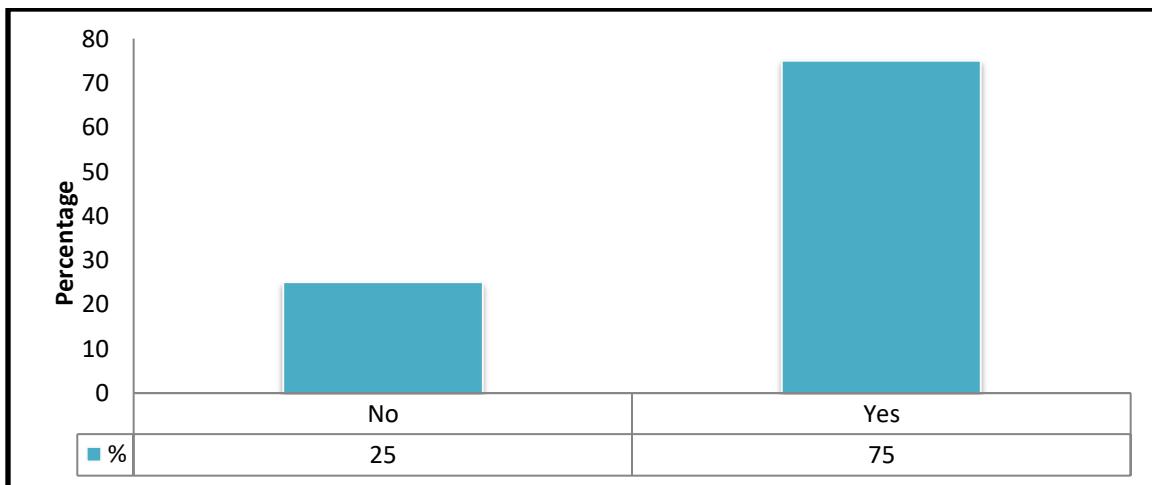


Figure 3.8: Have you ever tried to quit smoking?

Table 3-3: How many times you tried to quit smoking?

Attempts	%	N
One	11.4	4
Two	17.1	6
Three	25.7	9
Several	45.7	16
Total	100	35

3.1.3 Barriers to Smoking Cessation

Barriers to smoking cessation have been drawn from the respondents' self-identified reasons and causes related to smoking behaviors. As we discussed, a majority of smokers reported making several quit attempts but failed every time (See Table 3.3). Though they recognize smoking as a health hazard, they fail to give it up because of their individual beliefs, priorities, lack of knowledge and medical assistance. Most of the quit attempts in Pakistan are made without assistance. According to GATS 2014, 49% smokers tried to quit without assistance while only 9.1% opted for pharmacotherapy and 14.7% used counseling/advise for quitting. As the marginalized community's access to health facilities in Pakistan is limited²⁹, their lack of knowledge about the smoking cessation clinics is understandable.

1. Lack of self-efficacy

Self-efficacy is conceptualized as a self-control or belief in our ability to succeed the given challenges and complete a task successfully (Schnoll et al., 2011). As respondents have been unable to quit smoking

²⁹ WHO reports notable urban–rural discrepancies in human resources, particularly for doctors. An estimated 14.5 physicians per 10 000 population in urban areas is contrasted with 3.6 per 10 000 population in rural areas.

despite making several attempts, they try to justify the failure in two diametrically opposed attitudes – helplessness in giving up smoking and the expression of confidence in their strong will to quit as and when they wanted. One of the study participants said he did not have the will power to quit smoking while another was confident that he would be able to quit whenever he decided to. Others said the habit of smoking is too strong to quit.

2. Physiological barriers to cessation

At the individual level, physiological factors such as tension, stress, and headache are common in smokers. For one of the participants, worries keep him glued to smoking. While another maintained many reasons for not quitting smoking. These included tension, stress, headache, and poverty. However, a participant saw companionship in smoking, saying, "*when one is alone, what should one do but smoke. Cigarette is your companion in loneliness.*"

According to the literature, though the long usage of smoking leads to stress, tension, and headache, smokers feel smoking provides them relief. In the long run, it becomes a habit and creates stress, anxiety, and tension.

3. Peer Pressure

Peer pressure is a major barrier to smoking cessation. It is important to highlight that the environment in which smoking is accepted as normal social behavior works both ways – as an attractive and accepted invitation to initiating smoking and as a strong barrier to cessation. Friends, family members, school and collage fellows, and colleagues play a significant role in how an individual makes decisions³⁰. The participants' inability to resist peer pressure - the company of smoker's friends – remains a strong barrier to quitting smoking. One of the participants narrated the difficulty in saying no to smoker friends.

"If you have friends who are smokers, it is very, very difficult to give up smoking. When you are with them, you are bound to smoke."

Mostly respondents reported that close friends and surrounding environment are a barrier.

"It has happened more than often that I am in one of those quit smoking periods, when I met a smoker friend. And before I know I started smoking again."

³⁰ <https://novarecoverycenter.com/addiction/peer-pressure-and-drug-abuse-2/>

Some respondents understood that smoking brings no relief from tension and worries but pointed out that an environment in which smoking is accepted behavior, cessation is a difficult task.

"People think smoking brings some kind of relief, such as you forget your worries. I do not think that is the case. Peer pressure is a major hurdle in smoking cessation. Your surroundings are most critical to your attempt to quit. When you are among smokers, you will inevitably will start smoking sooner or later. Even a non-smoker will start smoking."

4. Craving

Some of the respondents said craving for the habit of smoking is a barrier. They say the habit of holding something in their hand, especially when they are alone, is too strong to give up. Even the real-real examples of how combustible smoking results in serious health problems fail to convince them to quit.

"One of my cousins in Lahore fell ill because of smoking. He was admitted in a hospital for heart disease. I saw his condition, got scared, and decided to quit smoking. For a brief period, I thought about getting sick because of smoking. I could not quit smoking because of its craving. You know your hands need something to hold and smoke. Your hands grow used to holding a cigarette"

5. Policy barriers

- Almost all the respondents called for strong restrictions on cigarette smoking. This was despite the fact that none of them seems to have no immediate plan to give up smoking. They wanted to ban combustible smoking inside homes, at public and private working places. In Pakistan, smoking is already prohibited "in all places of public work or use, and on all public transport"³¹. These include health, education and government facilities, universities, indoor offices, restaurants, and public transport but it does not include the category all other public places ([Drope et al., 2018](#)). However, this prohibition on cigarette smoking in all places of public work and transport is weakly enforced.
- Importantly none of the respondents mentioned that smoking is prohibited in all places of public work and on public transport, highlighting the fact that they did not know about it. While talking about banning smoking inside homes, most of the respondents were alive to the fact that children and women should not be exposed to SHS. They supported ban on cigarette smoking inside homes, saying one should not smoke in front of children. Exposure to secondhand smoke is a serious health concern in Pakistan. More than half of the non-smoking adults (56%) and one-third (34%) of youth (13-15 years) are exposed to SHS in public places ([GAT, 2104](#))

³¹ <https://www.tobaccocontrollaws.org/legislation/country/pakistan/summary>

- Though none of the respondents has succeeded in quitting smoking, most of them seek help in this regard. They want smoking cessation clinics at health facilities. As none of them did know about the availability of such clinics in Islamabad or elsewhere in Pakistan, there is a need to create mass awareness about the medical assistance available to give up smoking. As stated above, the success rate of quitting in Pakistan is only 2.6% as nationally half of the quit attempts, according to GATS 2014, have been made without any assistance. Importantly none of the smokers trying to quit smoking in the marginalized areas of Islamabad did seek any medical help from public or private institutions. As they consider smoking a habit with no medical consequences, they thought seeking medical help was not necessary. A respondent said: "I never went to a hospital or a doctor with the intention of quitting smoking. Honestly I never thought about smoking as an ailment." The study participants also did not know about smoking cessation clinics in Islamabad or elsewhere in Pakistan. During interviews, some of the respondents said they have for the first time in their lives have come to know about a smoking cessation clinic. "Frankly, you are telling me that there are smoking cessation clinics in Islamabad or in Pakistan. Before this, I did not know about any such clinic." The combination of not considering smoking a health hazard and a complete lack of knowledge about any medical help to give up smoking comes across as a major barrier to quitting in Pakistan.
- Lack of knowledge seems to be the major reason for not seeking medical assistance for quitting smoking. The respondent smokers in the marginalized communities did not consider smoking a health issue and therefore did not feel the need to consult a doctor in this regard. Further, they did not know about smoking cessation clinics. It is important to note that more unassisted quit attempts have been made in rural (56%) than in urban areas (40%) ([GAT, 2104](#))
- Certainly, there is an urge to quit smoking in the marginalized communities. However, on their own the smokers feel overwhelmed by the environment in which smoking is a normal social behavior. Smokers in the marginalized communities relapse into smoking after making a quit attempt. It is obvious that access to assistance for smokers is critical for making successful quit attempts.

3.1.4 HRP s and marginalized communities

Currently, electronic nicotine delivery systems (e-cigarettes) have become best next alternative for combustible smoking and less harm. According to the proponents, e-cigarettes are 95% less harmful than conventional or combustible tobacco ([Mcneill et al., 2015 & Nutt et al., 2014](#)) and it is useful for smoking quitting ([Bullen et al., 2013](#)).

In Pakistan, e-cigarettes are legally imported and allocated a Pakistan Customs Tariff (PCT) code – 8543 7030. The code describes e-cigarette as “a battery-operated device in the shape of a round tube resembling a normal cigarette...measuring approximately 150mm in length and 11 mm in diameter. The device consists of (i) an atomizing part incorporating an air sensor, a pneumatic pressure switch, a vaporizing chamber, a vaporizer and a replaceable cartridge with a mouthpiece, containing an absorbing material saturated with a liquid to be vaporized, and (ii) a battery part composed of a light-emitting diode (LED), a pneumatic pressure switch and rechargeable lithium battery.” The description also explains its use. “When a user inhales through the device, air flow is detected by the air sensor, which activates an atomizer that heats and vaporizes the liquid in the cartridge. This produces a vapors mist which is inhaled by the user. The product is presented in a box for retail sale together with a power cord, a charger and five cartridges.”

According to vendors, vaping hardware (starter kits and accessories) are imported exclusively from China while e-liquids are imported from the United States, United Kingdom and Malaysia. The HRP users seem indifferent to the question of legal status. Most of the users said they were not bothered about the legal status of vaping in Pakistan.

In this sample study, currently the knowledge about HRPs, especially e-cigarettes, can be best described as vague in the marginalized communities of Islamabad. Only one-third of the respondents said they know about HRPs. It is important to highlight that e-cigarettes are the only HRP they know about. None of the respondents, it seems, used the HRPs with the intent of smoking cessation. Those who used e-cigarettes did so more out of curiosity than anything else. There was no evidence of any respondent opting for a longer use of e-cigarettes with the intent of harm reduction or smoking cessation.

Friends are the main source of knowledge about HRPs. This also shows that the members of the marginalized communities may come to know about HRPs but they at present seem uninterested in buying, largely because of higher prices of HRPs.

An e-cigarette device in Pakistan costs Rs3000-Rs18000 (20-120 US dollars). The expenditure on e-liquids makes e-cigarettes costlier. Most of the respondents in this study are smoking local cigarette brands which

cost less than Rs2100 (14 US dollars) a month. The respondents who said they have used an e-cigarette took it from their friends. Only one respondent said he bought the e-cigarette.

Additionally, most of the respondents (56%) who have used an e-cigarette have no idea about their prices. This is mainly because they took the e-cigarette from one of their friends. It is evident that higher prices of the alternatives to combustible smoking are a major hurdle to using them for smoking cessation or as an HRP. One of the respondents shared his experience of using nicotine gum as a smoking cessation tool. However, he found the nicotine gum expensive. A pack of nicotine gum costing Rs800 (5.3 US dollars) was too expensive for the respondent. However, continued to smoke combustible cigarettes along with the use of nicotine gum.

Though there is vagueness about the HRPs, most of the respondents are ready to use e-cigarettes with the intent of smoking cessation or harm reduction. However, they want the prices of HRPs to be subsidized heavily.

4 Conclusions and Policy Recommendations

This qualitative study explores barriers to smoking cessation in marginalized communities in Islamabad and the possibility of using HRPs. It also explores the linkages between socioeconomic background of smokers with their combustible smoking, knowledge about the impact of smoking on health, access to smoking, and their knowledge and use of HRPs. Following the conclusions and recommendations.

Conclusions

- In the marginalized communities, the first combustible smoking experience usually occurs between 10-15 years age bracket. This may be due to the presence of older smokers in the household (fathers, uncles, brothers, etc.), no parental guidance or control, lack of knowledge about legal age for initiating smoking, etc.
- The main reason for starting smoking (10-20 years age bracket) is the company and friendship of smokers in the household, outside the household, and at the workplace. The environment in which smoking is seen as normal social behavior by elders and friends leads young people to start smoking in their teens.

- In the marginalized communities of Islamabad, the smokers are consuming more cigarettes per day than the national level. On average, a regular smoker in marginalized areas in Islamabad smokes 20 cigarettes or a pack per day.
- Respondents in the marginalized communities reported smoking more cigarettes than the usual. Tension is the main reason for these smokers consuming cigarettes more than their average consumption.
- For the smokers in the marginalized communities, their choice of cigarette brand is largely driven by affordability. They would opt for the least expensive legally sold brand in Pakistan. A little more than half of the respondents opted for Capstan, mainly because it is cheap. As cigarette prices in Pakistan are cheapest in the world, the cheaper options for smokers in the marginalized communities are multiple.
- In this sample study, most of the smokers have made at least one attempt to quit smoking. However, these attempts have been made without any medical help. Though there is urge to give up smoking, the attempts at quitting are not successful.
- As respondents have been unable to quit smoking despite making several attempts, they try to justify the failure in two diametrically opposed attitudes – helplessness in giving up smoking and the expression of confidence in their strong will to quit as and when they wanted.
- Peer pressure is a major barrier to smoking cessation. The environment in which smoking is accepted as normal social behavior works both ways – as an attractive and accepted invitation to initiating smoking and as a strong barrier to cessation.
- Lack of knowledge seems to be the major reason for not seeking medical assistance for quitting smoking. The respondent smokers in the marginalized communities did not consider smoking a health issue and therefore did not feel the need to consult a doctor in this regard. Further, they did not know about smoking cessation clinics.
- Currently the knowledge about HRPs, especially e-cigarettes, can be best described as vague in Islamabad's marginalized communities. None of the respondents, it seems, used the HRPs with the intent of smoking cessation. Those who used e-cigarettes did so more out of curiosity than anything else.
- Friends are the main source of knowledge about HRPs. Additionally; most of the respondents who have used an e-cigarette have no idea about their prices. This is mainly because they took the e-cigarette from one of their friends.

- Higher prices of the alternatives to combustible smoking are a major hurdle to using them for smoking cessation or as an HRP.

Recommendations

- Smoking cessation mechanisms seems to be missing from the tobacco control efforts in Pakistan, especially for the marginalized communities. Evidently, the smokers in the marginalized communities need help in quitting smoking. There is a need for establishing smoking cessation clinics in hospitals and creating buy-in about them through mass awareness.
- Pakistan needs to increase the prices of combustible cigarettes by increasing taxes on them. Easy availability of cheap smoking options is a major barrier to smoking cessation.
- Pakistan also needs to develop durable mechanisms to control illicit trade of cigarettes in order to restrict the options of buying cheap illicit or smuggled cigarette.
- The other demand side barrier is lack of tobacco-control law enforcement, especially in the marginalized areas. Tobacco law enforcement on smoking at the public and private places should be ensured.
- Lack of knowledge about alternatives (HRPs) to combustible smoking and their higher prices in Pakistan are a barrier to adopting them. There is a need for creating an understanding about HRPs, which should be backed by sensible regulation.
- There is a need for more research on HRPs in Pakistan. Currently the use of HRPs, mainly e-cigarettes, is unregulated and limited to the upper and middle classes. The unregulated use of HRPs in a regulatory vacuum may create space for abuse of HRPs in the form of fake products.
- The research on HRPs should be backed by advocacy campaigns in Pakistan and interaction with policy makers in order to highlight the potential of HRPs in smoking cessation. As the use of e-cigarettes are increasing, it will attract more attention, both by the government and the tobacco control stakeholders. In order to present a clear picture about HRPs, there is a need for more work on them
- As Pakistan is one of the largest tobacco growing countries, there is a need for a transformative study on tobacco farmers in Pakistan, providing them equally profitable alternative crops in line with a local agro-climatic zone.

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Qualitative Study Questionnaire

Barriers to smoking cessation in marginalized communities in Islamabad and the use of harm reduction products (HRPs).

Dear,

This is a health related study on the Barriers to smoking cessation in marginalized communities in the Islamabad-capital of Pakistan and the possibility of their use of harm reduction products (HRPs) led by the Alternative Research Initiative (ARI) supported by Foundation For A Smoke-Free World. You will be asked to depict your socioeconomic, smoking knowledge and experience, medical history related to smoking, smoking cessation and so on. All the data which given by you in this survey will be utilized for research purposes only.

Do you consent to participate in this study (please circle one)?

1. Yes 2. No

Individual Questions

1. Gender
2. Education
3. Employment Status
4. Occupation
5. Monthly Income
6. When you started smoking?
7. How many cigarettes do you smoke daily?
8. Now for how many years you have been smoking cigarette?
9. Which type of brand do you like?
10. Why did you start smoking?
11. What did you like about smoking?
12. Have ever tried to quit smoking?
13. How many times did you try to quit smoking?
14. For quitting smoking, did you seek any medical help?
15. If yes, you visited a public or private medical facility?
16. Have you ever visited a smoking cessation clinic in Islamabad or elsewhere in Pakistan?
17. What treatment was suggested for smoking cessation? (NRT, gum, bupropion)
18. For how long the treatment continued before you gave up?
19. What do you think are the reasons for the failed attempt(s) to quit smoking?
20. What do you think are the health impacts of smoking?
21. Have you faced any major illness which you think is/was because of smoking?

Use of E-cigarette

1. Do you know about e-cigarettes or any other HRP?
2. How do you come to know about e-cigarettes or any other HRP?
3. Have you ever used an e-cigarette or any other HRP with the intent of harm reduction or giving up combustible cigarette smoking?
4. From where did you buy the e-cigarette and e-liquid or any other HRP?

5. How would compare the prices of combustible cigarettes and e-cigarettes/any other HRP?
6. If expensive, how did you arrange for buying e-cigarettes and e-liquids or any other HRP?
7. For how long you have used e-cigarettes or any other HRP?
8. If you quit smoking and started again, can you identify the influences that led to relapse?

Perceptions and knowledge

1. Do you think that smoking should ban for both residents and visitors at home?
2. Do you think that smoking should ban in public and private indoor workplace?
3. Do you think the public and private health facilities should have smoking cessation clinics?
4. Have you ever been suggested the use of e-cigarette or any other HRP as a tool for quitting combustible cigarette smoking?
5. Should subsidized e-cigarettes/HRP be provided at the public and private health facilities/smoking cessation clinics?
6. Will you be ready to use subsidized e-cigarettes/HRP as a smoking cessation tool?
7. Do you think the federal and provincial governments should bring in laws/policies to use new alternative products to give up combustible smoking?