TOBACCO-FREE Times

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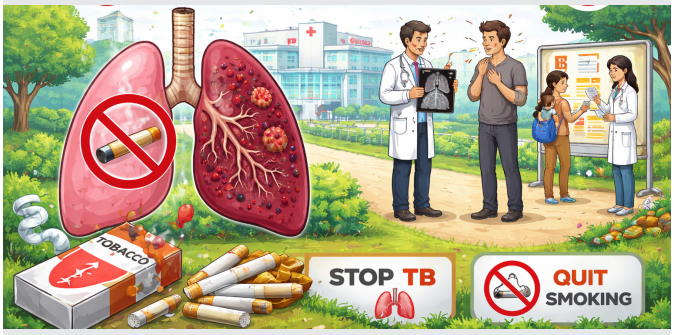
Tuberculosis & Tobacco Control: Advancing Integrated Action for Better Health Outcomes



Turning the Tide on Tobacco: RCTC in Action

The Resource Centre for Tobacco Control (RCTC) at the Department of Community Medicine and School of Public Health, PGIMER, Chandigarh has made a significant contribution to India's tobacco control journey by documenting and promoting effective practices from across the country. Through the publication of the Compendium on Good, Replicable and Innovative Practices (GRIP) of Tobacco Control in India, RCTC has compiled successful initiatives undertaken by different states and stakeholders under the National Tobacco Control Programme. The first two editions of GRIP have served as valuable knowledge resources, highlighting practical, evidence-based strategies that can be replicated and scaled up in other regions. By disseminating these best practices, the compendium has facilitated cross-learning among policymakers, researchers, program implementers, and public health professionals, thereby strengthening tobacco control efforts nationwide. Building on the success of the earlier editions, RCTC is now developing the third version of GRIP, which aims to further expand the repository of innovative approaches and support more effective implementation of tobacco control interventions in India.

Editor's Speak

Tuberculosis and tobacco together form a deadly combination—one that continues to challenge public health systems globally. Tobacco use not only increases the risk of developing TB but also delays recovery and worsens treatment outcomes.

At the Resource Centre for Tobacco Control (RCTC), we emphasize the need for integrated action. Embedding tobacco cessation into TB care is a simple yet powerful step that can significantly improve patient outcomes and reduce transmission. This edition brings focus to the urgent need for collaboration across programmes, stronger capacity building, and patient-centred approaches. By addressing these two epidemics together, we can move closer to achieving better health outcomes and a tobacco-free, TB-free future.

- Dr Sonu Goel,
Director, RCTC, PGIMER, Chandigarh

EXPERTS SPEAK

"RCTC has emerged as a trusted and dynamic resource center for the public health community, particularly for those engaged in tobacco control. Its extensive network and collaborative efforts continue to connect professionals and strengthen tobacco control initiatives across India and globally.

Dr. Rakesh Gupta,
President and Director (Public Health), SIPHER

"RCTC is doing exceptional work in advancing research on tobacco products and highlighting the harms associated with tobacco use. Their efforts are instrumental in influencing policy reforms and strengthening public health initiatives for a healthier future.

Mr. Ranjit Singh,
Legal Expert – Supreme Court of India

PROJECT UPDATES

National Conclave on Best Practices under the National Tobacco Control Programme (NTCP), Chandigarh, 11–12 March 2026

The National Conclave on Best Practices under the National Tobacco Control Programme (NTCP) was held on 11–12 March 2026 at Chandigarh, in collaboration with Vital Strategies. The conclave brought together 35 participants, including public health experts, policymakers, academicians, and programme implementers from across India. The primary objective was to strengthen the documentation and dissemination of best practices in tobacco control and to build capacity for developing structured, evidence-based case studies.

The event was graced by Shri Saurabh Joshi, Mayor of the Municipal Corporation Chandigarh, as the Chief Guest. Distinguished Guests of Honour included Prof. Suneela Garg, Professor Emeritus, National Academy of Medical Sciences, MoHFW, GOI, Dr. Manish Singh, Secretary General, Indian Association of Preventive & Social Medicine (IAPSM) and Dr Shivam Kapoor, Technical Advisor-STOP India and Global Monitoring, Tobacco Control, Vital Strategies. They emphasized the importance of evidence-based documentation and multisectoral collaboration in strengthening tobacco control initiatives.

The conclave featured a series of technical sessions led by eminent experts, including Prof. Sonu Goel, (RCTC & PGIMER), Dr Upendra Bhojani (Institute of Public Health Bengaluru), Dr Yogesh Jain (All India Institute of Medical Sciences Jodhpur), Dr Muralidhar Kulkarni (Kasturba Medical College Manipal), Dr Abhishek Ghosh (PGIMER), and Dr Gopal Chauhan (Govt of Himachal Pradesh). These sessions focused on key aspects of case study development, including framing outcome-oriented titles, defining problem statements, documenting interventions, measuring results, and ensuring sustainability. In total, 21 case studies were developed and presented, highlighting innovative tobacco control interventions across diverse settings.

Plenary Session at the 53rd Annual National Conference of the Indian Association of Preventive and Social Medicine (IAPSMCON 2026), Silvassa – 28 February 2026

A plenary session titled "Role of Medical Institutions in Tobacco Control: Roadmap Ahead" was held on 28 February 2026 during IAPSMCON 2026 at Silvassa, Dadra and Nagar Haveli and Daman & Diu. The session convened leading experts in public health and medical education to deliberate on strengthening the role of academic institutions in advancing India's tobacco control agenda. The session was chaired by Prof. Ashok Bhardwaj, President, IAPSM and Prof. (Dr.) R.C. Goyal, Dean, NAMO Medical Education and Research Institute, with an eminent panel comprising Prof. (Dr.) Pankaj Bhardwaj, Director, ICMR-National Institute for Implementation Research on Non-Communicable Diseases, Jodhpur, Prof. Manish Singh, Secretary General, Indian Association of Preventive & Social Medicine (IAPSM) and Prof. Bhavesh Modi, Director, ICMR - National Institute of Occupational Health, Department of Health Research, MoHFW, Govt of India. The session was attended by over 200 delegates.

Deliberations underscored the pivotal role of medical institutions in advancing the tobacco endgame through evidence generation, capacity building, and systems-level interventions. Key focus areas included integration of cessation services into clinical practice, research and implementation leadership, curriculum reforms, policy engagement, and strengthened community outreach, outlining actionable strategies for coordinated tobacco control efforts in India.

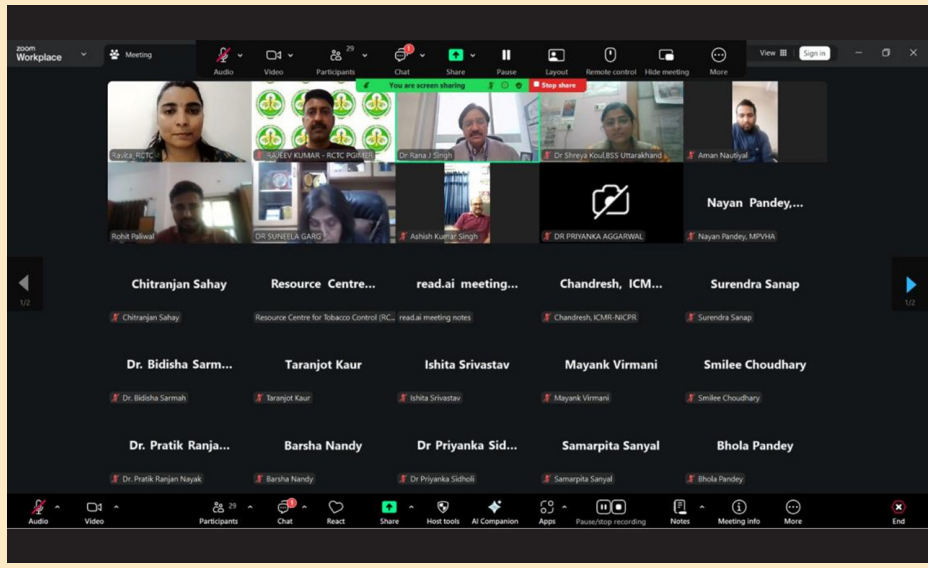
PROJECT UPDATES

Basic Course in Tobacco Control (BCTC): Second Live Interaction Session with Experts

On 2 March 2026, the Resource Centre for Tobacco Control (RCTC) conducted the second live interaction session under the Basic Course in Tobacco Control (BCTC) to strengthen participant engagement and enhance learning outcomes. The session provided a structured platform for participants to interact with facilitators, clarify doubts, and deepen their understanding of Modules 4 to 6. In line with the module-based course design, individual performance reports covering all six completed modules were shared, emphasizing the importance of consistent progress and timely completion.

A total of 36 out of 58 enrolled participants attended the session. The session was facilitated by Prof. Suneela Garg and Dr. Rana J. Singh, who addressed queries through practical examples and detailed explanations. Relevant study materials were also shared to support continued learning. Overall, the session contributed to strengthening conceptual clarity, improving engagement, and preparing participants for subsequent stages of the course.

All nine modules were successfully completed by 14 March 2026, and the practicum phase is scheduled to commence over the subsequent two weeks of March.



Official Release of the 41st and 42nd Editions of Tobacco Free Times – Bi-Monthly Newsletter

The 41st edition of Tobacco Free Times (TFT), the bi-monthly newsletter of the Resource Centre for Tobacco Control (RCTC), was officially released during IAPSMCON 2026 held at Silvassa, Dadra and Nagar Haveli and Daman & Diu on 28 February 2026. The edition focused on the theme "Tobacco-Free Vendor Licensing (TVL): A Smarter Way to Regulate Tobacco Sales," highlighting TVL as a strategic and evidence-based approach to regulate tobacco retail environments, reduce accessibility—particularly among youth—and strengthen the enforcement of existing tobacco control laws. The newsletter was released in the presence of Prof. Ashok Bhardwaj (President, IAPSM), Prof. (Dr.) R.C. Goyal (NAMO Medical Education and Research Institute), Prof. (Dr.) Pankaj Bhardwaj (Indian Council of Medical Research), Prof. Manish Singh, and Prof. Bhavesh Modi, along with other dignitaries and participants.

The 42nd edition of Tobacco Free Times (TFT) was officially released during the National Conclave on Best Practices under the National Tobacco Control Programme held on 11–12 March 2026 at Chandigarh. The edition focused on the theme "Planet Over Tobacco: Reframing Tobacco as a Climate and Environmental Crisis," emphasizing the environmental impact of tobacco cultivation, production, and post-consumption waste, and its implications for public health and sustainability. It underscored the need to reposition tobacco control within the broader climate and environmental agenda by highlighting the ecological damage associated with tobacco and advocating for sustainable, health-promoting alternatives. The newsletter was released in the presence of Shri Saurabh Joshi (Chief Guest), Prof. Sonu Goel, Prof. Suneela Garg, Dr. Manish Singh, Dr. Abhishek Ghosh, Mr. Mukesh Sinha (MPVHA, MP), Dr. Rakesh Gupta (SIPHER, Chandigarh), Dr. Gopal Chauhan, and Dr. Shivam Kapoor, along with other dignitaries and participants.

THEME CONTENT

Tuberculosis & Tobacco Control:

Advancing Integrated Action for Better Health Outcomes

A comprehensive policy and science brief at the intersection of two of the world's most consequential public health challenges — and the urgent case for unified action.

10.7M TB CASES GLOBALLY (2023)

700K TB CASES LINKED TO SMOKING

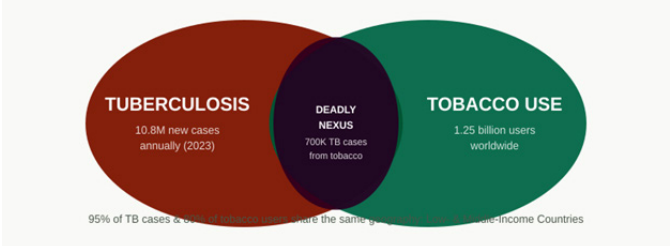
17.6% TB INCIDENCE FROM TOBACCO

1.3B TOBACCO USERS WORLDWIDE

The Deadly Duo: Understanding the TB–Tobacco Nexus

How tobacco use fuels TB risk, progression, and mortality

Few confluences in global public health carry the lethal weight that the tobacco–tuberculosis nexus does. Tuberculosis remains one of the top 10 causes of death worldwide and the leading cause of death from a single infectious agent. Tobacco, independently, accounts for more than 8 million deaths annually. Their intersection is not incidental; it is biological, epidemiological, and deeply systemic. Tobacco smoke is a potent immunological saboteur. Smoking increases the risk of TB infection, progression from latent to active disease, poor treatment outcomes, recurrence, and TB-related mortality. Macrophages in the alveoli, the critical sentinels responsible for engulfing and destroying Mycobacterium tuberculosis, become functionally impaired. The result is a lung environment that is both structurally damaged and immunologically weakened — a biological invitation for TB to take hold, flourish, and resist eradication.



WHO Global TB Report 2025 — Key Message

> Key drivers of TB incidence include undernutrition, HIV infection, diabetes, smoking, and alcohol use disorders.
>
> **— WHO Global Tuberculosis Report 2025**

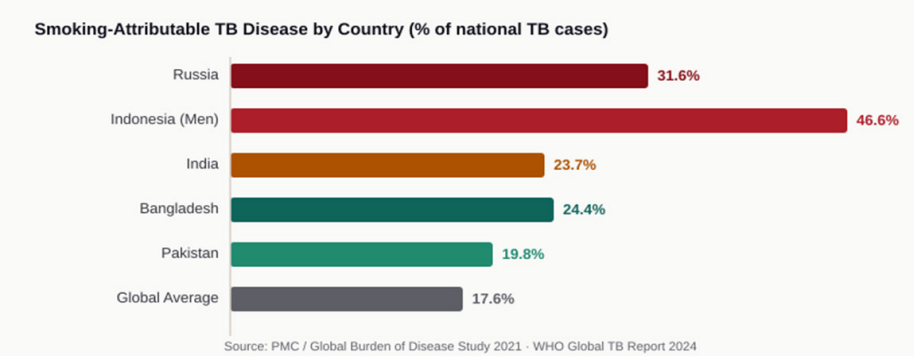
Understanding and addressing the TB–tobacco nexus is not a peripheral concern in public health strategy. It is central to any credible pathway toward the WHO's End TB targets — and to any honest accounting of preventable deaths in the 21st century.

The Burden in Numbers: Epidemiology at a Glance

Global and regional data on TB–tobacco co-prevalence and its public health cost

The numbers that define the TB–tobacco intersection are not abstractions — they represent the cartography of a preventable catastrophe. According to the WHO Global Tuberculosis Report 2025, an estimated 10.7 million people developed tuberculosis globally in 2024, resulting in approximately 1.23 million TB-related

deaths — a case fatality rate of 11.5%. Tuberculosis remains the leading cause of death from a single infectious agent globally and one of the top 10 causes of death worldwide, disproportionately affecting low- and middle-income countries where tobacco use, poverty, undernutrition, diabetes, alcohol use disorders, and HIV continue to amplify disease burden.



Among high-TB-burden countries, the geographic variation in smoking-attributable TB is striking. Russia bears the highest proportional burden, with an estimated 31.6% of TB disease and 28.1% of TB deaths attributable to smoking. Indonesia follows closely, where among men, tobacco contributes to 46.6% of TB cases. In India, studies suggest that 23.7% of TB patients report tobacco use, with disproportionately high rates of nicotine dependence complicating care.

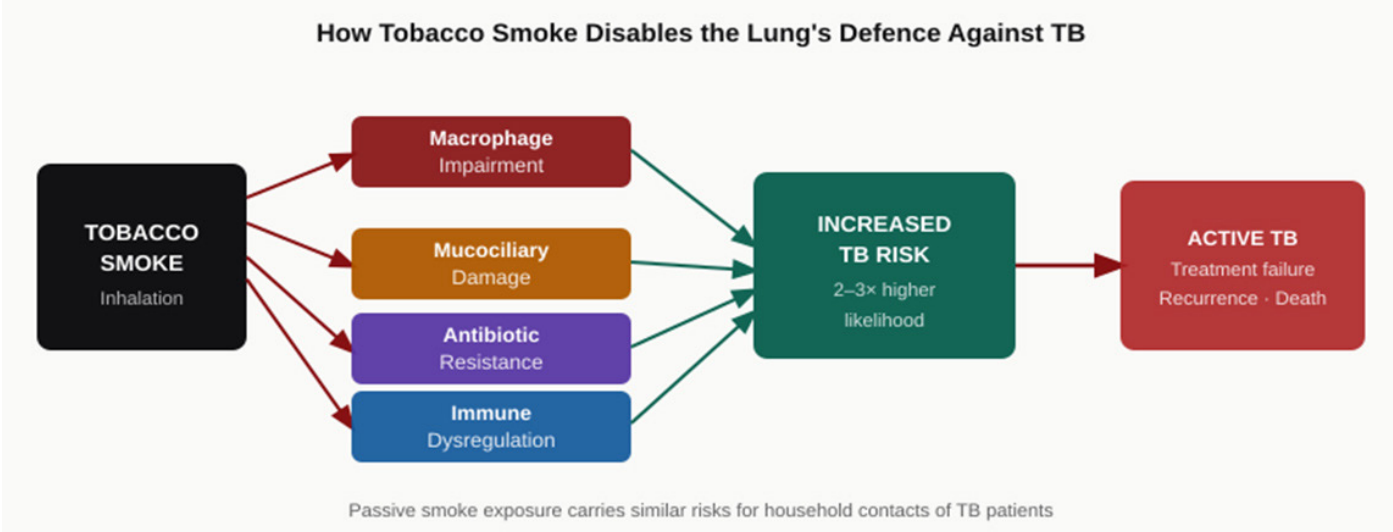
95% of TB cases and 80% of tobacco users reside in low- and middle-income countries — the geographic alignment of these two epidemics is not coincidental, but structurally determined by poverty, inadequate healthcare access, and predatory tobacco industry marketing. The WHO Global Tuberculosis Report 2025 explicitly identifies undernutrition, HIV infection, diabetes, smoking, and alcohol use disorders as key drivers of TB incidence globally, reinforcing the urgent need for integrated TB–tobacco control strategies. Notably, treatment of people with TB from 2000 to 2024 is estimated to have averted 83 million deaths — a figure that underscores how much more is at stake when tobacco use undermines treatment success.

From a disability-adjusted life years (DALY) perspective, the Global Burden of Disease study identifies tobacco and alcohol use as having the most significant impact on TB-related DALYs among all measurable risk factors — surpassing even dietary risks and hyperglycaemia. The WHO Global Tuberculosis Report 2025 further notes that approximately 47% of TB-affected households face catastrophic costs exceeding 20% of total household income — a threshold of financial devastation that tobacco expenditure only deepens. Among households facing drug-resistant TB, this proportion rises to a pooled average of 82%.

Biological Bridges: How Smoking Damages the Lungs' Defence Against TB

The science behind tobacco-induced immunosuppression and TB vulnerability

The biological relationship between tobacco smoke and tuberculosis susceptibility is mechanistically precise and extensively documented. Multiple, overlapping pathways exist through which cigarette smoke compromises the human body's capacity to resist, contain, and eliminate Mycobacterium tuberculosis. Understanding these mechanisms makes the case for cessation as a clinical intervention in the most concrete and compelling terms.



MACROPHAGE IMPAIRMENT	Alveolar macrophages — the primary intracellular refuge of M. tuberculosis — are profoundly compromised by tobacco smoke. Smoke exposure attenuates multiple intracellular signalling pathways involved in macrophage-mediated mycobacterial killing, reduces phagocytic efficiency, and impairs the respiratory burst response. The macrophage, rather than serving as an efficient eradicator of the bacillus, becomes a permissive host environment for bacterial persistence and replication.
MUCOCILIARY DAMAGE	Tobacco smoke progressively destroys the mucociliary escalator — the coordinated movement of mucus and cilia that physically clears inhaled particles and pathogens from the airways. In smokers, this barrier is structurally degraded, allowing M. tuberculosis to penetrate deeper into the pulmonary parenchyma with reduced clearance and increased opportunity for sustained infection.
ANTIBIOTIC RESISTANCE	A particularly alarming mechanism is the direct role of tobacco smoke in inducing gene mutations within M. tuberculosis that promote antibiotic resistance. Smoke components augment bacterial biofilm formation, creating protective niches that reduce drug penetration, thereby increasing the probability of treatment failure, MDR-TB emergence, and prolonged infectiousness.
IMMUNE DYSREGULATION	Tobacco smoke promotes immunosuppressive N2 neutrophil activity and enhances T-regulatory (Treg) cell responses, both of which dampen the adaptive immune response to M. tuberculosis. Smoking also disrupts the Th1/Th2 balance, which is critical for effective mycobacterial containment.
PASSIVE & SECONDHAND SMOKE	Passive smoking, secondhand smoke, and environmental tobacco smoke (ETS) exposure are independently associated with increased susceptibility to TB infection and progression. Household contacts of TB patients who smoke face a compounded risk — biological susceptibility amplified by proximity to an index case.

The risk landscape extends beyond conventional cigarette smoking. Beedi smoking, vaping, e-cigarettes, biomass fuel combustion, and indoor air pollution all share overlapping mechanisms of pulmonary damage and immune compromise. A comprehensive TB–tobacco control agenda must account for this full spectrum of inhalational exposures.

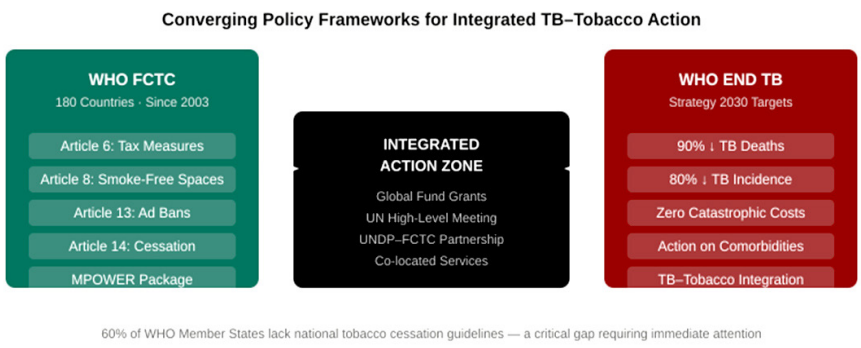
Policy in Action: Convergence of TB and Tobacco Control Frameworks

WHO End TB Strategy, FCTC, and national programme alignment

The policy architecture for addressing both tuberculosis and tobacco use has been constructed — with considerable deliberateness — in parallel rather than in concert. Yet the case for convergence has never been stronger. Two landmark global frameworks — the WHO End TB Strategy and the WHO Framework Convention on Tobacco Control (WHO FCTC) — contain within them the complementary mandates, structural tools, and political commitments necessary to drive integrated action.

The WHO FCTC, adopted in 2003 and now ratified by 180 countries, constitutes the world's most widely embraced health treaty. It provides a comprehensive demand-and-supply reduction architecture, encompassing price and tax measures (Article 6), protection from second-hand smoke exposure (Article 8), product regulation (Article 9), tobacco advertising restrictions (Article 13), and critically — tobacco dependence treatment and cessation (Article 14).

> Integrating tobacco cessation services within TB prevention and treatment programmes remains essential to achieving WHO End TB targets.
>
> **— WHO, WORLD NO TOBACCO DAY 2023 STATEMENT**



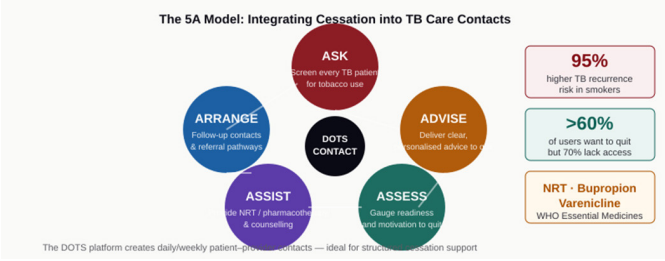
National clinical treatment guidelines for tobacco dependence do not exist in nearly 60% of WHO Member States — a systemic infrastructure gap that directly undermines both FCTC Article 14 obligations and TB programme effectiveness on the ground.

Despite this architecture, implementation lags profoundly behind intent. TB programme managers rarely receive training in brief cessation counselling. Surveillance systems for TB and tobacco remain largely siloed. Bridging these divides requires structural reform — co-located services, integrated staff training, joint data platforms, and shared accountability metrics.

Cessation as Treatment: Tobacco Quitting Within TB Care

Integrating cessation support into DOTS and TB treatment protocols

The encounter between a patient and the TB care system represents one of the most consequential — and most underutilised — opportunities for tobacco cessation intervention in low- and middle-income health systems. TB treatment is protracted, typically spanning six months or longer. It brings patients into repeated, structured contact with healthcare workers — a moment when motivation to quit tobacco is frequently elevated. And yet, in the vast majority of TB programmes globally, cessation support is either entirely absent or delivered in the most perfunctory terms.

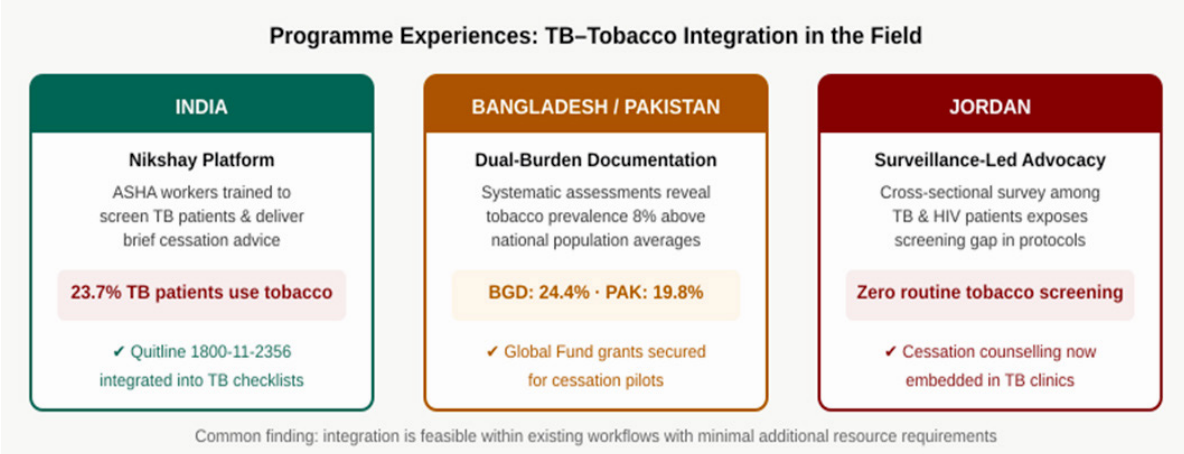


The evidence is unambiguous. Tobacco use during TB treatment is independently associated with treatment failure, delayed sputum conversion, medication non-adherence, increased risk of TB recurrence, and elevated all-cause mortality. A 2024 systematic review found that current tobacco users experience up to 95% higher risk ratios for TB recurrence compared to non-users. Smoking cessation during TB treatment has been shown to improve treatment outcomes and to reduce TB infection risk among household contacts — a benefit that extends beyond the individual patient into the community transmission network. The WHO's consolidated guidelines on tuberculosis diagnosis, treatment, and care — updated in 2025 — together with the WHO Clinical Treatment Guideline for Tobacco Cessation in Adults provide the evidence base for a comprehensive intervention package spanning behavioural support, pharmacotherapy, and system-level enablers. Practical integration requires that TB programme staff receive competency-based training in the 5A model: Ask, Advise, Assess, Assist, Arrange — and that cessation medicines are stocked and accessible at TB treatment centres.

Voices from the Field: Case Studies & Programme Experiences

Real-world examples of integrated TB–tobacco interventions

Beyond policy declarations and epidemiological projections, the practical reality of TB–tobacco integration is being shaped — imperfectly but meaningfully — in clinics, communities, and national programmes around the world. The following case experiences illuminate both what is possible and what barriers continue to constrain scale.



India: Embedding Cessation Within Nikshay

INDIA

India carries the world's largest share of TB burden, accounting for approximately 25% of global incidence according to the WHO Global Tuberculosis Report 2025. Recognising the compounding role of tobacco — with studies showing 23.7% tobacco use among TB patients and high rates of nicotine dependence — the national programme has begun piloting tobacco cessation brief interventions within the Nikshay TB case notification and management platform. Community health workers (ASHAs) are being trained to screen TB patients for tobacco use and provide structured brief advice during home visits.

Outcome Signal: Early pilot data indicates improved patient engagement with cessation messaging when delivered by trusted community TB workers in familiar settings.

Bangladesh & Pakistan: Dual-Burden Documentation

SOUTH ASIA

Research from Bangladesh demonstrates that 24.4% of TB patients smoke daily — a prevalence 8% higher than the general population. In Pakistan, the figure is 19.8%, again substantially elevated relative to population norms. These data have been instrumental in making the case to national TB programmes that tobacco use is not a peripheral co-morbidity but a central determinant of poor treatment outcomes. Both countries are exploring integrated screening protocols with support from the Stop TB Partnership and UNDP.

Outcome Signal: Documentation of elevated tobacco prevalence among TB patients has mobilised policy attention and secured Global Fund grant allocations for cessation integration pilots.

Jordan: Cross-Sectional Surveillance and Programme Advocacy

MIDDLE EAST

A cross-sectional survey in Jordan documented high prevalence of current tobacco smoking among both TB patients and people living with HIV. The study revealed that routine tobacco use assessment was absent from standard TB clinical protocols. These findings were leveraged by civil society and health ministry partners to introduce brief cessation counselling into TB outpatient clinic workflows, including physician training and patient educational materials in Arabic.

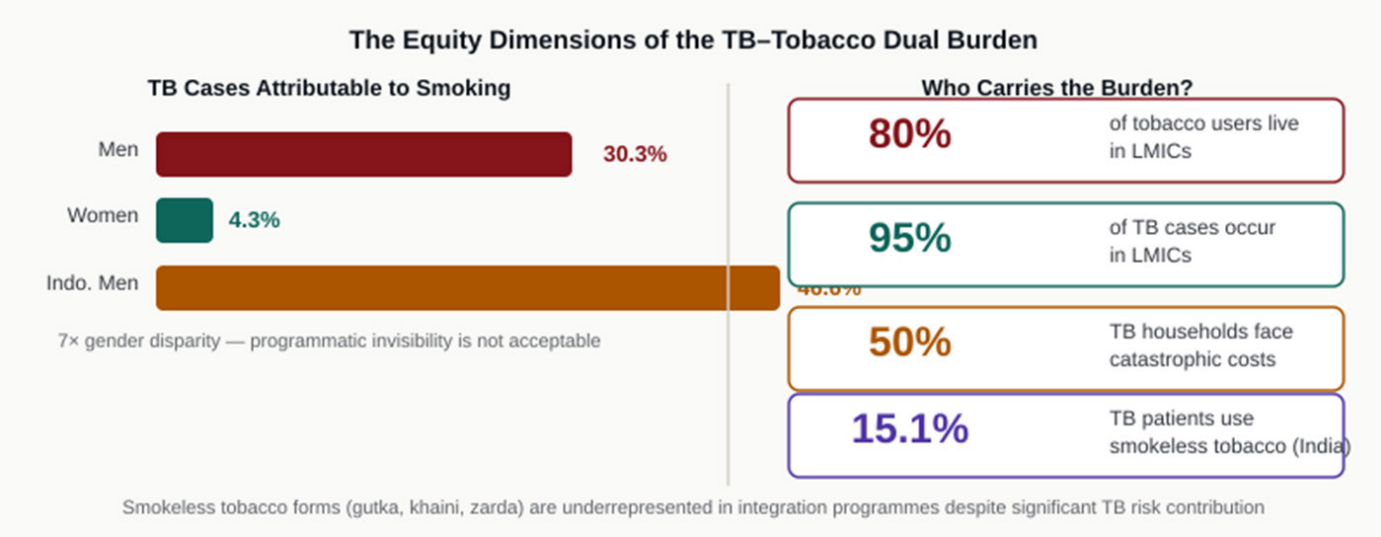
Outcome Signal: Facility-level implementation of routine tobacco screening demonstrated feasibility within existing clinical workflows and minimal additional resource requirements.

Across these experiences, common lessons emerge: cessation integration within TB care is feasible, acceptable to patients, and does not require prohibitive additional resources when embedded into existing workflows. The primary barriers are not clinical but structural — inadequate training, absent medicines, and the persistent siloing of TB and tobacco control programmes within health ministries.

Reaching the Vulnerable: Gender, Poverty & the Dual Burden

An equity lens on populations disproportionately affected by both conditions

The TB–tobacco dual burden is not distributed uniformly across humanity — it is concentrated along the fault lines of structural inequality: gender, poverty, geography, and social marginalisation. Any integrated response that fails to account for these dimensions will systematically underserve the populations at greatest risk and perpetuate the very inequities it claims to address.



The WHO Global Tuberculosis Report 2025 further highlights that broader determinants such as poverty, undernutrition, smoking, alcohol use disorders, diabetes, and HIV continue to shape TB epidemiology globally — with undernutrition identified as the single largest attributable risk factor for TB incidence among all five key drivers. Addressing these determinants in tandem with tobacco control is not optional; it is constitutive of any credible strategy to reach the 2030 End TB targets.

The Gender Dimension

Men bear a profoundly disproportionate burden at the TB–tobacco intersection. Among 32 high-burden countries, the proportion of TB cases attributable to smoking is 30.3% in men versus only 4.3% in women — a sevenfold disparity. In Indonesia, the figure reaches 46.6% among men. Gender-sensitive TB care must include routine tobacco screening for all male patients and culturally appropriate cessation support.

The Poverty Dimension

Poverty operates as a force multiplier for both TB and tobacco harm. An estimated 80% of the world's tobacco users live in low- and middle-income countries, where tobacco expenditure displaces resources from food, education, and healthcare — deepening the same undernutrition and access deficits that independently drive TB incidence.

The Youth and Initiation Risk

The tobacco industry's deliberate targeting of young people in developing countries creates the pipeline for the next generation of tobacco-dependent TB patients. Prevention-focused TB–tobacco integration must extend beyond clinical settings into schools, communities, and the regulatory landscape governing tobacco advertising and sales.

Smokeless Tobacco and Marginalised Communities

In South Asia, smokeless tobacco forms — gutka, khaini, pan masala with tobacco, and zarda — represent a substantial burden frequently invisible in integration programmes. In studies from India, 15.1% of presumptive TB patients reported smokeless tobacco use, requiring contextually sensitive cessation approaches.

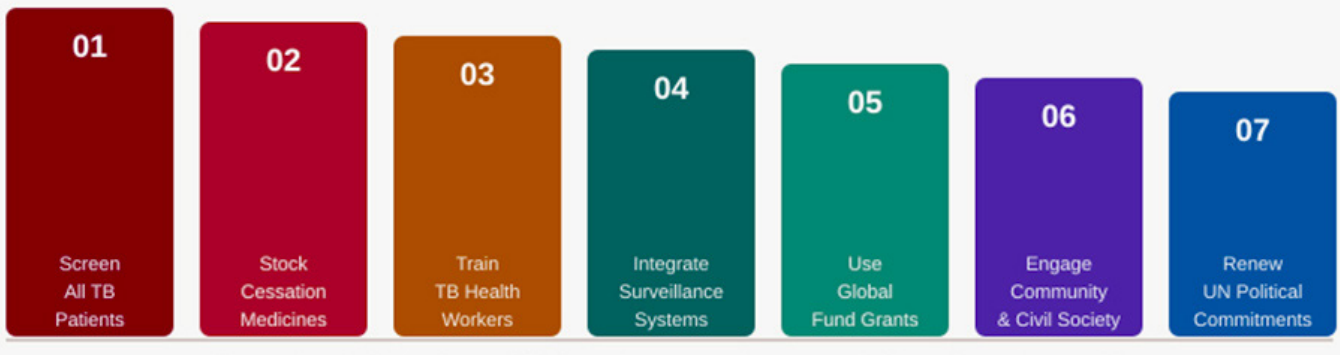
> The proportion of TB deaths attributable to smoking was more than six times higher in men than in women — a gendered inequity that public health programmes must make visible, not obscure.
>
> — GLOBAL BURDEN OF DISEASE MODELLING STUDY, JOURNAL OF GLOBAL HEALTH

The Way Forward: Recommendations & Call to Action

For clinicians, policymakers, programme managers, and communities

The evidence is comprehensive. The frameworks are in place. The WHO Global Tuberculosis Report 2025 makes clear that funding for TB services remains grossly inadequate — at only 27% of the global target — and that cuts to international donor funding now threaten the gains achieved. The costs of continued inaction, measured in lives, households impoverished, and treatment failures, are calculable and unconscionable. What remains is the translation of scientific and political consensus into operational reality. The following recommendations constitute a minimum agenda for integrated action across the stakeholder spectrum.

Seven Pillars of Integrated TB–Tobacco Action



Minimum Agenda for Action — Clinicians · Programme Managers · Policymakers · Communities

Source: WHO End TB Strategy · WHO FCTC Article 14 · Global Fund Integration Guidance · UN High-Level Meeting 2023

1

Mandate Tobacco Screening in All TB Clinical Protocols

Every TB patient intake assessment must include standardised tobacco use screening. Results must be recorded in patient registers and used to tailor treatment support. National TB programmes should revise standard operating procedures to ensure WHO FCTC Article 14 obligations are reflected in TB clinical guidelines.

2

Ensure Cessation Medicines Are Stocked at TB Treatment Facilities

Nicotine replacement therapy (NRT), bupropion, and varenicline — all on the WHO Model List of Essential Medicines — must be available within TB treatment centres. Access at the point of care is a proven enabler of cessation uptake. Drug procurement should be integrated into TB supply chain planning at national level.

3

Train All TB Healthcare Workers in Brief Cessation Counselling

The 5A model (Ask, Advise, Assess, Assist, Arrange) is an evidence-based, feasible, and low-resource intervention deliverable in any clinical encounter. National TB training curricula must incorporate cessation counselling as a core skill for physicians, nurses, community health workers, and DOTS supervisors.

4

Integrate TB–Tobacco Data into Joint Surveillance Systems

Tobacco use data and TB outcome data are collected through separate, siloed pathways in most countries. Integrating tobacco use as a mandatory variable in TB case notification forms would create the population-level evidence base needed to track progress and drive accountability.

5

Leverage Global Fund Grants for Tobacco Cessation Integration

The Global Fund's explicit openness to tobacco control activities within TB and HIV grants is an underutilised financing opportunity. National applicants must be supported to design, cost, and incorporate tobacco cessation components into grant proposals.

6

Amplify Community and Civil Society Engagement

TB-affected communities and survivors' networks are powerful, underutilised advocates for cessation. Community organisations with existing TB outreach infrastructure can be equipped to deliver cessation messaging as part of their routine work. Peer-to-peer support and engagement of religious leaders are contextually powerful channels.

7

Renew Political Commitments at the UN High-Level Meeting on TB

The commitments made at the 2023 UN High-Level Meeting on TB regarding tobacco use require concrete timelines, national accountability frameworks, and measurable targets. With a third UN High-Level Meeting on TB scheduled for 2028, the current review cycle provides a critical opportunity to elevate TB–tobacco integration from aspirational language to binding national milestones — and to ensure that tobacco control is embedded as a core pillar of every national TB strategic plan ahead of that review.

> Improving food security and reducing tobacco smoking globally will contribute significantly to the fight to end TB. These are not parallel agendas — they are a single, integrated commitment to human health.
>
> **— WHO, WORLD NO TOBACCO DAY 2023**

The path to ending tuberculosis runs unmistakably through tobacco control. Every cigarette extinguished in a TB patient's hand is a clinical intervention. Every cessation programme embedded in a TB treatment centre is a public health investment with returns measured in lives protected, households preserved, and a world incrementally closer to a future free of both epidemics. The science is settled. The frameworks are built. The imperative is moral, political, and urgent. The time for integrated action is not approaching — it is overdue.

Ireland Introduces Strict Ban on Vape Advertising and Youth-Oriented Products

The Irish government has approved new legislation aimed at curbing the rising use of vaping products among young people. Under the Public Health (Tobacco Products and Nicotine Inhaling Products) Amendment Bill 2026, shops will no longer be allowed to advertise or visibly display vapes.

The law also prohibits the use of bright colours, cartoons, and child-friendly flavour descriptions in vape products. These measures are intended to reduce the appeal of such products to minors.

Additionally, the sale of nicotine pouches (snus) to individuals under 18 will be banned. These products, which release significantly higher nicotine levels than cigarettes, have become increasingly popular among teenagers.

The legislation will come into effect later this year after parliamentary approval.

Source: The Irish Sun
https://www.thesun.ie/news/16621194/vape-sale-ban-advertising-colours-flavours-ireland

Belgium Urges EU-Wide Ban on Disposable Vapes and Stricter Regulations

Belgium has called on the European Union to implement stricter regulations on vaping products, including a ban on disposable e-cigarettes.

The country's health minister has raised concerns about increasing vaping rates, particularly among young people, and highlighted potential health risks from chemical exposure.

Belgium is advocating for EU-wide limits on ingredients used in vape products, along with restrictions on flavours. The European Commission is expected to introduce updated regulatory proposals later this year.

Source: 2Firsts
https://www.2firsts.com/news/belgium-calls-for-eu-wide-limits-on-vape-ingredients-and-ban-on-disposable-e-cigarettes

South Africa Rejects Tobacco Industry Proposal for Separate Regulations

South Africa's Department of Health has rejected calls from the tobacco industry to regulate cigarettes and non-combustible products separately.

The government supports a unified regulatory framework, stating that all tobacco-related products should be covered under a single law, with differentiation handled within the same legislation if required.

The decision comes amid ongoing debates around illicit trade, advertising restrictions, and youth access to tobacco products.

Source: Business Economy
https://iol.co.za/business-report/economy/2026-02-26-department-of-health-shoots-down-big-tobacco-push-for-differentiated-industry-regulation/

Singapore Enforces Strict Anti-Vaping Law with Heavy Penalties

Singapore has passed a new law significantly strengthening penalties for vaping-related offences. The updated legislation introduces fines, long-term imprisonment, and strict enforcement measures.

Adults who involve minors in the supply or use of vape devices (including Kpods) may face up to 20 years in prison. Users, sellers, and smugglers will also face sharply increased fines and jail terms.

Public venues such as clubs and bars are now required to prevent vaping on their premises. The law also expands the definition of tobacco products to include substances producing nicotine-like effects.

These measures aim to address rising concerns about health risks and illegal usage despite an existing vaping ban since 2018.

Source: VN Express
https://e.vnexpress.net/news/news/crime/singapore-passes-anti-vaping-law-with-jail-terms-of-up-to-20-years-5047651.html

Punjab Detects ₹1.5 Crore Worth of Unaccounted Tobacco Goods

Punjab authorities have uncovered unaccounted tobacco goods worth ₹1.5 crore during a statewide crackdown on tax evasion.

Raids conducted across multiple cities led to the seizure of cigarettes, bidis, and other tobacco products stored without proper documentation.

Officials have already recovered ₹12 lakh, with further penalties and legal action underway.

Source: Babushahi News
https://www.babushahi.com/view-news.php?id=218984

Himachal Pradesh Issues 567 Challans in Anti-Tobacco Drive

Himachal Pradesh Police conducted a statewide enforcement drive targeting tobacco sales near educational institutions.

The operation resulted in 567 challans and fines totaling ₹65,300. Authorities also seized prohibited tobacco products and registered multiple legal cases.

The initiative is part of a broader campaign to protect youth from substance abuse and ensure compliance with tobacco laws.

Source: The Indian Expres
https://indianexpress.com/article/cities/chandigarh/567-challans-issued-collected-under-tobacco-act-in-24-hours-hp-police-10582669/

Fresh Petition Filed in Bombay High Court Over Hookah Product Handling

A new petition has been filed in the Bombay High Court questioning the Maharashtra government's handling of seized hookah-related products.

The case highlights a previous stance allowing such goods to be transported out of the state instead of being destroyed, raising concerns about legal consistency.

The issue stems from earlier raids where large quantities of hookah products containing nicotine and other substances were seized. The petition seeks clarity on enforcement practices and legal precedents.

Source: Times Now
https://www.timesnownews.com/india/fresh-petition-filed-in-bombay-high-court-over-govts-stand-on-hookah-and-tobacco-goods-article-153926372

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