Smokeless Tobacco Control Policies: Analysing the Sri Lankan Ban

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Abstract

Background: The smokeless tobacco (SLT) epidemic in Sri Lanka is deeply ingrained in cultural, traditional, socio-economic, and environmental dynamics. The country introduced a comprehensive nationwide ban policy to combat this issue in 2016. This research study aimed to analyse this SLT ban policy to understand its successes and failures in the Sri Lankan context.

Methods: A multi-phased two-stage study (A and B) was conducted. Study A consisted of in-depth interviews and policy document reviews. Nine ban policy actors were interviewed. Twelve published and three unpublished policy documents were analysed. Twelve key stakeholders, including provincial and district health directors and heads of civil organisations, were interviewed in Study B. McConnell's Policy Success-to-Failure framework and the Health Policy Triangle provided the theoretical framework for the study. The data was analysed using NVivo based on two coding frameworks. Fourteen themes were generated.

Results Study A found that a small, homogenous group created the ban without much attention to the systematic factors. Study B revealed that policy implementors were not prepared to execute the plan. Therefore, the ban was not implemented in most places. Additionally, study B showed that the ban could harm the ongoing interventions of the SLT campaign. Key stakeholders, including the frontline workforce, community, religious leaders, and politicians, hesitated to support the implementation of the ban.

Conclusion: The study revealed shortcomings in the SLT ban, highlighting inadequacies in planning, implementation, stakeholder involvement, and cultural awareness. To address these issues, suggestions have been made for a more comprehensive, culturally sensitive approach that engages diverse stakeholders, including community and religious leaders, through a strategic framework.

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List of Abbreviations

ADIC Alcohol and Drug Information Center

AN Areca Nut

ASR Age-standardized Incidence Rate

BQ Betel Quid

CIR Cancer Incidence Rate

CPSLT Commercially Prepared Smokeless Tobacco

CTFK Campaign for Tobacco-Free Kids

FCTC Framework Convention of Tobacco Control

FODSP Faculty of Dental Studies, University of Peradeniya

FOMC Faculty of Medicine, University of Colombo

GBD Global Burden Diseases

GYTS Global Youth Tobacco Survey

LMT Lip, mouth, and tongue

MOH Ministry of Health MOL Ministry of Law

MOA Ministry of Agriculture
MOE Ministry of Education
MOF Ministry of Finance

MOPA Ministry of Public Administration

NATA National Authority for Tobacco and Alcohol

NCD Non-Communicable Diseases

NCR National Cancer Registry

OPML Oral potentially malignant lesions

PHI Public Health Inspectors

SEA Southeast Asia

SLMA Sri Lanka Medical Association

SLT Smokeless tobacco

STEPS WHO STEPS wise approach to NCD risk factors.

WHO World Health Organization

Declaration

I declare that this thesis is entirely my original work, and no one else has contributed to it. Before this submission, I did not present this work for any academic award from any institution. All sources referenced in this thesis have been appropriately acknowledged.

Conference abstracts

It is worth noting that certain sections of this thesis have been shared previously through conference abstracts, as well as a virtual recorded talk and e-poster presentation at The International Union Against Tuberculosis and Lung Disease's World Conference on Lung Health between the 8th and 11th of November 2022. The presentation, titled "Implementor perceptions of the success of non-FCTC smokeless tobacco ban: tobacco control program in Sri Lanka," can be referenced using the number EP-38-988.

Conflict of Interest

I also confirm that I do not have any conflict of interest related to the tobacco industry during this PhD study. Additionally, I received no financial support for this Ph.D. study from any sources, including the tobacco industry.

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Chapter 1: Overview of the Public Health Problem

1.1 Chapter Overview

The Smokeless Tobacco (SLT) epidemic has been a persistent challenge to public health in Sri Lanka. In this chapter, I present an introduction to a PhD study that delves into the success of the ban policy introduced to curtail and mitigate this epidemic. The chapter begins with an overview of the literature review, including the search strategy. It is then divided into four parts, designated A to D, that provide empirical insights into the SLT epidemic in Sri Lanka.

Part A delves into the challenges posed by the epidemic, examining them through the lenses of public health epidemiology, health and non-health impacts, and the psychoaddictive nature of the issue. Additionally, this section illuminates the various types of SLT products and their complex supply chains. Part B supplies empirical evidence regarding the sociocultural, political, economic, and environmental contexts surrounding the issue. Finally, Part C provides an overview of the diverse array of key stakeholders involved in the problem and their respective roles.

In the final section, Part D, the literature review's findings are synthesised, providing insights into the potential prerequisites for the success of the SLT ban and possible unintended consequences. The chapter concludes by presenting a working definition of the epidemic in Sri Lanka and identifying the knowledge gaps.

Overview of the Literature Review

This background chapter consisted of a systematically presented literature in the form of a scoping review. It aimed to map the key concepts underpinning the research area, primary sources, and available evidence types.

Search Strategy: The search strategy was meticulously designed to ensure the retrieval of comprehensive and accurate results on the specific SLT-related issues and their context in Sri Lanka relevant to the study scope. Each database was searched using a structured set of key terms, carefully selected to encapsulate the core concepts of the research questions. The search questions were divided into three parts, each addressing distinct aspects of the research topic. This ensures that the scoping review captures all relevant studies and evidence, providing a solid foundation for addressing the scope of this PhD project. These three components of the literature review are presented in Parts A, B, and C in this background chapter.

Part A (section 1.2 -1,6, p12-44) was confined to searching for specific SLT-related issues in Sri Lanka. Part A focused on:

- SLT challenges in Sri Lanka
- SLT ban and its Origin
- Similar policies in other countries
- Public Health Epidemiology of SLT
- Health and Non-Health Impacts of SLT
- Psycho-addictive Nature of SLT
- Harmful Chemicals in SLT available in Sri Lanka
- Synergetic Effects of Areca Nuts
- Complex Supply Chains of SLT products
- Traditional Betel Quids Use among Sri Lankans
- Non-traditional SLT products in Sri Lanka

Part B (section 1.7 -1.11, p45-83) of the scoping review was mainly focused on the context of the SLT epidemic in Sri Lanka. The main components of part B were.

- ❖ Socio-cultural context based on archaeological evidence, history, culture, beliefs, norms, rituals, and demographic variations of the communities
- ❖ Political context, including political structure, power systems, political trust and cultural sensitivity, decentralisation and mechanism of policy implementation, the influence of big tobacco industry in Sri Lankan politics, and health care delivery system of Sri Lanka to SLT policy making and implementation.
- ❖ Economic context, including marginalised people, unregulated SLT products and their macroeconomic challenges, post-covid economic crisis and increased trend in SLT use and balancing service needs of chronic SLT users with financial challenges in Sri Lanka
- ❖ Environmental context, including tobacco farming in Sri Lanka and industry sponsorship for the farmers, betels and areca nuts as exports under the Ministry of Agriculture, black market, border security, lack of standardisation of SLT products in Sri Lanka

Part C (section 1.12 -1.17, p84-87) of the scoping review presented the stakeholders of the SLT epidemic in Sri Lanka, including policymakers, policy implementors, interest groups, subject experts, high-risk SLT users and the community

Key Terms and Database Search: Various databases were utilised to ensure a comprehensive search, including health-specific resources (MEDLINE, PubMed) and interdisciplinary databases like the Web of Sciences and Scopus. The search terms were designed to include various keywords and subject headings relevant to the research questions and scope.

A few examples of keywords are smokeless tobacco, betel quids, chew, snuff, snus, Sri Lanka, mayo, thul, Ceylon Tobacco Company, estate sector, tea pickers, slum dwellers, oral cancers, OPMDs, areca nut cutter, betel quid trays, and Bhikkhu (Buddhist Priest). The search included both keywords and subject headings to ensure thoroughness. The .tw designation limits the search to title and abstract fields, enhancing the specificity of the search results.

Part A: The Problem

1.2 Smokeless Tobacco Challenges in Sri Lanka

SLT use is a neglected but critical global public health epidemic, causing severe health problems, including fatal head, neck and oral malignancies and cardiovascular diseases (Siddiqi et al., 2020). World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) defines SLT as any tobacco used in unburnt form either orally or nasally (World Health Organization, 2004). There are two categories of tobacco products: smoking and SLT (Chugh et al., 2023). One-fourth of the global population consumes tobacco (Siddiqi and Mishu, 2019; Mehrotra and Sinha, 2018). Approximately 25% of these global tobacco users, more than 356 million world population, consume it in the form of SLT (Mehrotra and Sinha, 2018). Sri Lanka is one of the countries with the highest SLT burdens in the world(Mehrotra et al., 2019; Somatunga et al., 2012). The SLT-induced lip, mouth and tongue (LMT) cancers are the most prevalent malignancies among Sri Lankan adult men (Amarasinghe et al., 2018; Somatunga et al., 2012). Sri Lankan government introduced a new policy, the SLT ban, as a solution to this dragging public health issue in 2016.

1.2.1.The SLT Ban Policy 2016

Although Sri Lanka was a high-burden country for SLT threats, the government didn't have a solid, standalone SLT control and prevention policy till September 2016 (Mahees et al., 2021). Most of the SLT control and prevention interventions had been integrated into the national tobacco program, of which the priority was controlling and preventing smoking tobacco, mainly cigarette use (Mehrotra and Sinha, 2018; Somatunga et al., 2012).

In September 2016, the government of Sri Lanka introduced a nationwide ban on SLT use. WHO FCTC does not endorse the ban policy (Chugh et al., 2023). Therefore, this ban policy falls under the non-WHO FCTC policy initiatives. This ban is referred to as the 'SLT ban policy' in the rest of this thesis. This policy prohibits the production, import, sale, and distribution of all SLT products nationwide (MoH, 2016). According to the law, those who violate the ban may face prosecution, fines, or imprisonment on

various levels. While many started to believe that the ban is a strong regulation that will help eradicate SLT use and uptake in Sri Lanka, some have raised questions about the long-term success of the prohibition of the habit and culture of SLT use in the country (Kong, Tao, and Golden, 2023).

Nevertheless, no research has been conducted on analysing the successes or failures of the SLT ban in Sri Lanka(Mahees et al., 2021; Amarasinghe et al., 2018; Somatunga et al., 2012). As such, I needed to expedite the development of systematic research methodology to scientifically analyse the SLT ban policy's successes. As a beginning, I compared and contrasted the successes and failures of similar bans in other countries.

1.2.2. Similar Bans in Other Countries and Their Success and Failures

SLT bans have been implemented in various countries with varying degrees of success and challenges. This section of the scoping review explores the experiences of Bhutan, Singapore, Australia, and some provinces of India, providing insights into their approaches, outcomes, and the factors influencing their successes and failures.

Bhutan: Bhutan is well known for its strict tobacco control measures, which include a complete ban on the sale and production of all tobacco products (Tuangratananon et al., 2019; Gurung et al., 2016). The Tobacco Control Act, implemented in 2004, prohibits the cultivation, manufacturing, and sale of tobacco and tobacco products. Despite the strictness of the law, Bhutan has faced significant challenges, particularly in enforcement and curbing illegal trade. The country's porous borders with India and the demand for tobacco products have led to a thriving black market, which undermines the ban's effectiveness. However, the evidence says Bhutan make efforts to serve as a global example of a nation committed to strict tobacco control. Bhutan has understood the importance of robust enforcement mechanisms of their laws and international cooperation to address the above cross-border smuggling (Rinchen, Taneepanichskul and Dawa, 2018; Rinchen, 2017; Gurung et al., 2016).

India: India is the third largest consumer of tobacco in the world, with a higher number of SLT users compared to smokers(Vidhubala et al., 2016; Pimple et al., 2014). Some regions in India, like Tamil Nadu and Mumbai, have banned certain SLT products like

Gutka and Pan Masala since 2013. These bans have had mixed success, reducing the availability and use of these products in some areas but facing challenges such as enforcement difficulties, the emergence of alternative SLT products, and resistance from users and producers. Socioeconomic factors like poverty and lack of awareness have been identified as continuously significant barriers to the effectiveness of these bans (Welding et al., 2022; Abdullah et al., 2022; Arora and Madhu, 2012).

Singapore: Singapore is widely known for its strict tobacco control regulations and proactive measures in public health world. In 2014, Singapore banned smokeless tobacco (SLT) products, such as loose-leaf, Plug, Twist, and Shisha (Tan et al., 2000). This ban came with strict penalties for violators, including fines of up to \$10,000 or imprisonment for six months, or both, for first-time offenders and fines of up to \$20,000 or imprisonment for repeat offenders. The success of Singapore's SLT ban can be attributed to several factors (Amul and Pang, 2018; Tan et al., 2000).

- Vigorous enforcement: Collaboration between various agencies, including the Health Promotion Board and the Ministry of Education, played a crucial role in enforcement.
- Comprehensive Policy: The ban was part of a broader strategy addressing emerging tobacco products like electronic cigarettes.
- Corruption Prevention: The Prevention of Corruption Act helped protect public policy from tobacco industry influences, ensuring the integrity of the ban's enforcement

Among those, Singapore's strategies are criticised for serving as a global hub for the tobacco supply chain (Amul and Pang, 2018; Tan et al., 2000).

Australia: Australia has implemented focused tobacco control programs, especially within Indigenous communities, where there are high rates of tobacco use (Gould et al., 2018; Chapman, 2008). Traditional tobacco is commonly used in cultural ceremonies, making traditional anti-smoking campaigns less effective. In response, Australian authorities have worked together with Indigenous leaders and organisations to create culturally tailored tobacco control programs. These programs have demonstrated:

-Culturally Sensitive Approach: Recognised the cultural significance of traditional tobacco while addressing the harms of commercial tobacco.

- Community Engagement: Involved Indigenous leaders in designing and implementing the programs.

These strategic approaches of the Australian government have aided in decreasing in tobacco prevalence within Indigenous populations, demonstrating the effectiveness of culturally sensitive health promotion strategies (Gartner and Hall, 2009; Bryan-Jones and Chapman, 2006).

The evidence from these countries emphasises several vital factors that influence the success or failure of bans on SLT. These factors include robust enforcement and penalties, cultural sensitivity and community engagement, challenges with illegal trade (such as cross-border smuggling), and context-specific socioeconomic factors like poverty and health education. In conclusion, studies on similar bans in other countries worldwide demonstrate that SLT bans can be effective when strategically approached. Their success depends on vigorous enforcement, cultural sensitivity, community engagement, and addressing context-specific socioeconomic factors.

1.2.3. Global SLT Policies and Their Impacts

A systematic review carried out by a consortium of renowned global researchers in SLT health found that the effectiveness of SLT policies has not been comprehensively studied compared to those for smoking tobacco(Chugh et al., 2023)The systematic review was initiated in 2019 and published in 2023. I was a co-author of it. The review's objective was to analyse SLT policies worldwide and assess their impacts on controlling and preventing SLT epidemics. The results of this systematic review summarised below, provided crucial insights for shaping the direction of this PhD thesis.

In the systematic review, we searched 11 electronic databases and grey literature in English and major South Asian languages from January 1, 2005, to September 20, 2021, to assess SLT policies and their effects (Chugh et al., 2023). In other words, we included all studies about SLT users that discussed relevant policies from 2005 to 2021. Policies issued by private organisations were not included. Two reviewers independently screened the articles, and data were extracted after standardisation.

The quality of the studies was assessed using the Effective Public Health Practice Project's Quality Assessment Tool. Outcomes for impact assessment included SLT prevalence, initiation, cessation, and health effects. Due to variability in policy descriptions and outcomes, data were synthesised descriptively and narratively.

In summarising the findings of this systemic review, 252 studies were eligible for inclusion out of 14,317 records. Fifty-seven countries had policies targeting SLT, with 17 having policies outside the World Health Organisation's FCTC. Eighteen studies assessed the impact, showing varied quality (six strong, seven moderate, and five weak) and mainly reporting on SLT prevalence.

Studies on FCTC-based policies indicated that these were linked to reduced SLT prevalence, ranging from 4.4.% % to 30.3% for taxation and 22.2% to 70.9% for multifaceted policies. A study on cessation showed a 13.3% increase in quit attempts among individuals exposed to FCTC policy measures compared to those not exposed. Those FCTC policy measures included education, communication, training, and public awareness. Furthermore, two studies evaluating non-FCTC policies, such as sales bans, reported significant reductions in SLT sales (6.4%) and use (17.6 combined sex). However, one study noted an increase in SLT use among youth following a total sales ban, likely due to cross-border smuggling. Nevertheless, the systematic review did not find any study on the impact of the SLT ban (2016) in Sri Lanka.

To conclude, this systematic review of global SLT policies and their impacts (2005-2021) highlights that a significant number of SLT burden countries have implemented control policies, with the majority being World Health Organisation's FCTC policies. A few countries, including Bhutan, Sri Lanka, Singapore, Australia, and some parts of India (as mentioned in section 1.2.2) have implemented non-FCTC policies, such as complete or partial bans. The evidence suggests that taxation and comprehensive policy measures are associated with a significant reduction in SLT use, while the outcomes of whole-sole SLT bans are controversial and evolving. Therefore, as mentioned above, this review underscored the importance of carefully analysing the successes or failures of non-WHO- FCTC SLT bans. For example, this PhD thesis has been committed to understanding the successes and failures of the SLT ban (2016) in Sri Lanka.

1.3 Public Health Epidemiology

The SLT is used by more than 356 million people worldwide, but the habit has been drastically confined to 29 countries, including Sri Lanka (Siddigi and Mishu, 2019; Somatunga et al., 2012; Amarasinghe et al., 2010b). These 29 countries, mainly in Asia and Africa, have been categorised as 'high-burden' of SLT epidemics. Sri Lanka is in 14th place on this list of highly affected countries with SLT menace (Siddiqi et al., 2020; Mehrotra and Sinha, 2018; Somatunga et al., 2012). Over 10% of the adult population in these 29 countries, including Sri Lanka, consume SLT and develop a range of chronic non-communicable diseases, including fatal head, neck and pharyngeal carcinomas and cardiovascular diseases. In other words, among 8 billion people in the global population, 1.3 billion consume tobacco. Among these 1.3 billion tobacco users, one-fourth are SLT users who mainly live in low and middle-income countries (LMIC), including Sri Lanka(Siddiqi and Mishu, 2019; Mehrotra and Sinha, 2018) in which a significant percentage of people develop SLT-attributed deadly diseases. These statistical data on the global distribution of SLT epidemics prove that the SLT epidemic is a central public health policy issue in low and middle-income countries. Therefore, it is not on public health policy agendas in most developed countries or international agencies operating from Europe or the USA. Thus, the governments of low and middle-income countries, including Sri Lanka, are responsible for setting effective policies to control and prevent SLT epidemics and seeking the support of global agencies without further delay.

Moreover, the two recent data sets from consecutive STEP surveys (2015 and 2021) in Sri Lanka revealed a significant increase in SLT use among the general population (18-69 years) despite enforcing the SLT ban in 2016. For example, The STEPs survey conducted in 2015 (from July 2014 to May 2015) reported 15.8% of overall SLT users, while the STEPS 2021 (during April, November and December) reported 17.5% of general SLT users, which is a significant raise, especially when the SLT ban is in place. In addition, the percentage of male SLT users rose from 26.0% to 30.3% between 2015 and 2021. Moreover, female SLT users rose from 5.3% to 6.4% during the same period. Furthermore, the 4:1 male-to-female ratio in SLT use in 2015 has been further widened to 5:1 in the 2021 survey. These data raised serious questions about the SLT ban in 2016, including whether the ban was in place or not. Is it just a paper document,

or has it been thoughtfully implemented? What are the barriers to implementing the ban? Is the prohibition the best solution to solve the SLT epidemic in Sri Lanka? And are there any problems implementing other non-ban SLT policies when the SLT ban is in place?

In addition to the rising prevalence of SLT use confirmed by two recent, consecutive STEPs surveys, a study conducted in 2021- five years after the implementation of the ST ban- at the National Institute of Oral Health in Maharagama, Sri Lanka, revealed that out of 83 OPD patients attended there for treatments 73 were betel chewers (Amarasinghe et al., 2023). Eight out of ten participants had been chewing betel quids (BQ) more than five times daily. As mentioned above, the study was conducted in 2021. The ban was executed in September 2016. Therefore, this study, which shows 88% of a sample taken at the OPD in a National Oral Health care setting are long-term BQ chewers and 58% chew BQ more than five times a day, is a proxy indicator of the poor progress in the SLT ban. In addition, the purpose of this study, conducted by Amarasinghe and colleagues, was to measure the effectiveness of a brief health education message on oral health effects caused by tobacco use delivered to patients coming to receive care at the National Oral Health Institute. As there is no research conducted yet to directly assess the success or failure of the SLT ban implemented in 2016, I argue the purpose of this study was a proxy indicator of poor progression in expected outcomes of the SLT ban in Sri Lanka. The reasons for these researchers to look back into essential Framework policy interventions include educating SLT users on the impacts of BQ use by 3-5 mins health messages at the OPD and raising the query on the progression of implementing the SLT ban in Sri Lanka. In other words, this study, which was conducted to measure the effectiveness of a short health message on preventing SLT use in 2021, provides some hints on poor successes in the SLT ban, which was excused in 2016.

Moreover, the above research conducted by Amarasinghe and colleagues, who are a group of self-funded investigators at the central hospital for oral care located in the capital city of the country, is an indirect sign of understanding the lack of attention of decision-makers in providing planned health education programmes to the long term SLT users. Health education programmes are a vital and fundamental policy initiative suggested by Article 12 in the WHO Framework Convention of Tobacco Control

(FCTC) to prevent and control global tobacco epidemics (World Health Organization, 2004). Health education is an evidence-based and cost-effective policy to receive positive results in controlling and preventing tobacco epidemics, including SLT menace(Bay et al., 2017; World Health Organization, 2004).

SLT consumption is a socially accepted, culturally inherited, long-lasting practice in the primary cultures in Sri Lanka(Amarasinghe et al., 2023; Mahees et al., 2021; Somatunga, 2004). According to the latest STEP survey conducted in 2021, 17.5 % of Sri Lankans are chronic SLT users. Though SLT use is 17.5%, around 30.3% of adult men consume SLT, while 6.4% of females use SLT. Therefore, the problem is more extensive than shown by the average national figures and is mainly confined to men. Compared to other SEA countries such as India, Bangladesh, and Pakistan, this wide gap in the female ratio of SLT use in Sri Lanka has not yet been well investigated (Chugh et al., 2023). The male-to-female ratio of SLT use in Sri Lanka is 5:1. It means when five men use SLT in Sri Lanka, only one woman consumes it. Little or no research has been conducted to determine the underlying reasons for this gap in sex ratios of habitual SLT use.

Though there are links between literacy rate and healthy behaviours, the significant gap between men and women in SLT use in Sri Lanka can't be explained because the male literacy rate in Sri Lanka is 93.28% and 92.38% in females (UNESCO, 2020). However, compared with the neighbouring countries with a high burden of the SLT epidemic, the percentage of female literacy in Sri Lanka is higher (UNESCO, 2020). However, there is no significant evidence to link women's literacy rate and the lower portion of SLT use among females and the higher percentage of SLT use among men in Sri Lanka, which needs further research.

Moreover, this gap in the male-to-female ratio in SLT use among adolescents in Sri Lanka is much broader than that of adults. For example, the recent GYTS survey conducted in Sri Lanka in 2015 revealed that when 4.2% of boys aged 13-15 in schools used the SLT, the percentage of girls who used SLT was 0.5%. That is an 8:1 sex ratio, twice as wide as the adult male-female ratio. These data reveal two facts: the surroundings of male adolescents in Sri Lanka provoke SLT use, which needs further studies to understand the underlying reasons, and female adolescents live in a more

protected environment where the peer pressure for SLT use is significantly lower when comparing the pressure getting by boy adolescents.

A recent study by De Silva and Ekanayake (2017) reveals that SLT use in adolescents in rural Sri Lanka is associated with gender, paternal occupation and maternal education. The same cross-sectional study conducted among 390 students (16-19 years) in nine schools in the Ampara district by giving a self-administered questionnaire revealed that 23% of male students in the sample use SLT while 3% of female students do so(De Silva and Ekanayake, 2017). This finding confirms the Recent increase in SLT use among male adolescents in rural Sri Lanka. The study was conducted before enforcing the SLT ban in 2016. Therefore, though I looked for a similar data set to compare the SLT use among the same age group in rural Sri Lanka after the SLT ban implementation, no recent published research was available to fulfil that purpose. This observation indirectly shows the need for research studies to compare the pattern and distribution of SLT use among adolescents and youths before and after the SLT ban implementation. For example, there has not been a Global Youth Tobacco Survey, a self-administered, school-based survey of students in grades associated with 13 to 15 years of age designed to track their tobacco use, since 2015 to compare the differences.

Although the research studies included are of low quality and do not provide in-depth details of all age groups, they give an overall view of the SLT burden in Sri Lanka. The epidemiological data presented by those studies reveals that the policymakers in Sri Lanka need to understand the psychological, behavioural and environmental factors causing more males to use SLT than females and develop policies accordingly. On the other hand, females (for example, mothers, adolescents and young girls) can be motivated as the messenger (controlling agent), bringing health education tips to the home and cutting down the SLT use in household and school settings(Srivastava et al., 2018; Secker-Walker et al., 2005).

Finally, the above brief presentation of the epidemiological data of the SLT epidemic in Sri Lanka revealed a significant rise in overall SLT use during the period of implementing the comprehensive SLT ban. While there was a substantial gap in the male-to-female ratio in SLT use before implementing the SLT ban policy, the gap has

been further widening during the period of implementation of the ban. In addition, empirical data among rural youths in 2016 shows the prevalence of both male and female SLT use is above the national figures. Although there is limited research and survey data available to accurately predict the direction of the SLT epidemic in Sri Lanka following the implementation of the SLT ban in 2016, the available information suggests that there has been a concerning increase in overall SLT use. Decision-makers must take responsibility for identifying the underlying causes of these trends despite the policy being in place.

In summary, despite the ban, data from two consecutive STEP surveys (2015 and 2021) reveal a troubling increase in SLT use in Sri Lanka. The overall prevalence of SLT use rose from 15.8% in 2015 to 17.5% in 2021, with significant increases among males and females. This raises questions about the ban's implementation and enforcement, suggesting that it may be more of a symbolic measure than an effective policy tool, which needs further research. Moreover, the literature highlights the deeprooted cultural acceptances and social practices surrounding SLT use in Sri Lanka. As presented above, the male-to-female ratio of SLT use is strikingly high, with a significant increase from a 4:1 ratio in 2015 to 5:1 in 2021. This disparity suggests that gender-specific factors and societal norms play a critical role in SLT use, which the current ban, by its nature, fails to address.

1.4 Health and Non-Health Impacts

For decades, reliable evidence has demonstrated the detrimental impact of tobacco use on both health and non-health factors in Sri Lanka (Arunatilake and Opatha, 2003). In this section, I present empirical evidence of the health effects of SLT use. Section 1.10 delves into the economic context and other related impacts.

The chronic use of SLT is a behavioural risk factor causing severe health hazards (Chugh et al., 2023; Siddiqi et al., 2020; Craig et al., 2019). These serious SLT-attributed problems range from head, neck and pharyngeal carcinomas and cardiovascular diseases to foetal deformities. All behavioural risk factors are not categorised as public health policy issues (Saltman and Ferroussier-Davis, 2000). For example, after adequate observations and interpretations of empirical data on its

impact for a period, SLT use has been realised as a public health policy issue in most SEA countries, including Sri Lanka (Buse, Mays and Walt, 2012). As presented in section 1.3. (page 23) more than 10% of the population in most of the SEA (and African) countries consume SLT in the long term and, therefore, develop fatal diseases (Siddiqi et al., 2015; Mehrotra and Sinha, 2018). Once a behavioural risk factor (or a health issue), such as SLT use in Sri Lanka, is categorised as a 'public health policy issue', it is supposed to be bought into the agenda-setting at the constitutional level (e.g., House of Parliament), and systematically develop evidence-based, effective policies (McConnell, 2017; Buse, Mays and Walt, 2012).

Therefore, the research evidence on the health impacts of SLT use is vital in prioritising the importance and urgency of making robust public health policies to control and prevent SLT epidemics. The range of health problems caused by chronic use of SLT includes potentially oral malignant lesions, oral, oesophageal, and pancreatic cancers, diabetes mellitus, cardiovascular diseases, mental illnesses, and osteopenia. Furthermore, mothers who use SLT before and during pregnancy experience several foetal deformities, including low birth weights, pre-term births, tiny gestational age babies, and stillbirths (Mehrotra and Sinha, 2018; Siddigi et al., 2015).

SLT-attributed lip, mouth and tongue cancers have been the most common forms of carcinomas among Sri Lankan adult men for decades and were growing annually. SLT consists of more than 30 chemicals causing malignancies, premalignant conditions and other adverse effects in the oral cavity and related organs in the human body (IARC Working Group on the Evaluation of Carcinogenic Risks to Humans and International Agency for Research on Cancer, 2007).

The National Cancer Registry, published annually by the National Cancer Control Program of the Ministry of Health, revealed that lip, mouth and tongue cancers among adult men in Sri Lanka gradually increased from 2005 to 2020. Though there was a slight decrease in lip, mouth and tongue cancer incidence rates from 2016 to 2019, the rates after 2016 were still higher than in 2013. Furthermore, there is a significant increase in the rate from 2019 (20.6) to 2020 (22.0). The Ministry of Health executed the SLT ban in 2016. In addition, the country faced a series of coordinated easter bombing attacks in several districts in April 2019. When considering these two

situational factors, I argue there can be two reasons for these changes in cancer incidence rate of lip, mouth and tongue cancers in Sri Lanka (- reducing the reporting between 2016 and 2019 and then raising again in 2020) (1) fear of been exposure to diagnostic and treatment centres immediately after prohibition of the SLT products, and (2) fear of attending to crowded places instantly following a series of threat to the national security by Easter Bombings. Nevertheless, the trend of statistics from the National Cancer Registry can be considered a gradual rise in the incidence rate of lip, mouth and tongue cancers in the last decade, an alarming indicator for urgent attention.

Though the National Cancer Registry reports the cancer incidence rate annually, it can't be treated as an immediate indicator to predict the successes or failures of the SLT ban 2016 for several reasons. SLT-attributed lip, mouth and tongue cancers have been proven to be developed due to the long-term consumption of other SLT products. Though there is no strong evidence on the duration of the SLT to be used to develop lip, mouth and tongue malignancies, the cancer incidence rate of these malignancies might take at least ten years to show a fluctuation due to the impacts of the ban implemented in 2016. Therefore, policymakers and researchers are responsible for finding different scientific approaches to predict the outcomes of the ban without waiting for changes in incidence rates of oral and related cancers.

As I mentioned above in section 1.2.1 (page 18), the content of the SLT ban policy is legislatively powerful, and it has been enforced against the long-term, culturally accepted, traditional betel quids as well as commercially prepared SLTs, which are mainly operated in the black market. Therefore, the success or failure of the SLT ban is debatable. Nevertheless, as mentioned above, the decision-makers can't wait decades to see the outcomes by interpreting the changes in the impacts of SLT use, including cancer incidence rate of lip, mouth and tongue cancers or other SLT-attributed chronic non-communicable diseases. Therefore, decision-makers and researchers must plan out various qualitative and quantitative methods, including the STEPwise approach in NCD risk factor surveillance (STEPs), Global Youth Tobacco Surveys (GYTS), cross-sectional surveys, the policy document analysis and in-depth interviews with key stakeholders to understand the direction of the ban's outcomes without further delay.

Moreover, according to the National Cancer Registry 2014, the incidence of malignancies in the oral cavity in Sri Lankan men standardised to the world male population was 15.6 per 100,000 population. Furthermore, once standardised to the global female population, the incidence of oral cavity cancers in Sri Lankan females was 3.7. As explained by the epidemiological data on SLT use among men and female, the number of SLT-using women is significantly low when compared to men in Sri Lanka. For example, when 30.3% of adult men used SLT in 2020, only 6.4% of women consumed it. These differences in behavioural pattern are confirmed by the differences in the lip, mouth and tongue cancers among men and women. When these lip, mouth and tongue cancers are the number one killer of men, it is in the 7th place or around in women's CIR list for consecutive recent years. These statistical changes in SLT use and cancer incidence rate in two genders are reflections of two critical initiatives: (1) the possibility of training female adults in households and occupational settings as the 'messenger'/ 'agent' to make aware the male SLT users in the consequences of long term consumption of those, high oral cancer rate in Sri Lanka and the ban (Shopland, 1995; Umberson, 1992) and (2) the resistances and barriers to be faced by ban implementors might be high as the willingness of male adults in obeying to legislative and terminate their habits are much less when compared to the females (Rudisill and Zhu, 2017; Steptoe et al., 2002).

On the other hand, though the number of lip, mouth and tongue cancer cases among adult women in Sri Lanka is significantly low in comparison to men, the attention of policymakers should be given to controlling the chronic use of SLT by females too, because two latest consecutive results of STEPs survey revealed increase trend in SLT use among the females (Somatunga, 2004; Amarasinghe et al., 2023). The STEPs survey 2015 reported the percentage of women who use SLT in Sri Lanka as 5.3%, while the 2020 survey reported the same indicator as 6.4%. On the other hand, this trend in the increased use of SLT among Sri Lankan women from 2015 to 2020 is a proxy indicator of a lack of awareness of the public on the ban implemented in 2016. Though the ban is in place, if the public is unaware, there should be significant problems in ban execution, which have not yet been identified.

The age-specific cancer rate of lip, mouth and tongue cancers in Sri Lanka discloses the highest number of these cancers reported among Sri Lankan men between 45 and 75 years of age (Ministry, 2019). The percentage of lip, mouth, and tongue cancers reported in the past 45 years was above 85% in two consecutive years from 2019 to 2020. Furthermore, according to the staging information of the lip, mouth and tongue cancer statistics in 2019, approximately 63.8% of the cases have been diagnosed at stages III and IV, which are advanced stages. The survival rate of lip, mouth and tongue cancers diagnosed at advanced stages is less than five years. Therefore, it is evident that SLT-attributed lip, mouth and tongue cancers mostly kill men at their productive ages (economically and socially) and need urgent attention. Moreover, as explained above, as the decision makers must wait at least a decade to look at slight changes in cancer rates following the SLT ban implementation, there is an urgent need to find alternative scientific methods without further delay to investigate the successes and failures of the SLT ban policy.

Lip, mouth and tongue cancers are preceded by Oral Potentially Malignant Diseases (Chugh et al., 2023). More research has been conducted in Sri Lanka on the prevalence and incidence of OPMD compared to the cancers mentioned above and other SLT-attributed non-communicable diseases. However, the quality of some is not up to standards. However, once the global prevalence of Oral Potentially Malignant Diseases was between 1 and 5%, and that of Southeast Asia was around 2%, the prevalence in Sri Lanka was 3.4.% (Somatunga et al., 2012; Napier and Speight, 2008). Moreover, statistical reports from Sri Lank hospitals show an increased trend in Oral Potentially Malignant Diseases among youths who use CPSLT (Mahees et al., 2021). These data on the prevalence of potentially oral malignant diseases further reveal that Sri Lanka has little time to waste in setting or reforming SLT controlling and preventive policies.

Though there are only a few pieces of evidence specific to SLT-attributed morbidities and mortalities except for that of cancer incidence rates and age-specific rates of lip, mouth and tongue cancers in Sri Lanka, the annual reports of the Ministry of Health reveal the incidence of tobacco-induced non-communicable diseases including cardiovascular, cerebrovascular, and neoplastic diseases are raising. Moreover, the global health statistics signify the danger of long-term use of SLT. For example,

research has found that SLT causes 650,000 overall deaths each year (Niaz et al., 2017). Moreover, the Globacan study 2020 confirmed that the total number of new cases of lip and oral cavity cancers as 377 713 and of deaths as 177 757 (Hernández-Morales et al., 2023; Sung et al., 2021). According to these findings of the Globacan 2020, SLT-attributed lip and oral cavity malignancies were at 16th place on the global cancer list and alarming for actions. The globe lost approximately 2.5 million DALYs and 90,791 human lives due to SLT-attributed oral, oesophageal, and pharyngeal malignancies in 2017. According to the Global Burden of Diseases (GBD) study 2019 on oral cancer conducted using thirty years of data (the 1990s to 2019s), the highest numbers of new oral cancer cases (3,54, 864) and oral-related deaths (1, 77, 384) were reported in 2018, not in early years of the study. These findings of the Global Burden of Diseases study further reveal an increased tendency of SLT-induced oral cancers. Not only that, due to SLT-attributed ischemic heart disease, the globe lost over 6 million DALYs and 2,58 006 in the same year (He et al., 2022; Kendrick et al., 2021).

In addition to the severe health issues, SLT use has been proven to be a threat to the environment. For example, plastic sachets used in packaging take more than 300 years to be photodegraded and add toxic particles to the soil. Moreover, the habit of spitting when chewing SLT causes the spreading of infectious diseases, including Covid-19 and tuberculosis (Chugh et al., 2023; Siddiqi et al., 2020).

Finally, given the overview of the health impacts of SLT use in Sri Lanka, the SLT-induced NCDs might lead to a public health crisis. The country is struggling with the highest prevalence of lip, mouth and tongue cancers among its adult men in decades, but still, there is no significant decline in the incidences. In addition, there is a new trend in increasing OPMDs among youths who consume CPSLT that are sold in the black market. In addition, annual hospital data alarm significant rises in all types of tobacco-attributed NCDs, including ischemic heart disease. Moreover, spitting following SLT chewing is a common habit in Sri Lanka, which spreads critical infectious diseases, including tuberculosis and COVID-19. There is no significant evidence of improvement in any of these outcome data following the execution of the SLT ban 2016. These empirical data presented under the epidemic's impacts show the challenge's gravity. The vast majority of the negative consequences associated with

SLT are attributed to its addictive and cancer-causing properties, as detailed in the subsequent section of this background chapter.

The literature presented under section 1.4 of this background chapter provides a comprehensive overview of the health and non-health impacts of SLT use in Sri Lanka, drawing on robust empirical evidence and numerous studies. However, while the piece is thorough, several areas would benefit from more profound analysis and critique. For example, the studies present detailed statistics on the incidence of SLT-related diseases; they rely on descriptive data without adequately exploring the causal mechanisms behind these trends. For instance, the literature discusses the increase in lip, mouth and tongue cancers. Still, there is a lack of in-depth investigations and discussions on the socio-economic, cultural and policy-related factors driving these increases. Exploring these underlying causes would provide a more nuanced understanding of the issue.

Furthermore, the ban's effectiveness cannot be immediately measured by cancer incidence rates due to the long latency of cancer development. However, it fails to propose alternative metrics or methodologies for evaluating the ban's impact in the short and medium term. For example, an analysis of trends in SLT sales, public awareness of the ban, or changes in SLT-related factors, for which there is a lack of research studies, could provide more immediate indicators of the policy's success.

1.5 Nicotine and Psycho-Addictive Nature of the Issue

The psycho-addictive characteristics of SLT need to be counted well in planning policies for controlling and preventing long-term SLT use (Arora et al., 2020; Gupta and Mehrotra, 2021). Nicotine is a psychostimulant found in the tobacco leaf(Gupta and Mehrotra, 2021). Nicotine is absorbed through the mucous membranes of the mouth or nose once a person chews or inhales SLT, the main SLT used in Sri Lanka (Hajdusianek et al., 2021).

This Nicotine reaches the brain through the blood circulation system and increases the blood dopamine level. The evidence reveals the dopamine released by the brain cells generates a range of pleasurable sensations within a few minutes of using SLT. According to the research studies conducted to discover the experiences of SLT users, these pleasurable sensations include a significant sense of relaxation, thrill, drop in anxiety/ stress, increased sense of memory, concentration, and reduction in tiredness, which keep the users adherent to the products (McKinney and Vansickel, 2016).

Policymakers need a scientific approach to developing multidimensional policies in controlling and preventing SLT use, of which a few essential, evidence-based components are participatory approaches in education, awareness and cessation activities(Arora et al., 2020; World Health Organization, 2004). Therefore, as I mentioned in section 1.2.1 (page 18), the content of the SLT ban is firm enough to ignore these policy initiatives under the categories of health education, awareness, and cessation programs. The decision-makers and researchers should investigate these critical areas of failures of the SLT ban that could have been inherent from its development stage, or that can be observed urgently in the implementation phase and reform.

1.5.1 Other Harmful Chemicals in SLT

In addition to Nicotine, SLT consists of more than 3,000 chemicals (Li and Hecht, 2022). Of these chemicals, twenty-eight have been proven to be at high risk for developing cancers. These carcinogenic chemicals include tobacco-specific nitrosamines (TSNAs), harmful metals (arsenic, beryllium, cadmium, chromium, cobalt, lead, nickel, mercury), radioactive elements (polonium-210) and polynuclear/polycyclic aromatic hydrocarbons (Stepanov et al., 2008; Vineis and Caporaso, 1995).

One of the key findings of the research conducted to identify these carcinogenic properties of the SLT products, that is not to be ill-treated in making policies, is that most of these chemicals and their quantities are decided by the ways and means of growing, curing, fermenting, and storing tobacco leaves (Gupta et al., 2022, 2019). For example, the evidence proves the percentage of TSNAs contained in each form of SLT product differs from their standards in manufacturing and storing. The most dangerous carcinogens under the TSNAs category include N-nitrosonornicotine (NNN),4-(methyl nitrosamine)-1-(3-pyridyl)-1-butanone and N-nitrosoanabasine.

Evidence revealed that unregulated SLT products, such as domestically produced betel quids, have higher TSNAs than regulated products. In addition, Polonium-210, another carcinogenic chemical that can be seen in SLT, was initially found in tobacco fertilisers. Moreover, polynuclear/polycyclic aromatic hydrocarbons, again carcinogenic elements, are formed when curing tobacco by heat(Nasrin et al., 2020; Gupta et al., 2019).

Therefore, it is evident that the percentages of the carcinogenic and other harmful chemicals found in each SLT product depend on several factors that can be controlled to some extent by regulating critical steps in manufacturing and supply chains. These fundamental elements that can be regulated include the type of tobacco plant, the variety of soil, harvesting techniques, pesticides used in the cultivation, fermentation processes, and storage conditions (Gupta et al., 2022; Nasrin et al., 2020; World Health Organization, 2004). Articles 9 to 11 in the Framework Convention provide policy initiatives to regulate these stages of the SLT production and supply chains directly and indirectly. Therefore, as I argue in section 1.2.1 (page 18), the SLT ban, by the superpower of its legitimacy, should not diminish the capabilities of these vital policies if they are in place to control and prevent SLT use in Sri Lanka. The researchers and decision-makers are responsible for determining the influence of the SLT ban on these critical areas of effective control of SLT control and prevention. On the other hand, if decision-makers conclude, without robust evidence, that they can ignore the value of these articles in the Framework Convention as there is a strong ban in place, there is a risk of the collapse of the SLT control program in Sri Lanka.

1.5.2 Synergetic Effects of Areca Nuts

When considering the SLT epidemic in Sri Lanka and its health impacts, the role of areca nut and its psychoactive and carcinogenic properties cannot be separated (Baruah, 2023; Athukorala, Tilakaratne and Jayasinghe, 2021). Areca nut is one of the main ingredients in preparing most traditional and commercial SLT products in Sri Lanka(Karunarathne and Ekanayake, 2016). The areca nut, called the betel nut in some regions, is the seed of a tropical palm tree called Areca Catechu. The areca nut is the most chewed natural product in the world. Approximately 600 million users worldwide use areca nut. The psychoactive ingredient in the areca nut is called

Arecoline. Arecoline, an alkaloid, has been classified as a group 1 human carcinogen by the International Agency for Research on Cancer (IARC). The Arecoline forms squamous cell carcinomas in the mouth and oesophagus by making histologic changes in the mucosae(Gupta et al., 2020).

Again, like tobacco, the alkaloid level in areca nut varies depending on the stages of areca nut, such as the level of growth, processing methods and storage conditions. Hence, the carcinogenicity varies(Gupta et al., 2023, 2020). Furthermore, the traditional betel quids in Sri Lanka consist of slaked lime, which is always used with areca nut (Hettiarachchi et al., 2020; Somatunga et al., 2012). Slaked lime enhanced the carcinogenic properties of areca nut (Secretan et al., 2009; Nair et al., 1990). These findings in the presence of areca nut in most of the SLT products in Sri Lanka are vital in planning and controlling the SLT epidemic in Sri Lanka because without setting policies to control and prevent areca nut use, Sri Lanka cannot diminish a significant portion of lip, mouth and tongue cancers. As presented above in section 1.3. (page 23), these malignancies have been the number one cancer killer of adult men in Sri Lanka for decades. Nevertheless, immediate research on the success of the policy development phase of the SLT ban is essential to find out the reasons for actions to be taken or not to be brought to prevent or control areca nut use in the country. For instance, we need evidence on how policies regarding areca nut could be combined with existing SLT control measures, including a ban. Exploring synergies between different regulatory approaches, such as integrating public education campaigns with stricter enforcement of sales restrictions, could improve the overall effectiveness of SLT campaigns. However, limited research evidence is available to compare and contrast these interventions or policies.

Section 1.6 (pages 37-44) of this background chapter further elaborates on the SLT policy issue in Sri Lanka by briefly presenting consumers' main types of SLT products.

In summary, the evidence on the psycho-addictive nature of SLT and its implications for SLT policy making is essential for a comprehensive understanding of the SLT epidemic in Sri Lanka. While the available literature offers a good foundation, several areas needed more in-depth analysis and critique to enhance its success and applicability. For example, the available literature rightly calls for multinational policies

but lacks specificity in how these policies should be integrated based on the psychoaddictive characteristics of nicotine according to the socio-cultural context of Sri Lanka. These socio-cultural characteristics include cultural practices, social norms, the role of SLT in daily life. Moreover, further evidence on psychological and social support systems is necessary for effective SLT cessation programs linked with a ban.

1.6 SLT Products and Their Complex Supply Chains

In this section of the background chapter, comprehensive evidence regarding SLT products and their intricate supply chains is presented. The gaps in discussing their cultural and societal connections, economic impacts, and local politics have been presented with literature in Part B (Cultural Context) of this chapter."

Both traditional forms of betel quids (BQs) and commercial preparations of SLT products (CPSLT) are abundant in contemporary Sri Lanka (Dhanapriyanka et al., 2022; Hettiarachchi et al., 2020; Somatunga et al., 2012). Traditional betel quid consumption has been a part of the primary culture and a style of sharing social relationships for centuries (Somatunga et al., 2012; Amarasinghe et al., 2010b). The most typical form of SLT Sri Lankans use is traditional betel guids. It is mainly confined to rural settings, where more than 80% of the population lives. In rural Sri Lanka, almost all adults have consumed betel quids at least once in their lifetime because betel quids are embedded in the primary cultures and religions of the country. Chronic consumption of betel guids more than five to six times daily is common among rural people in contemporary Sri Lanka (Amarasinghe et al., 2023). The traditional betel guids are available in the open markets, from village kiosks to wholesale shops in city centres. The urban and suburban youths mainly consume commercial preparations of SLT. Among these, Babul and Beeda are produced locally. Gutka, Hans, Panparag and Maawa are imported from neighbouring countries, including India, Bangladesh and Pakistan. Those are sold in the black market only to known customers (Mahees et al., 2021).

Neither traditional betel quids nor these commercial products are taxed or tested for their contents by the government of Sri Lanka (Somatunga et al., 2012; Amarasinghe et al., 2010b). The government doesn't monitor production disclosure or packaging

and labelling of SLT products. These commercial products cannot be taxed as they are sold on the black market(Mahees et al., 2021). Moreover, a significant proportion of traditional betel guids are home-made by consumers. Another large proportion is sold in open market events (Jayasinghe et al., 2021; Hettiarachchi et al., 2020). There are different levels of betel quid sellers ranging from small-scale retailers to large-scale wholesale businesspeople. By analysing this overview of the common forms of SLT products and their supply chains in Sri Lanka, as claimed in section 1.3. of this background chapter, the outcomes of the countrywide, comprehensive ban executed by the government of Sri Lanka are controversial. As mentioned above, the policy prohibits manufacturing, importing, selling and offering all SLT types in Sri Lanka. However, when we look into the manufacturing of traditional betel guids, the majority are home-made(Somatunga et al., 2012). The rest is mainly produced in small-scale industries. Imported CPSLTs are available only in the black market(Mahees et al., 2021). Other CPSLTs, which are produced locally, also cannot be seen in the open market. Therefore, it is evident that the ban can show positive outcomes only in the open market of traditional betel guids. On the other hand, as traditional betel guid is a vital symbol of the primary cultures of Sri Lanka, there is a predictable risk of raising denials on the ban enforcement. The SLT users, the public, informal community leaders and the members of parliament representing various communities are the influential stakeholders who can protest the legitimacy of the ban on this long-lasting cultural habit. To successfully solve the epidemic in Sri Lanka, the decision-makers are supposed to conduct robust studies on traditional and cultural concerns by critical stakeholders. The customs, rituals, myths and festivals related to SLT will be presented in detail in section 1.8.2. (pages 51-59).

Traditional betel quids are readily available, accessible and affordable in Sri Lanka. The country is one of the largest tobacco growers in Asia(Mahees et al., 2021). The smoking tobacco industry directly sponsors tobacco farming and has been excluded from the ban policy in 2016. Tobacco plantation is not prohibited by the ban policy (MoH, 2016). As a result, the plain tobacco leaves from various grades from various tobacco farmers are easily accessible at each corner of the country (Amarasinghe et al., 2023). In other words, Tobacco is cultivated on a large scale in most of the districts under the direct sponsorship of Ceylon Tobacco Company (CTC). CTC is the tobacco monopoly in Sri Lanka, which manufactures, markets, and exports cigarettes and is

located in the capital city (Colombo) of Sri Lanka. Local farmers supply all the raw tobacco needs for Ceylon Tobacco Company . Another set of farmers grows tobacco for bidi production and chewing purposes (Arunatilake and Opatha, 2003). The harvest from these agricultural lands goes to the local market for SLT consumers or traditional festivals and events, reflecting the abundance of tobacco leaves to be used by SLT users. For example, Ceylon Tobacco Company purchased 5,040 raw tobacco tons from local farmers 2013 and produced 4.035 million cigarette sticks. Ceylon Tobacco Company doesn't import any tobacco leaves for their products in Sri Lanka(Fernando, 2014). This proxy indicates abundance and attitudes towards tobacco agriculture in Sri Lanka.

Furthermore, the above evidence on raw tobacco production in Sri Lanka raises two concerns: i) How can the SLT ban policy be successful when plain tobacco leaves, the ingredients for SLT products, are abandoned in the local market? and ii) what is the validity of the ban policy/ how practical is the enforcement of the ban in a country where the traditional SLT products are mainly home-made CPSLT are sold only in the black market to known customers, and plain tobacco leaves are supplied without any hindrance by tobacco farmers?(Mahees et al., 2021; Thennakoon and De Silva, 2012). Therefore, decision-makers need to plan urgent investigations to find the place of the SLT ban policy in the SLT epidemic in Sri Lanka.

Following is a brief overview of these everyday SLT products, including their preparation methods, prices and supply chains(Mahees et al., 2021; Somatunga et al., 2012). This evidence on traditional betel quids and CPSLT use in Sri Lankans aids in defining the SLT epidemic in the country precisely. Defining the SLT epidemic, the public health policy issue under study, is the foundation for an in-depth analysis of the successes or failures of the policies developed to solve the epidemic and provide reform recommendations.

The traditional betel quids and similar local SLT products can be quickly produced in households(Hettiarachchi et al., 2020). In addition, all these varieties of SLT products can be rapidly brought from the nearest shop or the kiosk in all corners of the country(Amarasinghe et al., 2010b). Most of the local SLT products do not have standard packages or labels. Most SLT products, including betel quids, are un-taxed

and unregulated; therefore, none of the authorities are responsible for their ingredients or compositions.

1.6.1 Traditional Betel Quids

As mentioned above, traditional betel quid is the most common form of SLT product practised in Sri Lanka for over 2000 years (Somatunga et al., 2012). It is called "Bulath Hapaya" in Sri Lanka's primary language (Sinhala). Since ancient times, betel quid has been socially and culturally encouraged in Sri Lankan homes. The following are the main components of traditional betel quids.

- Betel leaf (piper betel), locally called bulath kola.
- A few pieces of areca nut (areca catechu).
- Slaked lime (calcium hydroxide).
- A few flakes of tobacco.

In addition to these main ingredients, other substances used in betel quids are cardamom, saffron, cloves, aniseed, and turmeric. All these ingredients are freely available to its users or at a low cost in Sri Lanka(Somatunga et al., 2012). The average price of one preparation of betel quid was Rs.10 in 2011, which was affordable even for marginalised people, including farmers, labourers, and tea puckers. When compared to the price of smoking tobacco products(Amarasinghe et al., 2023).

While the previous section discussed the popularity and widespread use of traditional betel quids in Sri Lanka, it also emphasised its historical and cultural significance, including its integration and cultural persistence. These ties, including the regulatory challenges, the dynamics of the black market, public health impacts, and agricultural practices, are presented with existing evidence in Part B (sections 1.7 to 1.11, pages 45 to 83) in this background chapter.

1.6.2 Non-traditional SLT products (CPSLT)

Recent evidence reveals an increasing tendency to use SLT products other than betel quids among youths and adolescents in several sociological and livelihood groups in urban and suburban areas. These non-traditional SLT products are employed as a secret subculture linked with the black market (Dhanapriyanka et al., 2022; Mahees et al., 2021). These products will be called 'other SLT products' or commercially produced SLT products for the rest of this thesis.

Most of the recent literature has been referred to those products as CPSLT. The main types of CPSLT used mainly by Sri Lankan youths and adolescents are Bulath Vita, Beeda, Pan Parag, Mawa, Red tooth powder, khani, tobacco powder, Babul, and Babul Beta(Mahees et al., 2021; Somatunga et al., 2012).

Among those, Sara Bulath Vita is a different type of betel quid presented as a cone. It is prepared by tightly wrapping grated coloured coconut kernels, areca nut scrapings, and a few spices in a betel leaf. The Sara Bulath Vita is a popular form of SLT sold on festival premises. Beeda is another type of SLT available in Sri Lanka. As mentioned above, evidence shows that neighbouring countries recently introduced Beeda to Sri Lanka. Beeda is made up of a quid wrapped in a betel leaf accompanied by a small sachet of a mixture of unknown products imported. Its price changes according to the size of the quid. However, the average price of Beeda goes from 15 to 50 per packet, which is generally affordable to low-income individuals. These are contained in cellophane packets.

In addition to the above five types of CPSLT, Khaini is another SLT product comprising tobacco mixed with lime and honey/alcohol packed in plastic sachets and kept between lips and gums(Somatunga et al., 2012). The quid is finally spat out or sucked. Hans is one of the most popular brands of Khani found in Colombo—the country's capital city. The quid is sucked or spat out. It costs around Rs.150 and is therefore popular among youth and adolescents, including slum-dwellers. Furthermore, Pan parag/Pan masala contains tobacco, areca nut, slaked lime, catechu (Acacia catechu), and some condiments. They import mainly from India and Pakistan. Pan Parag is

prevalent among adolescents, with an average price of around twenty Sri Lankan rupees. Mawa is another SLT product imported from neighbouring countries. Mawa is made from a blend of pieces or thin shavings of dried areca nut with tobacco flakes and slaked lime and consists of an attractive packet. Mawa is also prevalent among adolescents 13-15 years of school-going age and recent school leavers. Despite being urban or rural, recent evidence suggests a rising trend in using these non-BQ SLT products among young people in Sri Lanka.

Moreover, Red Tooth Powder is another CPSLT product available in Sri Lanka(Mahees et al., 2021). The leading supplier is India. It is a powdery preparation containing tobacco between the teeth and gums in consumption. It costs about Rs.150 per bottle and is again popular among school adolescents (13-15 years). The following commonly available product is plain tobacco powder. Tobacco powder is placed in the mouth and sucked or used nasally. It is widely available and affordable to poor people. The evidence reveals that adolescents prefer tobacco powder. There are myths and cultures related to plain tobacco powder. Older adults believe tobacco powder has a range of medicinal effects, including influenza and respiratory tract diseases. Another SLT product available in Sri Lanka is Babul, imported from India. It is mainly available in urban areas. Babul and babul-like products comprised tobacco leaf, lime, areca nut, and other spices. For example, Babul Beta, a babul-like product, is another brand popular among new starters and youths. Babul Beta is imported from Pakistan by different vendors.

Though little research is available on the prevalence, patterns and frequencies of different types of CPSLT among different sociocultural settings in Sri Lanka, analysis of some of the findings available in these studies aids in understanding the current situation. For example, qualitative research conducted in seven out of 24 districts, representing three main sociodemographic settings, which had the purpose of looking at the factors associated with the CPSLT in sociological view had identified that the Thul and Mawo as the most prevalent CPSLT in Sri Lanka(Mahees et al., 2021). In addition, they have identified snuff, dappi and salah as the other products used by habitual SLT users. The data was collected by conducting in-depth interviews with CPSLT users in different livelihoods and ethnic groups. The number of participants was 35. The seven districts where the study was conducted had been selected

according to the prevalence of SLT use in Sri Lanka. They were Colombo, Kaluthara, Gampaha, Kurunegala, Nuwara Eliya, Pullam and Anuradapura. The study participants were chosen with the guidance of Public Health Inspectors (PHI) and Police Officers of each area, who are working closely with their communities in implementing the rules and regulations related to tobacco control. Therefore, it is obvious the methodology of this study in finding out the factors linked with CPSLT use from a sociological angle is quite robust. Still, each result has not been presented with adequate quotes. Therefore, researchers have limited opportunities to analyse the findings for further understanding.

The same study which was conducted by the central government agency authorized to control and prevent tobacco epidemic in Sri Lanka- National Alcohol and Tobacco Control Authority (NATA)- in 2016, and funded by the Campaign for Tobacco Free Kids, highlighted seven critical findings of the CPSLT use; (I) control and prevention of CPSLT is difficult as socio-cultural, demographic, and regional factors provoke the use, (II) There are groups of interconnected, permanent customers for CPSLT business in each zone, which is mainly informal power groups (III) CPSLT users prefer to introduce themselves as group of people belong to a subculture with unique lifestyle, norms and fashions, (iv) the young groups engage in sport clubs, mainly rugger, football and cricket in urban and suburban areas expose to CPSLT then others in the same age, (v) the main components of the youth culture- music, fashion and premarital sex- are well-connected with CPSLT use, (vi) schools are the 'socialization agency' of CPSLT, and (vii) the main socio-economic and occupational groups who heavily consume CPSLT were three-wheel drivers, security officers, labourers, garment factory workers, bus drivers and conductors and porters (Mahees et al., 2021). As mentioned above, the study was conducted by NATA in 2016, the year the NATA office banned all SLT products in Sri Lanka comprehensively. There is a possibility these research findings will be a background research aid in coming to the policy decision. Still, I can't go to the validity and reliability of this study because it doesn't provide adequate evidence for its findings. Moreover, they have been confined to only 35 indepth interviews in seven districts. On average, they could conduct only five interviews in each district. On the other hand, they have skipped 17 districts out of 24 districts. Therefore, the area they could not cover was more than 70%. Moreover, I couldn't find any research or background paper conducted simultaneously for analysing the

sociology and factors associated with traditional betel quid chewing in Sri Lanka. Traditional BQs are the most prevalent SLT product in Sri Lanka, for which the country has roots going back 2,000 years. Therefore, without a deep understanding of the socio-cultural and other contextual factors causing betel quids consumption in Sri Lanka, policymakers may not be able to develop a robust policy to control and prevent the SLT epidemic in Sri Lanka.

The evidence pointed out the lack of regulation and taxation, but no comprehensive evidence was found explaining the direct reasons behind these regulatory gaps. Nevertheless, Part B of the background chapter (sections 1.7 to 1.11, pages 45 to 83) presents literature related to the investigation of political, bureaucratic, and economic challenges that hinder effective regulation and enforcement. Exploring the comparative literature between Sri Lanka's regulatory framework and that of other countries that have successfully implemented similar regulations could provide practical insights and potential strategies. However, there is currently a lack of evidence for such an approach.

Part B: Contextual Factors

1.7 Context of the Problem

This section presents an overview of the context of the SLT epidemic in Sri Lanka. There are two advantages for public health policy researchers or decision-makers in analysing the context of a public health issue. The contextual analysis aids in (1) developing a definition of the public health policy issue in concern (the SLT epidemic) and (2) systematically examining the success and failures (outcomes) of the public health policy(ies) in place to solve the public health issue (for this thesis- successes and failures of the SLT ban)(Buse, Mays and Walt, 2012).

In policy science, 'policy context' refers to the extensive background influencing the policy problem and decision. Likewise, the public policy issue of concern and its solutions (public health policies) cannot be well understood without profoundly exploring the context. For this study, the context of the public health policy issue of concern and its solutions will be called 'policy context' (Buse, Mays and Walt, 2012; McConnell, 2010b). The policy context is formed by two main contextual factors: systematic factors (Buse, Mays and Walt, 2012).

- A. Situational factors or triggering factors.
- B. Structural factors there are four main structural factors.
 - Socio-Cultural (section 1.8, pages 46-60)
 - Political (section 1.9, pages 60-72)
 - Economic (section 1.10, pages 73-78)
 - Environmental (section 1.11, pages 78-83)

A brief presentation of structural factors shaping the problem in the Sri Lankan context follows. Some policy scholars call them systematic factors.

1.8 Socio-Cultural Context

This section provides an evidence-based overview of the socio-cultural context of SLT use in Sri Lanka, particularly focusing on traditional betel quids and their historical, religious, and social significance. This section successfully outlines the cultural significance of betel quids and delved deeper into the anthropological aspects of this practice. The evidence on socio-demographic dimensions touches upon the social determinants of the SLT epidemic in Sri Lanka. Moreover, the literature provides insights into the impact of modernisation and urbanisation on SLT consumption patterns.

The SLT epidemic in Sri Lanka has strong links to culturally inherited, socially accepted, traditional betel quids consumption(Mahees et al., 2021; Somatunga et al., 2012). Traditional betel quids with tobacco are the most preventable SLT products used in Sri Lanka. In the 4000 years of written history in Sri Lanka, betal quid chewing and related practices have been reported as remarkable cultural symbols. As a result, there is a range of nationwide and provincial cultures, values and norms related to betel quids and plain tobacco leaves. These cultures, values and norms are linked with different beliefs, myths and attitudes. In addition, the evidence reveals betel quids and related traditions are connected to the country's main religions—Buddhist, Hindu, and Muslim. Moreover, the differences in sociocultural groups were identified in five settings- urban, rural, estate sectors and indigenous Vedda communities.

Therefore, the following briefly introduces the unique sociocultural features of the SLT epidemic, the differences in various social groups, and the historical evidence. This evidence on the sociocultural roots of the SLT epidemic aided in developing a working definition of the SLT epidemic in Sri Lanka. It explored the matches or mismatches between the SLT epidemic (the policy issue) and the ban (the policy).

1.8.1 Archaeological Evidence: History and Culture

Since the eleventh century, the royals in SEA, including Sri Lanka, have consumed betel quids— regularly in an elegant manner by using various gold and silver accessories/equipment to prepare and store the ingredients of the betel quids

(Strickland, 2002). The archaeological evidence reveals that 'betel quids chewing sessions' conducted in kings/queens' places had been a formal practice in ancient Sri Lanka. They used customised, treasured tools made from expensive materials such as ivory, gold, and silver to store the ingredients used in betel quids (areca nut, slaked limes). Figures 1.1. to 1.4.(page 50) reveal a few examples of these archaeological evidence (Backman, 2023; Museum, 2023)

Furthermore, only the kings or the other prestigious peoples in the country had this right to use luxury accessories to prepare and store components of betel quids (Goonatilake, 2010; Coomaraswamy, 1956). A few of these graceful accessories, including AN cutter ('Giraya'), betel holders ('Bulath Heppuwa'), 'Paddikama' (to spit following betel quids chewing), and lime boxes ('Killotaya') belong to ancient Sri Lanka has been exhibited in several famous museums worldwide, including the British gallery in London, the United Kingdom (UK).

For example, the gold and silver lime box, set with rubies and garnets, is shown in Figure 1.1. (page 50) in the World Art Museum in London. It belongs to the King of Sri Lanka, who ruled the country between 1798 and 1815. It has been used to store slaked lime and employed in betel quid chewing sessions. Moreover, the figure 1.2.(page 50) shows a female-shaped betel cutter made of brass and iron. It is exhibited in the British Museum in London, the UK. It belongs to 1898 when the last King of history ruled the country (before the Europeans Invented it). It had been used to cut areca nuts to be chewed with other ingredients of the betel quids.

Moreover, while kings and prestigious people held regular betel quids chewing sessions using luxurious accessories and apparatus, the general population made their betel quids chewing tools out of inexpensive materials, including brass and wood(Goonatilake, 2010; Pilimatalavuva, 2004). These betel quid accessories can still be seen in households, Buddhist and Hindi temples, and other cultural places in the country. For example, figure 1.3 (page 50) shows a traditional betel tray. It is made of brass and holds the ingredients needed to prepare betel quids domestically. The betel tray, locally called 'Bulath Heppuwa', is one of the leading traditional symbolic items to welcome people to households in Sri Lanka. Usually, the house-owner refills it and places it at the home entrance or living room as a daily custom.

Moreover, there is a norm that the betel tray should always be kept well-filled with all ingredients needed to make a 'delicious' betel quid. The areca nut cutter should always be available in the betel tray. Most visitors, including neighbours, come to the household and are invited to chew a betel quid by offering the betel tray to their hands. Offering a betel tray is considered a sign of friendship and favour. For example, the bride-to-be is supposed to welcome the bridegroom and his relatives by offering a betel tray when they see her at her parent's home for the first time (Somatunga et al., 2012).

Furthermore, the betel tray is essential the country's Buddhist to culture(Wickremeratne, 2012). Buddhism has been the main religion in Sri Lanka for centuries. The government in power is liable to protect Buddhism and Buddhist culture as ordered by the constitution. The Buddhist monks are invited to conduct 'Bana' ceremonies (Dhamma speeches) in households and different gatherings by offering a betel tray. Likewise, the betel tray is an everyday item in almost all Buddhist temples. In addition, as evidence reveals, Buddhist monks are one of the most prominent cohorts regularly chewing betel quids with tobacco countrywide(Amarasinghe, Warnakulasuriya and Johnson, 2021).

Likewise, Figure 1.4 (page 50) shows a traditional betel quid-induced spit-collecting pot. It is also made of brass and is locally called 'Paddikkama'. Paddikama is a common item seen in almost all Buddhist Temples in Sri Lanka(Kariyawasam, 1995). On many occasions and festivals, the people from Buddhist communities offer Paddikkama to Buddhist monks as a sacred/auspicious gift. The monks chew betel quids and spit saliva into these pots—the carers working in temples used to empty and clean these pots as a daily routine. In addition, Paddikama is a main household item in traditional Sri Lankan households. It is supposed to be placed permanently near the sitting chair of the primary occupant of the household, which is a sign of showing respect or representing the authority of the breadwinner.

Moreover, there is little evidence explaining how tobacco became a part of Sri Lankan culture and, thus, an ingredient of traditional Sri Lankan betel quid. The tobacco plant had been introduced to Sri Lanka by Dutch and English migrants who conquered the

country during 1500-1900 AC durations(Manogaran, 1974). They started to grow tobacco as a commercial crop in Sri Lanka.

The Sri Lankans who were socio-economically deprived had worked as labourers in these tobacco plantations(Dewasiri, 2007; Karunanayake, 1979). As a result, these labourers used to chew tobacco with betel quids(Sathananthan, 1988). Later, it has been a practice of the general population. Nowadays, people in Sri Lanka consume betel quids as a way of social affability (peer pressure). Tobacco Plantation continues in different regions of Sri Lanka. For example, Figure 1.5. (page 51) illustrates the farmers working on a tobacco plantation in a remote country.



Figure 2.1. A gold and silver lime box (Killotaya) belonging to the last king of Sri Lanka, Kandy (1798-1815)Source-World Art Museum in London



Figure 1.2. A brass and iron betel cutter (areca nut cutter)- female-shaped. The acquisition date:1898, from Kandy, Sri Lanka-Source-British Museum in London, the UK



Figure 1.3. A traditional betel tray (Bulath Heppuwa)- holding tobacco, areca nut, lime and areca nut cutter, a welcoming

symbol in Sri Lanka

Source: Researcher's photo gallery



Figure 1.4. Paddikama, the traditional BQ-induced spit-collecting pot- is made from a Brass set with traditional cravings.

Source: Researcher's photo gallery

A few pieces of literature compared this practice of chewing traditional betel quids for social affability to drinking coffee together in the Western world, reflecting the deeprooted norms and attitudes of SLT use in Sri Lanka(Rooney, 1995)



Figure 1.5. Tobacco farming in remote Sri Lanka(Source- Researcher's photo gallery)

In summary, presenting archaeological evidence, including figures 1.1 to 1.4 (page 50), proves the history and culture of SLT use and its nature in Sri Lanka. These artefacts symbolise social status and power dynamics in historical Sri Lanka. Additionally, exploring the provenance and authenticity of these artefacts and their representations in museums was a critical historical exposure to the SLT epidemic in Sri Lanka. Moreover, the following section provides insights into how these practices have persisted or transformed in contemporary Sri Lanka.

1.8.2 Beliefs, Norms and Rituals

There have been various beliefs and myths around traditional betel quids and tobacco consumption in Sri Lanka for centuries. Similar types of beliefs and rituals related to

SLT use can be seen among Red Indians in the USA and the Abor Genus people in Australia(Mukherjea, Modayil and Tong, 2018; Brady, 2002).

Some SLT users believe that tobacco has medicinal effects/ herbal powers and reduces oral health problems, including dental caries(Jayasinghe et al., 2021). Mothers in the plantation sector make their infants and toddlers inhale tobacco powder, as they have experienced it helping their children fall deep asleep until they return home after a longer working shift in tea plants(Ariyawardana et al., 2007).

Moreover, the poorest of the poor, labourers or potters, say they chew BQs to avoid hunger during their long working hours away from home(Amarasinghe et al., 2023)They are unaware of the danger of long-term use of SLT and are unwilling to give up these practices, which they believe are beneficial to their daily lives.

1.8.3 Socio-Demographic Variations

There are apparent differences in the prevalence, frequency, cultures, and traditions of SLT use in different socio-demographic areas of the country(Amarasinghe et al., 2023; Mahees et al., 2021). These are rural, estate and urban sectors. In addition, the traditional Vedda community exhibits a unique culture in SLT use. This section presents an overview of empirical evidence of the critical dimensions of sociodemographic differences of the SLT epidemic in urban, rural and estate sectors and the traditional Vedda community in Sri Lanka.

Urban slums: There are nine provinces in Sri Lanka. These nine provinces consist of 24 administrative districts. Of these 24 districts, Colombo, Gampaha and Kalutara are the three urban districts in Sri Lanka. The majority of the people in cities are poor. There is significant evidence of the high prevalence of SLT use among people living in low socio-economic status in urban Sri Lanka(Subasinghe, Hettiarachchi and Jayasinghe, 2023; Mahees et al., 2021; Subasinghe, 2015).

This habitual use of non-betel quids SLT, mainly by young people, can be primarily seen in numerous slums in the centre of the capital city- Colombo. For example, Figure 1.6. (page 54) shows one of the enormous urban slums in the capital city of Colombo,

in which the socio-economic status of dwellings is deficient, and dwellers have a higher tendency to use various types of addictive substances, including SLT(Mahees et al., 2021).



Figure 1.6- Urban slums in the capital city-The slum dwellers are one of the main categories of habitual SLT users in Sri Lanka (Pushpika, 2016)



Figure 1.8. A paddy field in rural Sri Lanka where betel quid chewing is a popular way to maintain friendliness (Researchers' photo gallery)



Figure 1.7. Tea pickers in the estate sector who are habitual SLT users (Researchers' photo gallery)



Figure 1.9. Indigenous Vedda people are habitual SLT users- spread in a few districts in the country (Researchers' photo gallery)



Figure 1.10. A leading parliamentarian invites monks by offering the traditional 'Dahath Wattiya'. An ideal Dahath Wattiya consists of betel leaves, tobacco leaves and pieces of areca nuts. (Researchers' photo gallery)

Estate sector: The second sociodemographic area with unique cultural features of the SLT epidemic in Sri Lanka is the estate or plantation sector(Amarasinghe et al., 2010a; Ariyawardana et al., 2007). The plantation sector comprises around 450 plantations spread across the country and is relatively isolated from broader society(Moore, 1989). The plantation sector mainly consists of an ethnolinguistic minority comprising 4.4 per cent of the total population of Sri Lanka. These ethnic Tamils, in thousands from South India, were shipped to Sri Lanka in the 1860s by the British, who ruled Sri Lanka. Thus, a cohort with exceptional cultures and traditions related to SLT use exists.

Most of the people in the estate sector, as shown in Figure 1.7. (page 54), are tea pickers. Their first generation had been housed in barrack-type "line" rooms in tea estates in the 1860s, where the current generations also live(Mohammed et al., 2019). Furthermore, they had been barely allowed to venture out of their homes apart from work or the tea estates. The most recent population census identified this group in 14 districts (where tea plantations are taking place) out of 25, the majority of whom are habitual SLT consumers. These districts include Nuwara Eliya, Badulla, Ratnapura, Kandy, Kegalle, Kalutara, Matara, Matale, Galle, Monaragala, Colombo, Kurunegala, Puttalam and Gampaha. Most live in the 'hill country'/ central Sri Lanka. Badulla, Bandarawela, Haputale, Rathnapura, Hatton, Ella, and Dikoya are the main towns and villages in the hill county/tea country(Ariyawardana et al., 2007; Samaraweera, 1981).

Approximately 60% of this ethnic minority are women, and almost all are tea pickers (Amarasinghe et al., 2010a). They speak Tamil, while most Sri Lankans talk to Sinhala. Most of the health indicators in the estate sector, including health literacy, are lower than the national average. They commonly face language barriers in receiving health education, health promotion programs and cessation activities (Virk et al., 2023; Amarasinghe et al., 2010b). These estate dwellers strongly bond with chewing betel quids throughout the day. They spend most of their daytime working in tea plantations. They have unique customs, rituals, and myths about SLT consumption, which have not effectively been subjected to research or behavioural change modifications (Amarasinghe et al., 2023; Ariyawardana et al., 2007). For example, they believe SLT helps them reduce hunger during long hours of working shifts, enhances mood, and keeps them energetic. Moreover, they believe tobacco leaf has a spiritual value. They

believe tobacco has a 'magical' power in healing infection. Furthermore, these tea puckers make their infants or toddlers breathe the scent of the tobacco leaves/ powders to make them sleep for long hours before going to work in tea estates. Due to these solid cultural bonds of tea pickers in the plantation sector of Sri Lanka with SLT products, the statistics in continuous decades show the highest prevalence of Oral Potentially Malignant Disorders in the plantation sector(Amarasinghe et al., 2010a; Ariyawardana et al., 2007). Moreover, oral carcinomas have been reported more than the national average in the estate sector for decades. Even though a few recent studies reveal tea pickers— use both traditional betel quid and commercial preparations of SLT, no in-depth research has been conducted to study these unique cultural patterns and their underlying factors.

Rural sector: The rural sector is the largest geographical area of the country, where 80% of the Sri Lankans live(Amarasinghe et al., 2010a). It covers more than 70% of the country's land area. The primary income source is agriculture, including paddy, coconut, and local vegetables. Therefore, rural dwellers are mainly farmers. These farmers represent the highest number of chronic SLT users in Sri Lanka. For example, figure 1.8. (section 54) illustrates a group of farmers working in a paddy field in Sri Lanka. The villagers/ farmers consume betel quids to exhibit social pleasantness, avoid hunger, and be energetic at work. Moreover, they consume betel quids to exhibit friendship and goodwill or to relax in the household. These practices were elaborated on in the early part of this section under archaeological evidence.

These rural populations mainly consume SLT as traditional betel quids (Amarasinghe et al., 2023; Somatunga et al., 2012). These betel quids are primarily prepared at home. Some buy those from local vendors in the village. Most villagers buy ingredients for betel quids preparations from Sunday fairs in the village or the nearest small town. In addition, the nearest betel quids seller is one of their intimate friends or relatives of the villagers. These rural, small-scale betel quids sellers buy ingredients from wholesale shoppers in the nearest city. Then, they prepare betel quids for commercial purposes. As mentioned above, in addition to consuming as a habitual individual practice, using it to maintain social intimacy is common in rural Sri Lanka. Moreover, SLT and related products and accessories are essential in many traditional and cultural ceremonies.

In addition to the farmers, the fishermen in the coastal area are another cohort in rural Sri Lanka who consume SLT products highly. The fishermen mainly use domestically prepared betel quids. In addition, they consume commercially prepared SLT, including Thul and Mawo (Mahees et al., 2021)As Sri Lanka is an island in the Indian Ocean, these fishermen live at all the country's boundaries, where illegal supplies of these commercially prepared SLTs from neighbouring countries reach without many disturbances.

Moreover, each village has one or a few Buddhist temples (Wickremeratne, 2012; Kariyawasam, 1995). The Buddhist Monks in these temples play the role of community leadership. The literature evidence says the primary culture in Sri Lanka has had strong bonds to the temple, lake and paddy field for centuries. Therefore, formal and informal community leaders strongly link with Buddhist temples in each village. The Buddhist monks are the most influential group in deciding the electoral perspectives and reputations of political parties in Sri Lanka. Nevertheless, as mentioned in the early part of this section, Buddhist monks are one of the most prominent chronic SLT users (mainly traditional BQs) in Sri Lanka. Therefore, context analysis of Buddhist culture and the SLT epidemic reveals two things: I) decision-makers should lobby the Buddhist monks and seek their community leadership in implementing the SLT ban in Sri Lanka, and II) implementation of the SLT ban in Sri Lanka could face lots of barriers if policymakers had not collaborated with Buddhist leaders at initial planning stages.

The other two main religions in Sri Lanka are Hinduism and Islam(Shah, 2017). Most Hindu people live in central Sri Lanka and the Northern Province. Hindu 'Kovils' (temples) are ample there, and Hindu Priests, like Buddhist monks, play a community role in Hindu communities. Likewise, most Islamic people live in the Eastern province of the country, and their communities are well known to the Muslim Mosques in the areas. No research is available to understand the patterns, cultures and rituals of SLT use among these communities and their leaders. One sociological study conducted by Mahees and his colleagues in 2016 reveals that Muslim women show an increased tendency to use CPSLT called Thul.

Indigenous Vedda community: Besides the above main sociocultural groups using SLT in higher percentages, the Sri Lankan Indigenous Vedda community is a unique population that regularly consumes betel quids for thousands of years (Blundell, 2012). Vedda people are confined to jungle-related communities in a few districts.

Figure 1.9.(page 54) shows a group of adult indigenous Vedda males gathered in a traditional event. Their lips and tongues are bright red as they chew betel quids several times daily. Decision makers are supposed to conduct in-depth research of the unique practices, culture, norms, and rituals of SLT-related traditions in the Vedda community, which aid in developing balanced, robust SLT control and prevention policies and reduce their SLT-attributed illnesses(Ranasinghe, 2020; Jayashantha and Johnson, 2016; De Silva, 2011).

As discussed in this section, though SLT use is mainly confined to poor communities, SLT-related traditions are a part of the primary culture in Sri Lanka and, therefore, accepted by all social classes(Mahees et al., 2021; Reed, 2002). Moreover, as presented in this section, BQ and its related cultures and traditions are strong enough to receive government/decision-makers' blessings and influence the government's political stability. For example, figure 1.10. (page 54) shows the speaker of the Sri Lanka Parliament offering a 'Dahath Wattiya'- a traditional tray- to Maha Sanga (to Buddhist leading monks). By providing this tray containing betel, tobacco and areca nut to a leading monk in the country, the speaker invited him to start a chanting ceremony in the House of Parliament. These practices resemble the place given to the BQ-related practices in Sri Lanka and their complex interlinks with political power.

I end this brief presentation of the sociocultural factors of the SLT epidemic in Sri Lanka by linking the impact of these SLT-related traditions, cultures, and myths with health literacy. The literature revealed that Sri Lankans- including habitual users and the general population- show less awareness of health risks attributed to SLT consumption(Amarasinghe et al., 2023; Mahees et al., 2021). As presented above, most habitual consumers are villagers, urban slum dwellers, labourers and estate tea puckers. They are from poor socio-economic status. Their level of health literacy is low; therefore, the awareness related to SLT-induced illnesses, including carcinomas and premalignant lesions, is inadequate. Further evidence revealed that SLT users in

rural and estate sectors do not know how to identify the symptoms of OPMD or oral cancers. In contrast, there is evidence that the majority of SLT users appreciate the stimulant qualities and 'medicinal effects' of the SLT. They value the exciting and energetic feelings given by SLT use. Moreover, the women in the plantation sector appreciate the habit, as it aids them to stay warm in cold tea estates. Furthermore, chewing tobacco helps them avoid bad breath and hunger in busy outdoor work.

Furthermore, spitting after chewing SLT products is a habit in Sri Lanka. Red marks can be seen everywhere people chew tobacco and slaked lime together (Staples and Bevacqua, 2006). Nevertheless, most SLT users are unaware of links between SLT, tuberculosis and other diseases caused by spitting after chewing SLT products (Yadav et al., 2018).

Finally, as presented in section 1.8 (pages 46-60), the public health policy issue under the study of this thesis, the SLT epidemic in Sri Lanka, has been a culturally sensitive, shared community practice for centuries. The most prevalent SLT product across the country is traditional BQ. Consuming BQ together is a traditional symbol of social affability in Sri Lanka. The majority of the chronic BQ chewers are socio-economically deprived people. Archaeological evidence reveals the BQ's use had been spread across all social classes, from kings to poor villagers in ancient Sri Lanka. In addition to this generalised practice across the country, there are clear distinctions in SLT-related cultures, traditions, and patterns across three main sociocultural settings-urban (slum dwellers, drivers, labourers), estate (tea puckers) and rural (farmers, Buddhist monks, villagers, fishermen) sectors. Therefore, it is obvious this empirical evidence in cultural sensitivity and the dynamic nature of the SLT epidemic in Sri Lanka provide a vital platform for analysing the successes and failures of the SLT ban policy in the Sri Lankan context as the study presented in this thesis (Muntyanu et al., 2022; Oyserman, Kemmelmeier and Coon, 2002).

This section offers a detailed, evidence-based overview of the socio-demographic variations in SLT use in Sri Lanka. It covers urban slums, the estate sector, rural areas, and the traditional Vedda community. Sections 1.2 (pages 18-23) and 1.3 (page 23-27) presented studies that use quantitative data to illustrate the prevalence and frequencies of SLT use across different socio-demographic groups. However, more

comparative studies are needed to enhance understanding. Despite limited evidence, the existing prevalence of SLT use in urban slums, estate sectors, and rural areas, along with the contributing factors, suggests the need for tailored approaches. Understanding how policies can be tailored to address different groups' specific needs and challenges and the role of cultural sensitivity is an insight provided by this section of the background chapter.

1.9 Political Context

This section thoroughly analyses the political context related to the SLT epidemic in Sri Lanka. It emphasizes the relationship between public health policies and political stability. The analysis offers insights into the connection between political theories, concepts such as political capital and trust, and the nature of SLT use in Sri Lanka, supported by evidence-based findings. Additionally, it presents evidence on how cultural practices and beliefs can either hinder or facilitate the implementation of SLT control policies. Furthermore, this section explored the economic and political power of the tobacco industry in Sri Lanka, including evidence-based lobbying efforts and economic contributions, which will provide a fuller picture of the challenges in implementing SLT bans.

The following section elaborates on the political structure from the national level to local governments and community leaders, and its impact on SLT policy implementation mechanism. It also provides insights into the capacity and readiness of the health system in Sri Lanka, including resource allocation, infrastructure, and the workforce involved in SLT control activities. Furthermore, the section notes the periodical elections in Sri Lanka and provides evidence of the impact of electoral cycles on health policy continuity and successes.

As a beginning of the section, it is well known that the governments are responsible for developing and executing public health policies for burning issues(Buse, Mays and Walt, 2012; McConnell, 2010b). Nevertheless, the government's business is to ensure its electoral prospects and popularity among the general population. In other words, the government's overall goal is to ensure political capital by winning the goodwill of its people(Buse, 2010; Hawkes et al., 2004). Therefore, as I presented in section 1.2

(pages 18-23) of this chapter, the influence of the SLT epidemic in Sri Lanka. As shown in section 1.8 (pages 46-60), it is evident that SLT use in Sri Lanka is a culturally inherited, socially accepted shared practice of the primary culture. Culture decides the government's political stability and electoral perspectives in SEA countries, including Sri Lanka(Oberst, 2018; Adeney and Wyatt, 2004; Neher, 1994). In such a context, the successes and failures of the SLT ban policy need to be investigated without further delay, and any gaps should be addressed.

Therefore, this section presents Sri Lanka's political context concerning the unique features of the SLT epidemic and its control policies. It will further consider the influence of cultural sensitivity of the policy issue in government business, the political system of Sri Lanka by which issues are getting into the agenda and decisions are approved, and the health care delivery system by which the public health policies are developed and implemented(Vaisey and Valentino, 2018; Oyserman, Kemmelmeier and Coon, 2002). I end this section of 'political context' by providing a short presentation of links between the big tobacco industry and its links with government businesses, mainly by being one of the primary taxpayers in Sri Lanka.

1.9.1 Political Trust and Cultural Sensitivity Epidemic

As evident from the above section 1.8 (pages 46-60), SLT use in Sri Lanka is a culturally sensitive, socially affable practice that has been strong enough to hide its negative health impacts for ages. Moreover, it is much more prevalent among disadvantaged communities. The low prices and informal, easy supply chains make it easier for poor people to consume SLT products in a regular pattern than cigarettes. A wide range of users, from rural adults, estate tea puckers and urban slum dwellers, are SLT addicted. Moreover, adolescents of school-going age and school leavers show an increased tendency to use CPSLT, which is available only in the black market. In addition, SLT consumption, unlike most other health risk factors, is psychoaddictive(Mahees et al., 2021; Somatunga et al., 2012).

The cultural sensitivity of any issues under government attention tends to encourage political neutrality(Zager and Yancy, 2011). Political neutrality aids in avoiding questioning the discriminatory practices embedded in fundamental social relations,

ensuring the government's survival. Evidence shows that culturally sensitive policy issues and political trust have close links(Chan et al., 2003). Political trust is one of the critical determinants of a government's political capital. Political capital is the trust, goodwill and influence politicians achieve from the public by pursuing policies people like or respect. When a politician or a government builds political capital in the long term, it is advantageous for the government to enforce some unpopular policies without damaging public trust.

1.9.2 Political Structure and Power Systems

The political structure is the backbone of the government(Fischer and Miller, 2017). The political structure of Sri Lanka, a democratic republic and a decentralised system, plays a critical part in determining the successes and failures of public health policies developed to control and prevent the SLT epidemic in Sri Lanka- for this study- the SLT ban(Björkman, 1985).

The political structure of Sri Lanka has been built on the voting power of the public, and it is a multi-party system(Kearney, 1983). Periodical elections select the members of the parliament according to the general public's choice. Therefore, people get the opportunity periodically to choose the local and national politicians and the government based on a few criteria, including public trust and respect for the primary culture and religions. As I presented in section 1.8 (pages 46-60), it is evident that SLT use is a part of the primary cultures and religions in Sri Lanka. Therefore, I argue that the SLT ban creates a grey area between public choices and political trust in Sri Lanka. Hence, decision-makers are supposed to investigate the successes and failures of the SLT epidemic without further delay. When considering all this evidence, there is a higher possibility that the government and the local authorities might support the ban implementation mechanism if they are confident that the ban policy will enhance their governing business, reputation and electoral perspectives.

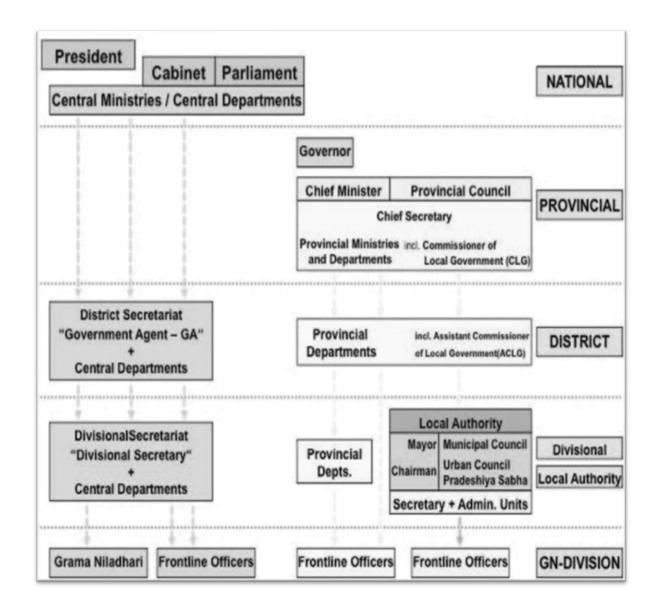


Figure 1.11. Political Structure and Decentralised Administrative System in Sri Lanka (Methodfinder, 2010)

Figure 1.11 illustrates the main components of the country's central and decentralised political systems. In this system, public policies are brought into the agenda and approved by the legislative body, followed by the executive body. The President of the government exercises the executive power of Sri Lanka, followed by the Prime Minister and the Cabinet of Ministers. The legislative power is assigned to the House of Parliament of Sri Lanka. There are 225 parliamentarians in the Sri Lankan Parliament. These central-level politicians are the chief decision-makers in designing and executing policies to control and prevent the SLT epidemic. They are called policy champions or actors according to their roles in policymaking and execution.

These parliamentarians represent the three main socio-demographic areas of the country: urban, estate and rural(Kearney, 1983). The voting system of Sri Lanka is based on population prevalence in each elective area. As a result, most parliamentarians are from the rural sector(Shah, 2017). As the SLT epidemic in Sri Lanka is prevalent mainly in the rural sector, culturally sensitive and socially accepted, these politicians play a significant role in agenda setting, designing, and executing policing in controlling and preventing the SLT epidemic.

Other factors affecting putting public health issues on the government agenda and making evidence-based policies; for this purpose, the SLT prevention and control policies are the level of knowledge, skills, and attitudes of decision-makers(Bowman, 2017; Buse, 2010). For example, in Sri Lanka, there are no specified educational or professional qualifications criteria in selecting parliamentarians who play a significant role in decision-making. Therefore, the decision-makers in Sri Lanka need a robust lobbying mechanism before making choices. Lobbying refers to the planned, logical effort made by the PAs to convince parliamentarians/elected government officials to support a particular policy(Godwin, Ainsworth and Godwin, 2012; Baumgartner et al., 2009) If PAs fail to plan a strong lobbying program, they risk facing many obstructions in getting constitutional approval, implementing culturally and socially sensitive public policies, and influencing the electoral perspectives of parliamentarians.

Policy champions are the main characters in the political context of a given problem(Roberts and King, 1991). Each policy has a policy champion/champion in policy science. The policy champion is referred to as a charismatic, powerful individual in each political system who has a pet policy that they fostered for years, waiting for a window of opportunity to open so that they can propose their approach as the solution to a persistent problem(Brick et al., 2018). According to the political system in Sri Lanka, the policy champion of a central-level policy is most probably the president, prime minister, cabinet minister or parliamentarian. As the SLT epidemic is a public health threat, the policy champion would be the Minister of Health in Sri Lanka.

The above paragraphs mentioned the critical characteristics of the central political system influencing the behaviour of the SLT epidemic and its control policies in Sri

Lanka. The following is a brief overview of the elements of the decentralised regional political system affecting the epidemic and its controls.

1.9.3 Decentralisation and Policy Implementation

The political administration of Sri Lanka was decentralised about three decades ago(Bardhan and Mookherjee, 2006). Therefore, the second layer of the decision-makers in the Sri Lankan political system are regional political leaders called local politicians(Gamage, 1993). As shown in Figure 1.11.(page 63), the local government is functioned by two parallel structures: the civil service and the provincial councils(Methodfinder, 2010)

The civil service dates to colonial times (Biedermann and Strathern, 2017). The country is divided into 25 districts according to the civil service structure. The Government Agent (GA)/ district secretary is the administrative head of the public services in each district. GA is a professional, a Sri Lankan civil servant of the Sri Lankan executive service, and appointed by the central government. GA is responsible for ensuring the political trust of the public in his district; therefore, he is accountable for monitoring and evaluating the progress of executed policies in his control, including public health policies. Usually, the district health directors report this progress to GA periodically.

In 1987, the government created the provincial council system in Sri Lanka(Samaratunge and Bennington, 2002). The central government devolved powers over health, land, the police, agriculture, education, housing, and finances to the provincial councils. The Chief Minister is the leader of the Provincial Council. The rest of the political leaders in a province are the board of ministers and the provincial governor. The president of the country appoints the provincial governor. This provincial political team has the entire power to design, implement, execute, and monitor policies in their administrative area. Moreover, they are responsible for ensuring their political capital. As the SLT epidemic is a culturally sensitive policy issue with significant differences in provinces, the role of these provincial leaders massively influences controlling and preventing SLT use.

The local government structure is the next layer of Sri Lanka's decentralised political system(Wickramasinghe, 2014). It consists of elected urban councils and municipal councils. The leader of the city council is called the mayor. The head of the metropolitan council is named the Chairman. They both are responsible for winning people's political trust, therefore maintaining the political capital. They can address critical public health issues in their authorised areas and influence policy implementation. This is called local universality.

As explained above, the decentralised political system with various layers of policymaking and executing power influences the SLT epidemic and its control policies in Sri Lanka(Buse, 2010; McConnell, 2010b). For example, as mentioned above, the local universality of the village-level political leaders is easily transferred to the people in that village. These people have the voting power to elect the next political leader. Local universality refers to the shared, stable characteristics of a given local setting(Enticott, 2012; Rauch, 2008; Burns, Hambleton and Hoggett, 1994). The shared stable practices include local values, beliefs, myths, spiritual habits, languages and traditions. The SLT epidemic can easily create a shared platform for these villagers to stand against any unfavourable policies set to control and prevent the threat, as it is a culturally sensitive issue with numerous long-lasting traditions, beliefs, values, and myths. The research evidence shows once the policies are set and excused against local practices and norms, there is a risk of policy failures.

Moreover, policy implementation scholars argue that local universality (such as adapting health promotion programs to the regional languages) is a key area to be accounted for in successfully translating central-level policies into local communities (Sausman, Oborn and Barrett, 2016). Furthermore, scholars who study policy implementation suggest that achieving local universality is crucial to effectively translating policies from central-level to local communities. These researchers have recognised that conducting contextual assessments, including political factors, is a valuable tool to thoroughly understand the distinctive practices and beliefs that affect public policy implementation in local contexts.

1.9.4 Health Care Delivery System in Sri Lanka

The healthcare delivery system is the primary mechanism in Sri Lanka responsible for controlling and preventing the SLT epidemic (World Health Organization, 2017; Rannan-Eliya et al., 2010). The government and the decentralised authorities have delegated the public health policymaking and enforcement mechanism to Sri Lanka's healthcare delivery system(Shah, 2017). I argue that the health care delivery system operating to solve the SLT epidemic in Sri Lanka can't be analysed without framing it inside the political system due to two reasons: I) the Health minister and the health secretary, the administrative leaders of the central Ministry of Health, are responsible for the political stability of the central government, and 2) The provincial health minister and secretary, who oversees the activities of provincial and district health directors, are responsible for the political stability of the provincial government. Therefore, as a navigation to explore the match between the SLT ban policy and the capacities and political responsibilities of the health care delivery system, in this section, I briefly present the key features of the health care delivery system of Sri Lanka.

On behalf of the government of Sri Lanka, the Ministry of Health plays a central role in designing and implementing policies for public health policy issues, therefore, in the SLT epidemic(Rajapaksa et al., 2021a; World Health Organization, 2017). Following is a brief overview of the structure and functions of the Ministry of Health and its decentralised agencies in making and executing policies to control and prevent the SLT epidemic in Sri Lanka.

The health minister is the head of the Ministry of Health. The health minister is the chief decision-maker in the country's curative and public health issues, including the SLT epidemic (Fernando, 2000) (MCU, 2015).

NATA office, under the direct leadership of the Minister of Health, is the central agency for controlling and preventing tobacco epidemics, therefore the SLT epidemic, in Sri Lanka (MOH, 2009). The Ministry of Health established the NATA office in 2006 according to legal provisions delivered by the NATA Act, passed in the House of Parliament. The chairman of the NATA, the head of the office, is appointed by the Minister of Health at his autonomy (Parliament, 2006). NATA office prioritises the main

problems of the tobacco epidemic in Sri Lanka and gets the attention of the minister of health. Moreover, the NATA office coordinates and supervises the policy formation, implementation, monitoring and evaluation phases of the tobacco control and prevention program in Sri Lanka(Rajapaksa et al., 2021b).

Figure 1.12 in this page demonstrates the central and decentralised healthcare delivery system in Sri Lanka(De Silva, Sinha and Kahandawaliyanag, 2012). Provincial and Regional leaders are the heads of implementing the policies designed at the central level. As presented above, Sri Lanka's political system was decentralised three decades ago.

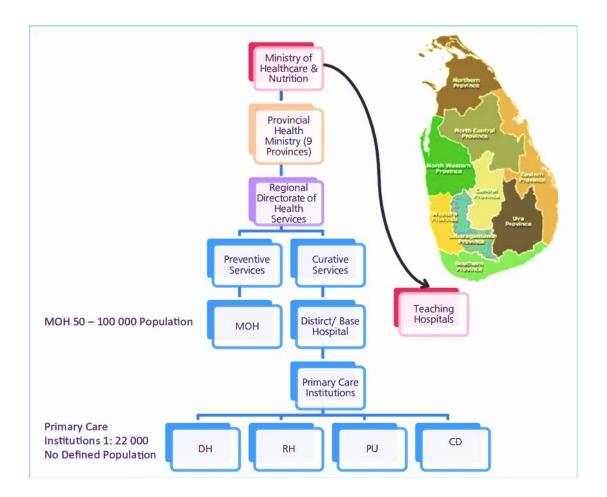


Figure 1.12- The central and decentralised healthcare delivery system in Sri Lanka (De Silva, 2012)

Therefore, provincial and regional directors should work with the provincial chief minister and other politicians to implement the policies in their communities. Moreover,

as stated in the 13th amendment of the constitution in 1987, health is a devolved subject in Sri Lanka. The constitution has delegated significant power in making decisions and implementing health policies to the provincial and regional health directors.

The Provincial Directorate of Health Services (PDHS) is the provincial head office (MCU, 2015). The PDHS works under the direct leadership of the chief minister, provincial minister of health, and the governor in administrating the public health and curative health institutions under its scope(Samarage, 2006).

The next layer of the decentralised healthcare system is the Regional Directorate of Health Services (RDHS). The PDHS supervise the RDHS(World Health Organization, 2017). The head of RDHS is called the regional director of health services. The Food and Drug Inspector (FDI) is a crucial agent working under the direct supervision of RDHS. FDI has been appointed an authorised officer to implement tobacco policies and legislation in the RDHS area. One RDHS area covers almost one district in Sri Lanka(World Health Organization, 2017; Samarage, 2006).

As a standard, the central ministry is supposed to conduct periodic monitoring and evaluation sessions with each PDHS and RDHS periodically(Rajapaksa et al., 2021a; World Health Organization, 2017). In addition, the central ministry is supposed to strengthen the capacity of the provinces and regions in various ways, including offering grants and providing logistics and human resources(Ahmad, 2005).

The Medical Officer of Health Office (MOH) (as shown in Figure 1.12, page 68) is one of the key agencies in each RDHS area in planning and implementing public health policies (World Health Organization, 2017). The public health workers allocated to the MOH office are the frontline officers taking part in various tasks in implementing public health policies at the community level. The MOH offices consist of medical officers specially trained for public health services, nursing sisters, midwives, and public health inspectors (PHI). The MOHs and PHIs enforce tobacco laws and regulations, including SLT- control and prevention (MoH, 2011).

Moreover, the literature revealed that MOHs, PHIs and FDIs in peripheral policy implementation systems have worked efferently in implementing laws against the big smoking (mainly cigarettes) tobacco industry in Sri Lanka for the last two or three decades(Wijesuriya et al., 2019). Moreover, the evidence says these officers are not very active in implementing the SLT regulations in the country. However, research is needed to identify the reasons for the different behaviours of frontline officers in implementing bans and rules against smoking and smokeless tobacco policies.

1.9.5 Tobacco Industry Influence

The big tobacco industry in Sri Lanka, Ceylon Tobacco Company, the monopoly in the smoking tobacco market, influences the tobacco control and prevention campaign in Sri Lanka(Perera et al., 2018). The fraud and devious strategies of Tls have attracted generations of users in Sri Lanka and the rest of the world for centuries(Buddhika et al., 2018; Lakmal et al., 2018). For example, Ceylon Tobacco Company (CTC), the monopoly of smoking tobacco (mainly cigarette) manufacturing in Sri Lanka, is a British American Tobacco Company subsidiary. The CTC is in the centre of the capital city of Sri Lanka and has operated for a century in Sri Lanka, sponsoring tobacco farmers nationwide in many ways, including facilitating the plantation, buying products at the doorstep, and providing subsidiaries.

Moreover, this big tobacco industry (TI) in Sri Lanka has strong ties with the political system for their business survival and growth(Perera et al., 2018). TI lobby the decision-makers against setting and implementing robust tobacco control and prevention policies through various strategies. Furthermore, TI has built strong connections with different layers of the community and villages in various ways and means(Buddhika et al., 2018). TI act as a job supplier to the people in the country. Moreover, evidence reveals that TI influences the agenda-setting stage of tobacco policy formation at the central government level.

Furthermore, the research evidence shows that TI strategically promotes tobacco consumption by publishing the negative consequences of novel policies(Shahriar et al., 2023). In addition, TI acts towards claiming legal barriers from the court against new tobacco policies set by the government.

Moreover, the evidence reveals that the TI indirectly promotes the initial uptake of SLT among the young generation(Peeters and Gilmore, 2013). They target school-going-age children. SLT consumption at an early age pushes people to consume tobacco in later life. Moreover, the SLT acts as a gateway for many other addictive substances, including Cannabis, Heroin, and Ice (Crystal methamphetamine)(Vedøy, 2016). Furthermore, the evidence says the TI promotes flavoured SLT made as candy-sweets- mints- and chips, mainly among school children and younger(Bansal-Travers et al., 2022).

Moreover, the research conducted by analysing TI's internal reports that have been produced for lawsuits in different countries revealed the indirect strategies used by the industry to promote tobacco use and prevent forming firm policies against tobacco use(Hecht and Hatsukami, 2022). The plan of TI in influencing policymaking and implementing policies includes hiring influential lobbyists, asking approval for significant activities, empowering lobbyists to donate directly to political campaigns, sending gifts, arranging trips, providing meals and seeking to design tobacco control and prevention policies favourable to their marketing strategies.

Furthermore, taxation on smoking tobacco products contributed significantly to Sri Lanka's gross national income(Amarasinghe et al., 2018; Arunatilake and Opatha, 2003). This interdependency between the government and TI influences tobacco control and prevention programs. The policy science theories claim that governments choose the policy agendas and make decisions to protect their survival and enhance their political capital.

Finally, I end this section on the context of the SLT epidemic by summarising its political factors. The SLT epidemic in Sri Lanka is mainly made up of chronic consumption of traditional BQs consumption for centuries and is a culturally sensitive, socially accepted public health policy issue. The policy researchers argue that governments should act strategically and systematically in dealing with culturally sensitive policy issues, which might be enough to determine the future of the government business. The overall aim of the government business is to enhance its electoral perspectives and ensure survival. In this rationale, I have briefly presented

the political structure, healthcare delivery system and big tobacco industry in Sri Lanka. The health minister is the critical policy actor (policy champion) of public health policy agenda setting, policy-making and execution in Sri Lanka. The SLT epidemic is one of the public health policy issues under his scope. He needs the approval of the government's president, the ministers of the Cabinet, and the House of Parliament to set policy agendas and make the ultimate policy decisions to control and prevent the SLT epidemic in Sri Lanka.

Nevertheless, the political structure in Sri Lanka is decentralised at the district and provincial levels. Therefore, the political and health leaders in regions have the authority to decide the level of implementation of policies made at the central level. Moreover, the local authorities determine the level of influence they have over a given policy issue. Healthcare delivery has been decentralised in parallel with the political system.

The frontline workers dealing with the SLT epidemic at the community level receive technical guidance in controlling and managing the SLT epidemic from the central health ministry. At the same time, local political authorities administratively instruct them. While local authority ensures political capital by gaining goodwill, the central health ministry works to provide the health and well-being of SLT users. In addition, The Ceylon Tobacco Company (a part of the British American Tobacco Company), the cigarette monopoly, is one of the primary taxpayers in Sri Lanka.

The political context of the SLT epidemic in Sri Lanka cannot be adequately understood without deeply analysing the interdependency of the government and the big tobacco industry for their business survival and growth. Being one of the primary income sources of the government, the big tobacco industry influences the government's policy agendas and the decisions taken by the government to control and prevent tobacco epidemics- including the SLT burden.

1.10 Economic Context

The economic context could play a significant role in the success or failure of policies developed to control and prevent the SLT epidemic in Sri Lanka. In other words, in addition to the sociocultural and political context, the effectiveness of SLT control and prevention policies seems influenced by the country's economic situation(Kostova and Dave, 2015; Thakur, Mehrotra and Nigam, 2013). Two main dimensions of the financial context might influence these decisions as follows.

- The majority of long-term SLT users in Sri Lanka are economically deprived people with low social and educational status(Mahees et al., 2021; Somatunga et al., 2012).
- II) The public policy agendas of the government are directly linked to the tax revenue from the smoking tobacco industry(Guindon et al., 2023; Perera et al., 2018).

Therefore, it is evident that without a deep understanding of the behaviour of the economic context of the SLT policy issue, policymakers may not be able to develop balanced policies to control and prevent the SLT epidemic in Sri Lanka. Furthermore, if policies were made ad hoc, the policy implementation faces many challenges, including resource wastage(Buse, Mays and Walt, 2012; McConnell, 2010a). Therefore, this is a brief presentation of the literature available to understand these critical dimensions of economic context and their influence on SLT ban successes and failures.

When examining the impact of the economy on the usage of SLT in Sri Lanka, various factors have been identified as contributing to this epidemic. These include the government's income and tobacco taxation policies, the recent COVID-19 pandemic and subsequent economic downturn, the legacy of a thirty-year civil war (1978-2008), and the devastating Tsunami of December 2014(Guindon et al., 2023; Sultana, 2022; Miller and Jordans, 2016; Jayasekara and Schultz, 2007). These factors have had direct and indirect effects on the prevalence of SLT use in Sri Lanka and are further discussed in this section.

There are two types of economy: micro and macro economy. Both macro and micro economies influence the depth and width of the SLT epidemic in Sri Lanka.

1.10.1 Macroeconomic Challenges and Unregulated SLT Products

The macroeconomy refers the large-scale national to incomes and expenditures (Amarasinghe et al., 2018). As presented in section 1.6 (pages 37 to 44), the SLT products in the country are primarily domestic and small-scale. Moreover, they are not regulated by any agency or not subjected to tax at any stage of the supply chain. Therefore, unlike smoking tobacco manufactured in CTC, the SLT products are cheap and easily accessible. The government rarely generate income by selling SLT products(Mahees et al., 2021; Somatunga et al., 2012). In other words, the government survives on the tax money received from smoking products manufactured by the big tobacco industry. Nevertheless, SLT-related oral, tongue and throat cancers are the most typical type of malignancies among adult men in the country. Therefore, the government is supposed to spend billions of Sri Lankan rupees on treating people with SLT-induced cancers and other SLT-related NCDs, which is a threat to the macro economy of the country. On the other hand, the income is the centre of government business. Therefore, the government tends to develop 'more challenging policies'/ tough legislation against the SLT epidemic in comparison to the smoking epidemic(Muntyanu et al., 2022).

In addition, as previously stated in section 1.9, there is a potential for individuals to resist the ban policy due to the cultural significance of SLT use in Sri Lanka. Governments often create proxy policies for various reasons, such as appeasing stakeholders by giving the appearance of addressing the issue and fearing the loss of political support if the problem is genuinely tackled. (McConnell, 2017; March, 1994). As noted in section 1.9 (page 61), resistance to the ban policy is possible due to the cultural significance of SLT usage in Sri Lanka. It is common for governments to implement proxy policies for various reasons, such as satisfying stakeholders by giving the impression of addressing the issue and fearing the loss of political support if the problem is genuinely addressed. Therefore, it is imperative to design scientific studies to determine the successes and failures of the SLT ban in Sri Lanka, its underlying

intentions and motives, and to forecast the future of the SLT epidemic and its impacts. The higher the effect, the higher the economic burden(Perera et al., 2023; Amarasinghe et al., 2018).

1.10.2 Economic Crisis and Increasing Trend in SLT Use

The recent COVID-19 pandemic and the post-pandemic economic crisis in Sri Lanka have been reported to cause an increasing trend in using domestic SLT products. The researchers have identified three reasons for this behaviour during Covid 19 period(Perera et al., 2023):

- Easy accessibility and accessibility of traditional BQs and similar products in the pandemic period and the economic crisis
- II. The unavoidable smoking tobacco supply chain was cut by multinational companies during the COVID-19 lockdown period.
- III. Inability to afford cigarettes and other smoking tobacco products due to a fall in personal incomes in the 19 period and the current economic crisis. Therefore, some smoking tobacco users have been reported to be shifted from their smoking tobacco products to the SLT.

1.10.3 Microeconomy and Marginalised People

The microeconomy is one of the other economic dimensions leading to the SLT epidemic and its control policies in Sri Lanka(Amarasinghe et al., 2018). Microeconomy refers to concerns related to financial decision-making at the individual and domestic levels. For example, most of the people in the country are poor. The SLT products in Sri Lanka are cheap, affordable, and easily accessible. Therefore, SLT is the 'tobacco of choice' among poor tobacco users. On the other hand, as claimed by policy analysts, The low socioeconomic status of the people led them to be less powerful. The power and the ability to raise the voice seeking health and well-being of rights are interrelated(Kiran, Davie and MacLeod, 2018).

Moreover, Low socioeconomic status is one segment of a vicious cycle (Barsha et al., 2023). The low economy leads to poor socioeconomic status and, therefore, poor

education, which leads to indecent jobs. This goes into a vicious cycle from generation to generation. On the other hand, sociologists and economists claim this vicious cycle is a proxy indicator of marginalised people's lack of power, voice, and health literacy (Barsha et al., 2023; Guindon et al., 2023). This concept of poor economy, less education, unemployment/ indecent jobs, and lack of health literacy are key factors to be considered in understanding the SLT epidemic in Sri Lanka and developing policies to solve the issue.

Another critical area important in assessing the economic factors causing the SLT epidemic in Sri Lanka is the Tsunami (2004) and thirty years of civil war lasted from 1978 to 2008. The evidence shows that people were directly or indirectly affected by one of the world's biggest tsunami disasters in December 2004. They are suffering long-term stress, forcing them towards SLT use or abuse(Chandrasekara, 2019; Dorrington et al., 2014; Gorman, 2005). The tsunami in 2004 killed more than 40,000 people who lived or visited coastal areas in more parts of the country. Moreover, thousands were displaced for a lifetime. These people and their loved ones had acute and chronic physical and psychological ill-health. Many affected people end up with long-term mental illnesses, including depression and stress. A few evidence show there is an increased prevalence of SLT use (and other addictive substances) among these tsunami-affected communities.

Moreover, the statistical evidence shows an increased prevalence of SLT use among poor people who were affected by the civil war(Dissanayake et al., 2023; Miller and Jordans, 2016; Barenbaum, Ruchkin and Schwab-Stone, 2004). A deadly, continuous civil war was held between the state and one of its minor ethnic groups between 1979 and 2009 in Sri Lanka. The war killed thousands of civilians, army forces and members of terrorist groups. Thousands of other people ended up in severe physical and psychological damage. Moreover, it destructed most of the country's economic, spiritual, and educational hubs. As a result, many people are economically, psychologically, and physically deprived. The research evidence shows that individuals who had been traumatised in many ways due to the war are more prone to consume SLT and other addictive substances compared to others. The vicious cycle of poor income, chronic stress, psychological illnesses, and substance misuse forces these victims to go for easily accessible, cheap SLT products as a temporary relief.

Moreover, the macroeconomy and microeconomy of Sri Lanka have complex links with the prevalence, patterns, and trends in SLT burden in the country. The SLT use is mainly confined to poor people in the country. The SLT products are cheap and unregulated. Therefore, the government rarely get direct revenue from the SLT industry in Sri Lanka. In contrast to this, the smoking tobacco industry is one of the primary taxpayers in the country. The CTC pay 80% of its cigarette price as government tax. The policy researchers argue that the government aims to ensure growth and survival. The income plays a significant role in achieving this overall aim.

Therefore, the economic contexts of the SLT menace and the overall tobacco epidemic explain how the government choose public health policy issues in agenda setting and how the government sets policies for various types of tobacco epidemics. Moreover, the microeconomy of the country- that is, the income of individual households- is weak. The recent triggering factors, such as Covid-19 and the post-Covid economic crisis, forced people from being poor to being poorer. These circumstances dropped the macro and micro economy and increased the number of SLT users.

Moreover, the low cost and easily accessible SLT products, when compared to smoking tobacco products, including cigarettes, are two of the main reasons for these changes. In addition, two disasters in the country's recent history have drastically damaged the economy and well-being of the people. Those are the Tsunami in 2004 (natural disaster) and the thirty years of civil war (artificial disaster). The evidence reveals there is an increased trend of SLT consumption (and substance abuse) among the marginalised people who were long-term victims of these two disasters.

1.10.4 Addressing Service Needs and Financial Challenges

Smokeless tobacco (SLT) users require a wide range of services to address the various challenges of their habit(Perera et al., 2023; Mahees et al., 2021; Somatunga, 2004). These services include health education, promotion programs, behavioural change modifications, long-term cessation efforts, regular screening for oral health conditions (including potentially malignant disorders or OPMD), specialised care

treatments, financial support for care packages, and social support for their families. These services often require significant government funding and substantial investment from victims to cover treatment and care costs for SLT-related diseases.

Moreover, the marginalised individuals who comprise a significant portion of chronic SLT users are often unable to advocate for their service needs due to the lack of power and support(Khokhar, 2019; Jayashantha and Johnson, 2016; Somatunga et al., 2012). As a result, they are frequently left without the necessary resources to address the health challenges that arise from SLT use, which can have a devastating impact on their quality of life and well-being.

In brief, this piece discusses the economic factors contributing to the SLT epidemic in Sri Lanka, shedding light on the affordability and accessibility of various types of SLT in the context of the country's microeconomy and macroeconomy. Furthermore, it presents evidence of how economic transactions contribute to the pattern of the SLT epidemic in Sri Lanka. The text also highlights how shifts in Sri Lanka's economic policies in response to major events such as the Tsunami and COVID-19 directly and indirectly impact the characteristics of the SLT epidemic.

1.11 Environmental Context

The environment of Sri Lanka facilitates the supply chains and long-term habitual consumption of traditional betel quids and commercially prepared SLT (Amarasinghe et al., 2023; Mahees et al., 2021; Karunanayake, 1979). Following are a few of those environmental factors revealed in the literature review.

- Tropical climate and soil conditions suitable for tobacco plants
- Wide-spread tobacco farming sponsored by CTC.
- Growth of a range of tobacco leaves in almost all regions of the country
- ❖ Abundance of areca nuts and betel leaves as domestic crops. (they are the other main ingredients of traditional betel quids)
- The agriculture ministry gave facilities to grow AN and betel leaves as export crops.

- Easy accessibility to betel quid sellers in each corner of the country
- Illicit markets operated efficiently via all-island coastal areas connected to the Indian Ocean, with the local economy handled by the political powers.

1.11.1 Tobacco Farming and Industry Sponsorship

Tobacco farmers spread all over the country. Tobacco is an economic crop in Sri Lanka approved by the Ministry of Agriculture (Ratnayake, 2008; Lindara, Johnsen and Gunatilake, 2006; Croucher and Islam, 2002). Europeans introduced the tobacco plant to the country as a commercial plant around 500 years ago (Karunanayake, 1979). These farmers provide almost all tobacco leaves needed for producing cigarettes and other smoking products by Ceylon Tobacco Company (Fernando, 2014). The remaining tobacco leaves are sent to local markets. The SLT sellers and users buy these loose tobacco leaves in regional markets, including Sunday fairs, to prepare the SLT products, mainly betel quids (Somatunga et al., 2012).

The Ceylon Tobacco Company - a cigarette monopoly in Sri Lanka- sponsors all the tobacco farmers in the country (Perera et al., 2018; Lakmal et al., 2018). Evidence claims the CTC sponsors tobacco farmers by, providing financial support, distributing seeds, periodic visits and buying at the sites, and welfare activities(Perera et al., 2019; Wijesuriya et al., 2019; Perera et al., 2005). This interdependency between TI and the local farmer in villages is more than 70 years old. Moreover, the tobacco grows in the country's dry and wet zones, including Galewela, Polonnaruwa, Mahiyangana, Ududumbara, Haliela and Buttala. The Ceylon Tobacco Company produces around 5 billion cigarettes annually using these tobacco leaves from rural Sri Lanka. Furthermore, the price paid by CTC for tobacco leaves is significantly higher when compared to alternative crops; these TI strategies prevent farmers from switching to public-friendly crops(CCT, 2021). The evidence shows that the Presidential Task Force on Alcohol and Substance Abuse Prevention, in collaboration with NATA, had set some policies to aid tobacco farmers in switching to alternative crops but had not been successful(Buddhika et al., 2018; Thennakoon and De Silva, 2012).

Table 1.1. Comparison of buying prices of tobacco leaves vs alternative crops (2018 Yala) adapted by (Thibbotuwawa and Dissanayaka, 2019)

Crop	Yield (Kg)	Income (Rs/Kg)	Expenditure (Rs/Kg)
Green Chili	10,143	214	33.23
Brinjal	22,545	89.4	12.18
Tobacco	4,791	400.00	58
Tomato	20,860	90.3	15.93
Carrot	12,819	143.5	28.62
Bitter Gourd	14, 814	113.2	24.32

Table 1.1. provides comparisons between the buying prices of one kilo of tobacco leaves and other common crops in Sri Lanka. There is a four to fivefold rise in the price paid for tobacco leaves compared to other crops, indicating the challenges in introducing alternative crops for tobacco farmers (Buddhika et al., 2018; Zhang et al., 2016).

1.11.2 Export Crops and the Ministry of Agriculture

In Sri Lanka, areca nut and betel leaves are the other main ingredients of traditional betel quid, the most prevalent SLT product in Sri Lanka. Areca nut and betel leaves are economic crops promoted as export crops by the Ministry of Agriculture in Sri Lanka(Mahees et al., 2021; Ratnayake, 2008). Areca nuts and betel leaves are available in almost all local markets in the country. All these factors promote traditional BQ consumption in Sri Lanka. The agricultural ministry conducts promotion programs to motivate the people to grow areca nuts in their households as an economic crop. They promote this activity by distributing areca nut plants at the household level. In addition, areca nut and betel are domestic plants seen in most houses' front or back yards for centuries(Somatunga et al., 2012).

1.11.3 Black Market and Border Security

Moreover, the country is more prone to illicit SLT business(Amarasinghe et al., 2023; Mahees et al., 2021). CPSLTs are imported illegally to Sri Lanka by neighbouring SEA countries, including South India, Bangladesh, and Pakistan(Mahees et al., 2021). Recent studies revealed that there is a rising prevalence of using Imported SLT products in Sri Lanka, especially among youths and adolescents in urban and suburban areas(Dhanapriyanka and Fransisku, 2021). These illicit SLT products reach the coastal regions by small boats. Illegal SLT products from neighbouring countries, including India, Bangladesh, and Pakistan, frequently reach the coastal areas of Sri Lanka. Organised groups distribute these illegal products all over the country. The majority of young SLT users have secret links with these suppliers. Therefore, it is evident that the law should be enforced as part of the ban policy implementation activities against these imported SLTs (seen only in the black market)(Mahees et al., 2021). The government must spend many more human resources, finances and logistics. Moreover, the government is supposed to enhance the security of the coastal areas, which is not that easy. The coastal region of Sri Lanka is extensive as it is an island in the Indian Ocean.

1.11.4 Unregulated Sales and Lack of Standardisation

Another factor facilitating the SLT epidemic in Sri Lanka is the abundance of SLT sellers in Sri Lanka(Perera et al., 2023; Amarasinghe, Warnakulasuriya and Johnson, 2021). These sellers vary from small-scale BQ sellers in the streets and mobile sellers to wholesale traders. Most village SLT users buy BQs and plain tobacco leaves from Sunday fairs or the local market(Somatunga et al., 2012). Other SLT products, such as Mawo and Thul, are made from plain tobacco leaves or available in various shops in villages and cities and sold secretly(Amarasinghe et al., 2010a). Imported SLT products are available mainly in shops in towns and cities and controlled by influential, informal groups. (Mahees et al., 2021; Perera et al., 2018)

The SLT products in Sri Lanka are not packed or labelled according to standards before sending to the market(Amarasinghe et al., 2023; Mahees et al., 2021; Somatunga et al., 2012). Moreover, there are no health warnings in the packets or

packaging. No facilities are available for laboratory checking for the components and chemistry in the SLT products.

Finally, as I presented in this section, several environmental factors motivate using SLT in Sri Lanka. Wide-spread tobacco farming provides loose tobacco leaves to the local market. People prepare traditional BQs, such as Thul and tobacco powder, using these tobacco leaves. The CTC sponsor the entire process of tobacco farming and buys the leaves at the farmers' doorstep. They pay fourfold higher prices for tobacco leaves when compared to normal commercial agricultural products in Sri Lanka. The government shows poor progress in the campaign launched to introduce alternative crops for tobacco farmers. Other ingredients of the BQs- areca nuts and betel leavesare domestic crops seen in most parts of this topical island. The agricultural ministry conducts promotional programs to encourage the growth of AN and betel leaves as export crops. There are no rules and regulations for using AN. In addition, Sri Lanka is an isolated island in the Indian Ocean surrounded by neighbouring countries such as India, Bangladesh, and Pakistan. These are countries with a high burden of SLT epidemic. Therefore, Sri Lanka is more prone to illicit drug selling and smuggling. These key areas highlight the critical environmental dimensions of the SLT epidemic in Sri Lanka. The policy issue might not be fully described without attending to these facts.

At the end of the 'policy context' section of the background chapter, I summarise the critical areas of the SLT epidemic in Sri Lanka: The context is where the policy actors work and make decisions. Therefore, the context of a policy issue (in this thesis, the context of the SLT epidemic in Sri Lanka) interacts with the policy process, content, and actors in a complex manner regarding the ultimate decision. Later, it interacts with policy implementation to create policy outcomes. A public health policy issue cannot be wholly understood without digging into its context. In the case of the SLT epidemic in Sri Lanka, the epidemic is an outcome of complex interactions between sociocultural, political, economic, and environmental factors. The SLT has been a traditional symbol of welcoming prestigious people and friends for centuries. The primary type of SLT is traditional betel quids, consisting of betel leaves, areca nuts and pieces of tobacco leaves. There are distinctive differences in traditions, cultures, patterns, and types of SLT use in the country's urban, rural and estate sectors. In

addition, the Indigenous Vedda community has been a unique group of habitual SLT users for thousands of years.

Moreover, as presented in section 1.9 (pages 60-72), the central government is responsible for problem identification, prioritisation, agenda setting, and setting public health policies to solve SLT threats(Buse, Mays and Walt, 2012). The Ministry of Health (NATA office) is the authorised central agent to act on behalf of the government in this task. Nevertheless, the power has been delegated to local authorities for three decades. Therefore, policy implementors can make administrative decisions (Lukwata et al., 2023)Moreover, the tobacco industry (smoking tobacco) is one of the critical taxpayers and, thus, can interfere with government policy-making and implementation processes. Governments are strategic enough to solve culturally sensitive policy issues without harming their electoral perfection and popularity.

As presented in section 1.10 (pages 73-78) the SLT is the 'tobacco of choice' of poor people in Sri Lanka. On the other hand, SLT-induced oral cancer is the number one cancer killer among Sri Lankan adult men. Therefore, this policy issue consumes many resources from the government (macroeconomy) and households (microeconomy). Furthermore, exceptional situational factors, including natural and man-made disasters, negatively impacted the resolution of the issue. The chronic victims of tsunamis and civil war are more prone to increased use of SLT. Therefore, the SLT epidemic combines a range of contextual factors. These policy issues are called 'complex/wicked' policy issues. Policy actors and implementors should be approached more logically and systematically when addressing complex policy issues.

This section of the environmental context of the SLT epidemic in Sri Lanka provides insights into the factors that provoke the issue. These include tobacco farming, big industry sponsorships, the value of betel leaves and areca nuts as export crops, and promotion programs conducted by the Ministry of Agriculture. These pieces of evidence highlight the importance of specific agricultural policies in controlling the epidemic. Moreover, evidence underscores the importance of encouraging farmers to switch from tobacco to alternative crops.

Part C: Stakeholder Dynamics

1.12 Stakeholders and the SLT Epidemic

The primary goals of this introductory chapter were two-fold: to provide a thorough definition of the SLT epidemic in Sri Lanka from the perspective of a public health policy analyst and to evaluate the coherence between the policy problem (i.e., the SLT epidemic) and the proposed resolution (i.e., the SLT ban) by analysing existing literature. Achieving these objectives might not be completed without looking into the diversity of its key stakeholders involved or affected by the SLT epidemic(Craig et al., 2019; Somatunga et al., 2012; Bryson, 2004). Their roles, expectations and perspectives are intertwined with the current circumstances, decision-making processes, and implementation strategies related to the epidemic.

The stakeholders are persons, groups, or organisations with assigned interests or influencing powers on a policy issue under consideration and the policy decisions to solve it(Brugha and Varvasovszky, 2000). As mentioned above, the SLT epidemic is a 'complex' public health issue in Sri Lanka(McConnell, 2016). The SLT epidemic in Sri Lanka is a culturally sensitive, socially accepted, shared community practice. Long-term consumption of SLT is a leading risk factor for serious health problems, including upper gastrointestinal cancers and cardiovascular and cerebrovascular diseases. There are multiple dimensions of contextual factors facilitating the treatment. Therefore, many stakeholders are engaging in the SLT epidemic and its policy decisions. The stakeholders of the SLT epidemic include policy actors, implementors, local and international non-governmental organisations, subject experts, SLT users, starters, and the public (community)(Mints and Kamyshnykova, 2019; Mendelow, 1981).

Following is an overview of the main parties involved in addressing the epidemics and their responsibilities. Those impacted by the SLT epidemic, interest groups and subject matter experts are among them. These experts are critical in generating knowledge and insights to combat the public health challenge. Meanwhile, others are

actively engaged in decision-making and implementation efforts to control and prevent the spread of the epidemic.

1.12.1 Policymakers

Policymakers are referred to the people with a vested power to make policies on behalf of the government (Buse, Mays and Walt, 2012; McConnell and Marsh, 2008). The Ministry of Health is the central agency formulating policies to control and prevent tobacco epidemics, including the SLT menace in Sri Lanka. NATA is the central office, working under the direct supervision of the Minister of Health and the leadership of a chairman in initiating these policymaking activities (Samarage, 2006). The primary duties of policymakers in tobacco control and prevention programs are to identify the problems, prioritise those, and set agendas and policies. During these critical functions, PAs should coordinate with all the key stakeholders, including the parliamentarians, policy implementors, interested groups, experts, tobacco users and the public.

1.12.2 Policy implementors

The next category of critical stakeholders of a policy process is policy implementors. Policy implementors implement the policy (Buse, Mays and Walt, 2012; McConnell and Marsh, 2008). The policy implementors are the employees working at the community level(Lukwata et al., 2023). The leading policy implementors of tobacco policies in Sri Lanka are provincial health directors, regional health directors, medical officers of health, public health midwives (PHMs), public health inspectors (PHIs) and food and drug inspectors (FDIs) (Ministry, 2020; Mallawaarachchi et al., 2016). The nature of the policy decides the other executors. For example, when implementing laws prohibiting SLT products, the government need the support of executors beyond the Ministry of Health, including police, excise, and customs.

1.12.3 Interest Groups and Subject Experts

The other category of critical stakeholders of the SLT epidemic is interest groups(Balane et al., 2020; Mints and Kamyshnykova, 2019). The expert groups are

one of the significant interest groups. They are interested in the policy issue and willing to share their specialist knowledge and contribute to policymaking. Experts contribute to identifying and defining the policy issue, analysing the policy context, and generating policy alternatives. This process is called 'expert consultations'. Generally, they do not have delegated power by the parliament for decision-making, but their interest and commitment in solving the issue is significantly high.

The key interested groups working in controlling and preventing tobacco epidemics in Sri Lanka are the World Health Organization (WHO), Alcohol and Drug Information Centre (ADIC), Dhamrivi Foundation, Expert Committee in Tobacco, Alcohol, and Illicit Drugs in Sri Lanka Medical Association (SLMA), Centre for Combating Tobacco (CCT) at the Faculty of Medicine, University of Colombo, and Centre for Research in oral cancers (CROC) at the University of Peradeniya(UNDP, 2019). The general goal of the interested groups in public health policymaking is to ensure the community is healthy and secure.

1.12.4 Community and High-Risk SLT Users

The community is another category of critical stakeholders which must be counted in almost all public health policy issues, including the SLT epidemic(DeHaven, Gimpel and Kitzman, 2021; Amobi, Plescia and Alexander-Scott, 2019; National Academies of Sciences, 2017). The community is the people or groups with common geographical interests affected by a given issue or the decisions taken to solve the issue. Therefore, the community has the fundamental right to raise its voice against public health problems. Moreover, they have the right to get involved in deciding to solve the problem.

As presented in section 1.8 (pages 46-60), the SLT policy issue is a culturally sensitive, widely accepted, traditional habit in Sri Lanka. While chewing betel quids is a generalised practice, some socio-cultural groups are identified as habitual users with high risk. They include the farmers in the rural sector, fishermen in the coastal area, tea puckers in the estate sector and slum dwellers in the urban sector. Moreover, religious leaders (mainly Buddhist Monks), schoolteachers, bus drivers and urban labourers are habitual consumers of SLT products. Furthermore, adolescents of

school-going age and school leavers are vulnerable to the SLT epidemic. Therefore, these vulnerable groups are critical stakeholders of the SLT epidemic and its control policies. Moreover, as the SLT is linked with a range of traditions, myths, and rituals, the public is also a vital stakeholder in the SLT epidemic in Sri Lanka.

There are two primary components of the SLT epidemic: the behaviour of the public and harmful SLT users. As presented below, one component causes the burden, while the other motivates consumption.

- The SLT use in Sri Lanka is a generalised, culturally sensitive, socially accepted, traditional practice in Sri Lanka. Traditional betel quids and their related products and accessories are the main symbols of people's life cycle (births, weddings, funerals) and main festivals (New Year ceremony, Vesak, Poson, and many other festivals)
- Though the public uses it as a symbolic item, the poor individuals are habitual SLT users. They end up with a series of health impacts, starting from OPMD to fatal oral cancers. These victims include labourers, farmers, tea puckers, fishermen, bus drivers, urban slum dwellers, job seekers and adolescents of school-going age. The male and female ratio of SLT use in Sri Lanka is 4:1. Therefore, when four men use SLT, only one woman uses SLT.

Understanding the stakeholders involved in the SLT epidemic in Sri Lanka is crucial for establishing clear definitions and roles in policy-making and implementation. It offers valuable insights into the varied interests and powers of different stakeholders, which can either lead to conflicts or synergies in planning and implementing SLT control programs. Additionally, it sheds light on how the priorities of health policymakers may clash or align with those of the tobacco industry or local farmers. Moreover, this evidence provides insights into the power dynamics among stakeholders, including who has the most influence over policy decisions and how this impacts the SLT epidemic.

Part D: Outcomes of the Introductory Chapter

Section D provides a condensed overview of the empirical data and insights presented in this thesis' introductory chapter. Three primary concerns are highlighted, including the optimal conditions for a successful SLT ban in the Sri Lankan context, potential unintended consequences that decision-makers may face if the ban policy fails, and of developing a comprehensive definition of the SLT epidemic in Sri Lanka.

1.13 Understanding the Policy Orientation

This study delved into analysing the successes and failures of the SLT ban policy introduced by the Sri Lankan government in September 2016 (section 1.2.1. page 18). As identified by the 'explicit content' of the extraordinary gazette released by the government, the ban policy might be characterised as follows:

- Judicial and authoritarian
- A relatively novel and non-WHO policy

Examining the success of the ban policy in Sri Lanka, given the socio-cultural sensitivity of the SLT epidemic, is crucial and timely needed. This is a vital outcome of this introductory chapter.

Moreover, drawing on the empirical data presented, five optimal conditions for the success of the SLT ban policy in the Sri Lankan context are posited, along with six potential unintended consequences. They have been presented in the following two subsections.

1.14 Identifying Possible Prerequisites

Based on the evidence presented in sections 1.2 to 1.12 (pages 18- 92) regarding the distribution, types and context of the SLT epidemic in Sri Lanka, a list of potential

prerequisites for The successful development and implementation of the SLT ban policy could be generated.

- A. Balanced and Robust Policy Development Phase, including.
- Rigorous examination of the SLT epidemics' contextual interlinks.
- In-depth analysis of SLT distribution and usage patterns.
- Identification of SLT types and their supply chains.
- Consideration of socio-cultural, political, economic and environmental factors.
- Understanding the perspectives and expectations of the diverse range of SLT stakeholders.
- B. Inclusive Decision-Making and Implementation, including.
- Participation in policy implementors and community leaders in decision-making processes
- Customised implementation plans for different socio-cultural settings.
- C. Centralised Collaboration and Monitoring, including.
- Strong collaboration between central authorities and regional implementors.
- Regular monitoring, evaluation, and reforms of strategies.
- D. Holistic Approach to Policy Implementation.
- Collaboration on non-ban policies alongside the SLT ban policy.
- Active enforcement of health education, behavioural change and cessation programs

1.15 Identifying Possible Unintended Consequences

Based on the empirical data presented in this introductory chapter, I could compile a list of potential unintended consequences of implementing the policy in the Sri Lankan context (sections 1.2 to 1.12, pages 18-92).

- i. Black-Market Expansion.
 - Possible conversion of SLT business to an illicit trade.
 - Risk of SLT becoming a concealed and hidden practice.
- ii. Diminished effectiveness of Other SLT Policies.
 - Reduced opportunities for non-ban SLT policies (health education, behavioural change communication and cessation programs) to be enforced effectively.

- Potential ethical challenges for health workers in providing services.
- iii. Neglect of Service needs.
 - Potential neglect of extensive service needs for SLT users and uptakes
 - Overemphasis on ban success to the detriment of necessary services
- iv. Reduced Healthcare Engagement
 - Fear generated by judicial power may deter SLT users from seeking healthcare services.
- v. Increased SLT-Attributed NCDs
 - Lower healthcare engagement might lead to a rise in SLT-attributed noncommunicable diseases.
- vi. Impaired Data Collection.
 - SLT users are reluctant to provide accurate information for research and surveys.
- vii. Social Unrest and Political Instability
 - Potential erosion of cultural traditions leading to social and political consequences.

1.16 Developing a Working Definition

Drawing upon the empirical data presented in this Chapter, the SLT epidemic in Sri Lanka may be defined as follows.

The SLT epidemic in Sri Lanka is not solely a public health threat but rather a complex outcome influenced by leading cultural practices, traditions, beliefs, governmental operations, socio-economic factors, and environmental conditions.

1.17 Rationale for the Research Project

The use of smokeless tobacco (SLT) is one of the primary and oldest ways of tobacco consumption worldwide(Siddiqi et al., 2020; Mehrotra et al., 2019). Chapter 01 presents empirical evidence that sheds light on the SLT epidemic in Sri Lanka, exploring its deeply rooted sociocultural, traditional, political, economic, and environmental dimensions (Part B, pages 45-84). In September 2016, the Sri Lankan government introduced a comprehensive ban on all SLT products (1.2.1, page 18). Based on the evidence presented, Part D of this chapter (pages 88-90) highlights the knowledge gaps between the SLT epidemic and the successes and failures of the public health policy- the SLT ban policy. It is also evident that no robust research studies have been conducted to provide recommendations for a way forward.

The SLT ban policy in Sri Lanka prohibits the manufacturing, import, sale, and offering of SLT products throughout the country (1.2.1. page 18). This explicit written content of the ban policy seems to be influential. It could impact the various dimensions of the SLT epidemic significantly, although there is no empirical evidence to support this assumption. If the ban policy is successful, it would be a significant accomplishment given the complex nature of the SLT epidemic in Sri Lanka. However, if it fails, it could result in unintended and severe consequences (sections 1.14 and 1.15, pages 88-90)

While Sri Lanka has recently banned the manufacturing, importing, selling, and offering of SLT (smokeless tobacco) products by this SLT ban policy under investigation, it's worth noting that this action was not explicitly recommended by the World Health Organization's Framework Convention on Tobacco Control(World Health Organization, 2004). The framework, ratified by 180 countries worldwide, provides evidence-based guidelines for preventing tobacco use and its related health consequences. However, countries may need help to adopt the framework precisely and can customise their strategies accordingly. Additionally, the framework is primarily based on empirical evidence from developed European countries, which may not apply to Southeast Asian nations like Sri Lanka (Craig et al., 2019; Zaatari and Bazzi, 2019). Hence, creating new policies tailored to the local context is crucial. However, these non-framework policies, including the SLT ban policy in Sri Lanka, need to be thoroughly researched and further reformed without further delay to effectively prevent

and control the SLT epidemics in low and middle-income countries (Chugh et al., 2023; Arora et al., 2020).

It's worth noting that, apart from Sri Lanka, only a few other places have implemented bans on SLT supply chains (section 1.2.2, page 19). These include Bhutan, Singapore, some regions of India, and Australia(Welding et al., 2022; Amul and Pang, 2018; Gurung et al., 2016; Gartner and Hall, 2009). However, since these bans are relatively new, there isn't enough data to determine their effectiveness and use them as examples. The evidence so far points to significant barriers and challenges to implementing such bans in these countries, with community denial being one of the main reasons(Vidhubala et al., 2016; Gurung et al., 2016; Chapman, 2008; Tan et al., 2000).

It's important to note that the context and circumstances of each country are different, including the culture, traditions, beliefs, political structure, types of SLT products, supply chains, and tax structures(Arora et al., 2020; Siddiqi et al., 2020; Gupta et al., 2011). Therefore, it's crucial to examine the success and failures of the SLT ban introduced in Sri Lanka in 2016 according to contextual factors in Sri Lanka (Part B, pages 45-83). This research project aims to fill this knowledge gap to some extent and shed light on the effectiveness of the ban policy. (Chugh et al., 2023).

Chapter Summary

SLT consumption is a neglected but life-threatening global public health epidemic. Sri Lanka is among the first few SLT high-burden countries in the world. The purpose of the background chapter was to provide an overview of the SLT epidemic in Sri Lanka, which is introductory to analysing the successes and failures of the SLT ban policy introduced by the government in 2016. The empirical evidence presented in this chapter revealed that the SLT epidemic is a complex issue deeply ingrained in Sri Lanka's cultural, traditional, and socio-economic fabric. Therefore, the problem might influence the political stability and electoral prospects of the government in place. Moreover, this chapter also identified culturally inherited and socially accepted traditional betel quids with tobacco as the most dominant type of SLT, mainly homemade and consumed by the marginalised adult population. Furthermore, SLTs other than traditional betel guids are available in the black market and distributed to young people by established groups. Therefore, the leading SLT supply chains in Sri Lanka were informal, unregulated, and tax-free. Consequently, the evidence presented within this chapter illuminates potential prerequisites and unintended consequences of implementing a ban on SLT within the Sri Lankan context, warranting further research. Additionally, by comparing the empirical evidence to regulations set forth by the SLT ban policy, seven research questions have surfaced, which will be addressed in upcoming chapters of this thesis.

Chapter 2: Aim, Objectives, and Methodology

2.1 Chapter Overview

This chapter presents the aim, objectives, methodology, and theoretical underpinnings of the research project to investigate the successes and failures of the SLT ban policy in the Sri Lankan milieu. The chapter is divided into five sections (2.2 to 2.6). Section 2.2 outlines the study's aim and objectives. Moreover, this section introduces the two stages of the research project—Study A and B.

The following section, 2.3, explains the step-by-step approach to developing the two-staged, qualitative case study. It covers the research philosophy, approach, choices, and strategy in different subsections. This section also provides an overview of the data collection tools, sampling techniques, and data analysis procedures selected for Study A and B and insights into their advantages and disadvantages.

Section 2.4 presents an overview of the logical sequence for building this research project's analytical framework. This section includes seven subsections, from 2.4.2 to 2.4.8. The purpose of each subsection is to shed light on the reasoning behind the inclusion of each policy analysis or policy science theory in the analytical framework and their relevance to the aim, objectives, and questions of this research project.

Finally, Section 2.5 provides an overview of the research strategy presented in a figure. The chapter concludes by summarising the steps of the research project and the key numbers for the different components of the research project (section 2.6).

2.2 Aims and Objectives

This research project aimed to examine the successes and failures of the SLT ban policy introduced in 2016 in Sri Lanka. The overall aim was divided into two objectives. Two separate studies (study A and B) conducted as part of this thesis achieved these objectives. The two objectives were as follows. Their sub-objectives have been presented in sections 2.2.1. and 2.2.2, respectively.

- To examine the successes and failures of the development of the SLT ban policy 2016 in Sri Lanka
- 2. To examine the perceptions and experiences of ban enforcers and related stakeholders on the successes and failures of the SLT ban 2016 in Sri Lanka

2.2.1 Objective One: Examining the Policy Development Phase

Objective 01 was established to investigate the ban policy development phase as Study A - Stage One of this research project. The ban development phase was examined using four interconnected and critical elements of health policymaking (section 2.4.4, pages 131-133), represented by four sub-objectives. In other words, the four sub-objectives of Study A provided a comprehensive understanding of the SLT ban policymaking process, which is the primary determinant of SLT ban successes or failures. These critical elements of health policymaking are policy content, policy actors, policy context, and policy process(Buse, Mays and Walt, 2012; Buse, 2010; Lee, Buse and Fustukian, 2002)Section 2.4 (pages 120-139) presents the combined analytical framework, which provided the theoretical foundation for this research project. It explains the links between SLT ban success and the effective interlinking of these four elements of health policymaking.

- I. To analyse the content of the SLT ban policy 2016 in Sri Lanka.
- II. To analyse the powers, positions, and interests of policy actors who developed the SLT ban in 2016 in Sri Lanka.
- III. To analyse the contextual factors that contributed to developing the SLT ban policy 2016 in Sri Lanka

IV. To explore the policy development process of the SLT ban 2016

2.2.2 Objective Two- Examining Stakeholders' Viewpoints

Objective 02 was formulated to investigate the successes and failures of the ban by investigating the stakeholders' viewpoints, as Study B - Stage Two of this research project. The study gathered opinions from key stakeholders through three interrelated dimensions of public policy successes (2.4.2, pages 125-128), represented by three sub-objectives. These three sub-objectives of Study B provided a comprehensive understanding of the SLT ban policy successes through process, programme and political success(McConnell, 2016, 2014, 2010a). McConnell's policy successes and failures framework provided the primary theoretical underpinning for this part of the research project. The study was limited to ban implementers, non-governmental organisations working in tobacco control and prevention activities in Sri Lanka for decades, and leading researchers investigating the SLT and SLT-related illnesses and attached to prominent universities in the country. As presented above (section 1.2.1, page 18), the SLT ban was introduced in 2016, and this study was planned during its early stages of implementation from 2019 to 2021. Therefore, in addition to experiences, the perceptions of these key stakeholders were gathered to find the answers to these three sub-objectives presented below.

- I. To analyse the process success/failure of the SLT ban policy 2016 in Sri Lanka.
- II. To analyse the programme success/failure of the SLT ban policy 2016 in Sri Lanka.
- **III.** To analyse the political success/failure of the SLT ban policy 2016 in Sri Lanka.

2.2.3 Interconnectivity between Objectives

This research project analysed the ban policy's success in the SLT epidemic in Sri Lanka. To achieve this goal, the study investigated the three dimensions of policy success - process, program, and politics, and analysed the complex interlinks between the critical dimensions of health policymaking(Buse, Mays and Walt, 2012; McConnell and Marsh, 2008). These parameters of the two objectives are interconnected. The

theoretical underpinnings in section 2.4 (pages 120-139) in this chapter further highlight the standard features of the indicators used to assess the policy's success in two objectives. For example, process success refers to the policy development and implementation processes (Buse, Mays and Walt, 2012; McConnell, 2010a; Lasswell and Lerner, 1951).

2.2.4 Linking Research Questions to Study's Objectives

The previous chapter (1.2 to 1.12, pages 17 to 87) presented empirical evidence that led to the formulation of seven research questions regarding the success of the SLT ban in Sri Lanka. The process of formulating the research questions and the outcome has been summarised below.

I have identified the following critical knowledge gaps (A and B) and associated research questions by comparing the working definition of the SLT epidemic (section 1.16, page 90) with the written policy content of the SLT ban policy, as seen in the extraordinary gazette released in September 2016 (sections 1.2.1 and 1.13, page 18, 88).

A. Traditional Betel Quids Chewing and its Cultural and Political Links

The prevalence of the SLT epidemic presented in section 1.3 (pages 23-27) reveals a potential incongruence between its socio-cultural roots (1.8, pages 46-60), electoral prospectus (1.9, pages 60-72) and the SLT ban policy (1.2, page 18). A significant challenge might be caused by prohibiting the enduring tradition of betel quid chewing, predominately practised by adult men for centuries. More knowledge is needed on how this decision influences the political stability of the governing body. Moreover, the influence of the ban policy on the informal and tax-free supply chains associated with these socially accepted cultural practices has yet to be investigated (1.6, pages 37-44).

B. Non-betel-quid SLT Products, Black Market, Youths and Secret Subculture
Besides the traditional betel quids, the presented empirical evidence showed that SLT
products like Thul, Mawa, Red Tooth Powder, Pan Parag, Khani, Sara Bulath Vita,

Beeda, and Babul are becoming more popular in Sri Lanka (1.6, pages 37-44). Moreover, evidence revealed that these are sold on the black market, mainly to known customers. Most of these customers are young and adolescents, particularly those with low socioeconomic and educational status.

Seven research questions were developed by summarising the empirical data presented in this introductory chapter, highlighting two main areas of the knowledge gap.

- a) How did various factors contribute to the decision-making process that led to the imposition of the SLT ban as the primary strategy in Sri Lanka? What was the rationale behind selecting the ban as the ultimate decision?
- b) What factors influenced the development of the SLT ban policy in 2016 in Sri Lanka, focusing on understanding the scientific rationale behind controlling the use of traditional betel quids?
- c) What motivated the choice of the SLT ban policy as a preventive measure against commercially prepared SLT use in Sri Lanka? What were the underlying reasons and the approach taken?
- d) To what extent are policy implementors successfully enforcing the SLT ban against the manufacturing, selling, and offering of traditional betel quids in Sri Lanka? What challenges exist and why? What strategies are employed for successful implementation?
- e) To what extent are policy implementers successfully enforcing the ban on the manufacturing, selling, and offering non-traditional commercially prepared SLT products? What are the existing challenges, and why do they exist? Additionally, what strategies are being utilised for successful implementation?
- f) What unintended consequences have arisen from implementing the SLT ban, and what strategies exist to overcome these barriers? Why and how do these unintended consequences occur?

g) How has the SLT ban policy affected cultural norms and expectations in Sri Lanka? How do the government and local authorities cope to ensure political stability if there is any cultural shock?

The present research project aims to address these questions and fill important knowledge gaps. Table 2.1 below illustrates the relationship between the research questions and the project's objectives. Study A pertains to Objective 01, while Study B corresponds to Objective 02.

Table 2.1- The Links between Research Questions and the Objectives

Research Questions	Study and Objectives		
Study A			
а	Sub-Objective 03		
b	Sub-Objectives 01. 03, and 04		
С	Sub-Objectives 01. 03, and 04		
Study B			
d	Sub-Objective 03		
е	Sub-Objectives 01, 02, and 03		
f	Sub-Objectives 01, 02, and 03		
g	Sub-Objectives 02 and 03		

Chapter 03 covers Study A's methods, findings, and discussion, as explained further in Section 2.5 (page 140). This study was conducted to address Objective 01. Chapter 04 elaborates on Study B's methods, findings, and discussion directly related to Objective 02.

2.3 Designing Research Methodology

This section briefly presents my scientific approach to crafting the methodological framework to answer the above research aim and objectives. For this purpose, I mainly followed Saunders' research onion. This 'research onion' aided in making interrelated, stepwise choices in building a holistic research methodology (Sinha, Clarke and Farquharson, 2018; Saunders, Lewis and Thornhill, 2009, 2007). In other words, Saunder's research onion, as shown in Figure 2.1.below, directed me to a systematic approach to a range of high-level, philosophical, strategical and technical decisions in designing my research methodology, which was the foundation for finding valid, realistic answers for above research objectives.

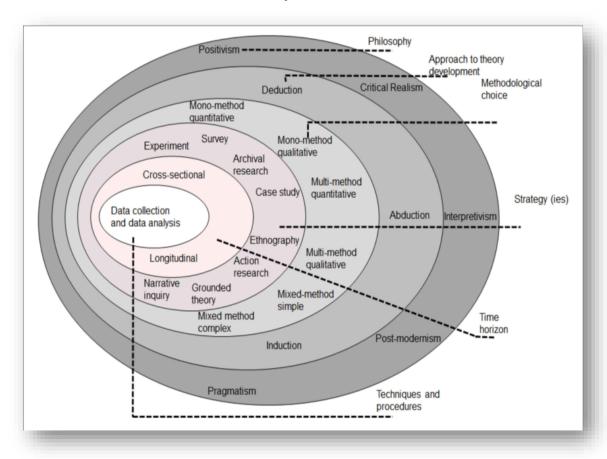


Figure 2.1. Research Onion (Saunders, Lewis and Thornhill, 2019)

Therefore, from section 2.3.1 to 2.3.7 (pages 101-119), I briefly present the ways and means of developing my research methodology under six topics. These topics, listed below, are compatible with the six layers of the onion illustrated in Figure 2.1.

- o Research philosophy (section 2.3.1, pages 101-103)
- o Research approach (section 2.3.2, pages 103-104)
- o Choices (section 2.3.3., page 104)
- o Research strategy (section 2.3.4, page 104-106)
- Time horizon (section 2.3.5., page 107)
- Techniques and procedures (section 2.3.6., pages 107-119)

2.3.1 Choosing Among Research Philosophies

The first choice I made in developing the research methodology was the philosophy of this research project. This is represented by the outermost layer of the onion, as shown in Figure 2.1 (page 100). Three central research philosophies/ sets of beliefs operate in the modern research world: positivism, interpretivism and pragmatism. A researcher is supposed to select one among three sets of beliefs in setting up his methodology (Alharahsheh and Pius, 2020). Each philosophy takes a different oncological and epidemiological viewpoint (Al-Saadi, 2014; Goertz and Mahoney, 2012). Considering philosophical fundamentals, I decided to confine myself to **interpretivism**, mainly for three reasons.

I. Aims and objectives of my research focus on an in-depth analysis of the successes or failures of the SLT ban in the Sri Lankan context. As presented in sections 1.2 and 1.12 (18-87 pages) and section 1.17 (pages 91-92) of the background chapter, the SLT epidemic in Sri Lanka is a complex construction of the country's social, cultural, political, environmental, and economic dimensions. Therefore, I decided to select interpretivism, which emphasises the effects of social, cultural and other factors of the SLT use on the outcomes of the ban. Moreover, interpretivism, in contrast to positivism and pragmatism, focuses on stakeholders' thoughts and ideas. Furthermore, interpretivism aided me in using my

interpretation of the policy-making and implementation experiences and stakeholders' viewpoints as this study's researcher.

- II. When looking into this study's research aim and objectives from ontological viewpoints, it is evident that the SLT epidemic's nature, the SLT ban's impact on it and how we know these realities can't be limited to a single objective thing. For example, as McConnell (2010) argues in his analytical framework, from success to failure (as presented in section 2.4.2, pages 125 and 128), the success of a public policy differs from one stakeholder to another. The stakeholders who contributed to the SLT ban wish for its success. The parties not invited or refused to participate in the SLT banmaking process will happily wish for its failures. Therefore, according to the nature of these research aims and objectives, it is evident that there can't be one reality. Thus, the success of the ban policy can't be found without investigating various viewpoints and thoughts of multiple stakeholders. Moreover, the data that will be raised from these different viewpoints cannot be interpreted without the active role of the researcher (while ensuring maximum reflexivity). All these philosophical desires can only be fulfilled by following interpretivism as the intellectual orientation of this study. Therefore, I decided to refrain from positivism and pragmatism and confine to interpretivism.
- III. Moreover, according to the epistemological viewpoint- that is how I can gather the knowledge gap emphasised in research objectives and come to an analysis- the knowledge about the successes and failures of the SLT ban in the Sri Lankan context cannot be achieved by numerical values(Moroi, 2021; Bruce, Pope and Stanistreet, 2018; Lerche, 2012). In other words, numerical values are received from measurement and observations through empirical research based on positivism. The knowledge that is supposed to be identified in answering this study's research aim and objectives is expected to provide a holistic view of the experiences, views, thoughts and ideas of policy actors and other key stakeholders of the SLT ban policy. In other words, the knowledge that the above research objectives should gather can't be confined to true, false or

meaningless, which are three fundamental and definite answers raised from positivism. Therefore, I decided to follow the interpretivism as my research philosophy.

After confirming interpretivism as the philosophical orientation of this research study, the next step of crafting the general research methodology was choosing among different research approaches. Choosing among the research approaches is represented by peeling off the second layer of Saunder's research onion. That approach will be presented in section 2.3.2 below.

2.3.2 Choosing Among Research Approaches

The research approach- inductive or deductive- was a vital decision in designing the research methodology as it was 'the broader method' of the study and informed the data collection and analysis processes. There are significant conceptual differences between inductive and deductive research approaches (Azungah, 2018; Schadewitz and Jachna, 2007). The second layer of Saunder's Research Onion illustrates these choices under the research approach (Figure 2.1, page 100).

Deductive data analysis is an approach that involves testing a specific theory or hypothesis(Young et al., 2020; Azungah, 2018)Researchers first define a clear and well-defined hypothesis or theory. They then collect and analyse data based on those theories to confirm or reject the hypothesis. This approach is different from inductive data analysis, where researchers begin by observing patterns in the data and then develop theories and hypotheses based on those observations.

Qualitative research aims to explore and understand the richness and complexity of phenomena by conducting detailed examinations of the context, meanings, and relationships(Creswell and Poth, 2016; Bachiochi and Weiner, 2004). The deductive approach is one way of conducting this type of research, where a theoretical framework or existing theory is used to guide the research. Based on this theoretical framework, specific research questions and objectives are formulated. These questions and objectives guide the collection and analysis of qualitative data.

The deductive approach involves identifying key variables, concepts, or themes derived from the theoretical framework, which are then used to code the qualitative

data(Saldaña, 2021; Elliott, 2018). This iterative process helps refine and validate the initial thematic framework. Finally, the findings are interpreted in the light of the theoretical framework. I chose the **deductive research approach** according to the aim of the study presented in this thesis.

2.3.3 Choosing Among Methodological Choices

Based on Saunder's research onion, I used the third layer, 'the choices', to determine the number of data types to include in my research study. This was the next step in developing my methodological framework. As shown in Figure 2.(page 100), there were three options- mono, mixed, and multi-methods. They could be qualitative, quantitative, or mixed directions(Youngs and Piggot-Irvine, 2012; Tashakkori and Creswell, 2007). Among those options, I decided to confine to qualitative- multi-methods choice because:

- The research aims and objectives focus on how, why, what for, and who types of in-depth questions are used to determine the successes or failures of the SLT ban development and enforcement. Therefore, the qualitative direction helped me deeply analyse how why, what for, and by whom, with what power, interests, and research questions.
- More than one research method was needed as the study consisted of two objectives and seven sub-objectives (section 2.2. pages 95-97). For example, analysing the SLT ban development (objective 01) needs a separate set of data collection methods, and examining the perceptions and experiences of stakeholders on the outcomes of the SLT ban (objective 02) needs another different set of data collection methods. Therefore, I decided to go for a multimethods choice.

After selecting the **qualitative multi-method** as the methodological choice of my research framework, the next step was to choose the research strategy. It is presented in section 2.3.4. as below.

2.3.4. Choosing Among Research Strategies

Choosing an appropriate research strategy is to establish a comprehensive research methodology. Research strategy is also known as research design. Modern research designs include experiments, surveys, action research, case studies, grounded theory, ethnography, narrative reviews, and archival research, showcased in the fourth important layer of Saunders' Research Onion in Figure 2.1 (page 100) (Alam, 2021; Creswell and Poth, 2016; Creswell, 2007).

For my project, I have selected the **case study research strategy**, which falls under the category of qualitative research. Additionally, I have provided a summary explaining the rationale behind my choice of this strategy.

Qualitative Case Study Research

A case study is a specialised form of qualitative research. Compared to other qualitative research methods such as ethnography, phenomenology, grounded theory, and narrative studies, case study research has advantages that make it a valuable tool for understanding complex phenomena(Creswell and Poth, 2016; Baskarada, 2014). Ethnography, for instance, is a time-consuming process that often involves high levels of subjectivity. Similarly, phenomenology is frequently challenging to analyse and interpret, making it less desirable for researchers seeking a more comprehensive understanding of a subject. In contrast, case studies offer a more in-depth knowledge of a particular case or phenomenon. They can be instrumental in situations where a deeper understanding of the subject is required. However, it's important to note that case studies have challenges, including generalisation and subjectivity concerns. Despite these limitations, case study research remains valuable in various fields, including policy sciences, social sciences, psychology, and business(Hewitt-Taylor, 2002).

Moreover, what makes a case study unique is that it is defined by the unit of analysis rather than the topic of the study(Creswell and Poth, 2016). This investigation unit is called 'the case', which refers to a specific policy, program, team, community, or organisation. For instance, this study examines the policy surrounding the SLT ban. Another distinguishing feature of a case study is that the phenomenon under

investigation is inherently bounded. The more precisely the phenomenon is delimited, the more limited the data will be(Baskarada, 2014; Exworthy et al., 2012).

The Qualitative Case Study Research facilitates a thorough analysis of an individual subject, ideally aligned with the research's objectives and focus(Hentz, 2007; Hewitt-Taylor, 2002). Specifically, the research queries crafted for this study are primarily centred on the questions of how, why, what, for whom, and with what kind of power and interest, all of which are intricately linked with the distinctive circumstances of Sri Lanka, as outlined in section 2.2 (pages 95-97) of this chapter.

The qualitative case study research methodology is beneficial when studying complex issues such as the SLT epidemic. This approach allows for a more in-depth exploration of the social, cultural, political, economic, and environmental factors contributing to the problem. By examining these various dimensions of the issue, we can better understand the challenges in implementing a ban on SLT in Sri Lanka.

Moreover, the qualitative case study research method is well-suited for analysing the Sri Lankan version of the SLT policy. It enables us to consider the unique cultural and social factors that shape the attitudes and behaviours of the population regarding SLT use. With this approach, we can better identify the most effective strategies for addressing the issue and promoting healthier behaviours in Sri Lanka.

Case study research presents an exceptional chance for researchers to interpret their findings based on their understanding and assumptions (Creswell and Poth, 2016; Creswell and Tashakkori, 2007). Drawing on my professional background in public health and clinical experience in the Sri Lankan health system, I could concentrate on the topic and its intricate connections to social and cultural factors. My choice to utilise the quantitative case study as a research strategy and maintain a reflexive journal will aid in advancing new knowledge in this research field.

The objective of this study is to analyse the impact of the ban policy on the prevalence of the SLT epidemic in Sri Lanka. The analysis will mainly focus on the social, cultural, economic, political, and environmental factors. It aims to evaluate the effectiveness of

the ban policy in reducing the use of SLT in the country and identify any contextual factors that may have contributed to the success or failure of the policy.

Case study research helps provide impartial and up-to-date knowledge and experiences regarding contextual factors (Baskarada, 2014; Hentz, 2007). This, in turn, aids in conducting a meticulous analysis and interpretation of research findings, leading to a more comprehensive understanding of the complex factors contributing to the SLT epidemic in Sri Lanka.

After selecting the case study as the research strategy in the qualitative mixed type choices, I chose the time horizon outlined in section 2.3.5.

2.3.5 Choosing Among Time Horizons

As outlined above in section 2.3 (page 100). the next step of designing the research methodology is deciding among different time horizons. As shown in Figure 2.1 (page 100). this is a far-in-distance layer of the Saunder's onion near the centre. There are two options- cross-sectional or longitudinal time horizon. Among those, I selected **two cross-sectional time horizons** to be aligned with my research aim and objectives(Creswell and Poth, 2016). For example,

- o for objective 01, in which I focus on the success of the ban policy development phase, I must receive the evidence from the period in which the policy was set up. That is a specific (cross-sectional) point in time.
- for objective 02, in which I focus on current views and thoughts of stakeholders on the SLT ban outcome, I am supposed to collect evidence for a given period, such as four to six months. That is the second certain point of time.

Therefore, to analyse the ban policy's successes and failures in the Sri Lankan context, I decided to confine the analysis to **two cross-sectional time** horizons/snapshots.

After selecting the time horizons, I reached the final but vital step of designing this research methodology. It consisted of the techniques and procedures used in conducting the research study presented in this thesis.

2.3.6 Choosing Among Techniques and Procedures

As shown in Figure 2.1 (page 100), determining the techniques and procedures was the most practical and multitasking stage of designing the methodological framework of this research study. It is the middle layer of Saunders' Research Onion. Therefore, this section was divided into four main sections to present the ultimate choice and its rationale. The study presented in the thesis was a two-staged, multiphase case study research; a few essential techniques and procedures were to be chosen. I have presented those in the following four sections from A to D.

- A. Choosing Among Data Collection Tools (pages 108-113)
- B. Choosing Among Sampling Techniques (pages 113-115)
- C. Choosing Among Transcripts Writing Techniques (pages 115-116)
- D. Choosing Among Data Analysis Techniques (pages 116-119)

Table 2.2 (page 109) illustrates those steps and the choices I have made.

A. Choosing Among Data Collection Tools

This research project was conducted in two stages using multiple research methods. Study A was a retrospective analysis of the development of the SLT ban in Sri Lanka between 2015 and 2016. Document analysis and interviews with policymakers involved in the SLT ban were selected as data collection tools for Study A. For Study B, the objective was to understand the opinions of various stakeholders regarding the effectiveness of the SLT ban. To achieve this, interviews were chosen as the primary data collection method. I picked these tools among the six data collection tools recommended for qualitative case studies: documents, archival records, interviews, direct observations, participant observations, and physical artefacts.

Policy Documents Analysis: Document analysis is an efficient method for data collection (Kayesa and Shung-King, 2021; Bowen, 2009). Document analysis is less time-consuming than other methods, such as conducting in-depth interviews, focus

group discussions, or observation. It enables the selection of relevant documents, is cost-effective, stable, and exact, and provides high coverage. Furthermore, document analysis is a precious research method that provides easy access to a wealth of documents available in the public domain(Wach and Ward, 2013).

This approach eliminates the need for author permission to access most documents, including policy documents such as Parliament Hansard reports, acts, regulations, and circulars. It also covers a vast amount of information. However, remember that this method may result in a lack of evidence. Combining different methods when conducting a qualitative case study is encouraged to achieve a more comprehensive understanding of research objectives.

Table 2.2. Techniques and Procedures Selected for Data Collection and Analysis

Techniques and Procedures	Study A	Study B
Data collection tools	Policy Document Analysis Semi-structured In-depth interviews with policymakers	Semi-structured In-depth Interviews with key stakeholders
Sampling techniques	Purposive Sampling Snowballing technique Eligibility Sampling and Data Sources for Policy Document Analysis	Stratified random and Purposive sampling
Developing Materials	Pre-coding frameworks 01 Interview Guide 01 Verbatim Transcripts	Pre-coding frameworks 02 Interview Guide 02 Verbatim Transcripts
	Interview Guide 01 Forward and Backward Translation Pilot testing Expert Opinion	Interview Guide 02 Forward and Backward Translation Pilot testing Expert Opinion
Transcripts Translations	Forward and Backward Translation Checking with Participants	Forward and Backward Translation Checking with Participants
Data analysis techniques	Thematic analysis and Power-Interest analysis	Thematic analysis and Power-Interest analysis

Moreover, combining other methods with policy document analysis aids in answering the objectives set in qualitative case studies to avoid potential disadvantages, such as lack of evidence, biased selectivity, and low retrievability. By combining multi-methods, some of these issues can be avoided, as was done in this project(Kayesa and Shung-King, 2021; Bowen, 2009). Biased selectivity, linked with the researcher's reflexivity, can be minimised by maintaining a reflexivity journal, as presented in the next Chapter. Moreover, collaborating, refuting, elucidating, or expanding data from document review through triangulation helps to guard against selectivity bias. In this project, I used a systematic approach that involved combining multiple methods, which allowed me to overcome some of the challenges of relying solely on document analysis.

Various categories of documents are available for analysis in multiple locations(Wach and Ward, 2013). To conduct a systematic approach to document analysis, eligibility criteria must first be established to determine which documents will be used to gain the necessary empirical knowledge to fill identified research gaps. In this study, I plan to analyse the successes and failures of the SLT ban development in Sri Lanka. To do so, I gathered SLT ban policy documents from multiple sources as determined by my eligibility criteria.

In-depth Interviews: I selected in-depth interviews as data collection tools for both Study A (for answering objective 01) and B (for answering objective 02) of the study presented in this thesis. An interview is essentially a deliberate dialogue between two or more individuals, with the primary aim of gathering information. Interviews prove valuable in generating meaning and interpreting reality. Through the interpretive process associated with interviewing, a distinct type of knowledge is produced that is neither predetermined nor singular(Legard, Keegan and Ward, 2003).

There are three standard interview methods: face-to-face, telephone, and online, including Zoom(Legard, Keegan and Ward, 2003). While face-to-face interviews are the most traditional method, telephone and online interviews are becoming more popular in the modern era due to their cost-effectiveness and accessibility. However, distance interviews may lack rich data due to poor rapport. The productivity of these methods depends on the researcher's background and techniques used for conducting the interviews.

There are two main types of qualitative interviews: semi-structured and unstructured. Among these, the semi-structured interview is the most used method by qualitative researchers (Jong and Jung, 2015). This type of interview involves a topic guide. Still, it allows the interviewer and participant to shape the discussion, giving them the flexibility to ask additional questions and explore tangents and probes. These tangents and probes help gain deeper insights into the investigated topic(Taylor, 2005).

Interviewing has several advantages (Mears, 2012; Legard, Keegan and Ward, 2003). It allows researchers to understand how participants perceive the world, events, situations, and experiences. The interview method provides data collection and production control and is flexible regarding questions. Furthermore, it offers an opportunity for follow-up on areas of interest, leading to more complete information. Additionally, respondents have the chance to understand the meaning of questions, thus improving the clarity of the collected data. According to Jong and Jung (2015), Lampard and Pole (2015), and Burgess-Limerick and Burgess-Limerick (1998), these advantages make interviewing a valuable research method.

Interviews serve as a form of social interaction between researchers and participants (Mears, 2012). However, interviews can present particular challenges and drawbacks. Ethics, power dynamics, and knowledge can all impact the accuracy and quality of the information gathered through interviews (Jong and Jung, 2015; Taylor, 2005; Legard, Keegan and Ward, 2003). One of the primary goals of qualitative researchers is to provide a platform for interviewees to express themselves, but this can result in challenges related to subjectivity, epistemology, power dynamics, politics, and transcription. For example, researchers may take subjective stances, impacting their objectivity. The concept of epistemology raises the question of whose perspective is being heard and whose is not. In addition, power dynamics between researchers and participants can lead to biases. Lastly, challenges often arise during the transcription of interviews (Arifin, 2018; Creswell et al., 2007).

In this research project, the process of interviewing became particularly complex in a few instances where the interviewer had a pre-existing relationship with the participants. In such cases, ethical considerations needed to go beyond the usual concerns about consent, confidentiality, and bias. The issues also involved power dynamics, authenticity, and the potential for harm (Pietilä et al., 2020; Burnette et al.,

<u>2014; Guillemin and Gillam, 2004</u>). In other words, the ethical dimensions of interviewing participants known to the interviewer cover power dynamics, role conflict, confidentiality, anonymity, emotional and psychological impact, informed consent and voluntariness, authenticity and reflexivity.

For example, preexisting relationships often come with established roles and expectations that can influence the interactions. If the interviewer is perceived as an authority figure or someone with significant influence, participants may feel pressured to provide socially desirable responses rather than honest ones. This power imbalance can compromise the authenticity of the data collected and may lead to skewed results that do not accurately reflect participants' true experiences and opinions (Schröder-Bäck et al., 2014; Beauchamp, 2007).

Moreover, the interviewer's dual role as both a researcher and a friend or colleague can lead to conflicts of interest. The interviewer may struggle to remain impartial and avoid allowing personal biases or prior knowledge to shape the direction of the interview. Maintaining professional boundaries while honouring the pre-existing relationship requires a careful balance and a clear ethical framework.

Moreover, confidentiality and anonymity are cornerstone ethical research practices, but it can be particularly challenging to maintain in scenarios where the interviewer and participants are acquainted. Participants may be concerned about the extent to which their shared information will remain confidential. Furthermore, anonymity can also be problematic, as the interviewer's prior knowledge of the participant might inadvertently influence the analysis and reporting of the data.

The authenticity of the data collected is another critical ethical consideration. The preexisting relationship between the interviewer and participant can lead to responses that are influenced by social desirability bias or the desire to maintain a positive relationship. To address this, the interviewer must engage in reflexivity, continuously reflecting on how their relationship with the participants might affect the data collection process and outcomes(Guillemin and Gillam, 2004).

Informed Consent

During this PhD project, it is crucial to prioritize the ethical treatment of all participants. A fundamental aspect of this ethical framework is to secure informed consent from each participant engaged in the study. The process of informed consent ensures that participants have a complete understanding of the research's nature, the involved procedures, and their rights as participants. The key components of a statement of informed consent encompass the study's purpose, procedures, confidentiality, risks and benefits, voluntary participation, and contact information.(Gillon, 2015; Beauchamp, 2007)A copy of the informed consent statement for this PhD project is included in appendix I and II (pages 325-327) of this thesis.

B. Choosing Among Sampling Techniques

Choosing the appropriate sampling techniques is a crucial part of research design that affects the accuracy and generalizability of study results (Alam, 2021; Azungah, 2018). In Study A, which aimed to examine the successes and failures of the development of the SLT ban, the snowballing technique was used. In contrast, Study B used purposive and stratified random sampling to investigate ban enforcers' and related stakeholders' perceptions and experiences of policy successes. Here is an explanation of why each sampling technique was chosen and the benefits and drawbacks of each.

Snowball Technique- Study A: Here's an overview of why I selected snowballing as my sampling technique. Additionally, it summaries the pros and cons of using snowballing to frame Study A's interview cohort.

Rationale:

1. Complexity of Policymaking Networks - Developing a policy, especially regarding public health, often requires a complex network of policymakers. Study A found the snowball technique to be a choice because it identifies and includes key policymakers who may not be easily reachable through traditional sampling methods. This is vital in understanding the policy-making process comprehensively (Elmusharaf, Farrokhi and Mahmoudi-Hamidabad, 2012; Higginbottom, 2004).

2. Expertise and Insider Perspectives - Policymakers hold unique insights into the reasoning, challenges, and considerations that influence policy decisions. Snowball sampling facilitates the inclusion of individuals with expertise and insider perspectives, enriching the qualitative data gathered through interviews (Creswell and Poth, 2016).

Advantages: Access to key informants, exploration of complex networks, and capturing diverse perspectives within the policymaking landscape(Gill, 2020).

Disadvantages: Potential for bias due to reliance on existing networks, risk of overlooking marginalised or dissenting voices, and sample size control challenges (Elmusharaf, Farrokhi and Mahmoudi-Hamidabad, 2012).

Purposive Sampling and Stratified Random Sampling- Study B: Here's an overview of why I selected purposive and stratified random samplings as my sampling techniques in Study B. Additionally, it summarises my insights into the pros and cons of using two methods.

Rationale:

- 1. Specific Stakeholder Groups: Study B explores the perceptions and experiences of ban policy enforcers and other related stakeholders. Since this is a diverse group with varying roles and responsibilities, purposive sampling allows for the deliberate selection of participants from these specific stakeholder groups, ensuring a targeted and relevant sample(Higginbottom, 2004).
- 2. In-depth Exploration: By purposively selecting participants with direct involvement in ban enforcement, the study aims to provide insightful and in-depth findings into the successes and failures of the SLT ban from the perspectives of those directly impacted(Shaheen and Pradhan, 2019).
- 3. Achieving Research Objectives: Purposive sampling aligns with the research objectives of Study B, which seeks to explore nuanced experiences and perceptions with distinct categories of stakeholders. This approach ensures that the sampled participants can offer valuable insights into the enforcement dynamics and outcomes of the SLT ban(Gill, 2020).

4. After stratifying the policy implementers by four socio-demographic regions, a few representatives were selected from each category using stratified random sampling. This helped me ensure that all island representatives in the policy implementer groups were included in Study B.

Advantages: Purposive sampling enables targeted and specific participant selection, enhances the depth of qualitative data, and aligns with the research objectives(Shaheen and Pradhan, 2019). Moreover, to improve the accuracy of the sample obtained for Study B, I divided the policy implementors into distinct sociodemographic regions. From each category, I randomly selected representatives. This approach increased the probability of obtaining a sample that accurately reflects the diversity and characteristics of the entire population. As a result, the perspectives and experiences of policy implementors from different regions were adequately represented in the study. This, in turn, led to more robust and generalised findings.

Disadvantages: The potential drawbacks of purposive sampling are overlooking perspectives from non-selected groups, challenges in generalising findings to broader populations, and the risk of subjectivity in the selection process(Gill, 2020).

C. Choosing Among Transcripts Writing Techniques

Verbatim Transcripts: Choosing the proper transcription method was crucial for understanding the successes and failures of the smokeless tobacco policy. I selected verbatim transcripts to capture the nuances of the participants' responses and portray their viewpoints. This step is crucial for precise and comprehensive analysis(Hagens, Dobrow and Chafe, 2009; Poland, 2003).

There are two main types of verbatim transcripts: complete and clean. I have chosen to use clean verbatim, which removes filler words and non-verbal expressions and focuses only on the essential content. Compared to other types of transcripts, such as intelligent, edited, and summary transcripts, verbatim transcripts have advantages and disadvantages(Hagens, Dobrow and Chafe, 2009). For example, Verbatim transcripts are crucial for maintaining the authenticity of data in interviews. They are handy for examining the language used by stakeholders in the field of SLT ban policy.

Moreover, these transcripts offer precise data analysis by capturing the exact words and expressions used by participants(Turner III and Hagstrom-Schmidt, 2022; Rowley, 2012). This level of detail enables researchers to identify subtle cues, hesitations, and emphases, leading to a deeper understanding of the complex attitudes, opinions, and experiences of the SLT ban policy. The nuanced analysis provided by verbatim transcripts can offer valuable insights into the cultural factors influencing this topic.

On the other hand, the process of verbatim transcripts is time-consuming(Dearnley, 2005; Oliver, Serovich and Mason, 2005). These transcripts can be lengthy and complicated to navigate, particularly for readers unfamiliar with the field. Moreover, transcribing every word and nuance can be time-consuming, potentially delaying the completion of the study. Moreover, transcribing verbatim can introduce the researcher's bias as representing pauses and intonations is subjective and can impact objectivity.

D. Choosing Among Data Analysis Techniques

In this section, I explain why I have chosen to use thematic analysis to answer the research aim, objectives and questions. Additionally, I clarify why I have decided to apply power-interest analysis techniques to address certain aspects of policy factors as outlined in section 2.2 (pages 95-97) of the research objectives.

Thematic Analysis: For the qualitative case study presented in this thesis, I decided to use thematic analysis as it aligns with the research questions, data nature, and overarching goals. Although there are other qualitative data analysis techniques, such as narrative analysis, content analysis, cross-case analysis, constant comparative methods, pattern matching, and grounded theory, they don't serve the purpose of this case study(Castleberry and Nolen, 2018; Javadi and Zarea, 2016). Thematic analysis involves identifying, analysing, and reporting patterns or themes within the data. It requires coding and categorising data systematically to identify recurring patterns or themes. The advantages of using thematic analysis are as follows(Clarke and Braun, 2017; Javadi and Zarea, 2016):

- Flexibility Thematic analysis can be applied to various research objectives and questions, allowing researchers to explore patterns relatively openendedly.
- ➤ In-depth Understanding This method provides researchers with a detailed and nuanced understanding of the data by capturing the depth and complexity of participants' experiences and perspectives.
- ➤ Contextual Insights Thematic analysis is particularly useful for gaining insights into the context and meaning of data. It helps understand the cultural and social aspects influencing the phenomenon under study.

However, one potential drawback of thematic analysis is that the interpretation of themes can be subjective, leading to researcher variations. This subjectivity can introduce bias into the analysis. Moreover, thematic analysis can be time-consuming, as coding and identifying themes requires careful consideration(Castleberry and Nolen, 2018; Clarke and Braun, 2017).

Power-Interest Analysis: As a sub-analysis technique under thematic coding, I chose power-interest analysis (also called stakeholder analysis) as a crucial method to gain insights into the power (delegated by the House of Parliament for policy making for tobacco control) and interests of policymakers, policy implementers, and other relevant parties involved in the ban-making and enforcement of SLT. In the Background Chapter, Section 1.12 (pages 84-87), I identified and explained the significant categories of stakeholders related to the SLT epidemic and ban. As mentioned before, the evidence regarding the critical stakeholders of the SLT ban in Sri Lanka was collected through policy document analysis and in-depth interviews. Therefore, I chose stakeholder analysis to analyse this data and determine their power, influence, and impact.

The power-interest matrix visualises the power and interest of stakeholders. The matrix enables the classification of stakeholders into four quadrants: High Power, High Interest, High Power, Low Interest (Keep satisfied), Low Power, High Interest (Keep Informed), and Low Power, Low Interest (Monitor). This classification aided in two ways: 1) to understand the weaknesses or strengths of the policy process and 2) to

tailor communication and engagement strategies based on the unique categories of stakeholder groups.

Data Saturation: A unique feature of this case study research is applying the critical concept called data saturation. It indicates the point at which no new information or themes are emerging from the data. Achieving data saturation ensures that the data collected is comprehensive and sufficient to understand the phenomena being studied(Elliott, 2018; Bachiochi and Weiner, 2004). The key steps in reaching data saturation include:

- Iterative data collection and analysis: Ongoing analysis and coding consistency are the key components of iterative data collection and analysis. For example, continuously analyse the data to identify emerging themes, patterns, and categories during the data collection. This iterative process helps monitor the emergence of new information. Moreover, a systematic coding process should be used to categorise data. When new data fits into the existing codes without the need for creating new ones, it indicates that no new themes are emerging.
- Repetition of themes: The next step in this process is to observe for redundancy in the data and reach the theoretical saturation. When the same themes, patterns, or responses repeatedly appear across different participants, it suggests that new data is not contributing additional insights.
- Sample size consideration: Saturation is likely reached when the new interviews with varied participants do not yield new information. Therefore, to make saturation precious, the researcher is supposed to yield new information.
- Triangulations: Gathering data from various sources enhances the reliability and validity of the data set in achieving data saturation. In this study, the sources included interviews and analysis of policy documents. Data saturation is reached when the information from these sources aligns with similar themes and no new themes emerge from the additional sources. Multiple researchers

can be involved in the coding and analysis process. Agreement among researchers that no new themes are emerging can confirm saturation. Nevertheless, only the PhD researcher conducted the data analysis in this case study, highlighted as a limitation in Chapter 05 (section 5.3.1)

- Member checking: Conduct member checking by sharing findings with participants and asking for their feedback. If participants confirm that the findings reflect their experiences or perceptions and no new themes are suggested, saturation may be achieved
- Documentation and reflexivity: Maintaining a saturation grid to track the emergence of themes across interviews and keeping a reflexivity journal to document the researcher's thoughts, decisions and observations about data saturation help make an informed judgement about when data saturation is achieved (Alam, 2021).

2.4 Choosing Among Theoretical Underpinnings

Studying public health policies for their outcomes is vital to policy analysis(An, Huang and Baghbabian, 2015). Various policy analysis tools have been introduced since the early 1920s, including formal cost-benefit, cost-effective, cost-effectiveness, qualitative cost-benefit, and multiple-goal policy analysis. However, these tools offer a limited view of policy analysis(Collins, 2005; Colebatch, 2005). They often focus on quantifiable changes, such as monetary benefits, with little regard for the impact on broader social, cultural, political, economic, and environmental dimensions and the systems they belong to. Nonetheless, policy researchers have worked hard in recent years to enhance the depth of analysis by using more thoughtful theories, concepts, and frameworks. I have adapted a set of innovative public policy analysis tools to establish a solid analytical framework and theoretical foundation for the research project presented in this thesis. This section provides an overview of the theories, concepts, and frameworks I have employed and their connections in addressing the objectives, research questions, and rationales.

2.4.1 Introduction to the Analytical Framework

Among the various theories, following two were particular important in crafting the combined analytical framework the research project presented in this thesis.

- The Health Policy Triangle- guided the development of research objective one and its four sub-objectives (section 2.4.4, pages 131-133) (Buse, Mays and Walt, 2012; Buse, 2010, 2008)
- McConnell's Framework from Success to Failure- led to the formulation of research objective two and its three sub-objectives (section 2.4.2, pages 125-128) (McConnell, 2018, 2017, 2010b)

In addition, the following theories and concepts were used to develop the analytical framework for the research project presented in this thesis.

III. Public health policy domain criteria (section 2.4.3. pages 129-130) (Smith et al., 2021; World Health Organization, 2020; Boscolo et al., 2020)

- IV. Stages heuristics model in policymaking (section 2.4.5, pages 132-133)(Lasswell and Lerner, 1951; Savard and Banville, 2012)
- V. Mendelow's power-interest matrix in stakeholders' analysis (section 2.4.6, pages 133-134) (Mendelow, 1981; Nankervis, Prikshat and Dhakal, 2019)
- VI. The EU policy-making framework and Policy Profession Standards Framework (section 2.4.7, pages 135-137) (Profession, 2019).
- VII. Hallsworth's criteria for judging the level of central intervention (section 2.4.8, pages 138-140) (Hallsworth, 2011a)

Figure 2.2. (page 124) summarises these key policy analysis theories employed in designing this analytical framework and their logical links. Moreover, as mentioned above, from sections 2.4.2 to 2.4.8 (pages 125- 140), I explain why I adapted each theory, concept, or criterion to meet the research objectives.

Linking the Policy Analysis Theories

Before delving into the overview of each framework, theory, and concept, here I provide a brief introduction to the links between them.

In his work, McConnell proposes a comprehensive framework for evaluating policy success. This framework (Table 2.3, pages 126-128) comprises three dimensions as follows.

- a) Process Success
- b) Programme Success
- c) Political Success

Moreover, McConnell categories policy success into five distinct categories in a spectrum as follows(Table 2.3, pages 126-128).

- Policy Success
- Durable Success
- Conflicted Success
- Precarious Success
- Policy Failure

Therefore, this framework provides policy researchers with a systematic approach to assessing their findings and assigning them to the appropriate category (2.4.2, pages 125-128).

Furthermore, it is crucial for public health policy to be strong and effective, meeting essential value-based criteria such as equity, social justice, participation, and proportionality. To ensure this, I have included these essential value-based criteria as a tool in the analytical framework (2.4.3, pages 129-130).

Moreover, Buse et al.'s Health Policy Triangle (HPT) is a valuable resource for public policy analysts as it examines the intricate four key components in shaping health policies. Buse and his colleagues underscored the following four main components in analysing health policymaking (2.4.4, pages 131-133).

- a) Policy Content
- b) Policy Actors
- c) Policy Context
- d) Policy Process

This Health Policy Triangle can be employed in evaluating the effectiveness of different policymaking and enforcement strategies.

Additionally, the policy cycle developed by Lasswell is a fundamental in policy science that plays a vital role in the logical approach to policymaking and implementation (section 2.4.5, pages 132-133). The main counterargument for Lasswell's policy cycles its rigidity in stepwise approach in policy making and implementation process. As seen in Figure 2.2 (page 124), the analytical framework of this study integrates other policy analysis theories with Lasswell's policy cycle to analyse the characteristics of the SLT ban policy. By applying Lasswell's theory by evading its rigid approach, we can assess the key features of a successful public policy, including being evidence-based, high-quality, and balanced. Lasswell's policy cycle outlines seven systematic steps in policymaking, which are referred to as the "stages heuristics model in policymaking."

Furthermore, effective evaluation of public health policies requires active engagement with stakeholders (Balane et al., 2020; Kumar and Subramanian, 1998). To examine how that critical stakeholder had been identified and managed in SLT ban-making and

implementation, I have integrated Mendelow's power-interest matrix in stakeholder analysis into the comprehensive framework. Mendelow's power-interest matrix aids in developing strategic stakeholder management plans, which involve securing stakeholder support, engaging with the community, and conducting public hearings. Section 2.4.6 (pages 133-134) of this chapter highlights the significance of incorporating Mendelow's matrix in the analytical framework of this research project.

Moreover, policymakers' skills and expertise are crucial in creating effective public policies (Gonczi and Hager, 2020; Profession, 2019; Bowman, 2017). To assess SLT ban policymakers' competencies in navigating the complex SLT epidemic in Sri Lanka, two competency frameworks were integrated into this analytical framework. By identifying their contributions, policy analysts can gain valuable insights into successes in policy making and implementation. These two frameworks. the EU policymaking framework and the Policy Standards Framework were presented in section 2.4.7.(pages 135-137) below.

Finally, I have incorporated Hallsworth's (2011) 'criteria for evaluating the degree of central intervention' to strengthen this framework. These criteria, which include complexity, uniformity, capacity, and risk, help evaluate the results of a public health policy formulated at the central level and implemented at the decentralized local level. This framework is well-suited to the unique circumstances of the SLT ban policy. The key areas related to these criteria, presented in section 2.4.8.(pages 138-140), include evidence-based, good quality, balanced policy, external engagements, appraisals, roles and accountabilities of stakeholders, feedback and evaluations, divergence of service needs, unintended vs. intended consequences, and techniques for solving complex public health policy issues(Hallsworth, 2012, 2011b, 2011a). By incorporating these principles, we can ensure that the intervention is well-informed, balanced, and effective while also considering the needs and perspectives of all stakeholders involved.

Figure 2.2 provides a summary of the key elements that have been added to the analytical framework of this research project by each of the aforementioned policy science theories, concepts, and frameworks. The figure is intended to provide a visual

representation of the various components that have been integrated into the analytical framework, their links, and overlaps.

Process, Programme and Political Success

Political feasibility, Benefits for target groups, legitimacy, sustainable coalition, cultural sensitivity, meeting objectives

Public Health Values

equity, justice, participation, proportionality, respect for autonomy, choice, dignity, respect for rights, affordability, accessibility

Policy Professional Standards

work with evidence, anticipate, negotiate, innovate, advise at political levels, understand the economy, engage with citizens and stakeholders, the function of public administration, project management, foresight, and communication skills.

Strategic Implementation

Variety and diversity in service needs, adaptation, flexibility, pilot projects, phased implementation, and central direction.

Stakeholder Management

Power, interest and influence of stakeholders, Stakeholder consultation, public hearings, community engagement

Logical Sequence in the Policy Process

Aligning Policy Content with Policy Context, Actors, and Process

Contextual Assessments, Designing alternative policy interventions based on the evidence, ex-ante impact assessment of various interventions, deciding on the best alternative, implementation logics, monitoring the progress, evaluation and learning, recording success, drawing lessons and reforms.

Figure 2.2. Framework for Analysing the Successes and Failures of Smokeless

Tobacco Policies in Sri Lanka

2.4.2. McConnell's Framework for Success to Failure

McConnell's framework examines the SLT ban policy in three main dimensions and places the results under five milestones of success to failure as shown in Table 2.3. Additionally, McConnell provides several criteria for policy analysts to conduct their analysis. These approaches can be applied to analyse the SLT ban policy within the scope of the working definition of the SLT epidemic mentioned in section 1.16 (page 90).

Table 2.3 (page 126-128) below shows that researchers and policy analysts can investigate three dimensions of the success or failure of the SLT ban. These dimensions are process, political, and programme. Each dimension has a set of indicators that can be used to investigate it. For example, four leading indicators to assess the process success are preserving policy goals and instruments, confirming legitimacy, building a sustainable coalition, and symbolising innovation and influence. The indicators to analyze the program's success are meeting objectives, producing desired outcomes, creating benefits for target groups, and meeting policy criteria (public health policy domain). Similarly, the indicators to measure political success include enhancing electoral prospects/reputation of government and leaders, controlling the policy agenda, easing the business of governing, and sustaining the government's broad values and direction.

To analyse the outcomes of the SLT ban in Sri Lanka, it is crucial to apply specific indicators. Additionally, to assess the success of each dimension, a logical spectrum has been developed by Marsh and McConnell (2010) and McConnell (2011, 2018, 2010a). This spectrum, called the 'policy success to failure spectrum', consists of five categories: 'success', 'durable success', 'conflicted success', 'precarious successes', and 'failure' (Table 2.3).

Table 2.3.- Spectrum of policy success (adapted from McConnell. 2018)

Policy	Durable	Conflicted	Precarious	Policy
success	success	success	success	failure
Policy as Process Success				
Preserving government policy goals and instruments Confirming the legitimacy of the policy	Policy goals and instruments preserved despite minor refinements Some challenges to legitimacy, but of little or no lasting	Preferred instruments are proving controversial and challenging to preserve. Some revisions are needed. Complex and contested issues surrounding policy	The government's goals and preferred policy instruments hang in the balance. Severe and potentially fatal damage to policy legitimacy.	Termination of government policy goals and instruments Irrecoverable damage to policy legitimacy
	significance	legitimacy, with some potential to taint the policy		
Building a sustainable coalition	Coalition intact, despite some signs of disagreements	Coalition entire, although vital signs of conflict and some potential for fragmentation	The coalition is on the brink of falling apart.	Inability to produce a sustainable coalition
Symbolising innovation and influence	It is not groundbreakin g in innovation or influence but still symbolically progressive.	Neither innovative nor outmoded, leading to criticism from both progressive and conservatives	Appearance of being out of touch with viable alternative solutions	Symbolising outmoded, insular, or bizarre ideas, seemingly oblivious to how other jurisdictions are dealing with similar issues
Policy as Programme Success				
Implementatio n in line with objectives	Implementatio n objectives were broadly achieved despite minor refinements or deviations.	Mixed results with some successes, but accompanied by unexpected and	Minor progress towards implementatio n as intended, but beset by chronic	Implementatio n fails to be executed in line with objectives.

			fa :l	<u> </u>
		controversial problems	failures, proving highly controversial and very difficult to defend	
Achievement of desired outcomes	Outcomes broadly achieved, despite some shortfalls	Some successes, but the partial achievements of intended outcomes are counterbalance d by unwanted results, generating substantial controversy.	Some small outcomes were achieved as planned but overwhelmed by controversial and high-profile instances of failure to produce results	Failure to achieve desired outcomes
Meet policy domain criteria.	Not quite the desired outcome, but sufficiently close to lay a solid claim to fulfil the criteria	Partial achievement of goals, but accompanied by failures to achieve, with the possibility of high-profile examples, e.g., ongoing wastage when the criterion is efficiency.	A few minor successes, but plagued by unwanted media attention	The apparent inability to meet the criteria
Creating benefits for a target group	There are a few shortfalls and possibly some uncommon cases, but the intended target group broadly benefits.	Partial benefits were realised, but not as widespread or deep as intended.	Small gifts are accomplished and overshadowe d by damage to the group meant to benefit. Also, it is likely to generate high-profile stories of unfairness and suffering.	It is damaging a particular target group.
Policy as Political Success				

Enhancing electoral prospects or reputation of government and leaders	Favourable to electoral prospects and reputation enhancement, with only minor setbacks	Policy obtains strong support and opposition, working equally for and against electoral prospects and reputation.	Despite minor signs of benefit, the approach proves an overall electoral and reputational liability.	Damaging to the electoral prospects or reputation of government and leaders, with no redeeming political help.
Controlling policy agenda and easing the business of governing.	Despite some difficulties in agenda management, the capacity to govern is unperturbed.	The policy proved controversial and took up more political time and resources in its defence than was expected.	Clear signs that the agenda and business of government are struggling to suppress a politically tricky issue.	Political failings are so high and persistent on the schedule that damaging government can govern.
Sustaining the broad values and direction of government	Some refinements are needed, but the broad trajectory is unimpeded.	The direction of government is very broadly in line with goals, but there are clear signs that policy has prompted some rethinking, especially behind the scenes.	The entire trajectory of government is being compromised.	Irrevocably damaging to the broad values and direction of government.

2.4.3 Public Health Policy Domain Criteria

To effectively prevent and control the SLT epidemic in Sri Lanka, it is crucial to consider a range of factors that are deeply intertwined with socio-cultural, political, economic, and environmental arenas. The background chapter discusses the contextual characteristics of the SLT epidemic in Sri Lanka in sections 1.8 to 1.11 (pages 46-83). These contextual factors are directly or indirectly linked to the value-based health criteria, dimensions of wellness, public health principles, and novel concepts such as health for all, universal health coverage, and disproportionate use of regulations on risk factors. By adding these criteria to the analytical framework, we can determine the success or failure of the SLT ban policy in Sri Lanka in a comprehensive manner (Peterson et al., 2021).

When developing policies to control and prevent the SLT epidemic in Sri Lanka, it is essential to follow four principles of public health: beneficence, non-maleficence, justice, and respect for autonomy. Policy analysts should evaluate the success of the SLT ban program from a health value perspective, considering factors such as equity, social justice, participation, efficiency, effectiveness, affordability, accessibility, and proportionality. This means that regulations on risk factors should be avoided if they disproportionately affect certain groups. By taking this approach, analysts can provide balanced recommendations for reforming the ban policy to positively impact the cultural, economic, and political aspects of SLT use, including traditional betel quids consumption and related customs, in Sri Lanka.

Health is not just the absence of diseases. WHO defines it as complete physical, mental, and social well-being. Decision makers must ensure people are protected from SLT-attributed non-communicable diseases (NCDs), communicable diseases (CDs) and other various harmful impacts. From this point of view, the SLT ban policy in Sri Lanka is supposed to consider the physical, intellectual, emotional, social, spiritual, vocational, financial, and environmental well-being of the vulnerable groups. In other words, the policy can be successful if policymakers and enforcers could apply public health policy domain criteria in policy making and implementation

The WHO's concepts of 'health for all' and 'universal health coverage' guide how to meet the diverse service needs of SLT users. These concepts offer direction on how to develop person-centred care in SLT cessation programs. The guiding principles of these concepts are crucial in providing value-based care, which includes individuality, independence, privacy, partnership, choice, dignity, respect, and rights. These value-based criteria are essential in ensuring the success of the SLT ban in preventing and controlling SLT consumption.

Moreover, the following are a few key public health values, and their working definitions added to the analytical framework of the research project to analyse the successes and failures of the SLT ban policy.

- Equity and Justice: By prioritising the principles of equity and justice, we can ensure a more constructive approach to policy-making. This involves the fair distribution of policy benefits and burdens across diverse populations, creating a more just society for all. By adopting this approach, we can promote a culture of inclusivity and enable a sustainable and effective policy implementation that benefits everyone(Peterson et al., 2021; Greenberg and Cohen, 2014; Hatfield, Salmon and Rapson, 2011).
- Participation and Proportionality: Encouraging public participation and encouraging proportionate measures contribute to a policy that reflects democratic values and societal fairness. To uphold democratic values and promote fairness in society, fostering public participation and implementing proportionate measures is essential(Liabo et al., 2020; Rose-Ackerman and Perroud, 2012; Ghai, 2001).
- Respect for Autonomy and Choice: Valuing individual autonomy and choice demonstrates recognition of diverse preferences and encourages policies prioritising personal freedoms(Lewis, 2022; Burchardt, Evans and Holder, 2015; Oshana, 2003).
- Dignity and Respect for Rights: Prioritising human dignity and respecting fundamental rights establishes a foundation for ethical policymaking that prioritises human dignity and respects basic rights(Gilabert, 2015; Mattson and Clark, 2011; Mokhiber, 2001).

• Affordability and Accessibility: To ensure the policy's effectiveness and compliance, it's essential to make it financially feasible and accessible to all members of society. This approach will help to build a more inclusive and supportive community(Beal and Foli, 2021; Riley, 2012).

2.4.4 The Health Policy Triangle

Buse et al. (2015) developed the Health Policy Triangle (HPT) framework by adapting key concepts of Walt and Gilson's (1997) policy triangle. It analyses health policies comprehensively from a political perspective. As shown in Figure 2.3 (page 132), the Health Policy Triangle is a framework that guides public health policy analysts to investigate policy decisions comprehensively. The triangle encompasses three main components:

- I. Policy Content and Instrument: Examining the type of policy instrument and its content against the vision and mission of the policy actors.
- II. Policy Context: Examining the skills and competencies of policy actors, including their professionalism and the structural and situational factors that influence the policy environment. This includes socio-cultural, political, economic, environmental, and international aspects.
- III. Policy Process: Understanding the policy decisions and their implications, considering the dynamics of powers and positions of policy actors.

Therefore, the Health Policy Triangle was suitable in analysing the gaps between the SLT ban policy and the working definition of the SLT ban policy, as shown in the figure. Moreover, the critical determinants of the successes or failures of a policy, such as political feasibility, public trust, and stakeholder pressure, can be systematically researched by applying Health Policy Triangle in the SLT ban policy analysis (Buse, Mays and Walt, 2012; Buse, 2010, 2008).

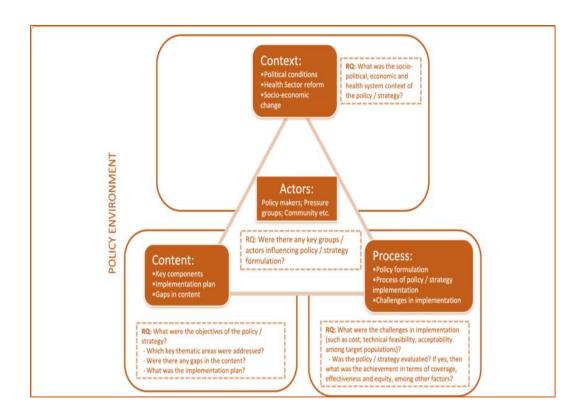


Figure 2.3. Health Policy Triangle as presented by (Srivastava et al., 2018)

2.4.5 Stages Heuristics Model in Policy Making

As presented above, Lasswell's stages heuristics model in policymaking provides a logical framework for understanding the policy process of the SLT ban policy. The stages model, known as the policy cycle, was introduced by Laswell in 1956. There were seven stages to the initial model. The stages model has been successful over decades in maintaining its prevalence and validity in the world of public policy analysis and policy research.

As shown in Figure 2.4 (page 133), the stages model is a logical approach that helps investigate how policies or policy alternatives are initiated, formulated, negotiated, communicated, implemented, monitored, and evaluated. It is one of the most widely used and long-standing scientific approaches to developing and analysing national and international policies.

The stages heuristic breaks down the policy process into several stages while acknowledging that the real-world process can vary from the theoretical approach. For

example, Lindblom (1959) argues that the policy process is iterative and influenced by the interests of policymakers, resulting in a "muddle through" approach. The 'power' of policy actors aided in adherence to the non-linear approach.

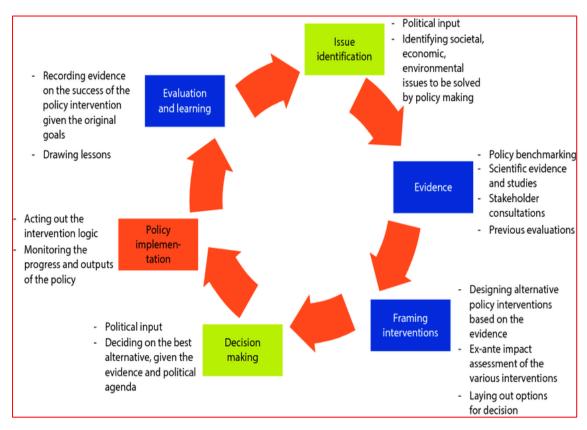


Figure 2.4. policy making model – stages heuristics model by Laswell (1956)-as presented by Haime et al.,2014.

As mentioned above, although the model has undergone changes by various policy scientists over the decades, as shown in this figure, the essential steps identified in most literature are problem identification and issue recognition, policy formation, policy implementation, and policy evaluation. The first two stages of the model mainly contribute to designing policies or policy alternatives.

2.4.6 Mendelow's Power-Interest Matrix

As mentioned above, to examine the complex relationships between fundamental elements of a policy-making process, the Health Policy Triangle, McConnell's frameworks, and public health domain criteria provided a robust guidance. However, one of the main of the study A of this research project was to analyse the powers, positions, and interests of policymakers in developing SLT ban policy (2.2.1, page 95).

Mendelow's power-interest matrix helps SLT ban analysts categorise individuals, organisations, or groups based on their power and interest.

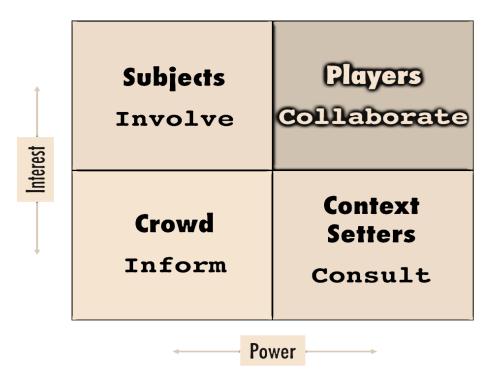


Figure 2.5. Mendelow's power-interest matrix (1991) source: getting stakeholder engagement right- Pichler (2015)

Mendelow's matrix is a tool used to classify policymakers based on their power and interest levels. This classification helps in prioritizing policymakers based on their significance in the SLT policy issue and provides insights into their perceptions, roles, and tasks within the decision-making mechanism. Researchers can also use this approach to categorize study participants according to their powers and interests.

Moreover, the matrix is depicted in Figure 2.5 (page 134). It is helpful in categorizing stakeholders involved in or contributing to the SLT epidemic based on their power and interest levels. This technique can aid in planning stakeholder management and community empowerment programs to control and prevent SLT epidemics in culturally sensitive settings.

2.4.7 Policy Profession Standards

This section delves into policymakers' pivotal role in creating effective policy instruments, as highlighted by Buse, Mays and Walt (2012) and Marsh and McConnell (2010). Policy instruments serve as the cornerstone of public policy, with the SLT ban in Sri Lanka being a prime example of legislation acting as a policy instrument. Policymakers may have varying motives for choosing one instrument over another, but the decision-making process should be grounded in sound reasoning and scientific evidence, with the ultimate policy objective at the forefront. The policymaker's competencies and skills are paramount in ensuring a successful outcome.

Numerous frameworks have been created to outline the skills and abilities required by policy actors in the intricate and modern arena of public policy design. For the study presented in this thesis, I included the following two frameworks(Schwendinger, Topp and Kovacs, 2022; Wallace et al., 2020; Profession, 2019).

- I. The Framework for EU Policy-Making Competencies
- II. The Policy Profession Standards Framework (table 2.4, page 136)

Following is an overview of fundamental skills and competencies presented in these two frameworks.

The EU policy-making competencies framework identifies five core and five fundamental competencies for policymakers. The five core competencies are as follows: (1) Anticipating, planning, and developing strategy; (2) Assessing impact and designing policy; (3) Preparing and adopting policy initiatives; (4) Negotiating interinstitutionally and internationally; and (5) Implementing, monitoring, and evaluating.

The framework for EU policy-making competencies highlights the crucial skills required to achieve policy successes. These skills involve offering political advice, thinking innovatively, working with evidence, being forward-thinking, engaging with citizens and stakeholders, and communicating effectively. Furthermore, the EU framework identifies four primary competencies: understanding economics,

knowledge of the law, familiarity with public administration and statistics, and proficiency in project management and negotiation.

Achieving stakeholder buy-in is an essential skill that significantly contributes to policy success. It involves engaging citizens and stakeholders by increasing their awareness of what is happening, why it is happening, and encouraging their participation in policy design and implementation. The benefits of stakeholder buy-in include achieving broader interests in investing in the good of the wider community, enhancing mutual trust, respecting each stakeholder's unique viewpoint, and promoting representation diversity. These positive factors are all indicators of future policy success or change.

The Policy Profession Standards Framework (Profession, 2019) is the next concept integrated into the analytical framework of a research project in this thesis. This framework outlines the necessary competencies and skills required by policymakers and consists of three main pillars: strategy, democracy, and delivery. The knowledge, skills, and activities required by policymakers are determined by these pillars, and each pillar has three levels: developing, practitioners, and experts. Table 2.4, below provides a summary of the knowledge, skills, and activities required for each level.

Table 2.4- An Overview of Policy Profession Standards Framework- Source: (Profession, 2019)

2021 Policy Profession Standards				
Strategy	1.1. Policy context and purpose	1.2. Data analysis and scientific advice	1.3. Participation and engagement	1.4. Working internationally
Democracy	2.1. Working with ministers	2.2. Parliament and Law	2.3. Finance	2.4. Multilevel government
Delivery	3.1. Policy delivery and systems	3.2. Governance and project delivery	3.3. Commercial	3.4. Evaluation

The Strategy pillar of the Policy Profession Standards Framework, as shown in Table 2.4 above, concentrate on the generation, evaluation, and application of evidence and analysis to comprehend the context and create new strategies. The Democracy pillar focuses on understanding and supporting good governance and accountability by

producing robust and challenging advice. Lastly, the Delivery pillar encompasses the skills, activities, and knowledge required for designing policy implementation and delivery systems in collaboration with partners and users. It includes the development of a plan for evaluating and improving the policies.

2.4.8 Hallsworth's Criteria for Judging the Effectiveness of Central Interventions

Finally, I combined Hallsworth's criteria for judging the effectiveness of a central intervention in a decentralised local setting into the analytical framework of this research study. Figure 2.6 below, shows the four criteria used to judge the level of significant government intervention: risk, uniformity, complexity, and capacity. I used these four criteria to develop the combined analytical framework and identify gaps in the SLT ban policy in preventing and controlling SLT use in Sri Lanka. Below is a brief explanation of how each criterion was applied.

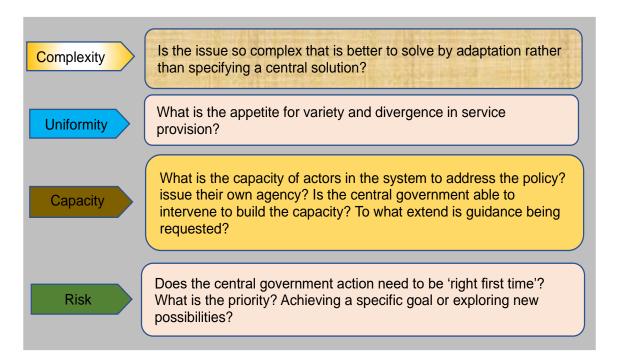


Figure 2.6. Hallsworth's four criteria for judging the central intervention.

Adapted from (Hallsworth, 2011a)

When analysing government policies or actions, four criteria must be considered. The first is to assess the level of risk and determine whether the priority is efficiency or exploration. The second is uniformity, which evaluates the variety and divergence of acceptable in-service provisions.

The third criterion assesses the complexity of the policy issue. It evaluates whether the problem is too complex to be solved by specifying a solution in advance and whether the system of actors should address it through adaptation. Additionally, it considers the likelihood that the central direction can control the actors responsible for implementing the policy in practice.

The fourth criterion is the capacity of the policy actors in the system to address the policy issue through their agency. It examines whether the central government can intervene to build such capacity and to what extent guidance or direction is requested.

The following are the working definitions of each criterion developed in the application to analyse the successes and failures of the SLT ban for this study.

- I. Risk—To evaluate the effectiveness of the ban on smokeless tobacco (SLT) in Sri Lanka, we need to consider the potential political consequences for both the central and local governments. Furthermore, according to the insights raised by studying empirically presented in Chapter 01, the ban may overlook the diverse service needs of marginalised individuals who rely on affordable, traditional betel quids with tobacco. This could also undermine the success of other WHO-recommended policies that aim to control and prevent SLT epidemics in Sri Lanka.
- II. Uniformity—The background chapter found empirical studies to prove significant differences in SLT in three socio-demographic settings in Sri Lanka: urban, rural, and estate sectors(1.8, pages 46-60). The working definition for the 'uniformity' of the SLT ban policy in Sri Lanka is its ability to similarly address the root causes of SLT epidemics in different regions of Sri Lanka(1.16, page 90).
- III. Complexity- Based on the empirical evidence in the background chapter, the SLT epidemic in Sri Lanka has various dimensions. Since complex problems can have multiple solutions, there can be competition among policy alternatives. The most unique characteristic of the SLT epidemic in Sri Lanka is its cultural sensitivity, which makes it complex. Therefore, the success or failure of the SLT ban policy depends on its ability to be a novel and innovative policy alternative that can withstand the cultural sensitivity of the SLT epidemic in Sri Lanka.

IV. Capacity—This study's 'capacity' refers to two aspects: the central authority's ability to meet peripheries' needs in implementing SLT ban programs and the policy's compatibility with government goals and responsibilities.

2.5 Overview of the Research Strategy

To conclude this chapter, which includes the aim, objectives, links with research questions, design of research methodology, and analytical frameworks, I summarise the overall research strategy of the study presented in this thesis. Figure 2.7 below provides a summary of the key components of this research strategy. The objective was to examine the effectiveness and shortcomings of the SLT ban in Sri Lanka. To address the knowledge gap identified in Chapter 01, a multi-method qualitative case study was conducted in two phases, Study A and B.

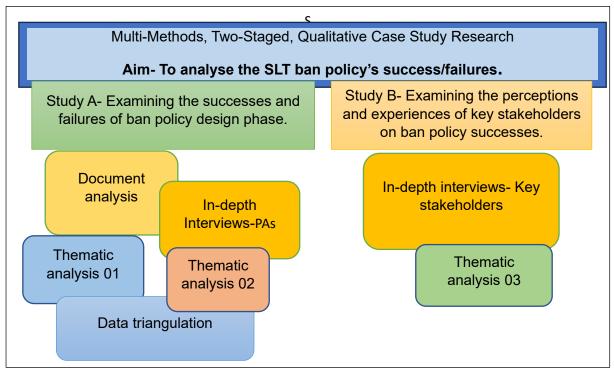


Figure 2.7. Two Staged, Multi-Methods Qualitative Case Study Research

Designed for Achieving Aims and Objectives of this PhD study.

Study A was conducted in two stages, utilising policy document analysis and in-depth interviews with SLT ban makers (Chapter 03, pages 145-234). The study population for interviews was identified by applying power-matrix analysis to the individuals identified in the policy document analysis. Data triangulation was planned to generate

the final themes and answer objective 01 of the research project. As presented in section 2.2 (pages 95-97) and Table 2.1 (page 99), Study A was designed to answer a few out of eight research questions. Study A was the first stage of the research.

Following Study A, Study B was conducted to gather the perceptions and experiences of stakeholders in the success of the SLT ban. Due to time and technical constraints, a few sets of highly influential categories of stakeholders were identified by applying the power-interest matrix. In-depth interviews were the planned data collection method. The findings of Study B were designed to be generated by thematic analysis and answer Objective 02 of this research project (section 2.2, pages 95-97, Table 2.1, page 99). The remaining set of research questions was answered by Study B (Chapter 04, pages 235-286).

2.6 Overview of the Research Programme

Table 2.5 provides a summary of the research program conducted in this PhD study. The study focused on identifying the links between the SLT epidemic, which is a policy issue, and the newly designed ban policy, which is the solution, in Sri Lanka. The main aim of the study was to find out the successes and failures of the ban policy. The table summarises the main logical approaches of the study, which include:

- Developing a working definition of the SLT epidemic in Sri Lanka from the perspective of a public health policy analyst (section 1.16).
- Formulating the research aim, objectives, and sub-objectives (section 2.2).
- Developing research methodology, along with procedures, techniques, and materials for studies A and B, in alignment with the research aim and objectives (section 2.3).
- Developing the combined analytical framework using a few crucial policy analysis tools and concepts (section 2.4).
- Generating and presenting results as themes and power-interest analysis (chapters 3 and 4).
- Conducting discussions based on analytical frameworks and existing literature (chapters 3 and 4).
- Generating recommendations while acknowledging the limitations (chapters 3, 4, and 5).

Table 2.5. – Comprehensive Analysis of SLT Ban Policy in Sri Lanka

Summary of the Overall Research Programme

Policy issue Vs Policy	Working Definition of Policy Issue The SLT epidemic in Sri Lanka a complex outcome of the main culture, tradition beliefs, government business, socio-economic divisions and the environmenta drives. Public Health Policy Ban on Manufacturing, Importing, Selling and Offering All Smokeless Tobacco Products Countrywide			
ie Vs				
	Stud	ly A	Study B	
St	To examine the successes and failures of the development of SLT ban 2016 in Sri Lanka		To examine the perceived and experienced successes and failures of SLT ban 2016 in Sri Lanka	
Study Aims	 To analyse the policy content of SLT ban policy. To analyse SLT ban policy actors' power, positions, and interests. To examine policy context led to develop SLT ban. To explore the policy process of developing the SLT ban policy 		 To analyse the process success of SLT ban policy. To analyse the programme success of SLT ban policy. To analyse the political success of SLT ban policy 	
Anal Frame	Policy development Gaps Combined Analytical Framework with a special focus to Health Policy Triangle		Implementation Challenges	
Analytical Frameworks			Combined Analytical Framework with a special focus to McConnell's Policy Success Dimensions	
	Two-staged Multi-methods Qualitative Case Study			
Dat	Stage I		Stage II	
<u> </u>	Policy Document Analysis	In-depth Interviews with Policy Actors	In-depth interviews with key stakeholders - Policy Implementors, Interest Groups and Experts	
n an	Coding Framework 01		Coding Framework 02	
Collection and Analysis	 Thematic Analysis 01 and 02 Power-Interest Analysis Source Triangulation 		Thematic Analysis 03	
	Findings, Discussions, Implications, Limitations, Recommendations			

Table 2.6 - Key Numbers for the Different Components of the PhD Project

Number of policy documents included for Study A	15 Published Primary legislation, Parliament Hansard Reports, National Tobacco Policies Secondary Legislation, Circulars, Internal Records (minutes, attendance reports)
The Number of Stakeholders Interviewed for Study A	The stakeholders involved in Study A are different from those in Study B. 09 Members of the subcommittee of SLT SLT ban policymakers—Subcommittee for Smokeless Tobacco Project in National Alcohol and Tobacco Authority of Ministry of Health Sri Lanka (9 out of 10 were interviewed).
The Number of Stakeholders Interviewed for Study B	09 participants - The stakeholders involved in Study A are different from those in Study B. Leading policy implementors in Sri Lanka representing 04 main sociodemographic regions- urban, rural, suburban and estate. - Regional Directors of Health Services (03) - Provincial Directors of Health Services (03) - Heads of non-government agencies (03)

Section 2: Methods and Results

Chapter 03- Investigating the Gaps in the Development of the SLT Ban Policy

3.1 Chapter Overview

This chapter presents the first phase of the Case Study Research, Study A. The chapter is subdivided into four parts: Study A's Aims (Part I), Methods (Part II), Results (Part III), and Discussion (Part IV).

Part I briefly recaps Study A's objectives, aims, and research questions (3.2).

Part II is the Methods section, which includes sections 3.3 to 3.7. This section provides the techniques and procedures for developing the coding framework (3.3), conducting policy document analysis (3.4), and conducting in-depth interviews (3.5). Additionally, it consists of data triangulation (3.6), reflexivity, and ethics sections (3.7).

Part III of the report is the Results section, comprising sections 3.8 to 3.11. This section presents the outcomes of various searching strategies used in the policy document analysis (section 3.8), the outcomes of triangulating primary themes from the policy document analysis and in-depth interviews (section 3.9), key themes along with supporting evidence (section 3.10), and the results of the Power-Interest analysis (3.11).

The chapter ends with Part IV, which consists of six insightful sections: a discussion of key findings (3.12), research gaps (3.13), methodological considerations (3.14), implications (3.15), recommendations (3.16) and a conclusion (3.17).

Part I – Study A's Aim and Objectives

Part I summarised Study A's aim, objectives, and research questions (2.2.1, pages 95-96 and Table 2.1, page 99).

3.2 Aims, Objectives and Research Questions

Study A aimed to examine the developmental phase of the smokeless tobacco ban introduced by the Sri Lankan government in 2016 as a solution to its dragging smokeless tobacco epidemic. The study had four sub-objectives (2.2.1, pages 95-96).

- I. To analyse the content of the smokeless tobacco ban (SLT ban) policy in Sri Lanka
- II. To analyse the powers, positions, and interests of the actors involved in the smokeless tobacco ban in Sri Lanka
- III. To analyse the contextual factors contributing to developing the smokeless tobacco ban policy in Sri Lanka.
- IV. To analyse the policy development process of the smokeless tobacco ban policy in Sri Lanka

3.2.1 Research Questions

As shown in Table 2.1(page 99)., Study A answered the first three out of seven research questions (a), (b) and (c) to a greater extent.

Part II- Methods

I conducted a retrospective study to explore the development phase of the SLT ban policy. I used two approaches in Study A: policy document analysis and in-depth interviews with SLT ban makers. In Chapter 2, Section 2.3.6 (pages 108-119), I explained why I chose these two data collection tools: their sampling techniques, material development, translation techniques, and data analysis techniques (as presented in Table 2.2, page 109).

Section 3.3 (pages 148-150) presents the methods for developing Study A's coding framework. It was the standard data extraction tool for policy document analysis and in-depth interviews for both methods.

After that, as the first half of this methods section, I present the techniques and procedures I used to conduct and analyse policy documents (3.4., pages 151-159). This includes selecting inclusion and exclusion criteria (3.4.1, pages 151), identifying data sources (3.4.2, page 152), searching strategies (3.4.3.,153), data extraction (3.4.4, page 154), data analysis (3.4.5, page 155) and data interpretation (3.4.6, page 156)

In the second half of this Methods section, I explain how I conducted in-depth interviews with policymakers involved in the SLT ban and how I interpreted the findings. This process consists of selecting the appropriate interview participants (3.5.1, page 159), developing an interview guide (3.5.2., page 160), conducting the interviews with SLT ban policy makers (3.5.3, page 162), writing and translating verbatim transcripts (3.5.4, page 164), extracting data (3.5.5, page 166), interpreting and generating themes and analysing stakeholders (power-interest analysis) (3.5.7., page 166)

The last two sections of this methodology present the process of triangulating findings from two sources (3.6, page 166) and the procedures and techniques used to ensure the study's reflexivity and ethics (3.7, pages 168-174).

3.3 Developing the Coding Framework

Study A employed a coding framework to extract data from policy documents and interviews to systematically provide inclusive answers to the SLT ban policy development phase's successes and failures. The coding framework was 'developed by including four essential dimensions: Policy Content, Policy Actors, Policy Context, and Policy Process. These dimensions work together to determine the success of a health policy-making phase. This is guided by the Health Policy Triangle framework (2.4.4, pages 131-133) created by Buse and colleagues in 2012.

Table 3.1 below briefly presents this coding framework's primary codes and subcodes with their working definitions in short. It consisted of four main codes representing each dimension above. Each code encompasses various subcodes ranging from 4 to 8.

Table 3.1. Coding Framework- Study A

A. Policy Content

A01. Policy Vision: Articulation of the overarching purpose and direction of the SLT ban policy.

A02. Intention: Clear statement of the government's purpose and desired impact in implementing the policy.

A03. Aims: Specific objectives the policy aims to achieve

A04. Mission: The overall strategy and approach to accomplish the policy goals

A05. Expected Outcomes and Impacts: Anticipated results and broader effects on public health and society.

A06. Innovation And Influence: Evaluation of novel ideas or instruments shaping the policy.

B. Policy Actors

B01. Positions: Roles and responsibilities of key individuals and entities involved in SLT ban policy development.

B02. Powers: Authority and capacities held by policy actors.

B03. Interests: Motivation and goals of stakeholders influencing the policy.

B04. Commitments: Dedication and obligation of involved parties to implement the policy.

B05. Skills and Competencies: Capabilities and expertise of policy actors.

C. Policy Context

C01. Situational Factors/Triggering Factors: Events or circumstances leading to the initiation of the SLT ban policy.

C02. Political Factors: Influence of political capital, policy champions, political and economic motivations, technological considerations, and environmental concerns (including spitting) C03. Cultural Factors: Societal values, traditions and norms influencing policy development.

C04. International Laws/Policies/Funds: Impact of global factors on the formulation and implementation of the policy.

D. Policy Process

D01. Emergence Of The Issue: How the SLT issue gained prominence on the policy agenda.

D02. Problem Identification And Definition: Methods and approaches used to identify and define the policy.

D03. Policy Alternatives: Examination of the options considered during policy development.

D04. Stakeholders' Consultation: Involvement of relevant parties in the decision-making process.

D05. Rationalistic Approach: Utilisation of logical reasoning and evidence-based decision-making.

D06. Protecting Government Policy Goals And Instruments: Strategies employed to safeguard policy objectives.

D07. Guaranteeing Policy Legitimacy: Measures taken to ensure the government's moral authority.

D08. Building A Balanced Partnership: Fostering collaboration between policy actors and supports to ensure effective policy implementation.

Code Letter (A-D): Main code/Mainstream

The first main code, 'Policy Content,' focuses on establishing subcodes that provide a clear vision, mission, and purpose for the SLT ban policy. It also looks into specific objectives and overall strategies of the policy. Moreover, it consists of subcodes to gather information on anticipated outcomes, impacts and influences. In this manner, data extraction under the 'policy content' code was supposed to provide an inclusive picture of the 'scope of the policy' in multiple aspects.

Their roles, responsibilities, authorities, and entities were defined in the Policy Actors' realm. Policymakers' motivations, commitments, and skills in the SLT ban policymaking were included as sub-codes.

The main code, 'Policy Context,' examined external factors such as triggering events, political influences, socio-cultural considerations, and global factors to understand the comprehensive contextual landscape that shaped the SLT ban policy-making.

The Policy Process code was supposed to look into step-by-step progress from issue emergence to policy formation and implementation. Its subcodes include problem identification, policy alternatives, stakeholder consultation, evidence-based

policymaking, strategies to protect policy goals, ensuring a balanced partnership, and legitimacy.

In summary, the objective of the coding framework from the Health Policy Triangle by Buse and colleagues (2012)- was to gather data to offer valuable insights into the successes and failures of the development of SLT ban policy within a broader context of public health and societal well-being.

3.4 Method 01- Policy Document Analysis

As mentioned above, policy document analysis was selected as one of the two methods to address the research objectives and questions in Study A (2.3.6.). To find answers systematically and comprehensively from multiple policy documents, I followed a step-by-step approach to synthesise and present evidence. The strategy included the following steps:

- I. Develop Eligibility Criteria (3.4.1, page 151)
- II. Defining Data Sources (3.4.2, page 152)
- III. Searching Strategy (3.4.3, page 153)
- IV. Data Extraction (3.4.4, page 154)
- V. Data Analysis (3.4.5, page 155)
- VI. Data Interpretation: Themes and Power-Interest Analysis (3.4.6, page 156)
- VII. Triangulation Themes with Themes from Interviews (3.9, page 182)
- VIII. Presenting Themes (3.10.1 to 3.10.4, pages 185-214)
- IX. Presenting Results of Power-Interest Analysis (3.11, page 215)

Out of these steps, this Methods section(Part II) presents the steps until the data interpretation (3.4.1. to 3.4.5). The rest of the steps, including results of power-interest analysis and triangulating findings with interviews and themes, are presented in the results section- Part III (pages 174 to 220).

3.4.1 Eligibility Criteria

I developed the eligible criteria based on the PICOS criteria outlined below.

Population

I included policy documents that issue warnings or notices to all SLT users (betel quid chewers and individuals using other SLT types, including Mawo and Thul) regarding the prohibition regardless of age. My efforts encompassed all national-level policy documents from 2006 onwards, and I did not impose any ministerial restrictions (as The National Alcohol and Tobacco Act, passed in July 2006, was referred to in the content of the extraordinary gazette released for the SLT ban policy in 2016). I included only documents in English or Sinhala, for which I had linguistic expertise available. The study searched for bills, acts, regulations, circulars, background reports, situational reports, and need assessment reports in grey literature.

Interventions

This analysis included policy documents from different sectors, including health, public administration, education, trade, law, and agriculture that related to the SLT ban either directly or indirectly. The study considered government-enforced policies and situational or background reports produced by government, non-government organisations, or universities. Policies like strategic plans at draft stages (not implemented) until September 2020 were not included.

Comparator

The absence of a ban policy in planning and implementing SLT control activities was considered a comparator.

Outcomes

Outcome measures were not included in Study A's research questions or objectives. Hence, they were not included in this study.

3.4.2 Data Sources

- I. To identify the published policy documents, I conducted a grey literature search on a few different online platforms as follows:
 - Google Search Engines
 - Official Websites of a few Non-Government Organizations and Universities known for tobacco control interventions and research activities, including Campaign for Tobacco-Free Kids (CTFK), Alcohol and Drug Information Centre (ADIC), WHO Country Office, Sri Lanka Medical Association (SLMA), Faculty of Medicine (FOMC), University of Colombo, Faculty of Dental Sciences

(FODSP), University of Peradeniya websites (these two universities have SLT and oral cancer research centres).

- The official websites of the House of Parliament, Sri Lanka
- Official Websites of Key Ministries of the government of Sri Lanka: These documents included Hansard reports, acts, bills, regulations, and circulars. The search was conducted on the Ministry of Health, Ministry of Public Administration, Ministry of Education, Ministry of Law, Ministry of Agriculture, and the Ministry of Finance.
- II. To identify the unpublished SLT-ban-related policy documents, including internal minutes, meetings, attendance sheets and circulars, I contacted the SLT-ban policymaker. Requests were made by university-owned email.

The following policy document types were searched from two kinds of data sources:

- Parliament Hansard reports
- Primary legislation, including Bills, Acts, and National Tobacco policies.
- Secondary Regulations related to SLT control and prevention.
- Circulars, including administrative, policy, employee, public, and health and safety.
- Internal records, including meeting minutes and attendance sheets.
- Background reports, including situational reports and white papers.

3.4.3 Search Strategy

To conduct an online search for relevant information, I used specific keywords such as "smokeless tobacco ban," "regulations," "prohibition of chewing tobacco," "betel quids," "snus," "Sinhala tobacco," "Thul," "Mawo," and "public policies." I also included relevant synonyms for these keywords. Furthermore, I adapted these keywords to match the context of our search engines, such as Google or ministry websites.

I searched the listed official websites and the Google search engine online. This search generated 65 documents, out of which 42 were duplicates and therefore removed. The remaining 23 documents were screened based on their title and summary, and five did not meet the eligibility criteria, leaving me with 18 documents for full screening. After reviewing all 18 documents, I excluded eight since they were related to the general tobacco campaign instead of the SLT ban. As a result, only ten documents were considered eligible for inclusion. To determine their eligibility, I manually checked the references cited in these articles, especially in the background papers. Ultimately, I found two pieces that met the inclusion criteria and were included, bringing the total number of published documents for analysis and review to 12 (Kayesa and Shung-King, 2021; Cardno, 2018).

Moreover, I sent an email requesting unpublished policy documents related to SLT ban policymaking. The policymakers shared three internal documents with me, which included important information such as primary objectives, activities, names, and designations of SLT ban policymakers, assisting organisations, meeting minutes, and attendance sheets.

Through this searching and screening strategies, I was able to gather a total of 15 documents, 12 of which were published and three were unpublished. The outcome of these online search results has been by 'Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA) flowchart in Figure 3.1 (page 175) under the Results section (3.8., pages 174-181) in four main categories: identification, eligibility, screening, and included.

3.4.3 Data Extraction

A data extraction form, consisting of two sections (I and II), was developed to extract the data. Section I was used to extract general identification details such as the document title, identification codes, extraction date, and website reference with URL. The document identification code was created using the author's name, published date, topic, and website name (Saldaña, 2021; Elliott, 2018). Section II of the form was designed to extract data under each code: policy content, policy actors, policy context,

and policy process. The coding framework used to develop this Section II is presented in Table 3.1(148-149).

The data extraction was done according to the READ approach. (Dalglish, Khalid and McMahon, 2020). To conduct the extraction, I used NVivo, a software designed for qualitative data extraction. I ran the software on a password-protected computer at the university. To set up the NVivo Project, I followed the identification details and codes in the above-described data extraction form. Each code and sub-code was assigned a different colour to make synthesising and interpreting data and generating themes easier. During the screening process, I highlighted and extracted statements, phrases, and quotes and stored them under each subcode in the coding section(Dalglish, Khalid and McMahon, 2020; Cardno, 2018).

3.4.5 Data Analysis

I used a systematic deductive data analysis approach based on the predetermined coding framework (Table 3.1, pages 148-149). Data analysis and extraction were iterative (Kayesa and Shung-King, 2021; Karppinen and Moe, 2012).

I defined criteria for each theme to guide these coding decisions in the framework. Then, after understanding the content, actors, processes, and context, I began the coding process by applying predefined codes to data segments. In this process, I developed a detailed codebook that included definitions and examples for each theme. Detailed notes about coding decisions and emerging patterns throughout the process were kept. After that, I condensed and organised the coded data to identify patterns, trends, or relationships. Data reduction techniques such as summarisation were used to synthesise findings. Next, I explored each theme, considering variations and nuances within the data. I also looked for connections between themes and any unexpected findings.

I analysed the coded data and generated themes against research questions, objectives, and the analytical framework. Moreover, I considered the implications of the findings and how they contributed to the existing knowledge. Furthermore, I separately gathered the evidence for power (authorised power by the Act), interests,

and commitments of policymakers under each subcode. These pieces of evidence were used to analyse each policymaker's power and interest. This helped me determine the impact of each policymaker on the SLT ban policy-making phase. I presented the results with evidence in section 3.11(pages 215-220).

3.4.6 Data Interpretation

There were two purposes for the data interpretation:

- A. derive overarching themes and interpretations from the analysed data to answer the objectives and research questions of Study A (presented as Part I below)
- B. Interpret the power and interest of SLT ban policymakers and other identified stakeholders as a part of answering to objective 02 (Presented as Part II below)

The following are the critical steps of the procedures.

To proceed with the data interpretation process, I refined the data after reaching the point of data saturation. Data saturation was achieved when I realised I could no longer find any new statements, quotes, or phrases to extract from the documents(Dalglish, Khalid and McMahon, 2020; Bowen, 2009).

A- Themes Generation

I revisited my memos and extended notes for the NVivo project and worked on refining them. Then, I returned to the categories and continued refining them until I could generate themes relevant to Study A's objectives and research questions (3.2). To fill in any gaps in the data, I repeatedly reviewed the documents in the NVivo Project. Finally, I used tables (power-interest analysis), quotes and statements to illustrate the refined data.(Castleberry and Nolen, 2018).

Finally, these themes from the policy document analysis were compared with those from interviews with the SLT ban policymakers (3.9, pages 182-185). In other words, data were triangulated. This approach in data triangulation generated common

themes, ensuring the accuracy and credibility of the findings. (Triangulation, 2014; Bachiochi and Weiner, 2004).

B- Power-Interest Analysis

Part of the second objective was answered by analysing policymakers' power, interest, and impact using the evidence from the same deductive data analysis approach presented above. The Mendelow power-interest analysis, developed in 1991, was the main theoretical underpinning for analysing policy actors' power and interest. Mendelow's concept was adapted to the study's analytical framework and presented in section 2.4.6 (pages 133-134) in Chapter 02. Using this theoretical concept on the data gathered under the second code of the codebook of this Study, the power, interest, and impact of the following policy actors were analysed.

- 1. Board members of the central agency responsible for tobacco policymaking in Sri Lanka—The analysis process continued with the 'proposed list of board members' evident in the National Alcohol and Tobacco Act (2007). This analysis helped to compare the powers and interests of SLT ban makers against the 'proposed board members'.
- SLT ban makers- The data extracted from minutes, attendance sheets, and project proposals revealed a set made the SLT ban of individuals listed under the 'SLT project committee.' The power-interest matrix was applied to this group of individuals based on evidence gathered from policy document analysis and interviews.

The results of this analysis were further cross-checked with data from interviews (Method 02) to answer some parts of objective 02 of Study A.

Following is a summary of the procedure I followed in analysing the powers and interests of the above two sets of policymakers.

a. Thematic coding- During data extraction and analysis, I identified recurring themes related to power and interest and categorised them into subcodes. This step laid the foundation for subsequent analysis.

- b. Identify Power Indicators- The power analysed in this approach was the 'power' delegated by the National Alcohol and Tobacco Act to the officers appointed to make tobacco control and prevention policies in Sri Lanka. I focused on language and instances revealing power dynamics within the coded transcripts. Moreover, I looked for expression of influence, control, access to resources, or authority. Furthermore, I extracted quotes and examples that illustrate the participants' perceived power in the context of policymaking.
- c. Identify Interest Indicators- I examined the coded transcripts for expression of interest. For this purpose, I looked for indications of concern, involvements, emotional attachment, or other factors that signify policymakers' level of interest in SLT ban-making. Relevant quotes and examples were extracted.
- d. Triangulation- I triangulated findings by comparing and cross-referencing data from multiple interviews. Moreover, the comparison was made between policy document analysis and interviews. In that way, I sought patterns and consistencies in the power and interest indicators across the different participants.
- e. Matrix Construction- A matrix called the power and interest matrix was designed to categorise policymakers based on their power and interest levels in a systematic way. The matrix is divided into four quadrants, placing individuals into one of the following groups: high power and high interest, high power and low interest, low power and high interest, and low power and low interest.
- f. Interpretation and Insights Generation- The constructed matrix was analysed to derive the matrix to derive insights into policymakers' power and interest dynamics. Explored how the identified power and interest levels influenced policymakers' roles in decision-making.
- g. Report and Documentation: The power and interest analysis results were presented in two tables in section 3.10.5 (Tables 3.4. and 3.5). The themes related to power and interest are presented in section 3.10.2 with quotes and examples from interviews and policy document analysis.

3.5 Method 02- In-depth interviews with SLT ban policymakers

As mentioned at the beginning of this Methods section and 2.3.6. (pages 107-119) in Chapter 2, interviews were selected as one of the two methods of finding answers to Study A's objectives and research questions (the other method was policy document analysis presented in section 3.4. above). As the nature of the overall aim of Study A, in-depth interviews with SLT ban policymakers by semi-structured interview guide were planned. The following were the main steps of this interview method.

- I. Selecting Interview Participants (3.5.1., page 159)
- II. Developing Interview Guide (3.5.2., page 160)
- III. Conducting interviews with SLT ban policymakers (3.5.3, page 162)
- IV. Writing and Translating Verbatim Transcripts (3.5.4., page 164)
- V. Data Extraction (3.5.5, page 167)
- VI. Triangulation Themes with Themes from Interviews (3.6, page 166)
- VII. Presenting Themes (3.10, pages 185-214)
- VIII. Presenting Results of Power-Interest Analysis (3.11, pages 215- 219)

Out of these steps, this Methods section presents the interpretation of interview data (3.5.1. and 3.6, pages 159-168). The Results section presents the findings of power-interest analysis, triangulating themes with policy document analysis, and the themes (3.10 to 3.11, pages 185-219).

3.5.1 Selecting Interview Participants

The purpose of selecting the interview as a research method for Study A was to gather the real-life experiences of policymakers involved in developing the SLT ban policy. As presented in section 3.2 (page 146), the research questions for Study A aimed to investigate the content of the SLT ban policy (i.e. vision, mission, aims, goals, and strategic plans), the policy actors (their power, interest, commitments, and skills), the policy context (socio-cultural, political, and economic contexts in which the policy

actors worked), and the policy process (the procedure of developing the SLT ban policy).

Additionally, Study A aimed to answer three research questions related to the rationale behind developing the SLT ban to control the use of traditional betel quids, how the SLT ban was chosen as the final policy instrument among other alternatives, and the rationale behind selecting the ban policy to control other commercial SLT products (as shown in Table 2.1). Thus, the most suitable individuals to be interviewed to answer these research objectives and questions were the SLT ban policymakers.

Identifying the study population was a complex task requiring a systematic, rationalistic approach as policy document analysis revealed two sets of policymakers (Table 3.4 and 3.5). As per the NATA Act of 2006, the National Alcohol and Tobacco Authority must have a board of members responsible for developing and monitoring tobacco policies. However, during this study (August and September 2021) and before, the central authority for tobacco control in Sri Lanka did not have such board members. Meanwhile, the extraction of data from unpublished documents such as minutes, attendance sheets, and the initial report of the SLT project confirmed that an SLT subcommittee created the SLT ban policy, which does not fall under the board of members. Therefore, after examining and analysing the table 3.4 and 3.5 (pages 216 and 218) a list of SLT committee members was identified. was selected as the interview participants. The information was confirmed by the National Authority of Alcohol and Tobacco, Sri Lanka. The subcommittee consisted of ten members, all selected as interview participants for this study.

3.5.2 Developing Interview Guide

Table 3.2 (page 161) illustrates the interview guide designed for this study. It was based on a coding framework from the Health Policy Triangle (Table 3.1, pages 148-149). The purpose of the interview guide was to align the interview process with the study's analytical framework and objectives (Turner III and Hagstrom-Schmidt, 2022; Kallio et al., 2016; Seidman, 2006).

Making it semi-structured allowed for flexibility and probes when necessary, resulting in deeper insights for researchers. Another purpose of the interview guide was to find the answers to identified gaps in policy document analysis.

Table 3.2. Interview Guide- Study A

Interview Guide: Exploring the Smokeless Tobacco Ban Policy Development

Introduction

- 1. Opening Statement:
 - "Thank you for participating in this interview. I am interested in gaining insights into the development of the smokeless tobacco ban policy in Sri Lanka. Your perspectives and experiences are valuable in understanding the various aspects of this policy. First, please provide an overview of your involvement in the policy development process."
- 2. Understanding Policy Content:
 - Policy Vision, Intention, Aims, Mission, Expected Outcomes, and Impacts:
- Can you articulate the overarching vision of the smokeless tobacco ban policy as you perceive it?
- o What, in your view, was the primary intention behind implementing this policy?
- o Could you discuss the specific aims and objectives that the policy aimed to achieve?
- How would you describe the mission and overall strategy adapted to realise the policy goals?
- What were the expected outcomes and broader impacts anticipated from implementing this policy?
- Were there any innovative ideas or policy instruments that influenced the formulation of this policy?
- 3. Examining Policy Actors
 - Positions, Powers, Interests, Commitments, Skills, and Competencies:
- Can you outline the roles and responsibilities of key individuals and entities involved in the SLT ban policy development?
- What powers and authorities did various policy actors possess during this process?
- What were the main interests and motivations of stakeholders who played a role in shaping this policy?
- Could you elaborate on the commitments and obligations demonstrated by different parties in implementing the policy?
- In your opinion, what skills and competencies were crucial for successfully developing and implementing the smokeless tobacco ban policy?
- 4. Exploring Policy Context:
 - Situational Factors, Political Factors, Cultural Factors, International Influences:
- How did situational factors or triggering events contribute to initiating the SLT ban policy?
- o In what ways did political considerations, including political capital and the influence of policy champions, shape the development of this policy?
- Were there cultural factors that played a significant role in influencing the policy context?

- How did international laws, policies, or funds impact the formulation and implementation of the SLT ban policy?
- 5. Navigating the Policy Success:
 - Emergence of the Issue, Problem Identification, Policy Alternatives, Stakeholder Consultation, Rationalistic Approach, Protection of Government Policy Goals and Instruments, Guaranteeing Policy Legitimacy, Building a Balanced Partnership:
- o Can you describe how the issue of SLT gained prominence on the policy agenda?
- What methods and approaches were employed to identify and define the problem addressed by this policy?
- Could you discuss the various policy alternatives considered during the development phase?
- How were stakeholders, including community members, consulted in decisionmaking?
- o In what ways did a rationalistic approach, based on evidence and logic, shape the policy development process?
- What strategies were used to protect government policy goals and instruments during the formulation of the SLT ban policy?
- How was policy legitimacy guaranteed, considering the government's moral authority?
- Can you share insights into how a balanced partnership was fostered between policy actors and supporters to ensure effective policy implementation?

Closing:

 "Thank you for sharing your valuable insights. Is there anything else you want to add or any aspect of the smokeless tobacco ban policy development we haven't covered in this interview?"

Like the coding framework presented in Table 3.1 (pages 148-149), the interview guide comprised a set of questions pertained to four main components: policy content, actors, context, and process (Table 3.2, page 161). It was pilot-tested with three national-level health directors from Sri Lanka's Ministry of Health. The pilot test was aimed to identify potential issues such as confusing or unclear questions. (Brooks, Reed and Savage, 2016; Van Teijlingen and Hundley, 2001). After pilot testing, I made minor changes to the question wording to improve the interview guide's clarity and flow. (Aung, Razak and Nazry, 2021; Brooks, Reed and Savage, 2016; Sampson, 2004)

3.5.3 Conducting Interviews with SLT Ban Policymakers

The interviews took place between July and October 2021 after receiving ethical approvals from the relevant organisations (3.7, pages 168-174). The policy document analysis identified and listed These SLT ban policymakers (Table 3.5, pages 218-219).

The identified participants were contacted via university email. The ethical approval forms, information sheet, interview guide, and consent form were sent to them, and their consent was requested. These information sheets and consent forms are available in Appendix II and III. (Gill, 2020; Shaheen and Pradhan, 2019; Elmusharaf, Farrokhi and Mahmoudi-Hamidabad, 2012).

The interviews were carried out strictly following the COVID-19 risk mitigation plan sanctioned by the research advisory panel (5.3.2, pages 311-312). The respondents sent me their preferred dates and timings for the online Zoom interviews.

After listing the SLT ban policymakers, I realised that some interview participants were my teachers and colleagues from my academic or professional life. Although some worked in different health settings or universities, we have had to work together at least once or twice for professional and academic reasons. The same issue was encountered during the interviews in Study B (regional and provincial health directors, university academics, and heads of civil organisations), discussed in section 4.3.4.(page 248) of the next chapter.

During my research interviews with these professional colleagues and teachers, I encountered several challenges when asking difficult questions and ensuring transparency in their responses. Some potential issues arose, including power dynamics, where colleagues and teachers felt uncomfortable providing honest responses due to perceived power imbalances. They also feared potential repercussions or damage to our professional relationships, worrying about judgement, damage to their professional standing or relationships within the work scope, and concerns about their responses being traced back to them.

To tackle these problems, I implemented a range of tactics, such as establishing a reliable connection with the individuals being interviewed, articulating the research objectives clearly, ensuring privacy and highlighting the significance of truthful responses. Additionally, I aimed to utilise informal language to decrease the possibility of participants feeling defensive or hesitant and fostered an atmosphere where interviewees felt comfortable expressing their opinions.

During the study, each interview lasted between 35 to 50 minutes. I used a computer owned by the university to conduct Zoom meetings. To ensure the interviews were recorded, Zoom application settings were configured to send a password-protected audio recording of the interview to the university Gmail account. A password-protected tape recorder was also used as a backup device for recording purposes. I conducted the interviews in both Sinhala and English, depending on the preference of each interviewee. Most participants preferred to speak in Sinhala, their first language. Therefore, audio recordings in Sinhala were translated into English before data analysis.(Aung, Razak and Nazry, 2021; Archibald et al., 2019).

The decision to keep the camera on or off during in-depth interviews can have various implications. During the Zoom interviews for this study, the decision was made to keep the camera on as it was apparent visual data could enhance data quality according to the nature of the research questions and objectives. Participants were given the chance to choose the option. The informed consent was received beforehand. Following were a few implications for the researcher and the participants on this decision.

- Non-Verbal Cues and Body Language: Having the camera on allowed me to capture non-verbal cues and body language, which could provide valuable insights into the participants' emotions, attitudes, and reactions.
- Building Rapport: Visual cues helped build a stronger rapport between the researcher and the participants. Facial expressions and gestures contributed to a more personal and engaging interaction.
- Observational Data: I could gather observational data about the participant's environment, which was relevant to the study. These included their workplace, living conditions, interests, delegated powers and contextual factors.
- Accountability: Keeping the camera on could enhance accountability and transparency in the research process, as both parties were aware of being visible to each other.

3.5.4 Writing Verbatim Transcripts and Translating to English

The purpose of creating transcripts was to accurately and comprehensively transfer all information obtained during interviews to a written document. It was necessary to preserve the nuances of the participants and ensure a faithful representation of their experiences and perceptions. Therefore, the verbatim transcript records the interviews (Hagens, Dobrow and Chafe, 2009; Oliver, Serovich and Mason, 2005; Poland, 2003).

The transcripts in Sinhala were translated into English using a forward-backward translation method. As a PhD researcher, I personally conducted all of these translations. Therefore, I followed the following techniques to approach the discrepancies systematically and conscientiously to enhance the reliability of research findings (Abfalter, Mueller-Seeger and Raich, 2021; Littig and Pöchhacker, 2014; Suh, Kagan and Strumpf, 2009; Temple and Young, 2004).

- a. I reviewed the original and back-translated transcripts, paying close attention to details, nuances, and context-specific elements.
- b. Documented discrepancies, differences, or areas where linguistic challenges and cultural nuances needed attention. This includes unique regional practices, traditional practices, and sub-cultures related to minor ethnic groups and marginalised young people.
- c. Taking an iterative approach and ensuring accurate reflection of intended meaning were critical strategies for translation accuracy.
- d. There were a few discrepancies, such as some requests made by policy champions to ban all types of SLT and areca nut products. Those were verified with the participants.
- e. Inputs were received from relevant participants for the five transcripts. These inputs confirmed that the translations were accurate and captured the intended meaning.

Transcript Storage, Security and Privacy of the Information

Since tobacco is a politically sensitive subject, and the interviews were conducted with key government professionals in Sri Lanka, I implemented certain procedures to ensure the security and confidentiality of the interview transcripts. As part of the procedure, I have adhered to the University of York's data protection policy and the ethical guidelines provided by two committees. One committee is the Research Governance Committee of the Department of Health Sciences at the University of York, and the other is the Ethics Committee of the Sri Lanka Medical Association. (3.7.2.) I adhered to the following techniques to ensure the security and privacy of the information(Kallio et al., 2016; Temple and Young, 2004).

- The transcripts were securely stored on university servers and computers that were password protected.
- II. The backup data was securely stored in the university's cloud platform with strong authentication measures.
- III. The transcripts had personally identifiable information (PII) removed and replaced with identification codes. These codes comprised a three-digit serial number, an acronym for the SLT ban maker's designation, and the interview date in yy/mm/dd format.

3.5.5 Data Extraction

The verbatim transcripts mentioned earlier were imported into the NVIvo software. The data extraction procedure used for the transcripts was like the one used for document analysis. As a result, to avoid repetition, the procedure was not reiterated. For more information, please refer to sections 3.4.4 (page 154)above.

3.5.7 Data Interpretation: Themes Generation and Power-Interest Analysis

Data interpretation was conducted similarly to policy document analysis to answer Study A's four research objectives and three research questions. The process involved two parts: the generation of themes and the analysis of policymakers' power and interests. The procedure was not repeated to avoid repetition. For more information, please refer to section 3.4.5 (page 155) above.

3.6 Methods of Data Triangulation

Triangulating findings involved synthesising and interpreting data from policy documents analysis and in-depth interviews. This research method aimed to enhance the credibility and validity of findings generated to answer the research topic (Flick, 2018; Youngs and Piggot-Irvine, 2012; Flick, 2004).

Following is an overview of the steps involved in triangulation.

- Step 01- Analysing data from policy document analysis and themes generation;
 Data Source 01 (3.3, page 148)
- Step 02- Analysing data from In-depth Interviews and themes generation; Data Source 02 (3.4, pages 151-156)
- Step 03- Themes Integration: Themes from the above two sources were brought together, and a unified table was created.
- Step 04- Identify Patterns and Themes: Integrated themes were analysed to identify the patterns and recurring elements. Looked for commonalities and differences across sources that contributed to a more nuanced understanding of the research questions and objectives.
- Step 05- Divergence Analysis: Explored the areas where there were discrepancies or divergences in the data. Efforts were made to understand the reasons behind the conflicting information. Methodological differences that contributed to those variations were understood. For example, the evidence from parliament Hansard Reports about reasons presented by the Minister of Health for the SLT ban policy conflicted with the reasons given by policymakers during interviews. These divergences helped produce more insights into the phenomenon's complexity under investigation.
- Step 06- Prioritise Strong Evidence: More weight was given to themes supported by both sources.
- Step 07- Contextualise Findings: Considered the broader context within which the data was collected, in this case study, Sri Lanka and counted the cultural, political, economic and situational factors that could influence the interpretation of findings.
- Step 08- Cross-Validation: Findings were validated by comparing them with established theories integrated into the analytical framework of this study (2.4, pages 120-139). Efforts were made to ensure the final themes were consistent with accepted policymaking and policy analysis principles.

3.5.6 Data Analysis

The data synthesis and analysis procedures used for the transcripts were like those used for document analysis. Therefore, to avoid repetition, the procedure was not reiterated. For further details, please refer to section 3.4.5 (page 155) above.

3.7 Reflexivity and Ethical Considerations

This section delved into the techniques and precautions taken to maintain a reflective and ethical approach throughout this study. The measures implemented to achieve reflexivity, outlined in section 3.7.1(pages 168-170), proved invaluable in navigating my biases, personal backgrounds, and experiences. By adhering to these practices, I cultivated a heightened sense of self-awareness, transparency, and objectivity, ultimately enriching the research process and cementing the reliability of the findings.

The ethical considerations summarised in section 3.7.2 (171-174) were crucial in guaranteeing the well-being of study participants, obtaining their informed consent, and maintaining research integrity. I employed various techniques to ensure confidentiality, voluntary participation, respect for autonomy, and appropriate handling of sensitive data. This commitment to ethical standards, from obtaining approval to storing data, helped preserve the research's credibility and trustworthiness.

3.7.1 Procedures for Ensuring Reflexivity

Maintaining reflexivity is an essential approach to upholding the quality of qualitative research. Quality assurance guarantees that qualitative analysis is dependable, valid, and rigorous(Deer, 2014; Guillemin and Gillam, 2004; Seidman, 2006). As detailed in section 2.3 (page 100-119) of Chapter 02, this research initiative utilised a multimethod, two-stage, qualitative case study that gathered and evaluated non-numerical data, including policy documents and interviews. The analysis centred on human interactions, perceptions, views, and experiences, highlighting the significance of reflexivity as a core element of qualitative research methodology. Hence, this section outlines the crucial factors that sustain reflexivity throughout the research project, explicitly emphasising Study A.

Reflexivity is an essential aspect of qualitative research that empowers researchers to be reflective and considerate of their backgrounds, influences, experiences, and biases throughout their investigations (Deer, 2014; Guillemin and Gillam, 2004). Rather than being a limitation, it is a strength that enables researchers to conduct more rigorous and reliable research by acknowledging and addressing their subjectivity. In this section, I will outline the fundamental techniques I employed to bolster my reflexivity, including cultivating self-awareness, embracing my role as a researcher, acknowledging my positionality, keeping a reflexive journal, maintaining transparency, practising bracketing, and engaging in peer debriefing.

As a researcher, I am engaged in a qualitative case study analysing the effectiveness of the SLT ban in Sri Lanka. Throughout this process, I have been aware of my background, social identity, experiences, beliefs, and values and how they may impact the research findings. The initial research objectives were established during my tenure as Director of Research for the Ministry of Health in Sri Lanka in 2018. My primary aim is to uphold the accuracy and consistency of this research endeavour.

Numerous factors led me to select this research topic.

Firstly, having spent 39 years of my life immersed in the culture of rural Sri Lanka, I have extensive personal experience with chronic betel quid consumption among the adult population. Secondly, as a medical practitioner who has worked in various healthcare settings throughout Sri Lanka, I have spent 19 years gaining professional experience with oral lesions and cancers attributed to SLT use among middle-aged Sri Lankans. Thirdly, I observed the domestic preparation, consumption, and sharing practices of traditional betel quid and related SLT products following the introduction of the SLT ban in September 2016.

Fourthly, I have firsthand knowledge of the continued, chronic consumption of SLT products by young men in the capital city of Sri Lanka, even after the ban was put in place. Fifthly, despite the ban being in effect for two years, I noticed that the number of betel quid sellers and their locations remained unchanged. Lastly, I witnessed a media conference broadcast by a group of healthcare practitioners and researchers, where it was announced that betel quids with tobacco and areca nut were now completely prohibited in Sri Lanka and that anyone dealing with those products would

face punishment. From the very start, these experiences led me to choose this research topic.

During a discussion with my thesis advisory panel and peers, I shared some of my experiences during the research project that may have influenced my negative perspective on the ban's outcome. I practised self-awareness throughout the process to ensure that my opinions and experiences did not unduly affect the project's results. I also kept a reflexive journal where I recorded my thoughts, emotions, and reflections. This practice helped me better understand my journey and how it impacted the research project's reliability, validity, and robustness.

I was fortunate enough to engage in four thought-provoking conversations with academic and professional colleagues from Sri Lanka, the United Kingdom, India, Pakistan, and Bangladesh. These enlightening dialogues centred around SLT and oral health and allowed me to gain valuable insights from experts in the field. These discussions helped me identify areas where I needed to reflect more and gave me different perspectives on their work. One of these invigorating conversations occurred at the international ASTRA conference in York, United Kingdom, in 2019. Two other stimulating discussions were presentations I gave in person at the Department of Health Sciences at the University of York. The fourth thought-provoking conversation occurred over Zoom, connecting SLT experts in Sri Lanka with a team of Health Science researchers in York.

I collaborated with the SLT ban makers as a qualitative researcher during the project. I made informed decisions about data collection and analysis and interpreted the data at various stages(Harding and Whitehead, 2013; Creswell, 2007). For a detailed discussion, please refer to sections 2.3.6 of Chapter 02 and 3.4 and 3.5 of this chapter(pages 107-119, 151, 159). To maintain objectivity and minimise bias, I was aware of my role as a researcher and used bracketing techniques during data collection and analysis. Additionally, I consistently reflected on my actions and decisions to ensure ethical standards were upheld throughout the study. This involved being fully aware of how my activities and findings could impact both the SLT ban makers and interview participants and taking steps to conduct the research in the most ethical manner possible. Section 3.7.2 below provides further details on how I ensured the ethical perspectives of this research study.

3.7.2 Research Ethics

Ethical principles were of utmost importance in the research project, which entailed conducting in-depth interviews to gather valuable insights into participants' perspectives, experiences, beliefs, and perceptions(Burnette et al., 2014; Beauchamp, 2007). The study was conducted in adherence to ethical considerations, such as obtaining informed consent, ensuring voluntary participation, showing respect for individual autonomy, safeguarding privacy and confidentiality, maintaining research integrity, minimising potential harm, handling and storing data securely, being culturally sensitive, practising reflexivity, providing feedback and reporting, and obtaining approval from ethics review boards in both the UK and Sri Lanka. Throughout the study, I engaged with SLT ban makers, regional ban implementers, SLT researchers, and civil organisation leaders during in-depth interviews to collect information. The study's qualitative interviews were guided by fundamental ethical considerations, which ensured the quality of this multi-method, two-stage case study. (Pietilä et al., 2020; Munhall, 1988).

Before conducting the research interviews, participants were thoroughly informed about the study's purpose, the researcher's background, the methods and procedures, potential risks, and benefits. The information was presented to them through an information sheet and a consent form in Appendix II and III. Written consent was obtained from each participant via email before the interviews commenced, and verbal consent was also obtained and recorded at the beginning of each interview. The consent form included a statement (number 6) affirming that participants had the right to withdraw from the study at any time without consequence. All pertinent details about the survey were provided to the participants through the clauses outlined in sections 1-9 of the information sheet (Appendix II).

When conducting research, it's essential to uphold ethical standards by considering voluntary participation and informed consent. As discussed in Chapter 02, section 2.3.6 (pages 107-119), both Study A (section 3.5.4, page 164) and Study B (section 4.4., pages 250-251) in this chapter utilised purposive sampling and snowballing techniques to select their participants. In Study A, which consisted of 10 participants

(section 3.5.1, page 159), it's worth noting that the participants were not coerced or influenced to participate. Instead, they were granted the autonomy to choose whether to participate, ensuring that external factors did not affect their decision.

Data for this study was sourced from authoritative legal documents, including Parliament Hansard Reports and notable individuals. The objective was to uphold participant confidentiality; therefore, data was rendered anonymous by section (a) number 07 of the consent form (appendix II, page 327).

To guarantee ethical conduct in the research project, I employed methods to handle sensitive findings with care. Policy research necessitates meticulous planning and communication to ensure that information is accurately and effectively conveyed while considering ethical considerations. To accomplish this, we implemented specific approaches such as abstaining from disclosing sensitive data and controlling the release of sensitive information. These practices were adhered to when presenting the results in tables 3.6 and 3.7 (pages 216- 219) of this chapter, as well as sections 3.10 (pages 185-215) and 4.5 (252-274) of the next chapter.

Throughout the data collection process, utmost care was taken to respect the autonomy and decisions of the participants. Before the interviews, participants were informed that they were free to decline any uncomfortable questions. Our priority was to ensure that the research process caused minimal harm. For instance, most participants in this study were unaware of the Minister of Health's statements at the House of Parliament regarding the SLT ban. To provide appropriate support without causing any embarrassment, relevant references were shared with them(Cleary, Horsfall and Hayter, 2014; Creswell, 2007).

Section 3.7.1 (168-170) discusses reflexivity as an essential aspect of qualitative studies. This refers to the researcher's self-awareness of their preconceptions and how they might affect the interview process and outcomes. Several steps can be taken to ensure reflexivity, directly linked to maintaining research ethics.

Moreover, this research project obtained ethical clearance from the Research Governance Committee of the Department of Health Sciences, the University of York, the United Kingdom, on 13th April 2021. In addition, approval was also received from the Ethical Review Committee of the Sri Lanka Medical Association, Colombo, on 4th July 2021. As per the laws of Sri Lanka, administrative clearance for the study was

requested from the National Health Research Council and Education, Training and Research Unit of the Ministry of Health in July 2021.

Confidential data has been safely stored in a password-protected computer owned by the university and linked to a central server. Moreover, the university's data management software has backed up the data. The data will be retained for a maximum of five years, and all storage and management procedures have been executed in strict compliance with the guidelines outlined in the UK Data Protection Act 1998.

As noted on the declaration page of this thesis, I shared the methodology and preliminary research findings at the World Conference on Lung Health hosted by The International Union Against Tuberculosis and Lung Disease (The Union) from November 8th to 11th, 2022. In addition, I delivered a series of presentations to my national, international, and university peers, as outlined in section 3.4.7 of this chapter. In the future, I intend to disseminate this valuable new knowledge through peer-reviewed publications, conferences, seminars, media outlets, and accessible reports during and upon project completion.

Conflict of Interest: Although no conflicts of interest were present during the study, I must disclose that some interview participants were individuals with whom I had professional and academic relationships, including colleagues, superiors or teachers. I discovered through the snowballing technique that some of these individuals were involved in the creation of the ban being studied. Despite this, it was essential to include them in the study. Furthermore, I learned during my research that a close relative of mine had contributed to the development of the SLT ban and held a high-ranking academic position at one of the universities involved in the study. For this reason, I interviewed him as part of my research efforts(Ahmad et al., 2022; World Health Organization, 2004).

I took appropriate precautions at every step to ensure the research process was done with integrity. I prioritised transparency and honesty, which are essential qualities for a researcher to uphold ethics in qualitative research. I reflected on the importance of integrity and its impact throughout the research process. Before collecting data, I informed my university advisory panel of these contacts. I took all necessary measures

to ensure the research was conducted relatively and unbiasedly(Chowdhury, 2015; Cleary, Horsfall and Hayter, 2014)

Part III- Results

In this section, I present Study A's results, which focus on the development phase of the SLT ban policy in Sri Lanka. The outcomes and results of Study A were presented in the following four sections.

- I. Outcomes of searching strategies (3.8.1, pages 174-175)
- II. Characteristics of policy documents (3.8.2, pages 175-181)
- III. Outcomes of Data triangulation (3.9, pages 182-184)
- IV. Themes with quotes and examples and Power-Interest Analysis (3.10, pages 185-214)

3.8 Outcomes of Policy Document Analysis

This section provides an overview of the searching strategies of the policy documents by a Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA) flow chart. Moreover, it presents characteristics of the policy documents subjected for full screening by their titles, URL numbers, author, type, and year of publication.

3.8.1 Outcomes of Searching Strategies

I have organised and presented the results of policy document searching and screening by a 'Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA) flowchart in Figure 3.1. below. As presented in section 3.4.3. in this Chapter(page153), the search and screening strategy found 15 policy documents for the full review to find the answers to Study A's research questions and objectives.

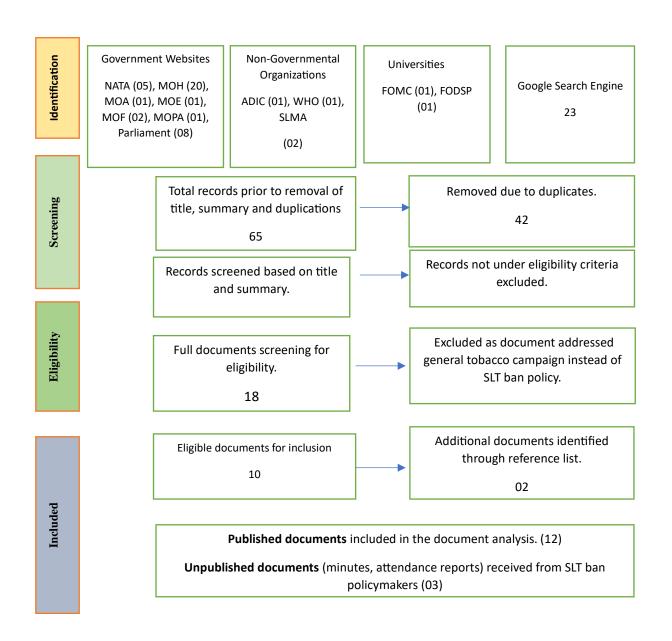


Figure 3.1. PRISMA Flowchart for Searching Strategy for Published Policy Documents - Study A (source-compiled by the author)

3.8.2 Characteristics of Published Policy Documents

Tables 3.3 and 3.4 below, provide a comprehensive overview of the publication characteristics, document types, authors, and year of publication for the twelve documents selected for review following the screening process.

- By title and URL address

Table 3.3 (pages 177-180) explicitly highlights the characteristics of the published policy documents, which is crucial for ensuring the validity and repeatability of this policy document review. These characteristics include the serial number, title, document ID, and full references complete with URLs. It's worth noting that each document's ID was created by combining the primary author, publication date, document title, published website, and saved version (PDF). These 12 published documents were subject to full screening.

- By author, type, and year of publication

Table 3.4 (pages 181) provides a detailed breakdown of the policy documents that were examined. It categorises them based on their document type, principal author, and the year of publication. Document type is one of the three criteria considered for inclusion in this policy document review, as mentioned in Section 3.4.1 (152-155). The table shows that out of the 12 documents analysed, the Parliament of Sri Lanka authored six, which was the majority. Four of these policy documents were Hansard's reports.

Table 3.3.- Characteristics of published policy documents related to SLT ban development in Sri Lanka- by the title, document compiler ID and the URL address.

Serial number	Title of the document	Document ID [author.date.topic.website.pdf]	Full reference with URL
1.	Parliament Debates (Hansard) Volume 164- No.7 May 26 2006	Parliament.26/05/2006.hanzard.srilankaparliment.pdf	https://www.parliament.lk/en
2.	Parliament Debates (Hansard) Volume 164- No.7 July 05 2006	Parliament.05/07/2006.hanzard.srilankaparliment.pdf	https://www.parliament.lk/en
3.	Parliament Debates (Hansard) Volume 223- No.8 February 19 2014	Parliament.19/02/2014.hanzard.srilankaparliment.pdf	https://www.parliament.lk/en
4.	Parliament Debates (Hansard) Volume 251- No.12 April 07 2017	Parliament.07/04/2017.hanzard.srilankaparliment.pdf	https://www.parliament.lk/en

5.	National Authority on Tobacco and Alcohol Act, No 27 of 2006, Parliament of the Democratic Socialist Republic of Sri Lanka	Parliament.29/10/2006.NATAact.NATA.pdf	https://www.nata.gov.lk/
6.	The Gazette of the Democratic Socialist Republic of Sri Lanka, Extraordinary, No 1481/25- Wednesday, January 24, 2007	NATA.24/01/2007.Authority officers. NATA.pdf	https://www.nata.gov.lk/
7.	The Gazette of the Democratic Socialist Republic of Sri Lanka, Extraordinary, No 1982/33- Thursday, September 01, 2016	NATA.01/09/2016.Regulations.NATA.pdf	https://www.nata.gov.lk/
8.	National Authority on	NATA.03/03/2015. NATAamendment.NATA.pdf	https://www.nata.gov.lk/

	Tobacco and Alcohol (Amendment) Act, No 3 of 2015, Parliament of the Democratic Socialist Republic of Sri Lanka		
9.	Investment Case for Tobacco Control in Sri Lanka, The case for scaling up WHO FCTC implementation	UNDP.00/05/2019.InvestingSriLanka. UNDP.pdf	https://www.undp.org/publications/investment- case-tobacco-control-sri-lanka
10.	Needs assessment for implementation of WHO Framework Convention on Tobacco Control in Sri Lanka	WHOFCTC. 02/2014.NeedAssesment.WHO.pdf	https://www.who.int/fctc
11.	Prohibition of use and selling of Betel, Tobacco and Areca nut	PA.06/05/2019.Prohibition.PA.pdf	https://www.pubad.gov.lk/

	related Products on the Premises of State Institutions Public Administration Circular: 11/2019		
12.	Prohibition of use and selling of betel, tobacco and areca nut-related products in hospitals and other health care institutes General circular; 01/14/2018 20/03/2018	MOH.20/03/2018.prohibition. MOH.pdf	http://www.health.gov.lk

Table 3.4. Characteristics of published SLT ban-related policy documents by author, type and the year of publication.

Serial number	Author	Type of the document	Year of publication
1.	The Parliament of Sri Lanka	NATA act	2006
2.	The Parliament of Sri Lanka	Hansard Report	2006
3.	The Parliament of Sri Lanka	Hansard Report	2006
4.	NATA office, Ministry of Health	Regulation	2007
5.	Convention Secretariat	Need assessment report	2014
6.	The Parliament of Sri Lanka	Hansard Report	2014
7.	UNDP (Copyright), Ministry of Health, WHO FCTC Secretariat, WHO, RTI International	Situational report	2015
8.	The Parliament of Sri Lanka	NATA Act (Amendment)	2015
9.	NATA office, Ministry of Health	Regulation	2016
10.	The Parliament of Sri Lanka	Hansard Report	2017
11.	Ministry of Health	Circular	2018
12.	Ministry of Public Administration	Circular	2019

The National Authority on Tobacco and Alcohol (NATA) Act and its amendment are essential primary legislation regulating the SLT ban policy. The timeline of parliamentary policy documents related to tobacco and alcohol regulation spans from 2006 to 2017, as shown in the second column of Table 3.4. above. During this period, the Ministry of Health's NATA office authorised two policy documents, which were regulations related to the NATA Act. The timeline of these two NATA regulations spanned from 2007 to 2016. Four other authors were involved in this documentation process, including the World Health Organization (WHO) Convention Secretariat, the Ministry of Health Sri Lanka, and the Ministry of Public Administration Sri Lanka. The WHO Convention Secretariat conducted an in-depth need assessment of tobacco control and prevention programs related to the implementation mechanism of the

WHO Framework Convention on Tobacco Control. The need assessment report was issued in 2014, as shown in the table.

3.9 Outcomes of Data Triangulation

The fundamental themes from policy document analysis and in-depth interviews were triangulated to answer Study A's research questions and objectives. Section 3.6 (page 166) presented an overview of the methodology used to systematically triangulate these themes through source integration, analysis, verification, and validation. In this section, I provide an overview of the results of this triangulation process, highlighting the similarities and differences that have been identified. Table 3.6 compares the themes generated from two data sources in a comparative table, highlighting their similarities and differences.

3.9.1. Shared Themes

Both analyses have identified that the ban policy was derived from the NATA Act. Additionally, it was found that an oral health expert served as the Minister of Health and played a significant role in promoting the policy. Furthermore, it was recognised that the ban policy was implemented as an immediate response to the increase in the import of SLT products.

Moreover, both sources identified common policy shortcomings, including the absence of evidence for comprehensive strategic plans, action plans, or monitoring and evaluation plans. Both contexts emphasise the need for evidence-based practices, thorough planning, and governance understanding improvements. These were the common themes identified in both analyses.

3.9.2 Divergent Themes

While integrating policy process themes, discrepancies arose regarding the ban on traditional betel quids. Themes from policy document analysis revealed recent circulars by ministerial levels banning traditional betel quids, but in-depth interviews with participants expressed regret and labelled the ban as premature. Though policy documents indicated that the minister of health did not intend to ban traditional betel

quids under this policy, the interviews revealed the same minister's eagerness to enforce a ban on all smokeless tobacco products across the island. Throughout the policy formation procedure, there were also contrasting viewpoints on the transparency of the House of Parliament in approving the SLT ban policy.

There were varying perspectives regarding the authority to establish policies. The policy documents identified the board members as the authorised decision-makers (powered by the NATA Act). Still, the bureaucrats who planned the SLT ban policy did not believe they possessed sufficient 'delegated' authority, as they were not members of the nominated board by the NATA Act.

Additionally, there were divergent understandings regarding the rationale for the ban. The policy documents viewed it as an effective measure in response to the surge in imported SLT products. At the same time, the individuals interviewed expressed regret that this ban, introduced against all SLT products, including traditional betel quids, was implemented hastily.

3.9.3 Comparative Table

Table 3.5 (page 184) summarises the similarities and differences of critical elements from two data sources. It illustrates the shared themes under each code in green and contrasting themes in blue with a short explanation.

In section 3.10 (pages 185-214), I provided a list of common themes and their supporting evidence. I finalised the themes by prioritising similarities, and after validating and contextualizing contrasting themes in the setting, I included a few of them in the final list based on the strength of evidence supporting those themes (including statements from Parliament Hansard reports). These contrasting themes offered additional insights into the gaps identified during the SLT ban policymaking.

Table 3.5. Comparative Table Showing Shared and Contrasting Themes by Two

Data Sources

Themes	Policy Documents Analysis	In-depth Interviews					
Policy Content							
Derivation from the NATA Act							
Oral Health Expert as the policy champion							
Surge of Imported SLT products							
Lack of Comprehensive Plans							
Ban was countrywide and for all SLT products	Two Different Evidence						
Policy Actors	1						
Role of Board of Members		No functional board					
No authorised power for SLT ban policymakers	No evidence						
Lack of research incorporation	No situational or background reports	Reacted to a triggering factor hastily					
Lack of Governance Support	No evidence						
Policy Context							
Lack of contextual analysis							
Immediate response to surge							
Policy Process							
Lack of extensive plans							
Lack of dialogues for outcome criteria							
Struggle of policy champion	No evidence						

Shared Themes	Contrasting Themes
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3.10 Main Findings with Evidence

The analysis covered 12 publicly available policy documents alongside three internal minutes. I achieved a 100% analysis rate, which was a great outcome. I took the initiative to personally email all 12 ban makers and received a response from 5 of them (42%). I followed up with phone calls for the remaining seven ban makers (58%). Data saturation was achieved when interviewing nine SLT ban makers. The initial themes we obtained from these two methods - policy document analysis and in-depth interviews - were instrumental in shaping the final themes.

While presenting the quotes and evidence related to a particular topic, I used the labels mentioned in the policy documents and the identification numbers assigned to each transcript. This approach helped me to organise the data systematically and present it in a more structured way.

The key findings from Study A have been organised around each objective and presented through a thematic lens (3.2, page 146). Section 3.10.1(page 186) delves into Objective I of Study A, which focuses on 'Policy Content' such as visions, missions, aims, policy instruments, and legitimacy and includes themes related to this objective.

Section 3.10.2 (page 195) explores themes related to 'Policy Actors', their interests, power, and intentions regarding Objective II. Objective III, which deals with contextual factors and articles, is discussed in Section 3.10.3 (page 202), where we present the relevant themes (Policy Context). Lastly, Section 3.10.4 (page 208) highlights themes and supporting evidence for Objective IV concerning the Policy Process. As explained in section 3.2.1 (page 146), three out of eight research questions are linked to be answered under these objectives.

3.10.1 Policy Content

Main Theme- The SLT ban falls under the National Alcohol and Tobacco Act, which is three decades old and has a scope beyond the WHO Framework Convention on Tobacco Control (FCTC).

Both the participants and policy documents made it evident that the ban on SLT was formulated as secondary legislation as per the National Tobacco and Alcohol (NATA) Act. Five of the nine participants stated that the prohibition was formulated by referencing two specific terms outlined in the NATA Act. The remaining four individuals mentioned that they were invited to join the subcommittee responsible for creating the ban at a later stage, which left them unsure about its origin. They said the regulation had already been drafted when they joined the subcommittee. For example, one participant shared... "we refered to the two main sections sections of the NATA act and establish the regulation." (Interview 01A-PoA01)

Another participant said...

"...I joined in the middle of the project as I was invited a little later. The initial draft was already in place when I attend the first meeting.." (Interview 08A-PoA08)

The main objective of the NATA Act, the primary legislation, was to establish a central authority within the Ministry of Health. This authority had been supposed to be responsible for developing policies to protect public health from the harmful effects of alcohol and tobacco consumption. In this requirement, this central authority, named the National Authority for Alcohol and Tobacco (NATA), was established to achieve four key goals. These four goals were as follows.

- 1. Establishment of the national authority on Tobacco and Alcohol to identify the policy on protecting public health...
- 2. For eliminating Tobacco and Alcohol-related harm through assessing and monitoring the production.

- 3. Marketing and consumption of tobacco products and alcohol products... to make provisions discouraging persons, especially children, from smoking or consuming alcohol,
- 3. By curtailing their access to tobacco products and alcohol products... (Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf)

As previously stated, the ban was created using sections 30 and 33 of NATA Act. Section 30 of the act grants the health minister the exclusive authority to establish regulations for controlling and preventing tobacco use in Sri Lanka as below:

"The minister may make regulations in respect of any matter required by this Act to be prescribed or in respect of which regulations are authorised or required by this Act to be made". (Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf) Per the NATA Act, the Minister of Health is supposed to adhere to the provisions that forbid them from disregarding the authority and power delegated to the Board of Members. In other words, the House of Parliament appoints a set of Board Members, and policies were supposed to be formulated as collective decisions among them. Moreover, the Act establishes clear guidelines for distributing responsibilities between the Minister and these Board Members. The primary purpose of these guidelines is to ensure that the Minister cannot act individually violating the power in the decisionmaking process for tobacco control and prevention programmes. Therefore, it is obvious that this approach of the NATA Act promotes a fair and balanced approach to decision-making and prevents any unconstitutional or unjust exercise of power by the Minister.. For example, the following statement in the NATA act ensures these boundaries are met to ensure balanced decision-making. If SLT Ban policy-making had followed these guidelines as they are, it would have been an ethical and balanced outcome.

"Without prejudice to the generality of the powers conferred by subsection (1), the Minister may make regulations."

(Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf)

Moreover, as mentioned above, by the NATA Act, the government of Sri Lanka appointed a broad management to make the decisions for controlling and preventing

tobacco epidemics, including the SLT epidemic in Sri Lanka. The evidence of the positions and contributions of these board members will be presented in section 3.7.2 under the results of the Objective II-policy actors.

Furthermore, as presented above, the study revealed that the SLT ban is secondary legislation to the NATA Act. Again, as I gave earlier in this section with evidence, the NATA act expresses a broad primary legislation, of which the vision is to ensure the public health of the people in Sri Lanka by controlling and preventing tobacco use. Moreover, the act clearly states it aims to establish a National authority which will work full-time in making policies to solve various public health threats caused by using tobacco and alcohol. However, as presented in the quotes above, policy actors confirmed that the ban was a fast decision, directly referring to sections 30 and 33. Section 30 of the NATA Act, as presented with evidence below, stresses the need to set regulations on the types and categories of SLT products. For example:

...minister may make the regulations: a)....,b) Specifying the types or categories of tobacco products which do not generate smoke...

(Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf)

These evidence reveal that the ban policy relied on two statements in the primary act. Moreover, no formal situational analysis or background report was conducted before the policy-making process.

The NATA Act is an important policy document, but it doesn't provide enough detailed and evidence-based policy guidelines for controlling and preventing the use of SLT. Additionally, the Act doesn't suggest a nationwide comprehensive ban on all SLT products, which could be a critical step in reducing the prevalence of SLT use. Section 30 of the Act doesn't offer specific SLT control and prevention policy directions. Therefore, it's essential to create comprehensive policies that address the issue of SLT use and its adverse effects on public health. Section 30 of the NATA Act reads as follows...

...Minister may make regulations.

- a) to Identify the tobacco products that are harmful or dangerous to human health, -
- b) b) to identify the types or categories of tobacco products which do not generate smoke....

(Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf)

Section 33 of the act outlines various areas, such as SLT, where secondary legislation may be developed.

...Minister may make regulations- a) Identifying the tobacco products that are harmful or dangerous to human health, b) Specifying the types or categories of tobacco products which do not generate smoke...

(Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf)

In a series of interviews with the SLT ban policymakers, specific concerns were raised regarding the lack of connection between sections 30 and 33 of the primary legislation and the justification for introducing the ban hastily. The question focused on their decision to impose a complete ban based solely on these two statements. Specifically, the interviewees questioned whether the evidence was sufficient to justify such a sweeping measure and whether less restrictive alternatives had been fully considered. The majority (10 out of 12) stated that they could not conduct a situation assessment or survey before formulating the policy. These statements align with the findings of the policy document analysis. The results of the policy documents indicated that no background reports, situation reports, or needs assessment surveys had been conducted before formulating the legislation. The following is one of the statements supporting these findings:

"...It would have been better if we had conducted a survey or a situational report before implementing the ban. But we couldn't. especially since we were in a hurry..." (Interview 02A-PoA02)

Instead of discussing the evidence that assisted in formulating the ban, policymakers said they believed the ban would be a good solution to solve the problem urgently. For example, of the SLT ban policymakers involved in the policy development process from the outset, the majority (seven out of nine) expressed their conviction that a ban was the optimal solution for managing the substantial surge in the importation of SLT

items from Kerala, India. They argued that they assumed the ban was necessary to protect public health and that the risks associated with SLT consumption outweighed any potential benefits. For example, one participant said:

"..We didn't have time to waste as large quantities of various types of tobacco and areca nut products were being imported into the country from India, particularly from Kerala." (Interview 01A- PoA01)

After the first few meetings of the subcommittee, some people were asked to join later. However, these individuals claim that they were told that the ban on SLT had already been decided before they joined. Therefore, they were not allowed to share their ideas or viewpoints.

Despite the lack of opportunity to contribute to the decision-making process, these individuals wholeheartedly endorsed the policy. For example, they have started believing that the ban was an effective measure to combat the problem of betel quid chewing and the subsequent development of oral cancers. Their endorsement had been based on their understanding of the harmful effects of SLT and the need for an urgent intervention to curb its use. Therefore, they supported the publication of the gazette and hoped it would bring about a positive change in the community. One of such a ban policymakers joined at a later stage of the ban-making process said:

"It was true there were no strong evidence from Sri Lanka to assume that a ban will be successful. But we had a gut feeling it would be successful..." (Interview 01A-PoA01)

"I wasn't there from the beginning. They invited me later on. I'm afraid I don't know how the ban was initiated. If you contact Dr. ..., you can hear the entire story. You could say that he was the one who started the process of making the ban." (Interview 08A-PoA08).

In September 2016, the Ministry of Health released the ban regulation as an 'extraordinary gazette'. The extraordinary gazette stated the main content as follows.

...No person shall manufacture, import, sell or offer for sale any tobacco products specified in Schedule I and II.

Schedule I- any smokeless tobacco product which does not generate smoke.

Schedule II- any flavoured, coloured, or sweetened cigarette that contains tobacco or any electronic cigarette that contains tobacco.

Smokeless tobacco product means any tobacco product does not generate smoke... (Policy document 06- NATA.01/09/2016.Regulations.NATA.pdf)

Based on the content of the regulation presented, the gazette has banned smokeless tobacco (SLT) products and electronic cigarettes that contain tobacco and flavoured, coloured, or sweetened cigarettes. However, after analysing the policy document, no evidence was found regarding the reasoning behind the prohibition of electronic cigarettes and flavoured cigarettes. It is worth noting that only one out of nine people interviewed knew these bans were included in the gazette. He said that these two bans, despite SLT, were added at the last minute to prevent any future epidemics in Sri Lanka, such as an electronic cigarette epidemic.

In addition, an analysis of policy documents has revealed four main legal actions that can be taken against anyone who violates laws related to the NATA Act. These four legal actions, listed in the NATA Act, cover the laws against violations of SLT bans. They are listed below.

- a) produced for a convention after a summary trial before a magistrate.
- b) Be subjected to a maximum fine of two thousand Sri Lankan rupees.
- c) imprisoned for a maximum one-year period.
- d) or undergoing both fines and imprisonment.

Moreover, Section 33 of the NATA Act further expresses these penalties given for lawbreakers as follows:(2) Any person who contravenes the provision of subsection (1) shall be guilty of an offence under this act and shall, on convention after summary trial before a Magistrate, be liable to a fine not exceeding two thousand rupees or to imprisonment for a period not exceeding one year or to both such fine and imprisonment.

(Policy Document 04- Parliament.29/10/2006.NATAact.NATA.pdf)

Approximately thirty years ago, Sri Lanka introduced the National Tobacco and Alcohol Act (NATA), the primary legislation to the SLT ban, to combat the tobacco and alcohol epidemics in the country. The evidence showed this. Howeverprimary legislation falls outside the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). As the primary goal of Study A was not to study the primary legislation, this study did not go into the details of the Act. However, study participants confirmed that the Act was formulated before the introduction of WHO FCTC and that there are discrepancies between the FCTC articles and the NATA Act.

While it was already known that the SLT ban (secondary legislation) was not in line with WHO FCTC, this new finding regarding the primary act is significant. Moreover, among the nine ban policymakers, five were familiar with the historical progress of the NATA bill, while the remaining four had limited knowledge about it. The Hansard report on the second reading of the NATA bill includes a few statements related to the history of the NATA Act. Additionally, one of the interview participants said a team of health science and medicine professors originally proposed the bill in the 1990s.:

"...and the bill's aim was originated by a team of professors in the 1990s. They mainly consisted of professors in health sciences, medicine, and related disciplines."

(Interview 01A-PoA01)

Furthermore, the available evidence has revealed that the primary reason for the extended delays in passing the NATA bill at the executive and legislative levels could be be attributed to the big tobacco industry's continuous and persistent lobbying efforts. The tobacco industry in Sri Lanka enjoys a monopoly on the manufacturing of

smoking tobacco. It has exerted significant influence over decision-makers responsible for passing the NATA bill.

Following is one of the statements made by an interview participant supporting these findings:

"Tobacco companies have been trying to influence high-level politicians since the beginning of the NATA bill. For instance, they contacted the health minister before the bill was read in Parliament. Luckily, xx could call the minister on the same day and inform him about the situation. He expressed his gratitude" (*Interview 08A-PoA08*) These lobbying efforts have been conducted through various means, including direct communication with decision-makers, funding political campaigns, and creating a public relations campaign to sway public opinion on the bill. The tobacco industry has also been accused of using its financial resources to develop a network of influential individuals who can promote their interests regarding the NATA bill. For example, one participant said,

"It says the tobacco industry was actively trying to influence the NATA bill by directly engaging with decision-makers and funding political campaigns. They were also using their financial resources to establish a network of influential individuals to promote their agenda" (Interview 07A-PoA07)

Despite widespread public support for the NATA bill, the tobacco industry's lobbying efforts have led to significant delays in its progression. These delays have caused frustration among the bill's supporters, who argue that the tobacco industry's influence over decision-makers undermines the democratic process and risks public health.

For example, one participant said:

"It took 20 years to get the NATA bill to parliament because the tobacco company consistently obstructed it" (*Interview 08A-PoA08*)

In essence, the tobacco industry's lobbying activities have hindered the progress of the NATA (National Anti-Tobacco Association) bill. These efforts have been carried out through various methods, and their negative impact on the democratic process and public health should not be underestimated. This finding shed light on the political context of the SLT ban and its possible effects on the smoking tobacco business. Following is one of the statements supporting these findings:

"...Although the development of the NATA bill began in the 1990s, it faced significant delays in being presented to parliament, mainly due to the extensive interference by the tobacco and alcohol industries. For decades, the tobacco industry spent large sums influencing most government decision-makers, including cabinet ministers and other parliamentarians.."

(Interview 01A-PoA01)

The PhD study did not deeply analyse the content of the NATA act, except for its vision, missions, and two sections related to the SLT ban, as it was not within the scope of the study. However, as a policy developed by non-WHO FCTC in 1997, there are gaps in addressing the tobacco issue in Sri Lanka. These gaps include the lack of provisions for the demand side, like behavioural change modifications, health education, and medical and therapeutic assistance to people seeking cessation aids. These deficiencies in primary legislation impact the quality of SLT control and prevention programs.

The Act has delegated the Board Members to develop new policies to address these gaps. Nevertheless, this study finds that when creating the SLT ban, the NATA office didn't appoint its Board Members. In other words, it is evident that the NATA, the central agency responsible for creating tobacco prevention and control policies, did not have authorised policymakers appointed by the act when the agency imposed the ban on SLT. The Act confirmed those nominated policymakers to represent all key government ministries relevant to tobacco control and prevention in Sri Lanka. Therefore, formulating a nationwide policy for a culturally sensitive issue without proper representation from all sectors could result in an information gap and a lack of insight generation. For example, one participant said,

"When we set up this subcommittee, there was no formal board of members at the NATA office" (Interview 01A-PoA01)In summary, the SLT ban was introduced to address the sudden increase in imported SLT products from India and neighbouring countries. This was due to newly imposed bans on SLT and areca nut products in

certain provinces of India and neighbouring nations from 2015 to 2016. Additionally, the ban policymakers believed that the ban would be the most effective solution to tackle the chronic use of betel quids and other SLT products in Sri Lanka. Moreover, according to this study, the SLT ban in Sri Lanka was introduced to reduce oropharyngeal cancers. Still, there is no evidence of any plans, monitoring or evaluation frameworks to support this specific regulation. The ban is based on sections 30 and 33 of the primary tobacco control legislation in the Sri Lanka-NATA Act, drafted in the 1990s. However, there are some gaps between the service needs of SLT users and the provisions of the NATA Act.

3.10.2 Policy Actors

Main Theme- The policymakers of the SLT ban were a small and relatively homogeneous group with limited power.

According to this study, the decision to prohibit Smokeless Tobacco (SLT) was formulated by a subcommittee consisting of roughly 10-12 members. Upon analysing internal meeting records, attendance sheets, and interview data, it was found that 7 out of 12 members were oral health experts, with one legal officer and one sociologist among them. The remaining members were invited to participate in the meeting once or twice. The subcommittee was established by the NATA (National Authority on Tobacco and Alcohol) Chairman in response to a request from a distinguished consultant in community dentistry who had connections to the National Hospital for Oral Health.

The subcommittee was initially established as the "Smokeless Tobacco Project" to develop SLT policies to address the service needs of high-risk groups. However, data from policy documents and interviews with some of the decision-makers revealed that the subcommittee struggled to obtain authorised power to create policies that would control and prevent the spread of the SLT epidemic in the country. This was because the official authority was with "appointed members", and the subcommittee members had no appointed power until the end. They further stated that one member of the SLT

committee was appointed as a broad member after years of tireless efforts. For example, the following is a statement made by a participant:

"...None of us were board members of the NATA as powered by the Act. We made several requests to appoint us to the board of members. ...Finally, they agreed to appoint one was in our team, Professor X, as a board member... after years of requests."

(Interview 01A-PoA01)

The members of the Smokeless Tobacco Project have been asking for authorised power in the SLT policy-making process since the beginning. After some discussion, they agreed to request official power for at least one senior professor on the committee. A statement made by one of the participants gives a shred of evidence for this finding:

"... Prof xxx suggested endorsing the project committee as a subcommittee by NATA and preparing a board paper for the NATA board." (Internal Minutes-40th meeting-30/09/2019-Smokeless Tobacco Project Committee)

After analysing policy documents, it was found that the main objective of the NATA Act was to appoint senior officers from various fields as board members. These members were supposed to develop and monitor tobacco control and prevention policies in Sri Lanka. However, despite the Act's provisions, eight interviewees reported that NATA did not have any board members in developing the SLT ban policy in 2015 to 2016.

... There should be 14 board members in the authority. According to the act, they all would be top-level officers of each ministry and a set of community leaders.

(Policy document 02-Parliament.05/07/2006.hanzard.srilankaparliment.pdf)

This indicates why a specific subcommittee was formed for the SLT control and prevention project. The subcommittee was formed with some external experts who did not have the direct authority granted by the Act to create the ban. However, interviews

revealed that these members had worked under the supervision of the chairman of the NATA.

The subcommittee was formed to address two issues. Firstly, there are gaps in the provisions provided by the primary legislation, and secondly, there is a mismatch between the current situation and the envisaged situation in forming SLT policies. This is another piece of evidence for this line of interpretation:

"...and the NATA was functioning without a broad of members at this time."
(Interview 04A-PoA04)

During the SLT project committee's initial stages, an essential document was discovered that shed light on the actors involved in the committee and the ban's formation. This internal minute was the committee's first document, listing the committee members, their roles and responsibilities, and the committee's objectives and goals.

Among the significant findings in this document were the eight organisations that would receive assistance to combat SLT tobacco, including the ban. The minute's detailed listing of these organisations highlights the committee's commitment to engaging with diverse stakeholders and creating a comprehensive strategy for achieving its goals despite being disrupted later. These are the listed organisations:

- a) National Cancer Control Programme
- b) Faculty of Dental Sciences University of Peradeniya
- c) Alcohol and Drug Information Centre (ADIC)
- d) Centre for Combatting Tobacco (CCT) University of Colombo
- e) World Health Organisation
- f) Apeksha (Cancer) Hospital
- g) National Dangerous Drug Control Board
- h) Verite Research
- i) Authorised Officials of Health, Police, Excise, and Customs.

- j) Sri Lanka Dental Association
- k) College of Dentistry and Stomatology of Sri Lanka.

Although these stakeholders were initially listed in the meeting minutes, seven out of nine SLT policymakers reported that only a handful of invitees from specific organisations attended meetings when necessary. They noted that the attendance of these invitees relied on the topics discussed in previous meetings despite regular communication.

Moreover, according to this study, each meeting had an attendance rate of 40% to 45% for regular members, while another 40-45% had valid excuses for not attending. The remaining members (15% to 20%) were absent in every meeting. One session had two invitees, but the other had none. Out of nine people, four mentioned that most members came from different work settings, such as hospitals and universities, making it challenging to attend the committee in Colombo. This resulted in longer communal times. Following is a statement made by one participant as an example of the finding:

"...you know it is not easy to travel to Colombo for a meeting from Kandy. Those days, we were not familiar with these kinds of Zoom meetings or online meetings. So, I attended only a few meetings..." (Interview 07A-PoA07)

The policymakers admitted that they had no specialised training in public policymaking, monitoring, and evaluation before implementing the SLT ban. However, they confirmed that they had undergone various training programs and awareness courses related to leadership and supervision at different stages of their academic and professional careers. Despite not having specialised training in public policy-making, monitoring, and evaluation, the policymakers were confident in developing and implementing the ban. The ban's effectiveness is yet to be determined. Still, the policymakers firmly believe it was a successful intervention for the long-lasting SLT epidemic and the oral cancer epidemic in Sri Lanka. As an example, one of the participants said: "...We gathered as a subcommittee as Dr X...invited us. Nothing was that formal. There were no rooms for arranging any policy-making training. But we managed..."

(Interview 03A-PoA03)

In addition, Table 3.4, which can be found in section 3.4.6 of this chapter, summarises the power-interest analysis of the ban makers based on the evidence presented in this research study. Furthermore, section 3.8 of this chapter will discuss these findings in conjunction with their power distribution.

Subtheme- The SLT ban makers embraced collective thinking.

As per the study, a select committee of specialists, primarily hailing from the same discipline, called for the SLT ban. The investigation revealed that this group lacked the mandate to formulate such a policy, yet they proceeded with it, guided by the chairperson of the National Tobacco and Alcohol Authority. Secondly, the study revealed that this group of experts were collective thinkers. This means they relied heavily on group and consensus-building rather than individual decision-making. This approach is often seen as an effective way to make informed decisions, as it considers all group members' perspectives and opinions. However, in this case, it raises questions about the legitimacy of the ban and the extent to which it was based on sound scientific evidence.

It can be inferred that the ban on smokeless tobacco in Sri Lanka was believed to be successful by 8 out of 9 ban makers right from the start of the ban formation. However, the ban was set as an urgent policy to prevent the surging rise of SLT from neighbouring countries following laws implemented in those countries. The study revealed that the ban formation lacked references to research evidence or contextual assessments. Although many interview participants expected the ban to impact the prevalence of oral cancers in Sri Lanka significantly, they also acknowledged that the long-lasting use of SLT in Sri Lanka has a multidimensional nature. Despite possible adverse effects, the confidence of the ban policymakers in their decision had been high. For example, one of the SLT ban policymakers said:

"...As you may be aware, Sri Lanka has been facing a high number of oral cancer cases for many years. The ban on betel chewing was expected to significantly reduce this issue, particularly among adult males, who are the most affected by oral cancer.

It is worth noting that oral cancer is the most prevalent form of cancer among men in Sri Lanka, and as a result, the government spends millions of rupees on the treatment of these patients...."

(Interview 02A-PoA02)

Another participant said:

".. It was clear that we all wanted to reduce the consumption of smokeless tobacco, particularly betel chewing, and take responsibility for decreasing the incidence of oral cancer...." (Interview 04A-PoA04)

Moreover, during these interviews, the majority said the committee members knew the answers to all my queries, including how, why, and what questions. They said that the so-called member pioneered the SLT ban formation. Furthermore, they (7/9) said they joined the committee as this pioneer invited them to join. For example, one participant said:

"...Dr x...knows every detail of this ST ban development is well known. This was mainly his project."

(Interview 03A-PoA03)

The decision to ban SLT was heavily swayed by the individual who presented the idea. Little critical analysis or scientific reasoning was applied, and alternative solutions were not explored. The ban was enacted hastily, likely in response to neighbouring regions with similar laws already in place. These factors suggest that the team responsible for the ban may have acted as a unified group without thoroughly weighing all possible options.

During the study, a participant known as the pioneer revealed that the Chairman of NATA had given him the liberty to select committee members personally. As a result, he had the power to extend an invitation for me to join the committee, reinforcing the previous statements. To illustrate this freedom, the pioneer explicitly stated that he had the authority to invite me as he saw fit. This affirms

that the choice to include me in the committee was entirely up to his discretion, by the Chairman of NATA's guidelines.

"And the chairman gave me total freedom to choose the members." (Interview 01A-PoA01)

Furthermore, none of the nine participants had any alternative proposals or policy ideas to share, and all said they were happy about the ban as a policy decision to control and prevent the SLT epidemic in Sri Lanka. One participant's statement serves as evidence of the group's tendency towards collective thinking when it comes to the ban policy:

"... We were responsible for doing something to reduce oral cancer numbers.

Banning was the best solution".

(Interview 04A-PoA04)

Although the initial intention behind the ban on smokeless tobacco (SLT) products was to reduce the import of such items from neighbouring countries between 2015 and 2016, the regulation now applies to all domestic SLT products, including betel quids. The decision has been controversial and has led to communication complexities. However, most interview participants believe this was the right time to ban local SLT products. Collective thinking has brought this noteworthy discovery to light.

Section 3.8.2 presented some interesting findings of the SLT ban policymakers (policy actors). The data showed that the makers of SLT's ban were a small team with limited power and diversification. They tended to think as a group. The project was started under the direct supervision and permission of the NATA Chairman, but none of the committee members had any appointed power. The pioneer of the SLT ban invited the other members, and the majority believed that the ban was one of the best solutions for the SLT epidemic in Sri Lanka. They assumed the ban would significantly reduce the number of SLT and areca nut-related oral cancers. The majority supported the ban as the ultimate decision without being concerned about potential unintended consequences. None of them had alternative policy options. Furthermore, the NATA

office had no appointed members or board of members to work with during the development of the ban.

3.10.3 Policy Context

Main theme- The ban's development failed to consider important structural factors.

In the background chapter, the reviewed literature illuminates the complex nature of the SLT problem. Various factors, including cultural traditions, beliefs, social status, political influence, and environmental conditions such as tobacco farming, impact this multifaceted issue. Despite these contextual complexities, the study's results indicate a limited connection between the SLT ban's policy formation process and the SLT crisis's underlying context.

Most (7/9) SLT ban policymakers interviewed shared that while they could not anticipate the unforeseen effects of the ban during its creation, they subsequently witnessed it drawing criticism from prominent figures in their community, including Buddhist monks and local politicians. They elaborated that using betel quids with tobacco leaves and similar items is deeply intertwined with Buddhist culture and traditions. Consequently, they noted that Buddhist monks have been vocal in their opposition to the ban, citing their desire to safeguard their customs from being harmed by such legislation. For example, one participant said:

"...Buddhist Monks were not happy. They thought this could be a cultural attack by Western countries..." (Interview A02-PoA 02)

Another participant said:

"... You know, when our monks are unhappy, we cannot do anything". (Interview A03-PoA 03)

Four of the nine participants shared their difficulties replacing traditional tobacco and areca nut trays with healthier betel trays in Buddhist temples. Unfortunately, this initiative did not produce the desired outcome. One participant mentioned that the healthy tray concept was not as popular as they expected despite being introduced to parliament by the minister. For instance, one participant said:

"...that healthy tray concept also was not as popular as we expected. Our minister introduced it even to the parliament. But you know..."

(Interview A01-PoA 01)

Four individuals regret holding a media conference right after implementing the ban. The meeting led to public backlash against the points discussed. The participants claimed that the Minister of Health and other high-ranking officials were absent at this national-level media conference. As a result, the message they were trying to convey was not effectively communicated to the intended audience. According to these four SLT ban makers, the SLT subcommittee wished to regulate the usage of areca nut alongside the ban on smokeless tobacco (SLT) products.

The committee could not find any law that specifically bans the use of areca nut, a carcinogenic substance present in traditional and commercial SLT products in Sri Lanka. The Minister of Health advised them to develop regulations for banning areca nuts. Still, they couldn't create secondary legislation based on it, so they included the areca nut ban within the SLT ban. The officials' primary objective in conducting the media conference was to ensure public safety and well-being. However, the decision to announce the ban on traditional betel quids along with SLT and areca nut during the media conference without the support of the Minister of Health had backfired, according to the four interviewees. For instance, the following are three statements made by these participants:

"... we aimed to somehow control this betel chewing habit, especially with areca nut and tobacco. That's why on that day, we wanted to say this law banned the dangerous practice..."

(Interview 01A-PoA01)

"...but you know, we couldn't find any act or other law to ban areca nut. Even in the agriculture ministry, there are no provisions for controlling the use of areca nuts. I don't know what we can do..."

(Interview 01A-PoA01)

"...however, if the minister led the media conference, things could be successful...but you know he could not attend that day..."

(Interview 03A-PoA02)

One of the participants mentioned that they found out later that the Minister of Health had instructed the policy enforcers in districts and provinces not to take the ban on traditional betel quids seriously despite the possible adverse effects. The minister's behaviour can be interpreted as a strategic approach to prevent any cultural shock over the sudden ban on traditional betel quids.

Sub-theme- During the parliamentary proceedings, some key intentions of the SLT ban were not disclosed.

After thoroughly reviewing the policy documents, it was discovered that the Minister of Health did not mention any details about prohibiting traditional betel quids during the parliament session, which was held with the purpose of presenting the regulation to the parliamentarians and seeking their approval. Notably, this session took place approximately eight months after the introduction of the legislation. It should also be emphasised that the minister stated that the ban on smokeless tobacco (SLT) was to prevent the emergence of illegal SLT products from Kerala, India, and other neighbouring countries. For instance, the minister of health made the following statement in 2017 during the House of Parliament session when seeking approval for the ban.

The Minister of Health: "....and some people request to ban these completely. But from the health side, the medium pathway is the best....and America and some similar countries have reversed their tough policies due to these bad experiences."

(Policy document 03-parliament.07/04/2017.hansard.srilanakaparliment.pdf)

Nevertheless, another finding from the policy document analysis shows a similar mismatch between the statements made by the health minister at the House of Parliament and the circular he issued later to health staff at the ministry level. According to this circular released for employees, the Ministry of Health has prohibited betel quid consumption with areca nut and tobacco in healthcare settings. The following evidence shows how the minister has struggled to ensure electoral perspectives over the comprehensive ban on SLT products in Sri Lanka.

For instance, the circular prohibiting betel quid chewing at the ministry of Health (2018) level says:

...Chewing betel quids has been a social and cultural habit in Sri Lanka since ancient times.

(Policy document 11- MOH.20/03/2018. Prohibition.MOH.pdf)

Three interview participants said the minister might not be happy to lose the votes or government popularity by saying he banned the traditional use of betel quid. They further said they suspect he and his government could face an election those days. For example:

"...really, I cannot believe it. He was the one who wanted this ban to be introduced sooner. Maybe he had an election, so he hid it. I don't know..."

(Interview 01A-PoA 01)

...and he was the one who wanted to ban smokeless tobacco and areca nut. He was worried people were dying from oral cancers.

(Interview 03A-PoA 03)

"...you know, in Those days, the minister sent us several requests to make a regulation for banning areca nuts, too."

(Interview 01A-PoA01)

Eight out of nine respondents in this study expressed confidence that enforcing the ban on betel quid and smokeless tobacco products would be relatively straightforward,

as they had believed that most individuals would adhere to the law. Respondents considered the ban robust legislation and did not anticipate any significant obstacles. Moreover, 7 out of 9 participants had presumed that both traditional betel quid users and those who consume illegal SLT products would comply with the law or else face legal consequences such as fines and imprisonment. For example, one participant said:

"...you know. This is a law. No one would be happy to get fined or go to jail. So, they were supposed to obey the law..."

(Interview 01A-PoA01)

And another participant said as below:

"...and people usually worry when they know they must go to jail and pay fines if they sell betel quids. So, we wanted to end up the trouble..."

(interview 02A-Poa02)

The discrepancy between statements made by ban policymakers at the interviews and the minister of health at the House of Parliament is a significant finding that shows the minister's struggle to ensure the electoral perspectives among the potential adverse effects of the ban policy over prohibiting traditional betel guids.

A majority said (6/9) that the unexpected rise of SLT and areca nut products imported from Kerala, India, was an emerging issue for Sri Lanka during 2015-2016. They further said the reason for this unexpected rise in importing SLT products was the banning of SLT and areca nut products in some provinces of India. Moreover, they said it is true that these drastic changes in entering imported SLT products to Sri Lanka led to speeding up the development activities of the ban. But they further said the primary intention of the Minister of Health and the subcommittee was to prohibit all types of SLT products in Sri Lanka, including the traditional betel quids. They further said the Minister of Health repeatedly asked them to make a regulation to ban the use

of areca nut in Sri Lanka as soon as possible. However, they said Sri Lanka has no primary legislation to help restrict the use of areca nuts, so they did not do that.

Nevertheless, after six months of introducing the ban, the minister had to table the regulation in the House of Parliament as ordered by the NATA Act. He might have understood the possible negative consequences, including losing political stability, in mentioning that the ban prohibited all SLT products, including traditional betel quids. So, he said any law against the betel quid, which is a part of the primary culture in the country. For example, the following was a statement made by the Minister of Health at the Parliament when he sought approval for the regulation. He said the comprehensive ban can cause lots of adverse effects. Therefore, as mentioned in the following evidence, he said the middle pathway best controls and prevents the SLT epidemic in Sri Lanka. Following is that statement.

The Minister of Health: "...Sri Lanka faces lots of issues because of tobacco and alcohol. The root causes may be unemployment, poverty, and job stress. Some people request to ban these completely. But when we think from the health side, the medium pathway is the best. When we consider world history, we can see what has happened to countries that banned these completely. They face many unexpected issues due to high consumption rates with the help of the underworld. America and some similar countries have reversed their tough policies due to these bad experiences."

(Policy document 03-parliament.07/04/2017.hansard.srilanakaparliment.pdf)

Finally, if I summarise the results presented in this section (3.8.3), which were generated parallel to objective III, the data from the policy documents review and the in-depth interviews with ban makers did not show any evidence of planned contextual assessments before the ban development. Policymakers assumed people would obey the law set by the regulation. Therefore, unintended consequences were not predicted. Some regret the ban was delivered prematurely without addressing the challenges. The evidence further shows the Minister of Health had tried to suppress the possible social and cultural unrest and ensure their political instability by weakening the complete implementation of the ban.

3.10.4 Policy Process

Main theme- There was a lack of logical integration between the ban policy development process and the underlying causes of the SLT epidemic in Sri Lanka

The findings of Study A suggest that the development of the SLT ban policy lacked a systematic approach. Interestingly, all nine policymakers participating in the study could not provide any scientific explanation for developing the ban. Additionally, the policy documents did not contain any detailed information about the stages involved in the development of the ban, except a brief statement in an internal report. This report indicated that the National Alcohol and Tobacco Authority and SLT subcommittee drafted, received approval, and implemented the SLT ban. However, aside from this internal report, there was no evidence of an evidence-based, step-by-step scientific process in creating the ban.

The Smokeless Tobacco Subcommittee carried out the following main activities....d) The NATA and ST Subcommittee was successful in drafting, obtaining approval and implementing the regulation prohibiting the manufacture and sale of ST products, Electronic Nicotine Delivery Devices and flavoured cigarettes, with effect from 01st Sep 2016 (Regulation No 01 of 2016)

(Internal report-overview of smokeless tobacco project/NATA)

Furthermore, during their questioning regarding the SLT ban policy-making process, the participants were found to be lacking in providing substantial reasoning, evidence, or steps taken to develop it. For example, one participant said:

"...Aha. Not really. We did not spend much time doing a full situational assessment or background reports".

(Interview 01A-PoA01)

Four out of nine participants recommended seeking clarification from the pioneer of the ban, as they were uncertain about the SLT ban-making process. Several (3/9)

others noted that they were invited to the meeting after the ban had already been proposed. Two members explained that the ban was hastily drafted using sections 30 and 33 of the NATA Act due to the situation's urgency, which left little time for a thorough contextual assessment, stakeholder analysis, and situational reports. For instance, two participants said:

"... as some parts of India banned ST and areca nuts, all products were coming to Sri Lanka; we also had to ban them immediately." (Interview 01A-PoA01)

"...You know, I joined the committee a little later. Ban had already decided when to join this. You can take full details by Dr... (Name of a committee member). I can say he owns all the credits for this ban."

Interview 2A-PoA02

Nine distinguished members participated in a study that left them uncertain about their decision to impose a ban on the traditional betel quid. They were worried about the effectiveness of the decision in preventing long-term quid use and curbing the sale of illegal SLT products in the black market. However, since the committee dissolved in 2020, its members haven't received any updates. Additionally, they mentioned that although they drafted the SLT ban, they didn't have any implementation or strategic plans based on the ban. For instance, two participants said:

"...we did not plan implementation. You know we had no power inside NATA until the end..."

(Interview 04A- PoA04)

"...they had already drafted the ban when we joined the team." (Interview 06A-PoA06)

Agenda setting is a crucial step in the policy-making process. However, seven out of nine participants were unaware of whether the Minister of Health brought the ban to the House of Parliament. For instance, one of the participants inquired:

"...are you sure? No, I did not know the regulation was sent to the Parliament. Can you share that Hansard report with me?" (Interview 07A-PoA07)

Nevertheless, the policy document review revealed that the NATA Act mandates the importance of following a scientific approach in tobacco control policymaking. Moreover, it gives clear directions to the involvement of all significant stakeholders in developing any regulations under the primary legislation. Furthermore, the act mentions that the decision-making process for any secondary legislation should include consultation with all stakeholders. Moreover, it mandates that all regulations and amendments receive final approval from the House of Parliament. This procedure ordered in the primary legislation of the tobacco control Sri Lanka is exemplary to ensure 1) proper protocol is followed, and 2) all voices are heard in the tobacco policymaking process. For instance, the Hansard report on the primary Act reading revealed..:

The minister agreed to bring all parties to the table to make amendments or regulations, including medical associations and unions. We will do that consultation process. Each piece of legislation needs approval by Parliament. The minister does not have sole power.

(Policy document 02- Parliament.05/07/2006.hanzard.srilankaparliment.pdf)

The NATA Act was amended to include a requirement for a systematic approach per the requests from parliamentarians. The representatives of minority ethnic groups and low socio-economic communities highlighted the importance of involving the voices of their constituents in the development and implementation of policies aimed at controlling and preventing tobacco epidemics, including SLT. In the second reading of the tobacco bill (NATA bill) in the House of Parliament, a parliamentarian representing a minority ethnic group in a rural sector made the following statement to emphasise the point.

A parliamentarian: "...according to clause 3, authority is a government-controlled body. Where is fair representation.... You must give expression to all stakeholders concerned.."

(Policy document 02- Parliament.05/07/2006.hanzard.srilankaparliment.pdf)

The results indicate a notable dichotomy between the directives stated in primary legislation and their actualisation in practical contexts. To put it differently, while the primary document offers robust guidance for crafting tobacco control and prevention policies, these directives have not been effectively integrated into tangible policy-making procedures.

According to a recent study, only one out of nine people knew the ban on smokeless tobacco (SLT) extended to electronic cigarettes and flavoured tobacco products. The individual who knew about this was the initiator of the ban and a committee member. He revealed that the decision to include these products in the prohibition was made at the last minute. The reason for banning these tobacco-containing electronic and flavoured cigarettes is to prevent potential future epidemics in Sri Lanka. Although developed countries consider electronic cigarettes as a harm-reduction strategy in cessation programs for smoking and SLT tobacco users, in Sri Lanka, they could cause another epidemic.

He further mentioned that during the drafting of the SLT ban regulation in 2015-2016, a new trend emerged where electronic and flavoured cigarettes were being used. Due to this, the decision was made at the last minute to include these two products in the ban regulation. This shows that most SLT ban policymakers were unaware that the ban had two additional products. Here are two examples that demonstrate this lack of awareness:

"...are you sure?.. Hmm...I did not know that Electronic cigarettes are also banned. I don't know why."

(Interview 06A-PoA06)

"Yes..yes..those bans were added at the last moment. We did not need any more issues. So, we banned those, too..."

(Interview 01A-PoA01)

The research on tobacco-related matters in Sri Lanka has highlighted the absence of a comprehensive scientific and contextual framework for developing policies in this area. While a total prohibition on tobacco products such as flavoured or electronic cigarettes may help prevent their use, policymakers face a dilemma when it comes to making decisions about deeply ingrained cultural practices like homemade betel chewing. Policymakers must evaluate such practices' social, cultural, and economic aspects before concluding. For instance, banning a tradition that has been a part of the Sri Lankan culture for centuries could have far-reaching consequences and may not be a practical solution. Therefore, there is a need to conduct a detailed assessment of the impact of such policies before implementing them.

Notably, a notable majority of respondents, precisely eight out of nine, expressed regret over the hasty implementation of the prohibition without adequate consultation. They have suggested that the authorities should have allowed ample time to inform the community and Buddhist monks before introducing the SLT ban policy. Furthermore, they have recommended that consultation meetings should have been arranged in multiple districts rather than just one in Kurunegala, considering that Sri Lanka has 24 districts. The respondents have also emphasised the significance of seeking opinions from local leaders and the public through these consultation meetings, a vital aspect overlooked in this scenario.

The respondents believed the SLT ban could have been more effective if the authorities had conducted proper health education, promotion, and cessation activities before implementing the ban. They suggested that such actions could have helped raise awareness about the harmful effects of SLT and the benefits of quitting. For example, the authorities could have organised workshops, seminars, and awareness campaigns in schools, colleges, and workplaces to educate people about the dangers of SLT use. For example, one participant said:

"...We regret that the ban was too early. We could have strengthened the basic interventions first..."

(Interview 04A-PoA04)

Of the 9 participants interviewed, 5 expressed regrets over the premature delivery of the SLT ban but still believed it should not be reversed. On the other hand, half of the participants said that the policymakers responsible for the prohibition later developed a comprehensive five-year strategy. This strategic plan, initiated around 2018-19, addresses the service needs not covered by the ban, providing a holistic approach to combating the SLT epidemic in the country. This strategic plan covers critical areas such as 1) strengthening health education and promotions, 2) staff training, 3) establishing a laboratory to test SLT products, 4) screening individuals with oral pathologies, and 5) strengthening cessation support. For instance, one participant said:

"Later we understood we need a wide range of strategies rather than fully really of the ban. So, wedeveloped a new strategic plan" (Interview 02A-PoA02)

Furthermore, the responses from most participants, precisely seven out of nine, indicate that their subcommittee was dissolved in 2020, which resulted in them no longer working with the National Alcohol and Tobacco Authority. Therefore, they have not received updates about implementing the SLT ban. For example, one participant said:

".. after the new chairman came, they dissolved our committee ..." (Interview 01A-PoA01)

Sub-theme- No SLT ban implementation plans had been devised as a part of the policy development process.

When asked about the implementation program for the SLT (Smokeless Tobacco) ban, all nine individuals expressed uncertainty and reported being unaware of any long-term, medium-term, or short-term strategic plans to carry out, monitor, and evaluate the ban implementation activities. They were unsure about the specific implementation activities and could not confirm if the implementers sent summary reports to the National Authority on Tobacco and Alcohol (NATA).

Furthermore, a closer look at the policy documents revealed that none of the fifteen documents had reported any action plans or strategic plans for ban implementation, monitoring, or evaluation. This lack of information regarding the SLT ban implementation program leads to concerns about the effectiveness of the ban and the

ability to monitor and evaluate its success. Without clear strategic plans and monitoring systems, ensuring that the ban is implemented effectively and measuring its impact on public health is complex. For example, two participants said:

"...As I can remember, we didn't develop any implementation plans". (Interview 01A-PoA01)

"Our subcommittee was dissolved in 2020. At that time, we didn't develop detailed plans, as you asked."

(interview 03A-PoA03)

In this section 3.8.4, I have summarised Study A's objective IV, which examined the policy process. The study found that the ban on smokeless tobacco (SLT) was quickly drafted by referencing two sections of the primary tobacco control legislation (2006) due to the urgent need to prevent an unexpected increase in imported SLT and areca nut products in several Indian provinces. The ban makers did not conduct robust contextual assessments, public hearings, or consultation meetings. Their primary goal was to ensure compliance with the law. Additionally, there was no evidence of strategic or action plans for implementing the ban.

3.11 Results of Power-Interest Analysis

As presented in section 3.5 (pages 159-166), I analysed policymakers' power, interest, and impact. The power in this analysis refers to the 'authorised' power by the House of Parliament. Interest means the individual's desire and commitment to find solutions to prevent and control SLT epidemics in Sri Lanka. Analysis was guided by Mendelow's power matrix presented under the analytical framework of this research study (2.4.6, pages 133-134).

3.11.1 Board of Members NATA

Table 3.6 (pages 216-217) showcases the power, interest, and impact of board members in making decisions to control and prevent the SLT epidemic in Sri Lanka. The study identified 14 members of the National Alcohol and Tobacco Authority's board. Among them, the Minister of Health had the highest power and interest, making their impact on SLT policymaking the most significant. Following that, 13 "authorised policymakers" were nominated and powered by the National Alcohol and Tobacco Act. Their influence was lower in comparison to the Minister of Health. Therefore, when prioritising policymakers, the Minister of Health was ranked the highest and is commonly called a 'policy champion'. The board members of the National Alcohol and Tobacco Authority were ranked second because their authorised 'power' was second to the policy champion.

3.11.2 SLT Ban Policymakers

As section 3.10 (pages 185-214) mentioned, the study revealed that a group of subcommittees developed the SLT ban, as board members were not appointed when developing the SLT ban policy. The outcomes of the analysis of the power, interest and impact of the individuals of this subcommittee were compiled in Table 3.7 (pages 218-219). The total number of these SLT ban policymakers was identified as ten. Except for the chairman of the NATA, none of the individuals in this list were found to have vested power delegated by the House of Parliament for policymakers. Therefore, their power was categorised as 'low'. However, they had been self-motivated to contribute to the SLT ban-making process; thus, their 'interests' were high.

Table 3.6.- Power, Interest, Positions, Estimated impacts and Priority Ranks of Authorised Key Policymakers and Interested Groups of ST Ban Development in Sri Lanka(Source- complied by the author following stakeholder analysis based on document analysis results, published documents) * PBA – powered by the act.

S. No	Stakeholder	Interest	Power	Estimated impact of ST ban development	Priority rank (1/2/3/4)
1.	Minister of Health Care Nutrition -2006	NATA bill was presented to the house of Parliament for the first time and second time in 2006	Appointing authority of the National Authority of Tobacco and Alcohol	High	1
2.	Member of the authority, Ministry of Health, who is not below the level of Senior Assistant Secretary	Appointing by the Minister of Health	PBA*	Moderately High	2
3.	Member of the authority, Ministry of Justice not below the level of Senior Assistant Secretary	Should receive the invitation from Chairman NATA to sit on the member board	PBA*	Moderately High	2
4.	Appointed Member 01- expert in Medicine/ other products related to tobacco and alcohol products	The Minister of Health should appoint them. May receive the title of 'Chairman of NATA as the wish of the Minister of Health.	PBA*	Moderately High	2
5.	Chairman of the National Dangerous Drug Control Board	Should receive the invitation from Chairman NATA to sit on the member board	PBA*	Moderate	3
6.	A representative of the Inspector-General of Police	Should receive the invitation from Chairman NATA to sit on the member board. Then nominated by the Inspector General of Police	PBA*	Moderate	3
7.	Member of the authority, Ministry of Education not below the level of Senior Assistant Secretary	Should receive the invitation from Chairman NATA to sit on the member board	PBA*	Moderate	3

8.	Member of the authority, Ministry of Media not below the level of Senior Assistant Secretary	Should receive the invitation from Chairman NATA to sit on the member board	PBA*	Moderate	3
9.	Member of the authority, Ministry of Trade not below the level of Senior Assistant Secretary	Should receive the invitation from Chairman NATA to sit on the member board	PBA*	Moderate	3
10.	Member of the authority, Ministry of Sports and Youth affairs not below the level of Senior Assistant Secretary	Should receive the invitation from Chairman NATA to sit on the member board	PBA*	Moderate	3
11.	A representative of the Commissioner-General of Excise	Should receive the invitation from Chairman NATA to sit on the member board. Then nominated by the Commissioner-General of Excise	PBA*	Moderate	3
12.	Appointed Member 02- expert in Medicine/ other products related to tobacco and alcohol products	Should be appointed by the Minister of Health -	PBA*	Moderate	3
13.	Appointed Member 03- expert in Medicine/ other products related to tobacco and alcohol products	Should be appointed by the Minister of Health	PBA*	Moderate	3
14.	NGO- Swarna Hansa Foundation	Technical support in policymaking, public empowerment	Power not authorised under the NATA act	Low	4

Table 3.7.- Positions, Powers, Interests, Impacts and Priority Ranking of Actual ST Ban Policymakers (Source- complied by the author following stakeholder analysis based on document analysis results, unpublished documents)

Actual Policy actors Serial number	Position and affairs	Power	Interest	Impact of policy decision
1.	Chairman, NATA (Former), Past President of the Sri Lanka Medical Association, Senior Research Fellow of the National Science Foundation (NSF), member, Board of the National Medicines Authority of Sri Lanka, Advisor, World Health Organization South-East Asia Public Health Network (SEAPHEIN)	High	High	High
2.	Senior Member, NATA subcommittee on Smokeless Tobacco, Professor in Dental Sciences and Former Dean, Faculty of Dental Sciences, Peradeniya, Chairman/ Organizing Committee, International Congress on OPMD, Oral cancer and Smokeless Tobacco and Areca nut (2019)	Low	High	Low
3.	Member, NATA subcommittee on Smokeless Tobacco, Professor in Dental Sciences, Faculty of Dental Sciences, Peradeniya, Secretary/ Organizing Committee, International Congress on OPMD, Oral cancer and Smokeless Tobacco and Areca nut (2019)	Low	High	Low
4.	Chief Coordinator, Smokeless Tobacco Subcommittee, NATA, Sri Lanka, Consultant in Community Dentistry, Head of Research and Surveillance Unit, Institute of Oral Health, Maharagama, Scientific Committee member, International Congress on OPMD, Oral cancer and Smokeless Tobacco and Areca nut (2019)	Low	High	Low
5.	Health Minister (Former), Ministry of Health, Sri Lanka and a former dental surgeon. Appointing authority of NATA	High	High	High
6.	Founding Director; Centre for Combating Tobacco, Faculty of Medicine (2016), University of Colombo, Member; Expert Committee on Tobacco, Alcohol and Illicit Drugs, Sri Lanka Medical Association since 2011; Honorary Chairperson, Board of Directors, Alcohol and Drug Information Centre (ADIC), Colombo; Honorary Consultant, Sri Lanka Sumithrayo-Mel Medura, Colombo; Senior lecturer in the Department of Psychiatry, Faculty on Medicine, the University of Colombo in Addiction	Low	High	Low

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	Psychiatry, Psychotherapy and Community mental health.			
7.	Former Deputy Director General (2015-2018), Presidential Task Force in Drug Prevention, President Secretariat, Colombo, Regional Dental Surgeon, Provincial Office of Health Services, Northwestern Province (2019-2021); Deputy Director, Centre for Research in Oral Cancer, Faculty of Dental Sciences, University of Peradeniya, Kandy (2018-2021), Advisory Panel, International Congress on OPMD, Oral cancer and Smokeless Tobacco and Areca nut (2019)	Low	High	Low
8.	Member, Expert Committee on Tobacco, Alcohol and Illicit Drugs, Sri Lanka Medical Association, Executive Director, Sri Lanka Sumithrayo, Mel Madura, Colombo (Drug Demand Reduction Program), Consultant, United Nations Development Fund, Member, Presidential Task Force on Drug Prevention, Advisor, National Drug Prevention Operation Unit, Senior Lecturer, Health Promotion Unit, Faculty of Applied Science, Rajarata University, Sri Lanka	Low	High	Low
9.	Secretary, technical advisory panel, Centre for Combating Tobacco, Faculty of Medicine, Colombo; Advisor, ADIC; Consultant Community Physician, Senior Lecturer, Public Health, University of Kelaniya, Research Fellow, Tobacco Control Research Group, Bath University, the UK, Deputy Project Director - Regional Consortium for Tobacco Industry Monitoring in the South Asia Region - Centre for Combating Tobacco Sri Lanka (2018 October onwards), Founder Editor – Tobacco Unmasked, Centre for Combating Tobacco, Sri Lanka – WHO FCTC sanctioned tobacco industry monitoring observatory in Sri Lanka (2016 onwards)	Low	High	Low
10.	Director, ADIC (Civil Organization on Demand Reduction of Alcohol, Tobacco and Other Drugs and advocate for effective policy formation for ATOD since 1996)	Low	High	Low

Part IV- Discussion and Conclusion

In the final section of this chapter, Study A was concluded with a thoughtful discussion and conclusion. The discussion succinctly outlined the study's main discoveries, compared them to the current literature, acknowledged any methodological limitations, and summarized the implications of the findings. The conclusion was the concluding part of Part IV (3.17, page 234).

3.12 Key Findings

This investigation into the development of the SLT ban policy in Sri Lanka, encapsulated in Study A, revealed critical insights into the legislative and decision-making processes.

The study's key findings revealed the SLT ban policy, enacted as subordinate legislation under the National Alcohol and Tobacco Act, operated within a policy framework established three decades ago. Interestingly, this foundational policy falls outside the World Health Organization Framework Convention on Tobacco Control (FCTC), indicating potential gaps in aligning national strategies with global directives.

Notably, the study illuminated the composition of the SLT ban's policymakers- a relatively small and homogenous group characterised by collective thinking. However, their limited influence (due to lack of delegated power by the Act) and the oversight of structural factors in the ban's development raised questions about the comprehensiveness of the policy. Strikingly, the primary intention behind the SLT ban was not explicitly disclosed during parliamentary proceedings, highlighting potential gaps in transparency.

Furthermore, a lack of logical integration between the ban's development process and the underlying causes of the SLT epidemic in Sri Lanka was identified. Perhaps more concerning was the absence of specific implementation plans devised as part of the policy development process, raising questions about the feasibility and effectiveness of the ban in addressing the SLT epidemic.

As presented in section 3.2.(page 146) the primary aim of this first phase of the qualitative case study (Study A) was to examine the SLT ban policy development

phase under four objectives. In summary, those four objectives were analysing the content of the ban policy, policymakers' powers, positions, interests and skills, contextual factors that contributed to developing the SLT ban and any systematic approach in decision making.

Drawing upon the empirical data presented in the Background Chapter, the SLT epidemic in Sri Lanka was not solely a public health threat but a complex outcome influenced by leading cultural practices, traditions, beliefs, governmental operations, socio-economic factors, and environmental conditions (1.8 to 1.11, pages 46-83). Moreover, the analytical framework of this research project was developed by combining a set of robust policy analysis theories based on this working definition of the SLT epidemic in Sri Lanka because the overall aim of the research project was to examine the successes and failures of the SLT ban in SLT epidemic in Sri Lanka in a broader manner (1.16. page 90).

Moreover, out of eight questions of the PhD thesis, three were supposed to be answered by Study A. Those, as presented in Table 2.1 (page 99) in the previous chapter, were questioning the rationale behind developing the SLT ban policy to control and prevent traditional betel quids use (research question a), the factors facilitated that decision to make (research question b), and the justification for selecting the SLT ban to prevent and control other commercially available SLT products despite traditional betel quids (research question c).

The results of this study and insights generated by them provide the answers to these gaps in knowledge raised under three research questions. As revealed by study's findings the policymakers overlooked systematic factors of the SLT epidemic, such as culture; therefore, could not find any significant scientific link between traditional betel quid chewing and the SLT ban policy. This was one sign of weak policymaking in formulating SLT ban policy in Sri Lankan context (Buse, Mays and Walt, 2012; McConnell, 2010a; Lasswell, 2013).

Moreover, insights gained from Study A revealed that the immediate cause that led to the SLT ban policy formation was a situational factor rather than the long-lasting sociocultural, economic or environmental factors of the SLT epidemic (Hallsworth, 2011b; Buse, 2010). As revealed by the findings, this situational factor was the unexpected rise in SLT products reaching from neighbouring countries, including some

provinces of India, to Sri Lanka during 2015-2016 due to SLT selling bans introduced there. This knowledge gained from the study indicates the lack of durability and applicability of the SLT ban policy to the long-term underlying causes of the SLT epidemic in Sri Lanka.

Moreover, as presented in Figure 2.2.(page 124), the successes and failures of smokeless tobacco policies can be comprehensively examined by investigating it under a few dimensions, including their political feasibility, cultural sensitivity, equity, proportionality, level of respect for autonomy, the signs of adhering to policy professional standards, and the level and quality of stakeholder consultation. Moreover, public hearings, community engagement and logical sequence in policy making and implementation matter in the success of a policy decision to control and prevent the SLT epidemic in Sri Lanka. This concept is directly linked to the working definition of the epidemic presented at the beginning of this thesis (1.16, page 90). In this framework, the insights of Study A revealed policymakers of the SLT ban policymakers did not make a sufficient effort to find a scientific approach to linking the use of commercial SLT products with the policy decision. Instead, as revealed by their statements, they had expected all ranges of SLT users to obey the common law laid down by the ban policy. This is another sign that indicates the weakness of the policymaking process and the lack of competencies.

Moreover, when comparing the results with policy success indicators listed in Table 2.3 in section 2.4 of Chapter 02 (pages 126-128, 136), the SLT ban policy seems unsuccessful in preserving governmental policy goals, confirming the legitimacy of the policy, building a sustainable coalition, and symbolising innovation. Moreover, the ban policy seems to be failed to meet the public policy values listed under domain criteria (2.4.3, pages 129-130). Additionally, the results revealed the lack of ability of the ban to enhance the electoral prospects of government, ease government business, and sustain the government's board values, which are three indicated listed under the political success of the public policy by McConnell (McConnell, 2018, 2010b).

Furthermore, Triangulating elements, or the initial themes generated following the interpretation of the findings of each method, are listed in Table 3.5.(page 216) show that most findings fall under the precarious success. As explained in section

2.4.2.(pages 125-128) precarious success in the spectrum of success to failures in public policy is an alarm for urgent policy reforms(McConnell, 2010b).

3.12.1 Comparison with Existing Literature

The results of Study A on the developmental phase of the SLT ban policy contradicted arguments that substance abuse prevention needs to follow international value-based standards (Saloner et al., 2018; Marlatt, Larimer and Witkiewitz, 2011; Room and Reuter, 2012; Glasner-Edwards and Rawson, 2010; Newman, 2001). For example, the opioid crisis, which is responsible for many injury-related deaths in America, encourages value-based collective responses at the local, regional, and central levels, according to research conducted by Saloner and colleagues in 2018 on public health strategy. This approach addresses various factors that contribute to the opioid epidemic, including poverty, racism, inadequate pain management, limited access to addiction treatment, and insufficient harm reduction services. Moreover, this innovative ecological framework involves improved data collection, stigma reduction campaigns, increased harm reduction and treatment funding, criminal justice policy reform, and regulatory adjustments for controlled substances.

This contradiction between the results of Study A and existing arguments on substance abuse prevention underscores the unique challenges and complexities associated with policy development in the context of the harmful use of SLT in Sri Lanka. While international value-based standards have been advocated in addressing substance abuse, the SLT ban's development phase in Sri Lanka appears to deviate from this approach.

For instance, the opioid crisis in the United States, as studied by Saloner and colleagues (2018), demonstrates the effectiveness of a value-based collective response at various levels of governance. This comprehensive strategy addresses not only the immediate consequences but also the underlying factors contributing to the epidemic, such as poverty, racism, and limited access to addiction treatment. The ecological framework implemented in response to the opioid crisis includes multifaced interventions, from stigma reduction campaigns to criminal justice policy reforms.

On the other hand, the divergence in the SLT ban policy development might suggest that the Sri Lankan context requires a tailored approach while aligning with broader international standards. The specific challenges and determinants of the SLT epidemic in Sri Lanka may necessitate different strategies, considering social, cultural, political, economic, and contextual factors while not violating global ethics in public health.

Furthermore, the comparison between different substance abuse prevention policies prompts us to reflect on the effectiveness of global models in diverse local contexts. It indicates that a one-size-fits-all approach to substance abuse prevention may not be suitable to tackle the unique challenges presented by different substances and situations even within one country. Policymakers and researchers must consider the intricacies of each substance-related issue, as demonstrated by the contrast between the SLT ban policy in Sri Lanka and the responses to the opioid crisis in the United States. This highlights the need for careful consideration of the unique factors that influence each substance-related issue to ensure the development of practical and culturally relevant policies within a value-based framework.

Moreover, the results of Study A challenge the need for a collaborative approach involving multiple stakeholders in policy-making for complex issues.(Stein et al., 2023; Buyucek et al., 2016; Kania and Kramer, 2013). This contrast between the results of Study A and the call for a collaborative approach from scholars mentioned above highlights a critical point of contention in policymaking for complex issues like the SLT epidemic in Sri Lanka. In other worlds, while this existing literature emphasise the importance of involving multiple stakeholders, Study A suggests that the SLT ban's development phase did not follow this collaborative paradigm.

For example, Buyucek and colleagues' systematic review (2016), focusing on social marketing interventions to control and prevent harmful alcohol use, underscores the significance of wide-ranging stakeholder engagement in enhancing the success of interventions. The findings from their study indicate that involving various stakeholders in planning, implementation, and monitoring contributes to more favorable outcomes (Buyucek et al., 2016). This collaborative approach aligns with established principles of collective decision-making and ensures a diversity of perspectives and expertise. Therefore, the high prevalence of the SLT epidemic in Sri Lanka, where traditional

betel quid chewing is the leading cause, highlights the need for collaborative policymaking.

However, applying this insight in preventing and controlling the SLT epidemic in Sri Lanka involves a nuanced understanding of the local dynamics. Therefore, future research may be necessary to identify the context-specific targeted approach for SLT issues and the appropriateness of incorporating collaborative approaches.

In other words, the insights generated from the contradiction found in approaches of the interventions studied by scholars such as Stein et al. (2023), Buyucek et al. (2016), and Kania and Kramer (2013) prompt policymakers and researchers in controlling and preventing SLT epidemic to consider whether a more focused, expert-led strategy while maintaining ongoing dialogues with stakeholders to ensure a comprehensive understanding of the issue and to incorporate diverse insights into the policymaking process.

Furthermore, a comparison between the findings of Study A and the results from Kickbusch's (2003) research on the recommendations made by the World Health Organization over time highlights significant differences in the approach to public health policymaking. The World Health Organization advocates for a context-specific, collaborative, and participatory approach to public health policy, emphasising the importance of understanding determinants, community participation, and stakeholder engagement. However, Study A reveals a deviation from these principles in the SLT ban policymaking process. The small, uniform group of policymakers overlooked the determinants of the SLT epidemic, leading to transparency issues and a lack of evidence-based policymaking. This misalignment highlights the need for a more tailored and inclusive strategy to address the complexities of the SLT issue in Sri Lanka.

Moreover, Kichbusch's research highlights a shift in the WHO's approach from a risk-based to a more holistic strategy, addressing underlying social, cultural, political, economic, and environmental factors contributing to health issues. However, the SLT ban policymaking phase, as identified in Study A, appears to lack adherence to those modern public health principles. The absence of scientific approaches, strategic lobbying, and engagement with diverse stakeholders raises concerns about the effectiveness of the policy.

Furthermore, WHO's emphasis on setting customised health targets at different levels using a 'setting approach' aligns with the insights from the gaps identified in SLT ban policymaking in Sri Lanka. The need for a shared understanding, broader legitimacy, and involvement of a wider group of communities resonates with the deficiencies observed in Study A.

Kickbusch's advocacy for governance theories and confined decision-making to 'meso' institutions contradicts the small group approach in the SLT ban policymaking. The WHO's encouragement of collaboration among various entities contrasts with the lack of network dissemination strategies in developing the SLT ban.

The broken links identified in Study A between the underlying reasons for the SLT epidemic and the policy decision emphasise the importance of expert gatherings, public hearings, and strategic approaches. The comparison with international recommendations underscores gaps in policymaking expertise in SLT control and prevention in Sri Lanka, signaling the necessity for developing handbooks, guidelines, and training programs to enhance skills and competencies among subject experts. This comparison of gaps identified in SLT ban policymaking with modern, context-specific, and collaborative public health approaches is imperative for more effective control and prevention of the SLT epidemic in Sri Lanka.

This comparison with the World Health Organization's recommendations in public health policymaking provides critical insights into the divergence between international best practices advocated by the WHO and Kickbusch and the actual policymaking process for the SLT ban in Sri Lanka. Addressing these gaps and aligning future policies with modern, context-specific, and collaborative public health approaches is imperative for more effective control and prevention of the SLT epidemic in Sri Lanka.

Likewise, the Ministerial Declaration by the United Nations Office on Drugs and Crime (UNODC) in 2019 underscores the collective responsibility of UN member countries' government representatives and ministers, including Sri Lanka, to collaborate in the global fight against substance abuse. This international commitment reaffirms the dedication of member countries to address addictive habits under international law and human rights. The declaration encourages international cooperation in decision-making, emphasising a balanced and evidence-based approach(CND, 2019).

However, as presented in this chapter, the key findings of Study A reveal a contrast between the international standards endorsed by the UNODC declaration and the policymaking phase of the SLT ban in Sri Lanka. The SLT policy-making process, characterised by a small group of homogenous experts overlooking determinants of the SLT epidemic, raises questions about the alignment with the balanced and evidence-based approach advocated on the global stage.

This contradiction highlights potential challenges in translating global standards into effective, context-specific policies at the national level. While international cooperation is encouraged, Study A suggests that the SLT policymaking in Sri Lanka may not fully adhere to the principles endorsed by the UNODC declaration. This discrepancy prompts reflection on better integrating global standards into local policymaking processes to ensure a more coherent and effective response to SLT use.

3.13 Research Gaps

Several research gaps could be identified based on the key findings and their comparison with existing literature.

- Alignment with global value-based and evidence-based directives: the study suggests potential gaps in aligning national strategies, particularly SLT ban policy, with global value-based and evidence-based directives such as the World Health Organization Framework Convention on Tobacco Control (2003) and United Nations Office on Drugs and Crime's Ministerial Declaration (2019).
- Comprehensiveness of Policymaking: the study highlighted the small and homogenous group of policymakers involved in the SLT ban development.
 Further investigations into the comprehensiveness of policymaking, considering diverse perspectives and potential influences, could be a valuable research avenue.
- Transparency in Decision-making: The lack of explicit disclosure of the primary intention behind the SLT ban during parliamentary proceedings raises questions about transparency and its alignment with the political context. Future research could delve into the transparency aspect of the SLT ban policy

- development process, its underlying reasons, and its impact on policy effectiveness.
- Logical Integration with Underlying Causes: The identified lack of logical integration between the SLT ban's development process and the underlying causes of the SLT epidemic in Sri Lanka suggests a research gap. Further exploration could focus on the implications of these gaps for the feasibility and success of the ban.
- Scientific Approach to Policy Linkages: The lack of a scientific approach in linking the use of SLT products sold in the illegal market with informal powers calls for alternative policies. Future research could investigate the importance of evidence-based policymaking and deeply assess systematic factors such as culture in addressing this harmful use of SLT products.
- Duration and Applicability of SLT ban policy: The study revealed that the SLT ban policy was an immediate response to a situational factor (triggering factor) rather than addressing long-lasting sociocultural, economic, or environmental factors. Future research could assess the durability and applicability of the SLT ban developed in response to this specific situation (an unexpected surge in importing SLT products from neighboring countries occurred due to the prohibitions on SLT and areca nut products in some provinces in India and similar countries during 2015-16.) compared to policy alternatives that could address broader, long-term, deep-rooted underlying issues.
- Stakeholder Engagement: The study identified gaps in stakeholder engagement and public consultations, which hindered the logical flow of policymaking. Further research could explore the role of stakeholder engagement and strategies for stakeholders' buy-in for the success of policies controlling the SLT epidemic in Sri Lanka. Moreover, future research could explore the impact of empowering communities in decision-making processes related to SLT ban policy or alternatives.
- Training for policymakers: A critical finding of this study is the need for new training for SLT policymakers in Sri Lanka. Further research could explore the specific training needs and strategies to enhance policymakers' skills and competencies in the SLT control and prevention field and propose the training manuals.

3.14 Methodological Considerations

This study in Sri Lanka identified gaps in developing the policy to prohibit the SLT products. As presented above, the study utilised qualitative research methods to derive insightful findings by adopting a combined analytical framework, which included a few modern policy-making and analysis theories. These theories included McConnell's (2010) policy success and failure framework, Buse and colleagues' (2012) Health Policy Triangle, and Power-Interest analysis tools derived from stakeholder management principles. The study provides insights into gaps in SLT ban policymaking using Hansard Reports, other primary policy documents, and policymakers' experiences. The meticulous planning and successful Zoom interviews aided in ensuring adaptability during the unexpected COVID-19 pandemic while mitigating risks (5.3.2, pages 311-312). The strategic approach relied on reflexivity and ethical guidelines to manage biases and ensure high-quality, unbiased data collection and interpretation.

However, Study A has several limitations that need to be addressed. This section presents insights into those inherent issues faced during the study. The impact of the Covid-19 pandemic was discussed in section 5.3.2 (page 311).

- Restricted Access to Policy Documents: One of the primary limitations of Study A is the reliance on only three unpublished policy documents. While these documents may offer valuable insights, the limited sample size raises questions about the data's comprehensiveness and representativeness. Ideally, a broader range of documents (remaining minutes and attendance sheets) would have provided a more nuanced understanding of the SLT ban policy-making phase. The scarcity of available internal policy documents might restrict the depth of analysis and limit the insights generated.
- Narrow Eligibility Criteria for Policy Document Review: Study A's eligibility criteria, focusing primarily on Parliament Hansard reports and policy documents from the central agency for tobacco control in Sri Lanka, may introduce bias and limit the applicability of findings. By excluding circulars and guidelines

issued by various Ministry of Health and regional health departments sections, the study might risk overlooking crucial perspectives and variations in the SLT ban. A border sampling approach, encompassing policy documents at diverse national, regional, and institutional sectors, could have enriched the study's scope, and contributed to a more comprehensive understanding of the SLT ban development phase.

- Interview Participants Number: The study falls short of the recommended minimum of twelve interview participants, as Taylor (2005) and others suggested. However, there is limited space to enhance the number of interview participants as a small group of professionals had developed the SLT ban policy. To improve the credibility and reliability of a study, it is recommended to invite a larger participant pool. This can be achieved by inviting policy champions, heads of other tobacco- and oral cancer-related units of the Ministry of Health, and various experts who had attended the SLT project subcommittee meetings occasionally. The larger the sample size, the more reliable and trustworthy the study's findings become.
- Challenges in Interview Dynamics: While conducting research interviews with professional colleagues and teachers, I faced specific challenges related to asking difficult questions and ensuring transparency in responses. Power dynamics emerged as a significant issue during the interviews, as some participants expressed discomfort in providing honest responses due to perceived imbalances. Additionally, the fear of potential repercussions, such as damage to professional relationships and standing, further hindered the willingness of participants to share openly. I have taken all the necessary precautions to navigate the interpersonal dynamics, as presented in section 3.5.3. This includes stating clear objectives, preserving privacy, highlighting truthful responses, using informal language, and creating a comfortable atmosphere for participants. However, biases may still influence the validity of the results. Despite my efforts to build a supportive and non-judgmental interview environment, these biases could affect the accuracy of Study A's findings in this chapter.

- Translation Methodology: The study's translation methodology introduces another layer of limitation. No professional translators engaged in the process, and no peer review was conducted in this PhD research. This raises concerns about the accuracy and reliability of the translated data. Without linguistic experts to ensure fidelity to the participants' intended meaning, the study opens itself to the risk of misinterpretation, potentially compromising the validity of the findings. However, transcripts were verified with participants, allowing them to confirm or rectify potential inaccuracies in the transcribed data, which could minimise the possible biases.
- Sole Interpretation and Source Triangulation by the Researcher: another notable limitation of this PhD research study is that qualitative data and themes generated were solely interpreted by the researcher, without the involvement of a second analyst. The absence of a second analyst introduces a potential source of bias, as the interpretation is inherently subjective. Different analysts may bring diverse perspectives and insights, contributing to a more comprehensive and nuanced understanding of the data. In other words, As the sole researcher on my PhD study, conducting the data analysis alone and not asking for the assistance of multiple coders was a limitation. However, if other researchers had been involved, I would have readily shared the codebook with them for feedback and validation. To ensure consistency in coding, we would have evaluated inter-coder reliability and addressed any discrepancies through constructive dialogue. The coding framework would have been refined accordingly to improve accuracy.

3.15 Implications

This section presents an overview of the potential applications, consequences, and significance of Study A's findings for various stakeholders, fields of study, and the broader community. The research implications identified in this chapter might help researchers, policymakers, and policy analysts understand Study A's broader impact and relevance. Moreover, this section presents policy implications, theoretical contributions, methodological implications, future research directions, and ethical implications.

- I. Policy Framework Misalignment: The potential gaps in aligning national strategies with global directives point towards the need for policy adjustments to ensure international value-based and evidence-based alignment.
- II. Policymaker Composition and Transparency: The lack of transparency in the parliamentary approval process and the small, homogeneous group in policymaking highlights the need for a more diverse and transparent policymaking process.
- III. Weakness in Policymaking Process: Lack of logical integration between determinants of the SLT epidemic, overlooking systematic factors such as culture, leading to a weak scientific link between traditional betel quid chewing and the ban policy, highlighting the need for a more evidence-based and comprehensive approach in policymaking.
- IV. The study findings suggest challenging arguments of existing literature for substance abuse prevention following international value-based standards. It questions the need for a collaborative approach involving multiple stakeholders for complex issues, in-depth context analysis, and community empowerment.
- V. Combined analytical framework with few modern policy success and policymaking theories underscore the possibility of future researchers to develop more insightful results by overcoming the limitations of this study.
- VI. Source triangulations by examining policy documents and policymakers' viewpoints aided future researchers in developing further precise research designs to analyse public health policies.

3.16 Recommendations

Based on Study A's findings and insights generated, several recommendations were emerged for refining the SLT ban policy in Sri Lanka.

- Encourage the inclusion of diverse perspectives and expertise in the policy-making process related to SLT control and prevention. Ensure the policy-making groups are more representative and transparent, fostering inclusivity and preventing potential biases associated with homogenous groups.
- Emphasise evidence-based policymaking by incorporating scientific approaches to link policy decisions with the underlying causes of the SLT epidemic. Policymakers should be encouraged to engage in comprehensive analyses that consider cultural (traditions, beliefs, norms, myths), political, economic, and environmental factors contributing to the epidemic. This will ensure the sustainability and effectiveness of policies in controlling and preventing SLT use.
- Foster stakeholder engagement through public hearings, community involvement, and strategic approaches to ensure buy-in and support for SLT control policies. This includes collaboration with local politicians, parliamentarians, community leaders, and religious figures to enhance the policy's legitimacy.
- Incorporating modern, value-based, international public health policy-making concepts into developing SLT control policies. This may involve training programs, guidelines, and handbooks to enhance the skills and competencies of policymakers in line with global best practices.
- Strengthen international cooperation by actively participating in global initiatives and collaboration for addressing the harmful use of SLT. This involves aligning national policies with international standards, sharing best practices, and contributing to a collective effort against SLT epidemics on a global scale.
- Promote empowerment and participation by incorporating participatory processes in the SLT policymaking approach. Encourage dialogue and engagement among diverse stakeholders, including health actors, regional health leaders, local authorities, and universities—professional organisations

and communities. The World Health Organization recommended adopting a 'customised health target approach' to address contextual variations in SLT use in Sri Lanka. This involves tailoring policies to specific settings and promoting a shared understanding of critical health issues, ensuring broad legitimacy and community involvement.

These recommendations aim to enhance the success, sustainability, and alignment of SLT control policies in Sri Lanka with international best practices, fostering a more comprehensive and inclusive approach to addressing the SLT epidemic.

3.17 Conclusion

In conclusion, Study A provides crucial insights into the development of the SLT ban policy in Sri Lanka. The findings underscore the need for reforms in the policy, particularly in its alignment with value-based global standards and context-specificity. The study highlights challenges in the policymaking process, including the homogeneity and limited influence of SLT ban policymakers.

Gaps in understanding the factors leading to SLT epidemic are illuminated, emphasising the complex interplay of cultural, socio-economic, and environmental contexts. Weakness in addressing the root causes, evidenced by a situational rather than a comprehensive approach, raises concerns about the policy's durability and applicability.

Comparison with international public health strategies reveals disparities, challenging the need for a collaborative approach and broad stakeholder engagement. The study recommends realigning national strategy, promoting diverse and transparent policymaking, and fostering evidence-based approaches. Policymakers are urged to address root causes, engage stakeholders through participatory processes, and regularly monitor policy outcomes. Therefore, this study critically examines the SLT ban policy, providing a foundation for its future improvements.

Chapter 4- Through the Lens of Stakeholders: SLT Ban Policy Successes and Failures

4.1 Chapter Overview

This chapter presents the second phase of the Case Study Research, Study B. It is divided into four parts: Study B's Aims (Part I), Methods (Part II), Results (Part III), and Discussion(Part IV).

To start with, Part I briefly recaps Study B's objectives, aims, and research questions (4.2, page 236). Part II is the Methods section, which includes sections 4.3 to 4.4(pages 237-251). It briefly explains the procedures and techniques employed for planning the in-depth interviews. This involves selecting stakeholders as interview participants and developing a coding framework and interview guide. Similar methods and procedures were followed as in Study A for conducting in-depth interviews, data extraction, deductive analysis, interpretation, and generating themes. To avoid repetition, cross-references to Chapter 03 have been made (3.5, pages 159-166). Part II also highlights the strategies used to maintain reflexivity and adhere to research ethics (4.4, pages 250-251). To avoid duplication, relevant areas have been cross-linked to section 3.7 (pages 168-174) in Chapter 03.

Section 4.5 (pages 252-268) covers Part III (Results) of the research. This section presents the research findings in themes supported by quotes. The themes are classified under three dimensions of policy success: process, program, and political success.

The chapter concluded with Part IV (pages 274-285), which includes seven sections: key findings (4.6, page 274), comparing with existing literature (4.7, page 277), research gaps (4.8. page 280), methodological considerations (4.9, page 291), implications (4.10, page 283), recommendations (4.11, page 284), and conclusion (4.12, page 285).

Part I – Study B's Aims and Objectives

Part I summarised Study B's aim, objectives, and research questions (2.2, pages 95-97 and Table 2.5, page 141).

4.2 Aims, Objectives and Research Questions

Study B was designed to investigate the perceptions and experiences of key stakeholders on the successes and failures of the SLT ban policy in Sri Lanka. The objective was divided into three sub-objectives.

- To analyse the process successes and failures of the SLT ban policy 2016 in Sri Lanka
- II. To analyse the programme successes and failures of the SLT ban policy 2016 in Sri Lanka
- III. To analyse the political successes and failures of the SLT ban policy 2016 in Sri Lanka

4.2.1 Research Questions

As shown in Table 2.1., Study B answered the last four out of seven research questions (d), (e), (f) and (g) to a greater extent (1.16, p90 and 2.2, p95-97)

Part II - Methods

In-depth interviews were the method of choice for collecting data for answering Study B's objectives and questions. Part II presents the systematic approaches I followed in planning and collecting data collection, organising, extraction and analysis steps.

4.3 In-depth Interviews with Stakeholders

Interviews with key people were selected to collect data according to the nature of Study B's aim, objectives, and research questions. The following were the main steps of the interview method, and they have been presented in the sections mentioned with the brackets.

- I. Selecting Interview Participants (4.3.1, p237)
- II. Sampling Strategies (4.3.2, p242)
- III. Developing the Coding Framework (4.3.3, p245)
- IV. Developing Interview Guide (4.3.4, p247)
- V. Conducting Interviews (4.3.5, p249)
- VI. Data extraction, analysis, interpretation, and theme generation (4.3.6, p250)
- VII. Reflexivity and Ethics (4.4, p250)

4.3.1 Selecting Study Participants

This section defines the study population. Moreover, it presents my systematic approach to setting selection criteria and sampling. This approach aimed to frame a study sample that could provide a rich set of data to answer the above three sub-objects and research questions (Gill, 2020; Robinson, 2014).

Study population

The study population of Study B was the stakeholders of the SLT epidemic. The stakeholders of the SLT epidemic were identified by the literature review presented in Chapter 01, by the insights gathering by conducting policy document analysis and in-

depth interviews with SLT ban policymakers presented in Chapter 03. Most stakeholders identified by the literature review were presented in section 1.12 of the background chapter. Moreover, my experiences in working in the Ministry of Health Sri Lanka for more than ten years aided this process. Table 4.1. (p240) illustrates these main categories of the SLT stakeholders in Sri Lanka.

According to these pieces of evidence, the stakeholders of SLT epidemic were three main categories: i) government officers directly involved in controlling and preventing the SLT epidemic by implementing the interventions and regulations developed by the National Authority of Alcohol and Tobacco- policy implementors ii) interest groups and experts and iii) those who were affected by the epidemic (physically, mentally, socially, culturally, economically). They include high-risk groups, SLT manufacturers, sellers, tobacco farmers, community, religious leaders, local politicians, and the public interested in betel quid-related traditions, rituals, and customs(Amarasinghe et al., 2023; Dhanapriyanka et al., 2022; Mahees et al., 2021; Somatunga et al., 2012).

Table 4.1. Key Stakeholders of SLT epidemic (SLT ban policy) in Sri Lanka

Stakeholder	Key Members
Category	
	Ministry of Health officials,
Policy Actors	National Authority on Tobacco and Alcohol (NATA) officials
	Parliamentarians (DDIII)
Deliandamantama	Provincial Directors of Health Services (PDHSs)
Policy Implementors	Regional Directors of Health Services (RDHSs)
	Regional Epidemiologists (Res), Medical Officers of Health
	(MOHs)
	Public Health Midwives (PHMs),
	Public Health Inspectors (PHIs),
	Food and Drug Inspectors (FDIs)
	Excise Department officials,
	Police Officers,
	Custom officers (Sea and Airports)
	World Health Organization's (WHO) country office,
Interested Groups	Alcohol and Drug Information Center (ADIC), Dhamrivi Foundation
and Experts	Expert Committee in Tobacco, Alcohol, and Illicit Drugs in Sri
	Lanka Medical Association (SLMA),
	Centre for Combatting Tobacco (CCT) at the Faculty of Medicine,
	University of Colombo. Center for Research (CROC) at the Faculty
	of Dental Sciences, University of Peradeniya
Llink wink own	Socio-cultural groups: farmers, fishermen, tea pickers,
High-risk groups	slum dwellers, Vedda community (Indigenous groups), religious
	priests. Specific occupational groups: schoolteachers, bus drivers,
	laborers, porters
	Youths, and adolescents: adolescents of school-going age, school
	leavers
Partners-SLT Supply	The SLT manufacturers, sellers, distributors, tobacco farmers,
Chains	illegal market dealers (local and international)
	Community and Religious Leaders
General Public	Local Politicians,
	the public, including those associated with traditions, myths and
	rituals related to betel quids, related accessories, and products

Selection Criteria

Due to logistical and financial incapacities and time constraints in interviewing participants from each type of stakeholder, the following inclusion and exclusion criteria were set to frame the interview participants. These selection criteria aimed to gain optimal insights into the successes and failures of the SLT ban policy through the lens of selected study groups (Shaheen and Pradhan, 2019; Creswell and Poth, 2016; Creswell et al., 2007).

Inclusion Criteria

The primary considerations for selecting the study population were their active participation in leading government-led regional campaigns for SLT control and prevention. Additionally, I sought to include stakeholders who work for generating expert knowledge and insights towards reshaping SLT control and prevention policies in Sri Lanka, while collaborating with the community and various other groups. Based on these crucial factors, I have identified the following individuals from Table 4.1 who meet these requirements(Balane et al., 2020; Craig et al., 2019; Mendelow, 1981).

1 Policy Implementors: Provincial and Regional Health Directors: As confirmed by the Gazette released by the Sri Lankan government on 24th January 2007, the regulation named 'Appointment of Authorised Officers' under section 16(a) of the National Authority on Tobacco and Alcohol Act, the Minister of Health had declared and appointed Food and Drugs Inspectors and Public Health Inspectors under the administrative and technical leadership of Regional and Provincial Health Directors as the authorised officers to enforce the tobacco control laws countrywide. In addition to this extraordinary gazette, section 16 of the National Authority of Tobacco and Alcohol Act (2007) declared the police officers and excise officers as other authorised officers. Therefore, the study included provincial and regional health directors as interview participants. A Provincial director administers all healthcare programs in the province, while a regional director administers those in each district (Table 4.2. and Figure 4.1). In other words, they are health leaders responsible for making decisions regarding implementing, monitoring, and evaluating SLT ban policy in their

respective regions. Therefore, it is evident that their perceptions and experiences on the success and failures of the SLT ban policy at the community level can provide valuable insights.

II. Interest Groups and Experts: Heads of Non-Government Organisations and Senior Researchers: Interest groups and experts included various subject experts and activists. For this research, leaders of non-governmental organisations and senior SLT researchers in leading universities were included in the selection criteria (Table 4.1, p240). Non-government organisations that had worked in tobacco demand reduction activities at the community level in Sri Lanka for at least the last two decades were included under this category. Senior SLT researchers who worked in subject-related research centres in two leading government universities for over five years were included under the expert category. Their role was to generate new knowledge and insights into controlling and preventing the SLT epidemic in Sri Lanka.

Exclusion Criteria

As mentioned above there were two main exclusion criteria.

- I. Individuals affected by SLT epidemic were excluded. They were high-risk groups, SLT manufacturers, sellers, tobacco farmers, community, religious leaders, local politicians, and the public interested in betel quid-related traditions, rituals, and customs
- II. The government officers (policy implementors) not under the authority of the Ministry of Health: Excise Officers, Police Officers, and Custom Officers

The main reason for this exclusion was this PhD study's financial, time, and technical constraints.

4.3.2 Sampling Strategies

The sampling techniques were applied to frame the interview participants from the above three sets of stakeholders presented under inclusion criteria (4.3.1, p237). Those sampling strategies aimed to ensure optimal representative samples of diverse viewpoints from each category amidst financial, time and technical barriers(Shaheen and Pradhan, 2019; Robinson, 2014).

Following is a summary of two approaches employed (A and B)

A. Sampling Provincial and Regional Health Directors by Stratified Random Sampling:

Through stratified random sampling, provincial and regional health directors were chosen to ensure representation from each socio-cultural setting. As a result, at least one provincial director and regional director participated in Study B and belonged to one out of four of these sociocultural settings. Sri Lanka is divided into nine provinces and 26 administrative districts. Therefore, the country has nine provincial health directors and 26 regional directors. These provinces and districts have been illustrated in Figure 4.1.(p245) below.

In addition, the country has four socio-economic, cultural, and demographic areas, as presented in sections 1.8. to 1.11(p46-83) in the Background Chapter (Part B in Chapter 01). They are called urban, suburban, rural, and estate. Table 4.2.below categories of each regional and provincial health director under these socio-economic, cultural, and demographic areas. The total number of Provincial Health Directors interviewed was 04. The total number of regional directors interviewed was 04.

Table 4.2. Provincial and Regional Health Directors (Policy Implementors) according to Administrative Areas and Socio-Demographic Settings

Socio- Demographic Settings	Provincial Director (09)	Regional Director (25)
Urban	Western	Colombo
Sub-Urban	Western	Gampaha Kaluthara
Rural	Northwestern North Central Northern Eastern Southern Central Sabaragamuwa Uva	Kurunegala Puttalam Anuradhapura Polonnaruwa Batticaloa Ampara Kalmunai Monaragala Hambantota Matara Vavuniya Manner Mullaitivu Kilinochchi Jaffna Trincomalee Rathnapura Kegalle Matale Kandy
Estate	Parts of Central, Southern, Sabaragamuwa, Uva	Nuwara Eliya Badulla Some parts of Matale Some parts of Rathnapura Some parts of Kegalle Some parts of Galle Some parts of Matara

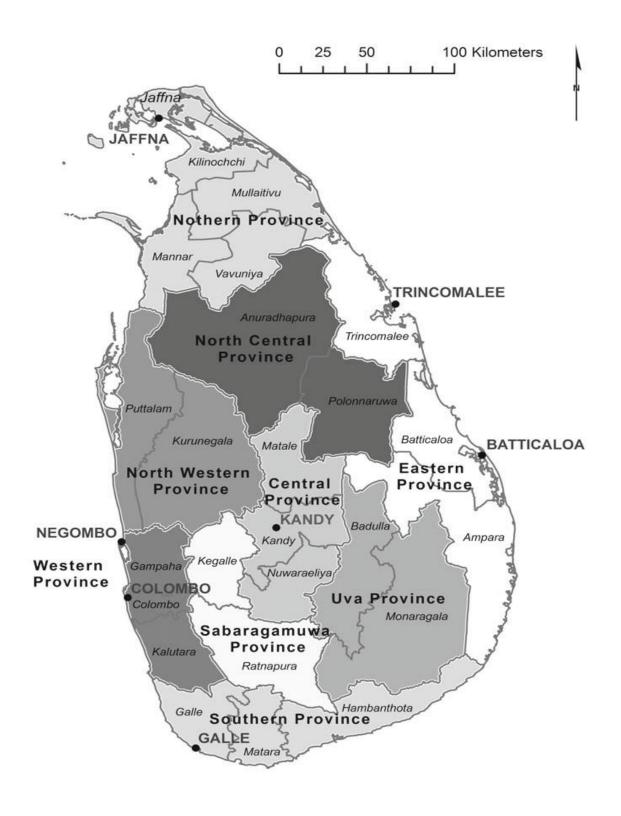


Figure 4.1. Administrative Province and district map of Sri Lanka Source: Produced by Dr. Janet Nackoney (Nahallage and Huffman, 2013)

B. Sampling Interested Groups and Experts – Purposive Samplings

The interview participants from interested groups and experts use purposive sampling methods. In this manner, the total number of heads of non-governmental organisations that operated for more than two decades in community-level tobacco control activities included in interviews was two. The total number of senior-level SLT researchers who worked for more than five years in a tobacco research Centre in a leading government university was two.

The total number of interview participants selected in Study B using these strategies was twelve. The selective criteria and sampling strategies presented in this section aided in including an essential set of stakeholders who could provide vital insights into the actual status enforcement activities of the SLT ban policy at the community level and its successes and challenges.

4.3.3 Developing Coding Framework

The coding framework for this study was designed based on the analytical framework presented in section 2.4 (p120-139) in Chapter 02. Table 4.3. presents an overview of the principal codes and subcodes of that coding framework. According to the nature of the research objectives and questions, it was mostly focused on McConnell's framework from success to failure integrated into the combined analytical framework (McConnell, 2010b; McConnell and Marsh, 2008).

McConnell's framework from success to failure provides theoretical underpinnings for understanding the success of a public policy in three dimensions: process success, programme success and political success. Table 2.3.(p126-128) in Chapter 2 presents the key indictors in a spectrum of success to failure that can be used in determining each of these successes. This coding framework is shown in Table 4.3. Below is based on these key dimensions of policy success to failure and their indicators. As a result, the coding framework has three main codes: process, programme and political success.

Table 4.3. Coding Framework for SLT Ban Successes- Main and Subcodes in Process, Programme and Political Successes

Main Codes	Subcodes
1) Process Success	 A. Legitimacy in the formation of choices A1. Constitutional Procedures A2. Quasi-constitutional Procedures A3. Values of Democracy A4. Values of Deliberation A5. Values of Accountability
	B. Passage of LegislationB1. Amendments to LegislationB2. Legislative Process
	C. Political SustainabilityC1. Coalition SupportC2. Stakeholder Involvement
	 D. Innovation and Influence D1. Policy Origin (Local vs. Global) D2. Policy Instruments D3. Policy Transfer/Diffusion
2) Programme Success	A. OperationalA1. Adherence to ObjectivesA2. Implementation ChallengesA3. Stakeholder Cooperation
	B. Outcome B1. Intended Outcomes B2. Unintended Consequences B3. Stakeholder Perceptions of Outcomes
	C. Resources C1. Efficient Resource Use C2. Resource Allocation
	D. Actor/InterestD1. Identification of BeneficiariesD2. Social EquityD3. Stakeholder Disparities
3) Political Successes	A. Government PopularityA1. Public PerceptionsA2. Electoral ImpactA3. Credibility Boost
	B. Re-election/election ChancesB1. Influence on ElectionsB2. Voter Support
	C. Credibility C1. Public Trust C2. Stakeholder Trust

The first main code- process success- consisted of four subcodes. These subcodes were designed based on the indicators listed in Table 2.3.(p126-128) in Chapter 02. Similar systematic approaches were taken in designing the other main codes and their subcodes. As a result, the main code, 'programme success', consisted of four subcodes and the main code, 'political success,' consisted of three.

4.3.4 Developing Interview Guide

The interview guide is presented in Table 4.4. below. It was designed based on the codes and subcodes of the coding framework of this study (4.3.3, p245). It consisted of open-ended questions under each subtitle directly linked to a subcode shown by numbers. This interview guide was subjected to pilot testing by presenting it to two healthcare directors. Those two healthcare directors, medical experts, had worked in the Ministry of Health Sri Lanka for several years. Their expertise helped refine the interview guide and change a few words to make it easy for the interview participants to understand—the open-ended questions supported by probing aided in encouraging the participants to share their perceptions and experiences.

Table 4.4- In-depth Interview Guide on the Process, Programme and Political Achievements of Smokeless Tobacco Ban Policy (2016) in Sri Lanka

1) Process Success

- A. Legitimacy in the formation of choices
 - 1) Can you describe policymakers' constitutional procedures in forming the SLT ban policy?
 - 2) In your opinion and experiences, were values of democracy incorporated into the decision-making process?
 - 3) In your opinion, were due processes of deliberation and accountability followed?

B. Passage of Legislation

- 4) Did you observe or contribute to any legislation amendment during its passage? If so, how did you respond to these amendments?
- 5) Can you share your insights into the legislative process? Did you get an invitation to contribute the final form of the ban?

C. Political Sustainability

6) In your opinion and experiences, what was the nature of the coalition's support for the smokeless tobacco ban? How did it contribute to the policy's political sustainability?

7) According to your experience, were there specific stakeholders or groups that played a crucial role in supporting the policy?

D. Innovation and Influence

- 8) In your opinion, how do you describe the ban? As an innovative idea?
- 9) Did you experience it involving flexibility and adaptation according to the sociocultural elements of different areas?

2) Programme Success

A. Operational

- 10) How closely does the ban adhere to its stated objectives?
- 11) Were any challenges encountered during the implementation phase, and how were they addressed?
- 12) How do you characterise the level of cooperation among stakeholders during the implementation?

B. Outcome

- 13) What were the intended outcomes of the ban, and to what extent were they achieved?
- 14) Were there any unintended policy consequences, and how did stakeholders perceive them?

C. Resources

- 15) How efficiently were resources allocated and utilised to implement the smokeless tobacco ban policy?
- 16) Were there any resource-related challenges faced during the implementation?

D. Actor/Interest

- 17) Can you identify specific classes, interest groups, or risk groups that benefited from the ban policy?
- 18) In your opinion, how did the policy contribute to the government's creditability?

3) Political Success

A. Government Popularity

- 19) How did the ban policy affect the popularity of the government? What was the public perception?
- 20) In your opinion, how did the policy contribute to the government's credibility?

B. Re-election/election Chances

- 21) Were there observable impacts on the government's re-election or election chances due to the ban policy?
- 22) How did voter support align with the government's stance on the policy?

C. Credibility

- 23) Can you share insights into the level of public and stakeholder trust in the government concerning the ban policy?
- 24) In what ways did the policy contribute to or detract from the credibility of the government?

4.3.5 Conducting Interviews

The goal of conducting interviews is to gather information organised and ethically to find the answers to Study B's objectives and research questions (Mears, 2012; Taylor, 2005; Legard, Keegan and Ward, 2003). The interviews were conducted between August and November 2021, following ethical approval from the University of York and Sri Lanka Medical Association (4.4, p250 and 3.7.2, p170). The interviews were conducted by Zoom technology (with the camera on) according to the agreed plan revised for COVID-19 risk mitigation. Each interview lasted between 40-45 minutes.

The steps and systematic approach followed in conducting these interviews were like that of Study A. Therefore, to prevent repetition, please refer to section 3.5.3.(p162) in the previous chapter. Like the experiences presented there, most of the interview participants involved in Study B were my teachers or colleagues from academic or professional backgrounds. Therefore, the same strategies presented in section 3.5.3 (p162), including fostering a comfortable atmosphere) were practised in conducting Study B to overcome the challenges of interviewing colleagues or senior professionals (teachers).

Writing Verbatim Transcripts and Translating to English

The main objective of creating transcripts is to transfer all information from interviews to a written document accurately and comprehensively. It is crucial to capture the nuances of the participants and ensure that their experiences and perceptions are faithfully represented. The techniques used to record the interviews (verbatim transcripts) and translate them from Sinhala to English were similar to those of Study A presented in Chapter 03 (3.5.4, p164). Most interviews were conducted in Sinhala, as preferred by the interview participants. Only a few participants were requested to conduct the interviews in English. Therefore, the same techniques presented in section 3.5.4 (p164) were used to translate the verbatim transcripts from Sinhala to English (forward-backwards translation). To prevent the duplication of the information shown, please refer to 3.5.4(p164). in the previous chapter.

Transcript Storage

Like the guidelines in section 3.5.5 (p166) of Chapter 03, each interview transcript was given a distinct identification code and securely stored for preservation. To distinguish between the interviews conducted for Study A and Study B, separate folders labelled with the respective study names were utilised.

4.3.6 Data Extraction, Analysis, and Interpretation

The data extraction, analysis and interpretation process started with setting up a new NVivo project according to the coding framework presented in section 4.3.3. (Table 4.3,p2477). Afterwards, I exported the transcripts saved in PDF format to the NVivo Project and data extracted to the subcodes under each main code. The rest of the data extraction, analysis and interpretation process was similar to Study A's; therefore, details were not repeated here to prevent duplication. Please refer to section 3.5.5. to 3.5.6(p166). A deductive data analysis approach was followed. The themes generated from the data interpretation were presented in section 4.5.

4.4 Reflexivity and Ethics

This section presents the strategies taken to ensure the reflexivity and ethics of Study B. Relevant areas were cross-referred to section 3.7 (p168-174)) in the previous chapter.

4.4.1 Reflexivity

Study B was focused on human interactions, perceptions, views, and experiences. Section 3.7.1. (p168) the previous chapter presents the researcher's background of this study project, its possible interference with formulating research objectives and questions, setting coding frameworks, interview guides, data collection, extraction, analysis and interpretation. Therefore, the fundamental techniques are presented in

section 3.7.1. In the previous chapter, cultivating self-awareness and embracing my role were applied in Study B to prevent reflective bias.

4.4.2 Research Ethics

Study B was conducted with the utmost adherence to ethical considerations, including obtaining informed consent, ensuring voluntary participation, respecting individual autonomy, safeguarding privacy and confidentiality, maintaining research integrity, and minimising potential harm. Moreover, data were handled and stored securely. Ethical approval was taken from ethics review boards in both the UK and Sri Lanka(Burnette et al., 2014; Beauchamp, 2007). The detailed presentation of these strategies I followed to ensure the ethical standards were presented in section 3.7.2(p170) of the previous chapter.

Part III - Results

This part presents Study B's results as themes. These themes were generated from the deductive data analysis and interpretation process described above. Moreover, these themes were categorised into three sections parallel to Study B's coding framework (Table 4.3, p247). As presented in section 4.3.3(p245), McConnell's framework provides theoretical underpinnings for designing the coding framework, from success to failure. Therefore, the following were the three categories of themes generated to answer Study B's objectives and research questions (4.2).

- I. Process Success (4.5.1, p252)
- II. Programme Success (4.5.2, p253)
- III. Political Success (4.5.3, p268)

4.5 Main Findings with Evidence

Study B's main findings were generated as themes. Sections 4.5.1 to 4.5.3. present the themes in three main categories aligning with Study B's coding framework (4.3.3, p245).

4.5.1 Process Success

Theme 01—The policy implementors were largely uninformed about the SLT ban, which caused them to be unprepared to implement it.

During interviews, it was discovered that all eight policy implementers interviewed in this Study B, were unaware of the ban. These interview participants, who are different from that of Study A, were regional and provincial health directors responsible for developing and implementing plans to control and prevent SLT use in their administrative regions. They stated that they were never informed by any officer from the Ministry of Health or the National Tobacco and Alcohol Authority about the prohibition of manufacturing, importing, selling or offering SLT products or betel quids. This lack of communication has resulted in a lack of enforcement of the SLT ban in

many areas. For example, two of the regional healthcare implementors said the following:

"...I do not know such a ban..."(Interview 01B- Regional Director Urban)

"...I have never implemented such a law in my region. No one told me..."

(Interview 08B- Provincial Director Rural)

Moreover, most policy implementors (7 out of 8) stated that their public health teams, who work under their guidance and supervision in their respective administrative regions, are actively enforcing the laws and regulations related to smoking tobacco. They expressed that if they had been informed about the ban on SLT, they could have made appropriate strategic plans accordingly.

When questioned about their stance on the feasibility of enforcing a ban on SLT manufacturing, importing, selling and offering in their respective regions, five out of eight policy implementers stated that it would be a challenging task. Their primary concerns were 1) the additional workload that would be placed on their staff and 2) the uncertainty regarding the outcome of such a ban. For instance, a provincial health director responsible for managing a rural area expressed concerns.

"...I don't think. How many tasks must be completed by each public health inspector in a month even now? You see, this Covid. They are exhausted..." (Interview 08B-Provincial Director Rural)

Another participant who is a regional director for a sub-urban area said:

"It will not be easy to implement such a ban. Public health inspectors have many duties even now. It will be very difficult..." (Interview 02B- Regional Director SubUrabn)

Furthermore, the results of Study B revealed that none of the regional and provincial heads (0 out of 8) had any implementation, monitoring, or evaluation plan for the SLT ban. Six of these eight stated that if they were informed about the SLT ban and advised

to enforce it by the central ministry, they would need adequate time to discuss it with their public health teams before making any plans.

They highlighted the possibility of failure of a ban on traditional betel quid, which is the most common form of SLT they have seen in their administrative areas. Moreover, two out of eight said enforcing such a law could waste human resources, logistics, and finances. The main reason for this argument was the inability to identify a formal SLT supply chain.

Additionally, four bureaucrats highlighted that many betel quid sellers are economically poor and doing small-scale business. Furthermore, they added that the betel quid seller in the village or small town is a well-known person to the rest of the people in the same geographical area that is a part of the society. Therefore, they highlighted that the context of betel quid sellers can be a significant challenge in implementing the ban successfully. They said that ban policy implementers might face many issues as local politicians will not be happy about such a program, thinking poor betel quid sellers lost their income. For example, one of the regional directors administrating the public healthcare in a rural district said:

"...those poor sellers. When they lost their income...no, no.. our local politicians will not help us in this policy..." (Interview 04B-Regional Director-Rural)

Another interview participant who was representing a civil organisation said:

"Betel quids are sold by very poor people in the community. Without a proper alternative, we cannot tell them to stop the selling." (Interview 09B- Interest group 01)

As mentioned earlier, the interviews conducted in Study B involved three parties, policy implementers, and two interest groups. While most policy implementers were unaware of the SLT ban, all individuals from the interest groups knew about the prohibition of selling, offering, and importing SLT that was introduced by the National Alcohol and Tobacco Authority a few years ago. These individuals had years of experience working with the National Tobacco and Alcohol Authority under the Ministry of Health. Out of four individuals, all stated that they were directly or indirectly involved

in forming the SLT ban. For instance, two had professional colleagues involved in making the ban, while two others had been invited to SLT committee meetings at least once. They had been in different jobs when they got these invitations to attend the SLT Control Committee. So, selecting these stakeholders for the in-depth interviews depended on their current role as head of a civil organisation working towards preventing and controlling tobacco epidemics or an SLT researcher in a leading university in Sri Lanka.

However, despite their involvement in forming the ban, all four individuals confirmed that the SLT ban was not actively implemented at the district or provincial level when the interviews were conducted. They also confirmed that most local decision-makers, including regional and provincial healthcare directors, were unaware of the law. For example, during the interviews, two individuals from the interest groups shared the following information:

"You know...I was invited to the meeting once...But nothing much on this ban was discussed" (Interview 09B - Interest groups 01)

"I know Dr. X...and their colleagues made this ban. And Prof. xx was also there" (Interview 10B - Interest groups 02).

4.5.2 Programme Success

Theme 01- Most participants predict a rising incidence of oral cancers caused by smokeless tobacco in Sri Lanka in the coming years.

Ten out of twelve interview participants expressed their belief that there will be a rise in new cases of oral cancers caused by smokeless tobacco (SLT) in the future despite the SLT ban. They highlighted that Sri Lanka does not have a consistent, continuous, well-spread campaign in place to control and prevent the long-lasting SLT epidemic. As presented above, the majority of the interview participants said the SLT ban is not implemented actively at the grass root level of their administrative regions. They further added that although a few annual events like the celebration of national days

related to the tobacco epidemic and oral health are held, during which special initiatives such as country-wide awareness programs, oral screening clinics, and health promotion workshops are conducted, these programs lack continuity. Moreover, they pointed out the absence of robust monitoring and evaluation programs; for example, a regional health director made this statement.

"....Nevertheless, in future, the number of oral cancer cases will be further increased in Sri Lanka. Compared to the smoking tobacco campaign, the ministry has no strong SLT campaign."

(Interview 03B- Regional Director Estate)

Additionally, seven out of twelve respondents noted a rising trend in the consumption of smokeless tobacco (SLT) among young people and school-going adolescents. They mentioned that these groups prefer commercially prepared or homemade non-betel quid products such as Thul, Mawo, and Babul. The respondents pointed out the existence of unidentified supply chains for these SLT products among the youth. For instance:

"Instead, in last few years there was a trend in increasing use of SLT among Youth, mainly due to advertisement in social media like Facebook and WhatsApp groups...so oral cancers might go higher".

(Interview 10B-Interest group 02)

Two respondents said that though we used to see betel quid sellers as small-scale, poor people, there are some large-scale betel quid businessmen in a few districts. Therefore, they believe betel quid consumption has increased. For example:

"community sees SLT sellers as small, poor individuals. But some betel quid sells are millionaires. For example, 'Bulath Mudallali' at X bus stop is one of the wealthiest businessmen in that area...so in future, the outcome will be worse (Interview 09B-Interest group 01)

"You know that betel quid seller is in the X city centre. He has a huge business. He makes whole sales too and distributes betel quid with tobacco to other towns by van delivery. So, people chew betel quids frequently and get cancers". (Interview 11B-Interest group 03)

Additionally, seven out of twelve respondents noted a rise in the consumption of SLT among young people and school-going adolescents. They mentioned that these groups prefer commercially prepared or homemade non-betel quid products such as Thul, Mawo, and Babul. The respondents pointed out the existence of unidentified supply chains for these SLT products among the youth.

Moreover, all respondents from interested groups (4 out of 4) stated that some largescale betel quid businessmen exist in a few districts. They believe these observations are signs showing betel quid consumption has increased.

Moreover, these four respondents emphasised that SLT supply chains have become extensive due to technological advancements such as smart mobile phones and enhanced transportation systems, which enable SLT products to reach consumers more rapidly and efficiently. They also believe that this trend will lead to an increase in oral cancer cases in the future.

The regional heads representing the most war-affected areas of the country (thirty years of civil war 1978-2008) claimed to observe a rising trend in using various kinds of SLT, especially among youths. Moreover, they said, postwar stress might be a reason for this observation in the increasing trend of SLT use in the northern province of Sri Lanka. They further added that illegal SLT products, among other addictive substances, easily reach their coastal areas from India. They highlighted an urgency in culture-sensitive, tailor-made, multiple initiatives for their province to prevent this rising surge of SLT use. They also highlighted challenges like human resources, logistics, and financial support. According to their views, these high-risk groups need close follow-up by those who speak Tamil.

Additionally, some interview participants (7 out of 12) mentioned that SLT (Smokeless Tobacco) supply chains have become extensive, primarily due to technological advancements such as smart mobile phones and enhanced transportation systems. Consequently, they underscored that SLT products can now reach consumers more

rapidly and efficiently. As a result of these findings, they believe there will be a future increase in oral cancer cases. For instance, two participants said the following:

"...we can't see any ban in action. But we witness mobile transporters and 'call and pick' services for betel-quid sales. Some marketing strategies include promotions like 'my betel quid is the best. So future...it is clear. The future is not good. I mean, there is a risk for increasing oral cancer rates" (Interview 10B - Interest group 03)

"...in my region, most are suffering from long-term post-war stress. They are substance-addicted, including various types of SLT. Banning. SLT in one night...I cannot imagine that...no. this needs better plans.." (Interview 08B- Provincial Director Rural)

According to a survey, 10 out of 12 individuals stated that influential entities run smokeless tobacco (SLT) businesses on school premises without significant obstacles. They claimed that the presence of businesses dealing with addictive substances, including SLT, Cannabis, Heroin, and ICE, is affecting almost all educational institutions, regardless of whether they are located in urban, rural, or estate settings.

The individuals being interviewed expressed their concern regarding the possible increase in oral cancers caused by the use of Smokeless Tobacco (SLT). They pointed out that SLT is a gateway to other substance abusers, such as Heroin and ICE. They urged the decision-makers to be cautious about issuing general bans on SLT without providing additional support to vulnerable young groups. For example, the majority anticipated the negative impact of not addressing cessation aid needs for youths. Here are three different statements made by the participants.

"... you know... You will be shocked if you hear the stories we get to know...even schoolgirls use different SLT products. The school has become an excellent place to promote health literacy. Rather than ban them, we must educate them. Otherwise, we can sit and watch how cancer cases go up ..."(Interview 12B-Interest group 04)

"You know...these businesses in schools are not visible. Can we only stop what is happening in schools by banning SLT? How? No...they cannot solve this by banning and sitting back...these kids will get cancers one day." (Interview 10B - Interest group 02)

"All going under the radars. In this way, you cannot prevent future increases in oral cancer cases. Health education is a must...talk to children in schools...talk to youths in slums, cities, villages...listen to them...listen to their true stories...you will get shocked...they need helping hands...ban...a joke" (Interview 12B - Interest group 04)

Additionally, almost all (4 out of 4) participants representing top interested groups shared their observations about the increasing trend in SLT use in Sri Lanka over the last two or three years. They pointed out that programs aimed at controlling and preventing SLT use, such as health education, health promotion, and cessation clinics, have not been actively conducted for the past few years. They assumed that the COVID-19 pandemic, which started in December 2019, and the economic crisis in Sri Lanka may have affected the activities of these programs. Following are two of those statements as evidence.

"I think there will be increased cases of oral cancers in future. People, especially youths in villages and towns, use different types of SLT. There is no control." (Interview 11B-Interest Group 03)

"...No one worries about these things. They all are busy with Covid...oral cancer cases will increase in future" (Interview 09B- Interested Group 01)

Additionally, three out of four interest groups said there was an increase in the usage of betel quids and other smokeless tobacco (SLT) products during the initial months of the COVID-19 pandemic. This shift in behaviour is attributed to the pandemic's impact on reducing the availability of tobacco products, particularly cigarettes, in various districts of the country. As a result, people have started to use betel quids and homemade SLT products such as Thul. For instance, this is evidence:

"...during the Covid pandemic, all shops were closed. People were at home. So, those addicted to cigarettes had no solution. They looked for alternatives. Most of them used betel guids. Some.. Thul. So future is not good" (Interview 12B-Interest group 04)

Theme 02- Many doubt the ban's effectiveness in controlling the traditional betel-quid-related SLT epidemic, given its complex ties to traditions, culture, society and economy.

Most of the interview participants expressed their uncertainty about the success of the SLT ban on the consumption of traditional betel quids. For example, all 12 participants interviewed expressed the possibility of significant challenges of enforcing a comprehensive ban on the long-lasting habit of chewing the traditional betel quids in Sri Lanka. As mentioned above, they could not provide concrete answers as most did not have field experience in SLT ban implementation. In other words, the ban was not in place in most administrative regions selected by stratified random sampling method covering all islands for this study.

They also mentioned that the use of traditional betel quids with tobacco pieces is deeply ingrained in societal practices, making it difficult to intervene. The participants pointed out that traditional betel quids have historical and cultural significance, which could result in this regulation clashing with traditional norms. 11 out of 12 participants talked about the rituals associated with the preparation and consumption of betel quids that have been passed down through generations, creating a significant barrier to change.

They (11/12) further highlighted that the country's most commonly used smokeless tobacco (SLT) product is the traditional betel quid, made in households and sold in small-scale businesses. Participants also emphasised that most betel quid sellers come from low socio-economic and educational backgrounds, and their families, including children, depend on the income earned from these traditional betel quids.

Eleven out of 12 participants further pointed out that betel leaves, areca nuts, and tobacco leaves have cultural and religious significance in ceremonial events.

Participants said that educating people about the health hazards of SLT is essential. Still, a sudden and comprehensive ban on all SLT products could lead to unintended consequences such as losing community trust in the government, violating equity, increasing social unrest, and violating individuals' rights to make informed decisions. For instance, these are the two statements made by interview participants.

"...I don't think it is possible. They prepare betel quids for their use at their homes. So, what can this ban do for that?..." (Interview 09B- Interest group 01)

"The ban will help to stop those products coming by airports and seaports. The custom officers can do it, But betel quids are mostly used by farmers, labourers, fishermen...I don't think this is a practical way to stop chewing betel quids by major groups..." (Interview 04B- Regional Director Rural)

Therefore, participants (9/12) suggested that it is essential to consider the cultural, religious, and socio-economic aspects of these products while enforcing a ban. They encouraged the government to engage in dialogue with all stakeholders, including betel quid sellers, to find a solution that addresses health concerns while ensuring the livelihoods of those involved in the production, distribution, and consumption of SLT.

Most of the interview participants said that It is common for betel quid vendors to prepare their products at home and then sell them at small kiosks along major roads. Some vendors buy their betel quids from wholesale businesses and sell them at a slightly higher price at their kiosks. These vendors tend to have low levels of education and come from disadvantaged socio-economic backgrounds. Often, these traditional betel quids are the primary source of income for the vendors and their families, including their children. The following is a statement made by one participant regarding this fact.

"...some betel quid sellers in my area are poor mothers. They do not have any other income to feed their children. Without alternative income sources, they will suffer..." (Interview 03B – Regional Director Estate)

Most participants (10/12) in the interviews discussed the challenges of implementing a blanket policy on smokeless tobacco (SLT) use in Sri Lanka. They emphasised the need to be flexible to consider the needs of high-risk groups in different settings. For example, a regional healthcare leader stated that people in his area who speak Tamil do not understand Sinhala awareness programs conducted through mass media such as television or radio. Therefore, their awareness of oral cancers and related pathologies is deficient. He also noted that the Hindu culture, the second largest culture in Sri Lanka, has a tradition of using betel leaves, tobacco, and areca nuts in ceremonies and religious and cultural events. According to him, the lack of mass media programs and detailed guideline books developed in the Tamil language makes it harder to raise awareness about the dangers of SLT use. He suggested customised policies and logistical, financial, and monitoring support from the central ministry would be necessary to address the issue.

Furthermore, participants from the estate sector and interest groups highlighted that the SLT epidemic in the estate sector (hill country or the central province) in Sri Lanka consists of a unique distribution pattern, consumption patterns, and reasons. They said that most people who consume betel quids and similar products in the estate sector are tea pickers, and most of these tea pickers are Tamil-speaking women. As a result, this region has some of the highest SLT-induced cancer prevalence rates in the country. Participants also noted that tea pickers use betel quids to help them stay awake, reduce stress, and increase energy.

"...people in my area...majority cannot speak Sinhala. So, I need the government to help me to do good awareness programs in their language...ban. I don't think it is practical..." ((Interview 08B – Provincial Director Rural)

Moreover, the interview participants (9/12) suggested that a flexible, culturally sensitive, and fair approach would be necessary to address the unique features of the SLT epidemics in individual settings. They recommended implementing the ban in stages or conducting pilot testing at various locations to learn from experiences and make improvements. This approach considers the economic and cultural considerations associated with the ban. Following is a statement provided by a representative from an interest group.

"...If they want to ban SLT mainly betel quids, I suggest moving forward slowly, implementing in few places, learning from experiences and reforming...that would be better. Otherwise...I don't think...you cannot do this in a hurry.." (Interview 10B-Interest group 02)

Overall, the participants emphasised the challenges of implementing a blanket policy on SLT use and highlighted the importance of being flexible, culturally sensitive, and fair in addressing the issue.

Theme 03 - A robust implementation strategy could help control the sale of commercial SLT products through black-market trade and challenge informal power structures.

The participants said overcoming traditional betel quid consumption by enforcing a ban seems challenging, but it could be a good policy for controlling commercial SLT products if implemented strategically. For example, eleven out of twelve participants emphasised that if the ban on prohibition against non-betel quid forms of commercially prepared SLT products were implemented impartially, it could help control their increasing prevalence. They mentioned Mawa and Thul as the most used commercial SLT products but also noted that young people consume Beeda, Pan Parag, Sara Bulath Vita, Khaini, and Babul. However, the participants pointed out that these products are unavailable in the open market. The commercial SLT products business is happening only on the illegal market in Sri Lanka and is controlled by powerful groups. Therefore, they were uncertain how effectively the ban would reduce the emerging use of these products in Sri Lanka.

However, the participants could recognise the opportunity of this regulation, especially to control and prevent newly emerging issues caused by these non-betel quid SLT products. A statement from one of the participants has been quoted below as evidence.

"...this ban, now you said to me, may be useful in controlling these commercial products...go out and see...what young groups use. terrible" (interview 10B- Interest groups 02)

Most participants (10 out of 12), including university academics and heads of non-governmental organisations, said they observe a growing trend among youths and adolescents in urban and suburban areas. Seven out of 12 participants said using Mawa, Thul, and Beeda, commercial products by teenagers, creates a secret subculture in many districts in Sri Lanka. These teenagers were happy to consider themselves part of this unique subculture with distinct lifestyles, norms, and fashions. According to the interviewees, this subculture identity was influenced by a recent Tamil movie broadcasted in India, where the main characters (heroes) used these commercial SLT products. One of the research participants made this statement.

"...the trend of using these commercial SLT products...you know Mawo and Thul have been increased. Later, we got to know Tamil Films is one of the reasons for this trend...I mean Tamil Nadu Films" (interview 09B- Interest groups 01)

Additionally, most participants (10 out of 12) said they had observed schools as key socialisation agencies in popularising commercial SLT products. During various awareness programs and activities, these stakeholders had identified schools as a place which plays a crucial role in shaping the attitudes and behavior of adolescents.

Some said (7 out of 12) the female adolescents in schools also had been addicted to commercial SLT products due to peer pressure. According to the findings of this study, similar patterns of commercial SLT use and a favorable attitude can be seen in most urban, suburban, rural, and estate schools despite their geographical borders. They further added that the popularity of virtual groups through social media enhances peer pressure among these adolescents. They said that the informal establishments around schools are abundant. Following are two statements made by interviews as pieces of evidence.

"...now you go out and see...what is happening in schools and around schools...no control at all... almost all schools...in villages, towns and Colombo big schools. School children use different types of SLT secretly..." (interview 10B- Interest groups 02)

"You should listen to stories of school children...especially girls...they use Thul in groups. This is common now" (interview 11B- Interest groups 03)

During the study, ten mentioned the existence of an informal power structure among the permanent customers of these commercial products. These networks of customers sustain the non-betel quid- SLT market, and they are often found in close-knit communities. Participants also stated that attempts to control the use and distribution of these products face resistance from these established social networks, making it challenging to break the consumption cycle. However, most stakeholders in the study agreed that the recent SLT ban policy presents an opportunity to control the blackmarket trade by implementing strict penalties for violations and targeting sellers and manufacturers. One participant stated,

"...this ban will be a step in the right direction towards controlling the use and distribution of commercial SLT products in the black market if implemented strategically." (interview 08B- Provincial Director Rural)

During interviews, participants (8 out of 12) emphasised the importance of developing robust strategic plans to manage informal power groups. These plans should involve collaboration between various agencies, such as the police, security, and legal departments. Participants believed healthcare teams could not enforce laws against these groups without a long-term participatory approach involving the police department. For instance, one participant made the following statement:

"Without police teams, PHIs cannot do this. Some local politicians are part of this business...so they are powerful...you know...implementing such a ban will not easy" (interview 12B- Interest groups 04)

During the interview, the participants emphasise the need to strike a balance between enforcing the law and addressing the other needs of young people addicted to commercial SLT products. They have developed an identity related to these products and their subculture. Ten out of twelve interviewees highlighted the importance of planning and delivering targeted social media awareness programs, school-based education programs, youth outreach programs, economic empowerment programs, and cessation support programs for these young people. Therefore, they stressed that implementing the SLT ban policy should not stigmatise young people and discourage them from seeking these services. As the illegal market under the control of power groups might not be eradicated quickly, they stressed the government is responsible for planning long-term strategies to address a wide range of service needs of high-risk groups...For example, one participant said:

"...as I believe, according to my experiences, by implementing the law, you cannot completely change the behaviours and attitudes of these young groups. Need carefully designed packages to establish their well-being, including cessation aids. Don't you?" (interview 03B- Regional Director Estate)

Theme 04- The majority underscored the potential of a comprehensive ban to obstruct the favourable results of the ongoing campaign.

As confirmed by study participants, the Ministry of Health in Sri Lanka had several interventions in place to control and prevent the SLT epidemic before implementing this ban. The participants called it the 'ongoing campaign', which includes screening programs, health education, and cessation programs. They said it is not a continuous, robust program but it lasts for decades. The Oral Health Unit, the Non-Communicable Disease Unit in the Ministry of Health, and the NATA office collaborate to implement these programs.

Five out of 12 said the primary health care staff at the community level have been conducting screening programs to detect OPMDs and oral cancers since 1980s. This screening program was included in the National Health Policy in Sri Lanka in 1990. However, evidence indicates that the program faces obstacles due to a lack of adequate guidelines for the workforce, the increased workload of the primary health care staff, as they are busy with maternal, childcare, and immunisation programs, and weak monitoring mechanisms.

Moreover, some of the participants (4 out of 12) talked about how the other components of current SLT campaigns are primarily coordinated by the Noncommunicable Disease Unit within the Ministry of Health, establishing connections with health sectors at the provincial and regional levels(Ministry, 2019; UNDP, 2019)The non-communicable disease unit collaborates with health and non-health sectors to carry out these programs. Their programs encompass health education and cessation, establishment of tobacco-free zones, mobilisation of community support, and training and capacity building.

Moreover, some of the participants (4 out of 12) talked about the short interventions for preventing and quitting tobacco in primary healthcare facilities have been in place for a few years(Amarasinghe et al., 2023, 2010b)These clinics are located at Healthy Lifestyle Centres in various socio-economic areas nationwide. Their primary functions include registering clients, assessing them, and providing brief interventions. However, insufficient evidence supports tailoring the interventions based on the specific context.

. As a result, most of the interview participants (nine out of 12) said the novel SLT ban might have an unfavourable impact on the ongoing SLT campaign. As mentioned above this ongoing program mainly covers health education, promotion, and cessation clinics for SLT users. Most interviewees (10 out of 12) stated that the existing SLT campaign is not a comprehensive and fully active program. Still, there is room to develop it into a multifaceted, robust campaign. Based on this option, they elaborated their answer. They added that prohibition is a dominant law, potentially undermining the validity of other interventions, such as health education.

Six respondents suggested educating the community about the health risks associated with SLT before implementing a ban would be better. They argued that the community should be informed about the issue and its reality before taking drastic measures. For example, the following are two statements made by regional healthcare directors.

"...you think...how we can plan a health education program in future and invite highrisk groups like traditional betel quid chewers or Mawo-eating youth groups. They will feel uneasy...(Interview 01- Regional Director Urban)

"I believe, first of all, these people, including high-risk groups, should be educated about the health risks of SLT. We can ban it after the community understands the issue and reality." (Interview 02B- Regional Director Suburban 02)

Moreover, half of the respondents (6 out of 12) said the ongoing COVID pandemic and economic crisis have significantly disrupted the so-called "SLT campaign." However, they stated that SLT control and prevention should build upon multifaceted interventions, including health education and cessation clinics, rather than a strict ban.

They posited that the prohibition would disturb these interventions' ability to effectively help high-risk groups in a participatory approach.

Some respondents (5 out of 12) emphasised helping high-risk groups make informed choices. They also highlighted the necessity of not allowing these SLT users, who are primarily poor people, to feel they had been discriminated against by banning their long-term habits overnight when rich people enjoy smoking.

Most respondents (11 out of 12) agreed there is a need to raise community awareness of the cessation clinics, including their location and dates. They recommended the use of mass media campaigns and word-of-mouth to increase attendance. However, they also stressed that high-risk groups should not feel uneasy or nervous about seeking advice or attending cessation clinics due to the ban's implementation. Furthermore, most respondents (10 out of 12) believed that collective initiatives, rather than a single law, are necessary to control and prevent the SLT epidemic. For instance, the following four statements were made by the interview participants.

"Most of the SLT users are poor people, so these poor people are the ones who die from SLT-attributed oral cancers. This issue needs more attention and programs. Not a sudden ban...As I believe this is injustice. They need more support than banning". (Interview 11B- Interest group 03)

"...No need to build unnecessary community unrest by urgently introducing these kinds of bans. They can be addicted to other substances like Cannabis. In my view, a ban on this urgency is not fair." (Interview 06B- Provincial Director Suburban)

"I think health promotion will be more effective in controlling SLT issues in my region. But you know, all are interested only in smoking tobacco issues. Because it has a glamour." (Interview 03B- Regional Director Estate)

"SLT issue in the plantation sector is a long-lasting complex issue. Only the ones who worked here will understand the gravity of it. Lots of issues...need a package of initiatives, funds and Tamil speaking public health teams" (Interview 03B- Regional Director Estate)

4.5.3 Political Success

Theme 01- Community and religious leaders are not prepared and hesitant to endorse the ban.

All participants in the interest group (4/4) indicated that community and religious leaders have a high risk of being against the ban. Moreover, they have experienced restrictions or possibilities of significant denials from local politicians, community leaders from main ethnic groups, and Buddhist monks from various parts of the country when discussing setting restrictions on the traditional betel quid used by people.

Moreover, almost all participants from interested groups highlighted the importance of strategic plans to effectively communicate with key individuals in the community and make them aware of the aims and expectations of the ban. They also emphasised the importance of being flexible and culturally sensitive in planning these activities. For example, these are a few examples showing a few statements made by four respondents:

- "..this will not be easy. This is now part of the culture. The leading Buddhist monks completely deny any ban against traditional betel quids..." ((Interview 12B-Interest group 04)
- "...As far as I know, none of the responsible parties properly communicated this law to the main community groups. As a result, for example, Buddhist monks think the ban is a cultural attack by the West..." (Interview 09B-Interest group 01)
- "...the government will not go forward with the ban if the Buddhist monks came forward against it..." (Interview 12B-Interest group 04)
- "... Who wants to lose the votes? When a government implemented the ban, poor betel quid sellers lose their income. So, they will never vote for the same government..." (Interview 10B-Interest group 02)

These experiences, observations, and perceptions added by the representatives of interest groups were confirmed by almost all policy implementers (8/8). As mentioned in presenting the first theme of Study B, these regional and provincial health directors were largely uninformed about the ban, so they did not carry out any ban implementation plans. As a result, during the interviews, they were asked to imagine the possible obstacles and challenges if they got a chance to implement the ban in their settings. Then they said they expect a significantly high restriction from the public, Buddhist monks, and local politicians mainly because of the cultural roots of the SLT in Sri Lanka. However, three out of eight policy implementers said these social and cultural denials could be significantly reduced if Buddhist monks and local politicians were informed and asked for their active participation in the campaign. For instance, the following is a statement made by one participant:

"..and we can't ask them to stop chewing betel quids in one night. For example, we use betels and tobacco to worship adults and religious leaders. Those are traditional symbols for weddings. We need to be rational..." ((Interview 09B-Interest group 01)

Moreover, nine out of 12 participants highlighted the importance of meeting other religious leaders, including priests in Hindu Kovil and Catholic Churches. Three leading SLT researchers stressed the importance of collaborating with them in planning activities. Following is one statement made by a participant:

"..you know, people listen to Buddhist monks. If the government ask their help in strategically implementing the ban, this policy might work to a significant level" (Interview 8B-Provincial Director Rural)

However, the same participants (five out of 12) said it was challenging to introduce healthy Betel trays to Buddhist monks and society as an alternative to traditional Betel trays. They told the National Alcohol and Tobacco Authority that they had conducted a national campaign to introduce these Health Betel Trays (without tobacco pieces and areca nut) a few years ago. Still, they could not see significant changes in the habit of using traditional betel trays with tobacco leaves. Therefore, they said they

expect substantial barriers and challenges in succeeding by implementing the SLT ban.

Theme 02- The prevailing opinion is that political leaders might hesitate to back the ban's implementation, fearing potential harm to their electoral prospects.

All 12 individuals interviewed expressed their belief that politicians will not support a ban on betel chewing because it could harm their chances of being re-elected. They pointed out betel chewing has been a socially accepted and long-standing tradition in Sri Lanka for centuries. Additionally, betel leaves, areca nuts, and tobacco symbolise the country's ceremonial, cultural, and religious events. They also explained that chewing betel quid in peer groups demonstrates hospitality and friendliness in Sri Lankan culture. Moreover, chewing betel quid with tobacco and areca nut is not limited to the Buddhist culture or leading ethnic group (Sinhalese) in Sri Lanka. Instead, it has been a common habit among minor ethnic and religious groups for centuries. Therefore, they did not believe the proposed SLT ban would enhance the government's or its members' reputation. For example, one of the participants said:

"The ban might cause lots of issues. Politicians might be in trouble if they agreed to implement this ban, especially against traditional betel quids. You know our people...this will not be easy" (Interview 10B- Interest group 02)

One of the participants shared a fascinating insight. The participant mentioned that the Minister of Health had advised the regions not to enforce a ban on traditional betel quid chewing and cultural practices when it was issued. The ban was introduced to bring about a cultural change, but the Minister of Health was concerned about the potential adverse effects of a sudden shift.

Though received only by one member, this information gave us a glimpse into the political influence that public health policies can have on culturally sensitive issues. The statement made by the participant highlights the importance of considering the cultural implications of any public health policy before implementing it.

The participant's statement also implies that the Minister of Health was aware of the potential backlash and negative consequences that could arise if the ban was implemented abruptly. Therefore, the Minister's decision to advise the regions not to enforce the ban can be seen as a proactive measure to mitigate any adverse effects of the sudden cultural change. Overall, this insight provides valuable lessons on the need to be sensitive to cultural issues when designing and implementing public health policies. Following is a part of the statement made by the relevant participant.

"... As I got to know, the Ministry X had indirectly informed the regions that it did not need to be taken seriously and that there was no need to enforce the law actively at the community level..." (Interview 12B- Interest group. 04)

During the interviews, all the participants represented interested groups, and the health directors of the plantation sector said (six out of 12) that residents living and working in the plantation sectors may have a change in their electoral preferences if their local politicians support the ban on betel quid. This is because betel quid consumption is a part of their daily routine and is believed to help them endure the geographical challenges and cold climate of the hill country, where tea pickers work outdoors all day on the estates.

They further added that it is evident that implementing such a ban would not be an easy task and could have negative consequences. However, they further said the hill country presents a unique set of geographical challenges, and the working conditions of tea pickers are arduous. Chewing betel quid has become a way for them to cope with the physical demands of their job and keep going. Therefore, a ban on betel quid could result in opposition from the workers and residents, leading to a backlash against the politicians who support such a ban. Following is a statement made by one of those participants.

"... As we know, the hill country is a cold place with many geographical challenges. Tea pickers work in these estates have a common habit of chewing betel quids throughout the daytime...they say betel quids keep them going...in such a situation a policy like this ban backfire" (Interview 10B- Interest group 02)

During the study, a regional director from a rural district emphasised that a significant portion of the Sri Lankan population, precisely 80%, lives in rural areas. This is a noteworthy statistic because chronic betel quid chewing is more prevalent in these areas. Betel quid is a mixture of betel leaf, areca nut, and slaked lime, often chewed for its stimulant effects. However, it is known to cause a variety of health problems, including oral cancer. The regional health director also pointed out that politicians representing rural areas are unlikely to support a ban on betel quid chewing unless an effective advocacy program is implemented. Chewing betel quid is a deeply ingrained cultural practice in many rural communities.

Additionally, almost all health directors who manage rural districts (2 out of 12) in Sri Lanka and interested group representatives (4 out of 12) who participated in the study shared similar opinions. They suggested that efforts to reduce betel quid consumption in rural areas require a well-designed advocacy program considering the cultural and social drives that motivate the habit.

"you know, we are in Asia...culture and traditions should be carefully handled. Government...The government will not be happy to enforce this. Banning betel quids in our country...it could be a serious decision..."

(Interview B09- Interest group 01)

Additionally, most participants (10 out of 12) expressed that, to their knowledge, local politicians are not informed about the SLT ban. They emphasised that successfully implementing the ban would require clear communication and collaborative efforts with the central and local politicians. For example, one of the participants said:

"you know...provinces in Sri Lanka are powerful. They have their chief ministers, health ministers. We cannot implement these laws at the provincial level if they have not been told well or they are not happy to support the ban..." (Interview B02-Provincial Director 02)

Part IV- Discussion and Conclusion

Part IV is the last section of this chapter. It provides a thoughtful discussion and a summary of the findings of Study B. The discussion briefly highlights the main discoveries, compares them with the existing literature, acknowledges any methodological limitations, and summarises the implications of the findings. The conclusion is the final part of Part IV (4.12). It presents seven following key areas.

- Key findings- summary of the themes (4.6, p274)
- Comparing findings with existing literature (4.7, p277)
- Research Gaps identified (4.8, p280)
- Methodological considerations (4.9, p281)
- Implications (4.10, p283)
- Recommendations (4.11, p284)
- Conclusion (4.12, p285)

4.6 Key findings

In Study B, I explored the experiences and perceptions of policy implementors, subject experts and interest groups on the successes and challenges of the SLT ban policy as an intervention to control and prevent the SLT epidemic in Sri Lanka.

The study revealed that the SLT ban policy implementors needed to be more adequately informed. This resulted in the policy, which was made public in September 2016 through an extraordinary gazette published by the National Alcohol and Tobacco Authority in the Ministry of Health, not being effectively communicated to the majority of regional and provincial health directors responsible for spearheading local campaigns aimed at preventing and controlling tobacco use. As a result, these officials needed to be adequately equipped to enforce the ban. The findings challenge the role of strategic planning for effective communication and collaboration with policy implementers in successfully implementing public health policies.

Studies indicate that enforcing a ban in Sri Lanka may face resistance from the community and religious leaders. The complex interplay between the prohibition and traditional, cultural, social, and economic facets of Sri Lankan society could cause their reluctance to support it. Others suggest that some leaders have already opposed the policy, while others anticipate that these influential groups might speak out against implementing such a sweeping measure. The insights generated from these findings are linked to the power of the community and religious leaders in Southeast Asian countries. Moreover, these findings highlight the challenges in collaborating with community and religious leaders in successfully implementing the SLT ban policy in the Sri Lankan context.

Moreover, according to the findings of this study, the current ban policy is not successful in reducing the prevalence of traditional betel-quid chewing. Given that betel quid is a widely consumed form of smokeless tobacco and is deeply rooted in Sri Lankan culture, this discovery highlights the potential risk of the SLT campaign's failure unless prompt reforms are initiated. The study participants, particularly the subject matter experts, suggested implementing culturally sensitive and participatory trials, followed by comprehensive advocacy campaigns, instead of the current blanket approach.

Furthermore, the study's findings supported the decision to prohibit the sale of commercial SLT, including Mawo and Thul. However, they further encouraged the need for a comprehensive approach to combat the long-term use of these products. The study results confirmed that these non-betel quid SLT products are only available through illicit channels and are often controlled by influential informal organisations. Considering the challenges in eradicating the black-market business, the findings proposed initiatives focusing on planned education and behavioural modifications for individuals, especially adolescents and young people, about the health risks associated with the long-term use of these unregulated SLTs.

Moreover, the research has shed light on the potential obstacles that may arise due to the SLT ban policy to other SLT control and prevention measures, such as health education, behaviour modification, and cessation support. Although the study has revealed a need for more effective implementation of these multidimensional initiatives at the community level in the current context, it is vital to acknowledge the SLT ban policy's impact on other evidence-based interventions in future settings.

One of the main findings of Study B was the lack of adequate supervision, technical guidance, monitoring, and evaluation from central authorities for SLT ban policy implementation strategies. It is evident from the findings presented above that the SLT ban policy was not being implemented in most regions of Sri Lanka at the time of this study. Therefore, the absence of indicators, progress meetings, or feedback forms for monitoring and evaluating SLT ban policy activities highlights the underlying reasons for this failure. Those can be considered signs of a lack of a strategic plan for policy implementation.

Another important finding of this study was that political leaders may be hesitant to support the ban on betel quid chewing due to the fear of community unrest. This hesitancy was closely tied to betel quid chewing being a tradition for over a hundred years, and the government's goal was to preserve the primary culture of its citizens. The insights generated from this finding aid in understanding the links between the electoral perspectives of politicians and the use of traditional betel quids in Sri Lanka, and therefore, it is essential to consider policies that can secure the political capital of those representatives. The insights of this finding help in understanding the relationship between politicians' electoral viewpoints and the use of traditional betel quids in Sri Lanka. Therefore, it is essential to lobby politicians effectively for policies to be successful. On the other hand, these findings recall the importance of policymakers adhering to policies that can secure the political capital of those representatives.

As presented in section 2.2 in Chapter 02 (p95) and section 4.2 (p236), this is the second or last phase of two staged multi-method qualitative case study research planned to analyse the SLT ban in Sri Lanka (Study B). The primary aim of this study was to examine the perceptions and experiences of key stakeholders working in the community on the SLT ban's successes and failures and provide recommendations. As a result, Study B was planned to gather the data and interpret it under three policy dimensions: process success, programme success, and political success.

4.7 Comparison with Existing Literature

The results of Study B have affirmed the recent research that emphasises the tendency to disregard the policy implementation process during the introduction of policies. This disregard can potentially lead to policy failures, as underlined by Peckham et al.'s findings in 2022. This issue is especially pertinent in intricate policy domains characterised by a scarcity of collaborative policy-making and decentralised governance. Peckham and colleagues' study in 2022 on a novel policy implementation support program, which the English Department of Health developed for the Care Act 2014; this act represented the most substantial modifications to social care provision in the past sixty years. The Implementation Support Programme was created by the Department of Health and its partners to assist local authorities in fulfilling their social care responsibilities as outlined in the Care Act. The effectiveness of the programme was evaluated through research studies. The results indicate that it successfully enhanced readiness for implementation, particularly in challenging policy contexts.

Additionally, similar recent studies by Marsh and McConnell (2010), Wandersman (2009), and Giacchino and Kakabadse (2003) have shown that implementation support programs are crucial for the success of policies. Study A's critical findings in gaps in SLT ban implementation support these conclusions. The study found that the implementers of the SLT ban policy were not adequately prepared to enact the law, which led to the program's failure.

Furthermore, recent research conducted in India has highlighted the importance of having a strategic approach to policy implementation. The study aimed to identify the factors influencing the implementation of welfare-oriented public policy schemes across networks and processes. The findings of the study conducted by Natesan and Marathe in 2017 highlight the significance of 'administration factors', such as accountability, process clarity, and power devolution to the implementor in determining successful implementation. The research also emphasises the importance of resources in achieving successful implementation.

Additionally, the findings of Study B question the necessity of an efficient communication mechanism between policymakers and regional implementers for the

successful enforcement, monitoring, and evaluation of the tobacco ban policy. To support this evidence, a discourse analysis study was conducted to determine the effective communication methods to convey policy expectations within primary care settings in Canada, the USA, and other regions. Ashcroft and colleagues(2019) discovered that the communication process between policymakers and implementers may require as much attention as the policy content intended for dissemination. They also found that continuity and relationships are crucial to successful policy implementation in primary healthcare settings. They suggested that designing communication models, ensuring a relational approach between policymakers and implementers, can enhance the success of new initiatives, particularly during transformative reforms. (Ashcroft, Kennedy and Van Katwyk, 2019).

A study was conducted to determine what makes peripheral places matter in Denmark(Sørensen and Svendsen, 2023). The study applied the concept of political capital within a multiple-capital framework encompassing 476 rural parishes. The findings of Study B were supported by this study, which suggests that there is a possibility of failure of the SLT ban policy due to resistance by local community leaders and politicians. The study discovered that political power varies in rural areas depending on the citizens' economic, social, and physical status. However, it was found that the development of the rural regions is positively related to the amount of local political power. The evidence presented emphasises the significance of engaging communities, community leaders, and politicians in the reform of the SLT ban policy to yield positive results. Since traditional forms of SLT products are deeply ingrained in the primary culture of Sri Lanka, the stability of the government and local authorities in power further reinforces this behaviour within the regional context discussed by Sorensen and Svendsen.

The World Health Organization's strategy for engaging religious leaders encourages national governments and spiritual heads to work together to achieve common goals at the community level. Study B's critical findings on resistance of religious leaders to the SLT ban policy underscore the importance of this collaboration between both parties for the successful implementation of the SLT ban policy at the community level. For example, the WHO notes that throughout history, religious leaders, faith-based organisations, and faith communities have consistently played a crucial role during health emergencies. Their contributions extend beyond just providing medical services

and humanitarian assistance. They also offer channels to share vital information, promote health-preserving practices, and reduce fears and stigma. Furthermore, these entities reassure people within their communities, fostering a sense of solidarity. To achieve a collaborative and harmonious engagement, the WHO suggests advocating for their inclusion with adequate funding and highlighting their critical roles in the community, the value they bring to the table, the importance of mutual respect, and adherence to shared values. These principles form the foundation for a successful partnership(World Health Organization, 2021).

The results of this study indicate insufficient collaboration with religious leaders when planning and implementing the SLT ban policy, which led to their resistance towards the law. Another study conducted in Nigeria recently highlighted the significance of engaging religious leaders from diverse faiths to influence norms and behaviours related to family planning and contraceptive use. This highlights the gap identified in Study B(Adedini et al., 2018). The study aimed to assess the connection between exposure to family planning messages based on religious texts and contraceptive use in Nigeria. The results showed that women who had been exposed to such messages from religious leaders had a significantly higher rate of contraceptive usage compared to those who had not been exposed to such messages. This highlights the importance of involving religious leaders from different faiths as agents of change to influence norms and behaviours related to family planning and contraceptive use. To implement context-specific policies effectively, it is crucial to conduct interventions that capitalise on the influence of religious leaders.

In 2009, Gaudine and their colleagues conducted an action research study that supports the insights generated from the key findings of Study B. The study focused on developing culturally sensitive interventions for Vietnamese health issues. The methodology of the study highlighted the importance of community engagement to be successful in solving problems similar to the culturally sensitive SLT epidemic in Sri Lanka. The study emphasised the significance of context-specific strategies and community engagement. To address the stigma of HIV/AIDS, the study collaborated with a diverse advisory committee that comprised local leaders and representatives from various community organisations. The committee played a crucial role in identifying the health issue of concern through a series of meetings conducted in Vietnamese.

The action research methodology involved in-depth individual interviews and focus groups with infected individuals, their families, community members, and leaders. Open-ended questions allowed participants to express the impact of stigma on their lives, identify possible causes, and suggest strategies to address the issue(Gaudine et al., 2009). The advisory committee used these findings to suggest interventions that could help reduce the stigma identified in the study. This project is an excellent example of how policymakers can collaborate with communities to solve healthcare problems. The study highlights the significance of including the community in the process, allowing diverse perspectives to be heard and understood to address health challenges. Ultimately, this fosters consensus for change.

A study was conducted in the northern regions of Canada to evaluate Aboriginal programs to understand the participation of Indigenous people and the cultural sensitivity of the programs. The results of this study provide evidence to support the causes of the failures identified in Study B. Their study in Canada says that Indigenous communities have been facing long-standing socio-economic challenges that have hindered their progress. As a result, the Royal Commission on Aboriginal Peoples (1996) emphasised the importance of involving individuals from these communities in formulating public policies that affect them and promoting their autonomy. The study had been conducted to study the success of this participatory approach. To prioritise cultural sensitivity, measures have been devised, and local participants participated in the evaluation. The findings indicated a gradual integration of cultural sensitivity, suggesting a positive shift in this direction. The research underscores the importance of strengthening the participatory approach and cultural sensitivity for further positive results (Jacob and Desautels, 2013).

4.8 Research Gaps

Based on the main findings of Study B and their comparison with existing literature, the following research gaps could be identified.

 Strategies for enhancing the successful implementation of the SLT ban policy and its reforms through strategic planning and communication with policy implementers.

- Explore methods to collaborate with the community and religious leaders in successfully implementing the SLT ban policy and its reforms.
- Explore alternative approaches, such as culturally sensitive and participatory trials, to increase the efficacy of the SLT ban policy, with a focus on traditional betel-quid chewing prevalence.
- Explore targeted educational strategies to address illicit non-betel quid SLT products and reduce their use among young people.
- Investigate the potential collateral effects of the SLT ban policy on other evidence-based interventions (such as health education and behavioural modifications) and propose strategies to mitigate any negative impact.
- Examine the reasons behind the failure to provide supervision, technical guidance, monitoring and evaluation by central authorities for the successful implementation of the SLT ban policy.
- Explore the strategies to effectively lobby and engage political leaders to secure support for the policy, balancing cultural preservation and public health goals.
- Investigate the importance of a strategic plan for policy implantation, including key performance indicators (KPIs), progress meetings, and feedback mechanisms to ensure successful policy implementation.

4.9 Methodological Considerations

In Study B, I took care to involve a broad range of stakeholders, considering financial, technical, and time limitations. To ensure representation from various settings and acknowledge the diverse patterns of SLT use, I employed stratified random sampling to select provincial and regional health directors based on their socio-cultural backgrounds, encompassing urban, suburban, rural, and estate environments. Furthermore, to bring diversity and expertise to the study, I included senior researchers from universities, directors, and deputy directors of non-governmental organisations. By incorporating these varied expert groups, I aimed to gain a comprehensive perspective on the successes and challenges associated with the SLT ban policy.

Moreover, the decision made by the study to terminate the interview process upon reaching data saturation was intended to investigate experiences and viewpoints extensively to obtain a thorough and all-encompassing comprehension of the subject matter. Nonetheless, Study B's sampling approaches possess certain innate methodological constraints.

- Excluding other policy implementors (police, excise and customs officers) under ministries other than Health, SLT supply chain members, high-risk groups, and the community (general public) limits the study's depth and applicability (Table 4.1, p240)
- The study's focus on provincial and regional health directors excluded insights from frontline implementers (public health and food and drug inspectors). Inclusivity can achieve a nuanced approach to policy implementation challenges. Future researchers can potentially achieve more comprehensive financial, logistical, and time capacities.
- Excluding stakeholders like SLT manufacturers and distributors limited the study's ability to explore market-related implications of the SLT ban policy.
- Omitting high-risk groups from the interview process limited the ability to address real-world complexities of the SLT ban policy implementation.

Moreover, limiting the study to only interviews is a drawback; stakeholders' perspectives could have been gathered through focus group discussions, and data could have been triangulated for better insights into the problem addressed by the study if permitted by the time and financial requirements.

Additionally, in-depth interviews were utilised in Study B to gather experiences and presentations. Therefore, the methodology of Study B shares limitations with Study A, which is related explicitly to interview participant numbers, interview dynamics, and translation methods (3.5, p159-166). Furthermore, data collection for Study B took place during the COVID-19 pandemic, creating its unique challenges and restrictions. Section 5.3.1(p306) discusses these limitations, obstacles, and strategies for overcoming them. Sections 3.14(p229) and 5.3.1(p306) in each chapter have been cross-references to prevent redundancy.

4.10 Implications

Within this section, I aim to offer a summary of Study B's potential implications to researchers, policymakers, and analysts seeking to deepen their comprehension of Study B's broader impact and significance.

- ❖ Collaboration and Communication with Policy Implementors: policymakers should prioritise effective communication and collaboration with policy implementors of public health policies.
- Community and Religious Engagement: Recognising the influential role of community and religious leaders and seeking their support for policy implementation in culturally sensitive public health policy issues.
- Customised Approach for Traditional Practices: Acknowledging the cultural significance of traditional habitual consumptions and developing tailored approaches to address the prevalences.
- ❖ Addressing Issues on Illicit SLT Products: Recognising the challenges in eradicating the black-market businesses of SLT products and implementing educational initiatives for risk awareness. Identify adolescents and young people as target groups in planning these awareness-raising programmes.
- ❖ Holistic Approach to SLT Control: Consider the potential impact of the novel policies on existing evidence-based interventions and develop integrated strategies to ensure a holistic approach.
- Centralised Supervision and Monitoring: Recognising the importance of regular monitoring mechanisms for successful policy implementation and establishing an efficient implementation system for monitoring and evaluation.
- Political Sensitivity and Lobbying: Understand the political hesitancy related to traditional practices, plan effective lobbying mechanisms, and emphasise the importance of preserving cultural practice while addressing public health concerns.
- ❖ Long-Term Policy Planning: Emphasizing the need for a long-term strategic plan for policy implementation for policy successes. This includes comprehensive plans with key performance indicators, conducting progress meetings, and establishing feedback mechanisms.

4.11 Recommendations

Following the completion of Study B, recommendations were formulated to tackle the gaps and challenges in implementing the SLT ban in Sri Lanka. Moreover, these recommendations were aligned with various stakeholders' captured perspectives regarding the ban's practicality and relevance in the local context. The recommendations are designed to offer practical and effective solutions that can be implemented to enhance the current state of affairs.

- Establish regular communication channels, training programs, and workshops to keep policy implementers well-informed and engaged.
- Conduct outreach programs, workshops, and dialogues to build understanding and cooperation between policymakers and influential community figures.
- Involve local communities in the design of interventions, respecting cultural norms and traditions while promoting public health goals.
- Implement school-based programs, social media campaigns, and community workshops to educate the youths on the dangers of using unregulated SLT products.
- Coordinate efforts across different SLT control initiatives, ensuring that policies align and reinforce each other to achieve maximum impacts.
- Implement regular progress meetings, feedback mechanisms, and indicators to assess and improve the effectiveness of policy implementation across all regions.
- Provide evidence-based information to political leaders, highlighting the longterm benefits of the policy and addressing concerns related to community unrest.
- Establish clear timelines, milestones, and mechanisms for ongoing reviews and policy adaptation, considering changing societal dynamics and challenges.

4.12 Conclusion

In conclusion, the findings of Study B, which delved into the experiences and perceptions of key stakeholders regarding the SLT ban policy in Sri Lanka, shed light on various challenges and opportunities for enhancing its success. The study highlighted the significant gap in communication and collaboration with policy implementers, particularly the regional and provincial health directors tasked with enforcing the SLT ban.

Inadequate information dissemination led to a lack of preparedness among officials, hindering the effective enforcement of the policy. This underscores the need for strategic planning and robust communication channels to ensure that policy implementers are well-informed and equipped for successful implementation.

Resistance from the community and religious leaders emerged as a potential barrier, emphasising these figures' influential role in the Sri Lankan context. Collaborative strategies that respect cultural norms and engage these leaders are essential to navigating potential opposition and garnering support for SLT control measures. Moreover, political hesitancy to support the ban on betel quid chewing, rooted in fear of community unrest, emphasised the delicate balance required between preserving cultural practices and advancing public health goals. Effective lobbying and engagement with political leaders were recommended to navigate these complexities.

Section 3: Dis	scussion and	d Conclusion	
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Chapter 5: General Discussion

5.1 Overview

The research in this thesis has made several new contributions to the public health policy, focusing on the smokeless tobacco ban in Sri Lanka. My PhD research has helped me propose tailor-made policies to address the SLT epidemic in Sri Lanka. Moreover, the research has crafted an intricate description of the SLT epidemic in Sri Lanka by systematically evaluating current literature about clinical and epidemiological data, SLT supply networks, a range of products, as well as sociological, cultural, political, economic, and environmental factors along with diverse stakeholder perspectives. This description can be used to develop strong policies to prevent and control the issue. Additionally, the study has refined existing public and health policy analysis theories, concepts, and frameworks to evaluate any public health policy's successes or failures to control and prevent the SLT epidemic in the Sri Lankan context. The two-stage multi-method qualitative case study research was designed to identify gaps and contribute to reforming the SLT ban policy for a more inclusive, informed, and flexible implementation in the Sri Lankan context. The research was conducted by a director of the Ministry of Health in Sri Lanka, a medical professional, ensuring that the findings were more accurate and that the implications and recommendations were culturally and contextually appropriate. The research from this PhD has laid the groundwork for inclusive decision-making, strategic planning, comprehensive training, culturally sensitive programmes, and targeted stakeholder engagement in making policies to control and prevent the SLT epidemic in Sri Lanka. This chapter summarises and discusses the key aspects of the PhD research and some of the unique challenges that had to be overcome, such as the coronavirus pandemic.

5.2 Summary and Integration of Key Findings

This research was conducted to analyse the successes and failures (challenges) of the SLT ban policy that the Sri Lankan government introduced in September 2016. The study consisted of two phases - Study A and Study B. Study A focused on the development phase of the SLT ban policy. On the other hand, Study B examined the perceptions and experiences of key stakeholders regarding its successes and failures.

Study A generated results in four areas of public policy development: policy content, policy actors, policy context, and policy process. Study B produced results in three primary dimensions of public policy success: process, programme, and political success. The main findings and their interlinks against the analytical criteria are illustrated in Table 5.1(p290).

Moreover, the power-interest matrix was also applied to the critical members identified in the analysis of policy documents, policymakers, and stakeholders interviewed in Study A. The insights gained by this stakeholder analysis and their links to the successes and failures of the SLT ban are discussed at the end of this section.

5.2.1 Gaps in SLT Ban Policy Development (Study A)

• Policy Content- The policy content analysis revealed that the SLT ban policy (2016) was positioned as a subordinate legislation under the National Alcohol and Tobacco Act. This legal anchoring provided a robust foundation for enforcement. However, the National Alcohol and Tobacco Act predates the WHO Framework Convention on Tobacco Control (FCTC) and falls outside its scope, suggesting a potential misalignment with international standards. This could impact the ban's effectiveness in addressing global tobacco control goals.

Table 5.1. Understanding Policy Nexus: Integration of Themes derived analysing the development and implementation of the Smokeless Tobacco Ban in Sri Lanka by a Multimethod Case Study Research

Analytical Criterion	Themes and Subthemes
Policy Content	1. The SLT ban falls under the National Alcohol and Tobacco Act, which is three decades old and has a scope beyond the WHO Framework Convention on Tobacco Control (FCTC).
Policy Actors	 The policy-makers of the SLT ban were a small and relatively homogeneous group with limited influence. The SLT ban policymakers were individuals who embraced collective thinking.
1 Olloy / totolo	The ban policy's development failed to consider important structural factors.
Policy Context	5. Some key intentions of the ban policy formation were not disclosed during the proceedings at the House of Parliament
Policy Process	6. There was a lack of logical flow between the ban development process and the underlying causes of the SLT epidemic in Sri Lanka.
	7. No SLT ban implementation and monitoring plans had been devised as a part of the policy development process.
Process Success	8. The policy implementors remained uninformed about the SLT ban, causing a lack of readiness to implement it.
Programme	9. Most participants predicted a rising incidence of oral cancers caused by smokeless tobacco in Sri Lanka in the coming years.
Success	10. Many doubted the ban's effectiveness in controlling the betel quid-related SLT epidemic, given its complex ties to traditions, culture, society and economy.
	11. A robust implementation strategy could help control the sale of commercial SLT products through black-market trade and challenge informal power structures.
	12. The majority underscored the potential of a comprehensive ban to undermine the favourable results of the ongoing SLT campaign.
Political Success	13. Community and religious leaders were not prepared and were hesitant to endorse the ban14. The prevailing opinion is that political leaders might hesitate to back the ban's implementation, fearing potential harm to their electoral prospects.

- Policy Actors Identifying a small and relatively homogenous group of policymakers, primarily oral health experts, involved in the SLT ban-making. This raises concerns about the inclusivity and diversity of the decision-making process. While collective thinking is acknowledged as a positive aspect in setting policies for a neglected global epidemic such as the SLT burden, it limited the ability to generate a range of policy alternatives. Moreover, the limited influence of this group may indicate potential challenges in representing diverse perspectives and considering the broader socio-cultural context.
- Policy Context- Understanding the context in which the policy was formulated
 is crucial for ensuring its relevance and addressing the root causes of the SLT
 use. Therefore, overlooking structural factors, including socio-cultural, political,
 economic, and environmental drives, in the development of the ban is a
 noteworthy failure. Moreover, the lack of disclosure regarding the primary
 intention during parliamentary proceedings underscores potential transparency
 issues.
- Policy Process- A coherent policy process is essential for the success of public health interventions. The absence of a logical flow between the ban development process and the underlying causes of the SLT epidemic in Sri Lanka is a significant concern. A well-integrated policy process is essential for the success of public health interventions. The lack of planning to implement the SLT ban indicates a strategic gap undermining the policy's success.

5.2.2 Stakeholders' Viewpoints (Study B)

 Process Success – Informed and engaged implementors are pivotal for translating policy into action. The finding that policy implementors were largely uninformed about the SLT ban raises concerns about the readiness and capacity for successful implementation.

- Programme Success The participants predicted a rise in the incidence of SLTattributed oral cancers, highlighting the urgency of addressing the SLT epidemic. However, they doubt the ban policy's ability to tackle the issues effectively. They underscored that its intricate connections to traditional, cultural, social, and economic aspects of traditional and commercial SLT needed careful consideration.
- Political Success- Building solid political support is crucial for successfully implementing public health policies. Most study participants were concerned about hesitancy by the community and religious leaders. Moreover, most were worried about the reluctance of political leaders due to electoral considerations.
 All those pointed to political challenges.

5.2.3 Integration of Findings (Study A and B)

Integrating findings from Study A and Study B highlights a complex interplay between policy development and implementation realities. While Study A identified structural and transparency issues in forming the SLT ban policy, Study B illuminated the on-the-ground challenges faced by implementors and stakeholders. The lack of alignment between policy intent and community realities, coupled with gaps in communication and oversight, suggests a need for a more holistic and collaborative approach to addressing the SLT epidemic in the Sri Lankan context.

In other words, this comprehensive analysis underscores the importance of formulating effective SLT control policies and ensuring their seamless integration into the social fabric through transparent development, stakeholder engagement, targeted communication, and robust implementation strategies.

For instance, the insights derived from the combined findings of this PhD thesis highlight the importance of considering the broader context, including the environment, culture, and political factors, when developing and implementing public health policies such as a ban on SLT to a long-lasting complex public health problem like SLT epidemic in Sri Lanka. The perceived shortcomings in the SLT ban can be attributed to a lack of customisation based on the specific context, which emphasises the need to tailor policy responses to individual environments. The study's findings offer

valuable insights into this process, including the impact of contextual factors on SLT policy development, the challenges faced during development and implementation, the importance of adapting responses to specific contexts, and the key areas of concern when developing complex interventions for SLT control and prevention programs, with a particular focus on SLT bans.

For example, in Sri Lanka, the cultural acceptance and traditional use of smokeless tobacco (SLT) products greatly influence the effectiveness of the SLT ban. Chewing betel quid, which involves using SLT, is deeply ingrained in social rituals, religious practices, and daily habits. This cultural significance indicates that SLT policies need to take into account not only the health risks but also the cultural importance and societal norms associated with SLT use.

Furthermore, given Sri Lanka's diverse geographic and socioeconomic landscape, it is essential to implement different approaches to policy. Rural, estate, suburban, and urban areas vary in terms of access to health services, reliance on SLT-related agriculture for livelihood, and levels of health risk awareness. It is crucial to customise interventions for SLT control and prevention to these specific settings to ensure their relevance and effectiveness.

Additionally, it is essential to note that the political environment in Sri Lanka and the impact of the tobacco industry are key factors shaping the effectiveness of the SLT ban. For instance, the significant economic influence and lobbying power of the Ceylon Tobacco Company could potentially hinder policy efforts. Therefore, it is crucial to develop effective SLT policies to consider these political dynamics and involve stakeholders from various backgrounds to form a supportive coalition for bringing about change.

Furthermore, findings reveal that insufficient engagement with the communities most affected by the SLT ban was a significant failure in the implementation phase. Successful public health interventions often depend on active participation and buy-in from local communities. Engaging local leaders, traditional healers, and community organisations in the policy development process can foster greater acceptance and adherence.

The insights obtained from this study's findings closely align with the theories and concepts outlined in the updated framework for developing and evaluating complex

interventions, which is based on the guidance of the Medical Research Council in the United Kingdom(Skivington et al., 2024). According to the literature, developing complex interventions involves several key steps, including defining the problem, understanding the context, and designing solutions with stakeholders. This approach ensures that interventions are grounded in the lived realities of those affected and are more likely to be effective.

On the other hand, evaluating complex interventions requires flexible and adaptive methodologies. For example, the Medical Research Council (MRC) framework for developing and evaluating complex interventions emphasizes iterative testing, stakeholder involvement, and real-time adaptation based on feedback(Skivington et al., 2024).

In summary, the failures of the SLT ban in Sri Lanka highlight the critical need for public health policies tailored to the local context. Policymakers can develop more effective and sustainable solutions by considering cultural, environmental, and political factors during both the development and implementation phases and by drawing on established frameworks for complex interventions. Tailoring responses to specific contexts, involving local communities, and adopting a multi-sectoral approach are essential steps towards addressing the SLT epidemic in a culturally sensitive and contextually relevant manner.

5.2.4 Addressing Research Questions

In Chapter Two, Table 2.1.(p99) displays the eight research questions planned to be addressed in this research project. The research questions focus on the challenges of implementing the SLT ban policy and its impact on two main types of SLT products in Sri Lanka: traditional betel quids and commercially prepared illicit SLT products. The questions explore the reasons behind this policy decision and its unintended consequences, cultural shocks, political instability, and the practicality of tracing, monitoring, and evaluating the progress of the ban enforcement activities. The main results based on the themes are summarised in Table 5.1. above(p290), this research project provides answers to almost all these questions to a satisfactory level. When considering the limitations caused by the study sample interviewed in the second

phase of the case study (Study B), further research with diverse stakeholders in the future will enhance further knowledge of these critical queries.

5.2.5 Comparing Findings with Existing Literature

The findings presented in this thesis align with a study conducted by Crammond and Carey in Australia in 2016, highlighting the challenges of implementing upstream changes to reduce the global prevalence of diseases and health disparities. Their study found that though public health policy researchers have high expectations of implementing robust policies to control the global burden of diseases and health inequities, their concern with conceptualising the concept of 'policy' is minimal. The study's findings align with those presented in the thesis, highlighting the need for the public health domain to pay more attention to policy definition, content, context and process.

The study revealed that public health policy researchers lack an understanding of the concept called 'policy', politics, policy process, and policy context. The researchers recommend that policymakers gain more profound policy knowledge by examining (public) policy discussions, dialogues, actions, and documentation, whether formal or informal and available in many arrays. In other words, the study emphasises the importance of a well-integrated policy process that acknowledges the diverse contexts and inclusivity in enhancing the effectiveness of public health policies (Crammond and Carey, 2016).

Furthermore, compared to Crammond and Carey's study, which emphasises the limited range of policy analysis in the public health field, the study presented in this thesis offers a qualitative analysis of an SLT control and prevention policy, providing greater insight into the subject matter. In addition to Crammond and Carey, several other recent studies, including those conducted by Lee and Morling, (2020), Kokkinen et al., (2017), Wright, (2017), and Smith and Katikireddi, (2012) reveal similar findings in their research on enhancing the impact of public health policies.

Moreover, as mentioned above, the study's findings in this thesis provided insights into a complex interplay between policy development strategies and implementation challenges. Most of the findings confirmed this complex interplay to a greater extent.

For example, overlooking structural factors influencing the SLT epidemic in the policy-making process has led to difficulty in disclosing the SLT ban's primary intention at the House of Parliament level. Furthermore, stakeholders' viewpoint on the possibility of political leaders being hesitant to back the ban's implementation in the light of fearing potential harm to their electoral prospects was an impact of the lack of contextual assessment and stakeholder buy-in strategies during the ban development phase. The findings of a case study research conducted by Bryan-Jones and Chapman (2006) showed similar results. Their research found that the political environment in Australia hindered the policy-making process for legislation to combat the harmful effects of second-hand smoke. This case study on the history of Australian government responses to the hazards of passive smoking provides an interesting illustration of the gradual development of public health policies due to insufficient targeted communication with decision-makers such as politicians.

Moreover, as Bryan-Jones and Chapman (2006) claimed in their study, despite Australia's reputation as a global leader in progressive tobacco control, the last decade has witnessed a delay in enacting comprehensive second-hand smoke legislation, leaving bars, clubs and pubs as the only indoor public spaces where smoking is legally permitted. In-depth interviews with stakeholders revealed several political factors, including a perception among politicians that there isn't a significant demand for smoking bans in hospitality venues, successful opposition by tobacco industry groups on regulation, and issue wear-out, which have contributed to this sluggish progress. This case study from Australia, similar to the case study presented in this thesis, suggested that advocates should persist in urging governments to use second-hand smoke as a health issue rather than making concessions to industry groups. These researchers further emphasise that advocates should continue to convince politicians to make robust policies. Furthermore, their findings provide insights into advocating for politicians on fundamental health considerations and mobilising community support(Bryan-Jones and Chapman, 2006).

Furthermore, a study conducted by Gneiting in 2016 found that factors leading to the successful implementation of tobacco control interventions include contextual complexity of the policy issue, inclusivity of non-health expertise in the policy-making process, seeking political support, strengthening the involvement of the public, and managing the strength of opposition to policy changes. The findings of this study align

with the factors influencing the political and process success of the SLT ban success in Sri Lanka (Table 5.1)(Gneiting, 2016).

Additionally, the research presented in this thesis focused on Sri Lanka as the study setting. Still, it's worth noting that Bhutan and Singapore have also implemented a complete ban on SLT(Chugh et al., 2023). However, one key difference is that, unlike other countries, Sri Lanka has not imposed limitations on tobacco cultivation. In other words, these bans completely restrict the cultivation, production, distribution and sale of cannabis, except for Sri Lanka. In contrast, some countries have imposed partial bans on importing and selling certain types of SLT, including Australia, Bahrain, Brazil, India, Iran, Tanzania, Thailand, New Zealand, and the UK(Chugh et al., 2023). In this section of the Discussion and Conclusion Chapter, I will briefly discuss the similarities and differences between literature findings related to the success and failure of bans, as well as the findings of this case study. I will also list future research opportunities. To start, I will provide an overview of a few literature comparisons on the successes and challenges of SLT bans in other parts of the world and how they correlate with the insights generated from the Sri Lankan case study presented in this thesis.

Beyond the Ban: Persistent Challenge of Illicit SLT Products in Tamil Nadu, India (2016 Study)

India ranks as the third-largest global consumer of tobacco, with a noteworthy prevalence of SLT products outnumbering cigarette users. In 2016, a study conducted by Vidhubala and colleagues in Tamil Nadu, India, revealed that the Gutka and Pan Masala Ban 2013 was being systematically violated. The study found 65 SLT products belonging to 23 different brands and 26 distinct varieties, all being sold by shopkeepers as containing 'tobacco.' Out of these, 65% of the products explicitly indicated the presence of tobacco, while 15.4% purported to contain Pan Masala. Only 57% of these products had been registered. Due to promotional messages and inadequate information about health risks, these products are readily available and affordable and convey a misleading sense of harmlessness to consumers. The study showed that, similar to the insights generated by the SLT Ban analysis Case Study from Sri Lanka, the Indian government needs to develop and implement comprehensive policies to

regulate the production, import, and sale of illicit SLT products. The study also emphasised the need for coordinated international efforts to address the SLT epidemics effectively (Vidhubala et al., 2016).

- Unmasking the Success of the SLT Ban in Mumbai, India: Lack of Robust Implementation Measures (2014 Study)

The Cigarettes and Other Tobacco Products Act of 2003 (COTPA) is India's primary legal framework for tobacco control. A notable decision by the Government of Maharashtra in 2012 banned the manufacturing, sale, and distribution of Gutka and Pan Masala. A study conducted by Pimple and colleagues 2014 to assess the effectiveness and enforcement level of the COTPA and Gutka and Pan Masala ban revealed widespread noncompliance in Mumbai. The study was conducted as a twostage random sampling process of the educational institutions in the Mumbai metropolitan region(Pimple et al., 2014). Interviewing vendors listed within 100 yards of six academic institutions revealed 32.4% of tobacco retail outlets in violation of relevant sections (section 6) of COTPA. Violations included stacking and open display of tobacco products (51.3%) and displaying Gutka and Pan Masala packets (41%). This study, similar to the themes presented in this thesis's second phase of the Sri Lankan case study, found no robust implementation plans to activate the SLT ban in the Mumbai metropolitan area. Therefore, Pimple and colleagues recommended urgent actions by civic administration and public health departments to establish solid and sustainable measures to implement these SLT regulations effectively.

- Persisting Challenges: High Tobacco Usage in Bhutan Demands Targeted Interventions despite Comprehensive Bans.

Despite a complete ban on the cultivation, production, distribution, and sale of tobacco products in Bhutan since 2004, the country has seen a rise in tobacco usage rates, especially in the form of SLT. This has been indicated by two nationwide surveys conducted in 2012 and 2013 (48% reported using SLT in (Rinchen, Taneepanichskul and Dawa, 2018)National Health Survey in 2012 and 30% reported using tobacco in the Global Youth Tobacco Survey in 2013). Therefore, Gurung and his colleagues

conducted a cross-sectional analytical study, utilising secondary data from the nationally representative Non-communicable Disease Risk Factors Surveillance STEPS Survey in 2014. As revealed by this cross-sectional study conducted after ten years of the comprehensive tobacco ban in Bhutan, 19.7% of its study population (2820 adults aged 18-69) consume SLT. The study revealed that exposure to health and tobacco warnings (mainly by mass media) was beneficial. The study recommended targeted behavioural interventions, especially for males, younger age groups, and alcohol users, accompanied by stricter implementation of tobacco control measures (Gurung et al., 2016).

A study conducted by Rinchen and Taneepanichskul investigated the prevalence of tobacco consumption among adolescents in a school environment in Bhutan. The study included 378 eighth-grade students (aged 11-19 years) recruited from four schools in Wangdue Phodrang district in May 2016, 47% of whom were male. The study found that 11.10% of the students had used SLT in the month preceding the survey. The factors associated with this behaviour included gender, tobacco use by siblings and friends, and experimentation with alcohol. Despite a comprehensive ban introduced in 2004, this study highlights the growing public health concern about tobacco use among both male and female adolescents (Rinchen, Taneepanichskul, and Dawa, 2018).

- Balancing Acts: Singapore's Tobacco Control Success, Challenges, and Road Ahead Amidst Criticism.

The review conducted by Amul and Pang in 2017 in Singapore revealed that the country's tobacco control program, marked by strict regulations and proactive measures, has been a global success story. The early implementation of laws such as the Smoking (Prohibition in Certain Places) Act and the Tobacco (Control of Advertisements and Sale of Tobacco) Act showcases Singapore's commitment to public health. Pioneering initiatives, including the ban on public smoking since 1970, have positioned Singapore as a leader in tobacco control. This hostile environment for the tobacco business in Singapore for more than four decades, with substantial proactive fines, was an accessible context for authorities to ban SLT products, including Loose Leaf, Plug, Twist, and Shisha, in 2014. The decision was further

supported by the refusal of emerging tobacco products, including electronic cigarettes, in 2014. Offenders are liable to a fine of up to \$10,000 or imprisonment for six months or both. Repeat offenders are subjected to penalties of up to \$20,000 or both.

As revealed by Amul and Pang in this review, another factor that aided in this success story in Singapore is the collaboration of various agencies in enforcement activities. These agencies include the Health Promotion Board and the Ministry of Education. Moreover, the Prevention of Corruption Act is a foundation for protecting public policy from tobacco industry influences(Amul and Pang, 2018).

Nevertheless, Illicit trade in tobacco remains a concern, and Singapore has yet to ratify the Protocol to Eliminate Illicit Trade in Tobacco Products. The tobacco industry, though describing the market as "limited" and "difficult", continues to play a significant role in Singapore's global distribution hub, creating economic complexities for tobacco control. Moreover, the campaign faces considerable criticism. For example, some local experts have criticised the ban as "lazy policymaking". The tobacco control community remains divided on some decisions, including the electronic cigarette ban. The review provides recommendations to draw inspiration from countries like Finland and New Zealand, which have set timelines for tobacco-free nations. The researchers recommend striking a balance between innovation, rigorous governance, and addressing emerging criticisms as the key to sustaining and advancing Singapore's tobacco control, potentially setting the benchmark for others to follow (Amul and Pang, 2018)

In summary, comparing this case study's research findings with various studies conducted on SLT bans in other countries showed more similarities than discrepancies. These similarities include:

- Illicit SLT Products Persistence: Despite bans, there are challenges in curbing illicit SLT products.
- Implementation Gaps: A lack of robust plans to activate SLT bans leads to widespread noncompliance and violation.
- Rise in SLT Use Despite Bans: There is a persistence of SLT usage in post-ban periods, highlighting the gaps in targeted interventions and stricter implementation measures.

The research study on Singapore's ban implementation produced findings significantly different from those of other studies and this case study. It serves as an example of success amid challenges. Singapore has been successful in tobacco control thanks to its strict regulations and proactive measures that have led to a hostile environment for tobacco businesses and usage. This success is exemplary. Yet, this comparison further highlights Singapore's challenges, including illicit trade and criticism, emphasising the need for continuous innovation and governance.

Additionally, comparing the context-specific characteristics of the SLT epidemic in Sri Lanka and its policy decision to global cases and their success stories, this thesis drew additional insights into reforming the SLT ban in Sri Lanka as follows.

- Global Success Stories 01- Importance of Cultural Sensitivity in Tobacco Control Programmes

One of the key findings of this research study is the mismatch between the blanket approach of the SLT ban and the cultural sensitivity of the SLT epidemic in Sri Lanka. Therefore, it was evident that designing culturally sensitive programmes is crucial for the success of public health interventions. When addressing behaviours deeply rooted in cultural, social, and economic contexts. Following is literature evidence for a few success stories from Australia, New Zealand and the United States.

- Australia: Indigenous Tobacco Control Programme (Colonna et al., 2020;
 Gould et al., 2018; Chamberlain et al., 2017)
 - Challenge: Indigenous communities in Australia faced high rates of tobacco use, with traditional tobacco often used in cultural ceremonies. Conventional anti-smoking campaigns were not resonating with these communities.
 - Culturally Sensitive Approach: Australian authorities collaborated with Indigenous leaders and organisations to develop culturally tailored tobacco control programmes. These programmes respected the significance of traditional tobacco while addressing the harms of commercial tobacco.
 - Success: By incorporating cultural elements and engaging community leaders, smoking rates within Indigenous populations decreased. The

success stemmed from acknowledging and integrating cultural practices into health promotion efforts.

- New Zealand: Smokeless Campaigns for Māori Communities (Glover et al., 2014a, 2014b; Glover and Cowie, 2010)
 - Challenge: Maori communities in New Zealand had disproportionately high smoking rates. Conventional anti-smoking messages were struggling to connect with this demographic.
 - Culturally Sensitive Approach: Health agencies in New Zealand worked closely with Māori leaders and utilised traditional Māori Values and symbols in their anti-smoking campaigns. The messages emphasised the importance of whanau(family) and community well-being.
 - Success: The culturally tailored campaign increased awareness and reduced smoking rates among Maori populations. The approach recognised the unique cultural context and values of the Maori community, making the campaigns more relatable and compelling.
- United States: Campaigns Targeting African American Communities
 (Kong et al., 2020; Kong, Singh and Krishnan-Sarin, 2012; Secker-Walker et
 al., 2005)
 - Challenge: African American communities in the U.S. were experiencing higher rates of tobacco-related illnesses. Standard campaigns were not adequately addressing the specific challenges faced by this community.
 - Culturally Sensitive Approach: Public health campaigns in the U.S. collaborated with African American Influencers, organisations, and churches to create culturally tailored anti-smoking messages. The campaigns addressed the historical context, social influences, and community support system.
 - Success: By acknowledging the cultural nuances and collaborating with community leaders, these campaigns saw increased engagement and positive behavioural changes within African American populations.

Drawing inspiration from these global success stories with the key findings presented in Table 5.1. above (p290), the key takeaway messages that might help develop better policies in Sri Lanka are collaboration, respect for cultural practices, tailored messaging, and community involvement.

Global Success Stories 02- Stakeholder Engagement in Developing and Implementing Context-Specific Tobacco Control Programmes is Critical.

One of the key findings of this research project is the need for inclusiveness and collaboration of stakeholders in decision-making and implementation plans. Stakeholder engagement, including stakeholder buy-in, is critical to successfully addressing complex public health issues. Following are a few pieces of evidence from Canada and Thailand with a particular focus on strategies to secure stakeholder buy-in:

- Canada: Tobacco Reduction Programmes and Indigenous Stakeholders
 (Habash, Sheppard and Steiner, 2021; Lee, Eckhardt and Holden, 2016; Lee,
 Buse and Fustukian, 2002)
- Challenge: Indigenous communities in Canada faced high rates of tobacco use.
 With cultural and historical ties to traditional tobacco. Implementing the tobacco reduction programme required addressing indigenous stakeholders' unique challenges and perspectives.
- Stakeholder Engagement Strategy:
- Cultural Respect- Canadian authorities collaborate with Indigenous leaders and elders, respecting the cultural significance of tobacco. They recognised the distinction between commercial and traditional tobacco.
- ❖ Community Involvement- Programmes were designed with active involvement from Indigenous communities. Elders and community leaders were integral in shaping strategies, ensuring cultural sensitivity, and providing insights into effective communication within the community.

- ❖ Buy-In Success- The strategy fostered a sense of ownership among indigenous communities. There was increased buy-in by involving stakeholders from the inception, leading to tremendous success in reducing tobacco use.
- Thailand- Temple-Based Smoking Cessation Programmes (Chaisai et al., 2022a, 2022b; Kungskulniti et al., 2012)
- Challenge: Thailand faced challenges in reducing smoking rates, with a significant proportion of the population being Buddhist monks like Sri Lanka. Engaging religious leaders and temples was crucial for success.
- Stakeholder Engagement Strategy
- Customised Messaging- Smoking cessation programs were tailored to align with Buddhist principles and values. The messaging focused on the benefits of a smoke-free lifestyle for spiritual and physical well-being.
- Collaboration with Monastic Authorities- Authorities within the Buddhist monastic community were actively developing and promoting anti-smoking campaigns. Temples served as focal points for awareness and support.
- Buy-in Success- The tailored approach and collaboration with religious leaders increased acceptance and adherence to smoking cessation efforts among monks and the broader community.

The main insights derived from these global success stories in effective stakeholders for policy success include cultural relevance, active involvement, evidence-based communication, customised messaging, partnerships and collaboration, as shown in Table 2.2.(p109) the analytical framework of this research project (2.4, p120-139).

5.2.6 Areas for Future Research

The preceding section of this Discussion and Conclusion Chapter has illuminated the similarities and differences between this study's findings and those of previous research. Based on these comparisons and the insights gained from combining the results of the two stages of this case study, several areas require further investigation and exploration, as they represent research gaps.

- Analysing the Successes of Comprehensive Policies: Research is needed to
 assess the overall success of comprehensive tobacco control policies,
 including the success of total bans versus partial bans on SLT products.
 Understanding the long-term outcomes and unintended consequences in
 analysing the successes of such policies can inform future decision-making.
- 2. Factors Influencing Illicit Trade: Future researchers might delve deeper into the factors contributing to the persistence of illicit SLT products despite bans, identifying the root causes such as supply chain vulnerabilities and consumer demand. That research will guide more targeted interventions. Assessing informal power structures operating in the black market and undermining the bans.
- 3. Implementation Challenges and Solutions: There is a need for research focusing on the specific challenges faced while implementing SLT bans and effective strategies to overcome the obstacles. Insights into enforcement mechanisms, stakeholder collaboration, and public awareness campaigns might contribute to better policy implementation.
- 4. Sociodemographic Factors in SLT Use: Understanding the socio-demographic factors influencing SLT use post-ban is crucial. The research will explore how age, gender, socioeconomic status, and cultural factors contribute to the consumption of illicit SLT products despite regulatory measures.
- 5. Health Communication and Awareness: Further studies are required to assess the effectiveness of health communication and awareness programs in influencing SLT consumption patterns. This might include evaluating the impact of warning labels, public health campaigns, and education initiatives on changing consumer behaviour.
- 6. Comparative Analysis of Ban Policy Approaches: A more comprehensive comparative analysis of different countries' policy approaches towards SLT bans is needed. This might include an in-depth examination of ban

- development processes, including legal frameworks, enforcement mechanisms, and the political and cultural contexts that shape these policies.
- 7. Public and Key Stakeholders' Perceptions and Attitudes: Investigating public and key stakeholders' perceptions and attitudes towards the SLT ban is crucial. Understanding how individuals perceive these ban policies, including potential resistance or support, can inform the development of more culturally and socially acceptable and successful regulatory measures—examining methods to engage better and prepare community and religious leaders to endorse and support the SLT ban, recognising their influence and role in shaping public opinion.
- 8. Cross-Country Learning for Culturally Sensitive Strategies: Research focus on facilitating cross-country learning by identifying successful elements of culturally sensitive SLT control strategies and interventions that can be adapted and implemented in different political settings. Further explore complex ties between betel quid-related SLT use and traditions, culture, society, and the economy. Investigate culturally sensitive approaches to address SLT use while respecting local practices.
- 9. Economic Impact of Bans: Assessing the economic impact of SLT bans, mainly where SLT is the primary income for tobacco farmers, marginalised small-scale traditional product manufacturers and sellers (betel quids and similar varieties), is essential. Research might explore the economic complexities and potential alternatives for regions or individuals heavily dependent on tobacco farming and the SLT industry.
- 10. Political Will and Electoral Impact: Further studies are needed to investigate the relationship between political leaders' support for the SLT bans and their electoral prospects, identifying strategies to garner political will and mitigate concerns about potential electoral harm.

Addressing these research gaps will contribute to a more nuanced understanding of the challenges and opportunities associated with SLT bans.

- 11. Studying the policy-making skills and competencies of SLT-related decision-makers.
- 12. Exploring how the SLT ban policy can be aligned with the context and political powers of various settings in Sri Lanka.
- 13. Investigating how value-based international standards can better align with the local context, considering the challenges faced in implementing the SLT ban in traditional and cultural SLT use in Sri Lanka.

5.3 Methodological Considerations

When comparing with the recent research studies connected to examining the SLT ban policies, the study presented in this thesis consisted of a more advanced research design, data collection methods, data sets, sources, and analysis techniques (5.2.5., p294-302). Yet, this case study research has a significant number of inherent problems. This section delves into providing insights into those issues in research methodology and the real-life challenges faced during the study.

5.3.1 Inherent Problems of Research Methodology

Firstly, adopting interpretivism, the philosophical choice of this research design aligns with the intricate nature of the SLT epidemic. In other words, selecting interpretivism as the philosophical choice of this Sri Lankan case study in successes and failures of the SLT ban acknowledges the influence of socio, cultural, political, and economic factors. Acknowledging that interpretivism can introduce subjectivity into the research process is essential (Alam, 2021; Creswell and Poth, 2016; Baskarada, 2014; Creswell, 2007). This means that the researcher's interpretation may affect the objectivity of the findings. Although I have included measures to mitigate potential bias by practising reflexivity (3.7, p168 and 4.4, p250), it is essential to note that certain limitations may still exist.

Secondly, it is essential to note that the research presented in this thesis has a limited scope due to its qualitative focus, the epistemological viewpoint. Section 2.5 of Chapter Two explained that the research design relied solely on qualitative data due to financial and time constraints and inadequate statistics on SLT use and uptake patterns post-ban in Sri Lanka. However, incorporating qualitative data as a mixed research method could provide a broader understanding of the prevalence and trends related to SLT use(Creswell and Poth, 2016; Al-Saadi, 2014; Creswell, 2007). Moreover, it is essential to consider that qualitative data is subject to interpretation bias, which could affect the reliability of the findings. As a mitigation strategy, source triangulation was integrated into the first stage of this case study, Study A (3.6, p166).

Thirdly, the research design of this study took an inductive approach. While inductive approaches are exploratory and allow for the emergence of new theories, they may lack generalisability (Azungah, 2018; Schadewitz and Jachna, 2007). Therefore, the results of this study are context-specific and may not be readily transferable to other situations. However, the study endeavored to illustrate how the outcomes could influence policy changes in Sri Lanka's culturally and politically delicate environment and offer valuable perspectives for comparable settings. This was conducted to accommodate the inherent limitations of the inductive methodology employed in the research.

Fourthly, the case study research strategy causes the findings to be context-specific (2.3.4., p104-106). Although case studies provide a detailed analysis of a particular setting, such as Sri Lanka, in this study, they are challenging to apply to different contexts. Furthermore, case studies may need to fully represent the complexity and diversity of broader situations (Alam, 2021; Baskarada, 2014; Exworthy et al., 2012; Chiseri-Strater, 1996). A comparative analysis with existing literature is recommended to overcome these limitations of case study research strategies and gain a more nuanced understanding. This approach was conducted in Section 5.2.5 above (p294). Incorporating a mixed-method approach in future research could be a more effective strategy to overcome the limitations observed in this case study(Atchan, Davis and Foureur, 2016; Diefenbach, 2009). This approach combines the depth of qualitative insights with the broader perspective of quantitative data, providing a comprehensive understanding of the research topic.

Fifthly, as presented in section 2.3.5 (p107). this research relied on two cross-sectional time points in this thesis's Research Aims and Methodology Chapter. It is worth noting that more than two cross-sectional time points may be required to fully capture the dynamic nature of policy implementation and stakeholders' viewpoints over time. Therefore, to address this limitation, future researchers may consider incorporating a longitudinal component to track changes. For instance, a longitudinal time horizon can help track the changes and development of stakeholder perceptions and policy outcomes over an extended period. This approach can provide a more nuanced and comprehensive understanding of the evolving nature of the SLT ban(Kapoulas and Mitic, 2012; Schonfeld and Mazzola, 2012; Tierney and Clemens, 2011).

Moreover, while snowball and purposive sampling are appropriate for the objectives of the study presented in this thesis, they carry inherent biases. The sampling technique known as snowball sampling is prone to bias. In the study noted in section 3.5 (p159-166), a small, homogeneous group consisting of almost all the SLT ban makers were interviewed. This means that the reliability and validity of Study A are unlikely to be compromised using snowballing techniques. However, in future research, researchers need to be more careful with their sampling techniques to ensure more accurate findings, especially when dealing with many policymakers(Gill, 2020; Higginbottom, 2004).

Additionally, purposive sampling might overlook specific perspectives. For example, as presented in section 4.3 (p237), in my thesis, I intentionally selected three types of stakeholders from a diverse range of those affected by the SLT epidemic in Sri Lanka (as listed in Table 4.1, p240). However, I should have included several key stakeholders, such as police officers, customs officers, political leaders, community and religious leaders, and consumers. As a result, some important perspectives were excluded from my research. While I have acknowledged the potential bias of my purposive sampling technique, future researchers may want to seek more logistical and financial support to track the perceptions of these diverse ranges of stakeholders on the SLT ban(Elmusharaf, Farrokhi and Mahmoudi-Hamidabad, 2012; Suri, 2011).

Moreover, I had to rely solely on policy document analysis and interviews to gather data to answer this case study's objectives and research questions. Limiting oneself to only two data collection methods may result in overlooking other valuable sources

of information(Flick, 2018; Schonfeld and Mazzola, 2012; Bachiochi and Weiner, 2004). In the future, researchers can expand their data collection approach by including additional sources, such as participant observations or archival records. This diversification can enhance our understanding of the SLT epidemic, its context, and the ban implementation mechanism, providing a more comprehensive view. Further, when considering the limitations of the data sources for policy document analysis, I relied on publicly available policy documents and a set of minutes and project overviews sent by SLT ban policymakers (3.5, p159). While acknowledging the potential bias that can happen by restricting to a limited number of documents related to SLT ban-making processes, future researchers can investigate more internal sources for comprehensive analysis.

As presented in the relevant sections of two result chapters (3.10, p185-214 and 4.5, p252- 268), thematic analysis was valuable for deriving meaningful insights from qualitative data. However, like any research methodology, thematic analysis is also subjected to inherent limitations, especially when juxtaposed against alternative data analysis. Techniques. For example, thematic analysis involves subjective interpretation during the identification and naming of themes, which may introduce bias(Castleberry and Nolen, 2018; Javadi and Zarea, 2016).

It is essential to have a transparent and unbiased process for analysing data to reduce subjectivity in thematic analysis (Williams and Moser, 2019; Elliott, 2018; Hyett, Kenny and Dickson-Swift, 2014). One way to achieve this is by using a coding framework, which was applied in Study A based on the Health Policy Triangle framework presented by Buse and colleagues in 2012 (Table 3.1. p148-149). Similarly, the coding framework used in Study B of this PhD study was based on indicators for measuring three dimensions of policy success by Alan McConnell in 2010 (Table 4.3, p247).

It is essential to acknowledge that while thematic analysis is helpful, it may only partially capture some contextual nuances compared to more context-specific approaches. In future research, combining thematic analysis with context-specific methods, such as grounded theory or ethnography, may be beneficial to gain a deeper understanding of the unique contextual factors that influence the phenomena being investigated. For instance, further studying the success of the SLT ban policy and implementing it in a culturally sensitive manner in the Sri Lankan context may require

this approach. Triangulating data sources and using mixed strategies, such as quantitative and qualitative, can aid researchers in mitigating the bias resulting from relying solely on thematic analysis (Young et al., 2020; Creswell and Clark, 2011).

The aim of applying an integrated analytical framework to this qualitative case study was to systematically assess the successes and failures of the SLT ban policy in the Sri Lankan context. By incorporating a few key theories and frameworks, I strived to understand the policy landscape comprehensively. As shown in section 2.4 (p120-139), the analytical framework was based on McConell's Policy Success Framework and Spectrum (2010) and Buse and colleagues' Health Policy Triangle (2012). However, future researchers may want to address certain aspects of this analytical framework (An, Huang and Baghbabian, 2015; Buse, Mays and Walt, 2012; Buse, 2010).

The Health Policy Triangle (HPT) is a framework used to analyse health policies from a political perspective. However, one limitation of the HPT is that it primarily focuses on policy development and decision-making, neglecting the challenges related to policy implementation. It's important to remember that success in controlling epidemics, such as SLT, depends on policy decisions and how well those policies are executed on the ground(Baggott, 2015; Buse, Mays and Walt, 2012).

It is worth noting that there is a risk of subjectivity when using McConnell's spectrum to categorise policy analysis outcomes into five milestones ranging from success to failure. Various analysts may interpret The same indicators differently, leading to disagreements in the final assessment. Additionally, the framework may prove challenging for analysts who need to be better versed in policy analysis. It requires a solid understanding of the indicators, dimensions, and logical spectrum, which could be overwhelming for those new to the field(McConnell, 2018; Baggott, 2015; Brownson, Chriqui and Stamatakis, 2009).

5.3.2 Covid 19 related Impact: Challenges and Opportunities

It is crucial to acknowledge the methodological considerations that affect research. This will help readers gain a better understanding of the challenges that researchers face in real-life situations. For example, I encountered a significant challenge at the beginning of the second year of my PhD project. The COVID-19 pandemic began in

China in December 2020 and rapidly spread worldwide. As a result, I had to revise my data collection plan, which had yet to begin. The international travel restrictions posed a significant obstacle to the planned field visits to Sri Lanka for data collection (Chinazzi et al., 2020). To address this challenge, I collaborated with my PhD thesis Advisory Panel to develop a robust risk mitigation plan. A brief overview of changes to the initial data collection plans follows.

Adapting Data Collection Methods: The initial reliance on face-to-face data collection was replaced with innovative remote methods. Leveraging online tools, such as video conferencing, became the cornerstone of this adapted approach. This shift was crucial for maintaining the momentum of the research during the period of uncertainty (Loosemore et al., 2012)

Developing a Detailed Protocol: A detailed protocol was designed to ensure the accuracy and reliability of remote data collection. This protocol encompasses guidelines for conducting remote interviews, confined to open-sourced policy documents, sending requests for policy actors to email the internal records, recording data, and maintaining data quality standards. Participants were actively informed of these guidelines, fostering collaboration in the new data collection process (<u>Alam</u>, 2021; <u>Harding and Whitehead</u>, 2013).

Success of the Risk Mitigation Plan: Despite the unprecedented challenges posed by the pandemic, the risk mitigation plan proved successful. The interview participants were favourable to meeting online as it helped them to select a convenient time, even late at night, and spend quality time answering questions. One of the main reasons for this preference was that almost all interview participants were extremely busy with COVID-19-related health services in Sri Lanka due to their profession. Policy actors shared internal policy documents by email without delays. Adequate data was collected, allowing for the completion of the study. This experience underscored the importance of adaptability and flexibility in research, especially when confronted with unforeseen challenges like the COVID-19 pandemic(Jee, 2020; Singh, Bandewar and Bukusi, 2020). On the other hand, learning from challenges, such as pandemics, contributes to a deeper understanding of the complexities inherent in developing and implementing the SLT ban in Sri Lanka.

5.4 Implications

This concluding section explores the implications of the study's findings across various dimensions of the SLT ban policy. Each dimension, from policy content to political success, was meticulously examined to uncover potential challenges and suggest avenues for improvement (Table 5.1, p290). The analysis delves into the legal framework, policy actors, contextual considerations, the policy development process, implementation dynamics, and the broader socio-political landscape. These implications shed light on the current strengths and weaknesses of the SLT ban and offer accountable recommendations for refining and fortifying the policy. Through a comprehensive exploration of these implications, this section aims to contribute valuable insights to the field of public health, policy development, and tobacco control, emphasising the need for continual assessment, adaptation, and inclusivity in the pursuit of effective SLT control measures.

In general, insights derived from this PhD research project suggest that the failure of the SLT ban in Sri Lanka could potentially be addressed by tailoring the ban into context-specific strategies. Interventions to control and prevent the SLT epidemic in Sri Lanka should consider incorporating cultural practices. For instance, policies could focus on preventing the tradition of SLT use while introducing substitutes and improving the health literacy of vulnerable groups. These policies should be customized to meet local needs and conditions. In rural areas where SLT farming is a major source of income, alternative livelihood programs should be implemented alongside the SLT ban to minimize the economic impact.

Another important policy implication suggested by the study is that addressing the SLT epidemic requires a multisectoral approach, involving health, agriculture, education, and economic development sectors. Policies should promote cross-sector collaboration to ensure comprehensive and sustainable solutions.

Divided by the main thematic areas of the research projects, the following are some relevant policy implications generated by the findings.

Policy Content: The robust legal anchoring of the SLT ban within the National Alcohol and Tobacco Act provides a solid foundation for enforcement at the national level.

However, the finding that the policy falls outside the WHO Framework Convention on Tobacco Control (FCTC) scope raises questions about its potential limitations in addressing transnational aspects of tobacco control. This misalignment underscores the importance of periodic reviews and amendments to ensure policy coherence with evolving international standards.

Policy Actors: Identifying a relatively homogenous group of policymakers signals potential limitations in representation and diversity within the decision-making process. To enhance inclusivity, it is recommended to establish mechanisms for engaging a broader range of stakeholders, including representatives from diverse communities, advocacy groups, and public health experts. This approach ensures a comprehensive and representative perspective in policy formation.

Policy Context: While overlooking structural factors (sociocultural, economic, political, and environmental dimensions) of the SLT epidemic in policy development is a sign of fragile policy decisions, not disclosing the primary intention of the SLT ban policy during parliamentary proceedings was its indirect outcome. Moreover, this lack of disclosure of the policy's primary objectives introduces transparency challenges. To address this, policymakers should prioritise clear communication and public disclosure of the policy's primary objectives. This transparency fosters public trust, aligns with democratic principles, and ensures the policy remains relevant to the population's evolving needs. Comprehensive contextual assessment aids in exploring the structural factors and maintaining transparency in the policy-making process.

Policy Process: The absence of logical integration between the SLT ban development process and the underlying cause of the epidemic reveals a potential weakness in the policy's strategic foundation. Conducting a comprehensive review of the policy process, incorporating evidence-based approaches and stakeholder input is recommended. Developing and implementing a detailed action plan can enhance the logical coherence of the policy, ensuring it is well-aligned with the broader goals of tobacco control.

Process Success: The uninformed state of policy implementors presents a clear obstacle to successful policy execution. To address this, it is crucial to invest in comprehensive training programs and communication strategies tailored to the specific needs of implementors. Regular updates and feedback mechanisms should ensure ongoing engagement and awareness, empowering implementors to navigate policy implementation challenges effectively.

Programme Success: The anticipation of a rise in oral cancer cases due to SLT highlights the urgency of addressing the SLT epidemic. However, doubts about the policy's effectiveness suggest a need for culturally sensitive interventions. Programs should address traditional, cultural, social, and economic factors contributing to SLT use. Collaborative efforts with local communities and cultural influencers can enhance the program's resonance and effectiveness.

Political Success: Hesitancy among communities and religious leaders and concerns about potential political reluctance underscores the need for strategic political engagement. Policymakers should actively involve these key stakeholders in the policy development process. They are addressing their concerns and emphasising public health benefits. Building political support through targeted communication strategies can strengthen the foundation for successful policy reform and implementation.

5.5 Recommendations

Finally, in response to the identified implications within the previous section, this segment offers a set of comprehensive recommendations aimed at refining and fortifying the SLT ban policy. These recommendations encompass multifaced dimensions and outline strategic steps across policy alignment, inclusive decision-making, transparent policy development, strategic planning, training, cultural sensitivity, stakeholder engagement, and a strategic framework for SLT control in Sri

Lanka. The objective was to provide a roadmap for enhancing the policy's success, aligning it with international standards, and addressing potential shortcomings in its development, implementation, and cultural relevance.

Policy Alignment:

- Initiating a comprehensive review of the SLT ban to explore avenues for alignment with international standards, including evolving public health policy values. It is recommended to align with the WHO Framework Convention on Tobacco Control at the initial stage and then look for opportunities to go beyond that.
- Collaborating with international bodies and experts can provide valuable insights into best practices and facilitate the necessary adjustments for global coherence.

Inclusive Decision-Making:

- Establishing participatory mechanisms, such as public forums, stakeholder committees, and consultations, to ensure a diverse range of perspectives is considered in policy decisions.
- Encouraging the active involvement of representatives from marginalised communities, advocacy groups, and public health experts to enhance the inclusivity of the decision-making process.

Transparent Policy Development:

 Implementing clear communication strategies to disclose the primary intention and objectives of the SLT ban during parliamentary proceedings. Transparent policy development fosters public trust, mitigates scepticism, and reinforces the legitimacy of SLT control and prevention policies.

Strategic Planning:

- Conducting a thorough review of the SLT ban's policy process, incorporating evidence-based approaches and stakeholder input.

 Developing a detailed plan that logically integrates with the underlying causes of the SLT epidemic.

Training and Information Dissemination:

- Investing in comprehensive training programs for SLT policy implementors tailored to their specific roles and responsibilities.
- Establishing regular information dissemination mechanisms to keep implementors informed and engaged.
- This investment ensures a knowledgeable and capable workforce for successfully implementing the SLT ban.

Culturally Sensitive Programmes:

- Reform the policy to make it culturally sensitive, acknowledging traditional festivals, customs, and rituals related to betel quids and related products while applying the ban on high-risk consumption.
- Addressing the intricate connections between SLT use and traditional, cultural, social, political, and environmental factors.
- Collaborating with local communities, cultural influencers, and grassroots organisations to ensure programme resonance and success within diverse cultural contexts.

Stakeholder Engagement:

- Developing targeted strategies to engage community and religious leaders in the SLT ban policymaking process.
- Address their hesitancy through open dialogue by providing evidence-based information on the policy's benefits.
- Strengthening political support involves building relationships with key stakeholders.
- Communicating the positive impact of the SLT ban policy.

The following is an elaboration of two key recommendations: proposed policy training (including its aims, content, resourcing, delivery, and evaluation) and a reformed lobbying mechanism.

Proposed Policy Training

The training programmes for SLT ban implementors aim to equip policy implementors with the skills necessary to enforce the SLT ban, which is one of the recommendations of these research findings. This includes ensuring consistent and up-to-date information flow, maintaining high engagement and informed decision-making, and developing a robust and capable workforce that can handle the complexities of implementing the SLT ban across various contexts(Schwendinger, Topp and Kovacs, 2022; Thomson, 1991).

The proposed training program for SLT ban implementors will include a comprehensive module covering the health impacts of SLT, the diversity of users, various implementation contexts, the rationale behind the ban, and the specifics of SLT policies. It will also address the roles and responsibilities of multiple implementors, such as provincial directors, regional health directors, medical officers, and public health inspectors. Additionally, the module will provide training on legal aspects, enforcement strategies, and handling violations of the SLT ban. The community interaction strategy will focus on effective communication techniques, handling resistance, and promoting the benefits of the SLT ban(Patrick and Sturgis, 2013).

The resources will include training materials, trainers, and technology. Training materials will involve developing manuals, online courses, and interactive workshops tailored to different levels of implementors. In addition, I will need to hire experienced public health professionals, legal experts, and community engagement specialists. Furthermore, digital platforms for information dissemination, online training modules, and regular updates are essential resources for this proposed training module.

The training program will include workshops, seminars, online learning (courses, webinars), and field training, including practical sessions and simulations, to prepare implementers for real-world scenarios(Bowman, 2017; Toward, 2008).

The evaluation involves feedback mechanisms, performance metrics, and ongoing improvement of the training module. I will conduct regular surveys and feedback sessions with participants to assess the effectiveness of the training programs. Performance metrics will include monitoring the implementation process, compliance rates, and community response to measure the impact of the training. I will improve continuously by making iterative updates to the training programs based on feedback and emerging challenges (Gonczi and Hager, 2020).

Proposed Reformed Lobbying Mechanism

As mentioned above, reforming the lobbying mechanism is one of the other main recommendations of this research project. The primary objectives of the reformed lobbying mechanism are as follows:

- Strengthening political will and support for the SLT ban
- Engaging and mobilising key stakeholders, including policymakers, community leaders, and the public
- Influencing policy and legislative changes through evidence-based advocacy
- Ensuring sustained commitments to the enforcement and monitoring of the SLT ban

The reformed lobbying mechanism will include stakeholder mapping and engagement, evidence-based advocacy, communication strategy, legislative advocacy, and coalition building(Godwin, Ainsworth and Godwin, 2012).

Stakeholder mapping and engagement involve identifying key stakeholders and building relationships with them. This includes politicians, policymakers, community and religious leaders, public health experts, and local and international civil organisations. Maintaining these relationships through meetings, workshops, and communication channels ensures the plan's success(Brugha and Varvasovszky, 2000).

The lobbying process needs to rely heavily on an evidence-based approach (Baumgartner et al., 2009). This includes collecting and presenting solid data on the health impacts of SLT, economic costs, and success stories from other regions and countries. Additionally, it involves supporting research initiatives that provide new

insights and evidence on the effectiveness of the SLT ban and publishing findings in reputable journals and media outlets.

The communication strategy will include public awareness campaigns and targeted messaging(Ashcroft, Kennedy and Van Katwyk, 2019; Godwin, Ainsworth and Godwin, 2012). This will involve developing and launching comprehensive public awareness campaigns using traditional media, social media, and community events to emphasize the dangers of SLT and the advantages of the ban. Targeted messaging will target audiences, including policymakers, the general public, and specific high-risk groups, to achieve the greatest possible impact.

Legislative advocacy can be achieved through policy proposals and lobbying efforts. Policy proposals involve developing clear position papers and advocating for specific legislative changes, which are then presented to relevant government bodies. Lobbying efforts include organizing meetings with key legislators, providing testimony at legislative hearings, and conducting policy briefings(Gupta, 2018; Howlett, McConnell and Perl, 2017).

The establishment of coalitions will involve developing partnerships and working together on initiatives. We will consider forming alliances with local and international organisations, healthcare providers, academic institutions, and other relevant groups to enhance our partnership advocacy efforts. Collaborative initiatives will include joint campaigns, research projects, and public events to increase the reach and impact of our lobbying activities (Chari et al., 2020).

The implementation plan for the proposed lobbying mechanism will include several key steps(Chari et al., 2020; Baumgartner et al., 2009): preparation, engagement advocacy, consolidation, and monitoring. As mentioned, the preparation phase will involve stakeholder mapping, data collection, and message development. The proposed timeline for completion is one to three months.

The engagement and advocacy phase will involve stakeholder meetings, public campaigns, and policy proposals(May and Winter, 2009; Baumgartner et al., 2009). The proposed duration is four to six months.

Consolidation and monitoring, the third phase includes legislative advocacy, partnership and coalition and monitoring and evaluation. Regular surveys and stakeholder feedback can be monitored(Godwin, Ainsworth and Godwin, 2012; McConnell and Marsh, 2008). The impact of the planned lobbying mechanism will be shown by tracking legislative and policy changes and public health outcomes (monitoring changes in SLT usage rates and related health outcomes as indicators of the policy's impacts).

Other factors to consider for creating a successful reform lobbying mechanism include continuous improvement through a feedback loop, adaptation, allocation of human resources (including advocacy teams comprising of advocacy specialists, public health experts, and communication professionals), and consultants for specialized tasks such as data analysis and legislative drafting. Financial resources should also be allocated for this purpose(Chari et al., 2020).

By implementing these proposed reforms in lobbying mechanisms based on the findings of this research, Sri Lanka would strengthen its efforts to control and prevent the SLT epidemic, ensuring a healthier future for its citizens(Mahees et al., 2021; Perera et al., 2018; Somatunga et al., 2012).

5.5.1 Proposed Strategic Framework

To finish, Figure 5.1. below (p323) outlines the recommendations generated by this research project for a strategic framework for SLT control in Sri Lanka. This framework emphasises key components and subsequent steps. The central focus is on effective policy implementation aligned with value-based international standards.

The subsequent steps outlined for the initiative include:

1. Multifaced Approach: Implementing a comprehensive and diverse strategy to tackle SLT use from various angles.

- 2. Evidence-Based Formulation: Emphasizing the importance of formulating policies and strategies based on scientific evidence and research.
- 3. Continuous Stakeholder Engagement: Advocating for ongoing involvement and collaboration with stakeholders to ensure sustained efforts in SLT control.
- 4. Monitoring and Evaluation: Establish continuous monitoring and evaluation mechanisms to assess the effectiveness of implemented measures and make informed adjustments.

This strategic framework might provide a holistic approach to addressing SLT use in Sri Lanka, integrating policy, stakeholder engagement, cultural sensitivity, and evidence-based practices for comprehensive and sustainable control measures.

SMOKELESS TOBACCO CONTROL IN SRI LANKA

KEY COMPONENTS

- 1. Policy Alignment & International Value-based Standards
- 2. Inclusive Decision-Making & Transparent Policy Development
- 3. Strategic Planning & Comprehensive Training
- 4. Culturally sensitive Programmes & Targeted Stakeholder Engagement



WAY FORWARD

- Multifaceted Approach
- > Evidence-Based Formulation
- Continuous Stakeholder Engagement
- Monitoring and Evaluation

Figure 5.1. Strategic Framework for Effective Smokeless Tobacco Control: Insights from a Two-Stage Multimethod Case Study Research in Smokeless Tobacco Ban in Sri Lanka

5.6 Conclusion

In conclusion, this research delves into the complexities surrounding the Sri Lankan government's SLT ban policy, shedding light on its successes and challenges. Study A, focusing on policy development, unveils the robust legal foundation of the ban but points to potential misalignments with international standards and questions the inclusivity of decision-making. Study B, examining stakeholder perceptions, highlights concerns about the readiness of implementors, doubts about the policy's effectiveness, and political challenges. The knowledge generated by this research on the successes and challenges of the SLT ban in Sri Lanka is groundbreaking as this is the first study of this kind.

The integration of findings underscores a complex interplay between policy development and implementation realities. Structural and transparency issues in policy formation, coupled with on-the-ground challenges, suggest a need for a more holistic and collaborative approach. The research's methodological considerations, particularly the adaptability during the COVID-19 pandemic, exemplify the importance of flexibility in research.

Implications and recommendations provide a roadmap for defining the SLT ban policy. Alignment with international standards, inclusive decision-making, transparent policy development, strategic planning, and cultural sensitivity are critical areas for improvement. Training, information dissemination, and stakeholder engagements are crucial for successful policy implementation. The presented strategic framework offers a comprehensive approach, emphasising a multifaced strategy, evidence-based formulation, continuous stakeholder engagement, and robust monitoring and evaluation.

This research advocates for a nuanced, adaptive, and collaborative approach to address the smokeless tobacco epidemic in Sri Lanka, ensuring policy effectiveness and societal impact. The study contributes valuable insights for policymakers and researchers in formulating and implementing public health policies, especially concerning culturally sensitive issues like SLT control.

Appendices	
Appendices	

Appendix I

Information Sheet

Analysing the smokeless tobacco ban 2016 in Sri Lanka

I am Dr Suranji Dahanayake (MBBS, MSc, MD), Senior Registrar in Medical Administration attached to the Ministry of Health Sri Lanka. I would like to invite you to participate in the research study titled 'Analysing the smokeless tobacco ban in Sri Lanka' conducted by myself in Sri Lanka, mainly with policymakers and key stakeholders of the smokeless tobacco control prevention program in Sri Lanka.

1. Purpose of the study

In 2016, Sri Lanka launched a complete ban on manufacturing, importing, selling or offering all types of smokeless tobacco (ST), including e-cigarettes and flavoured cigarettes. This research aims to understand the policy formation process and success of the ST ban (excluding e-cigarettes and flavoured cigarettes) in Sri Lanka. This includes an in-depth understanding of the problem identification and definition, agenda-setting and policy formation stages of the policy development process of the ST ban and exploring the perceptions and experiences of key stakeholders on the ST ban's success. The research will identify the key areas (gaps or advancements) of the policy development process and the success of the ST Ban 2016.

2. Voluntary Participation

Your participation in this study is voluntary. You are free not to participate or withdraw from the study at any time despite consenting to participate earlier. There will be no repercussions for that decision. If you decide not to participate or withdraw from the study, you may do so anytime.

3. Duration, the procedure of the study and participant's responsibilities

The procedures to be carried out are interviews with policymakers and key stakeholders (including university academics and provincial and regional health directors). With your agreement, the interview will be audio-recorded, transcribed and analysed. My supervisors and examiners will access the results report generated from the analysis and the audio recordings when needed. No one else will have access to the audio recordings.

The interviews will be conducted from July to October 2021 2021. I will be collecting all the data by myself. Due to the Covid 19 pandemic (considering travelling restrictions and safety precautions to prevent the virus's spread), the interviews will be conducted by telephone or online video-conferencing software. I will arrange the interviews with you at a time that suits you. The interview will last for up to 30-45 minutes.

4. Potential benefits

For taking part in this research, you will not receive a direct benefit. However, it does offer you an opportunity to indirectly inform the interested groups about the gravity of the policy development process in developing the ST ban in 2016 and inform the government of the ban's success.

5. Risks, hazards and discomforts

It is unlikely that you will experience any direct risks of taking part in this research.

6. Reimbursements

You will not receive any reimbursement for participating in this study as this is a self-funded PhD study.

7. Confidentiality

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Confidentiality of all records is guaranteed, and no information by which you can be identified or published. As some of you are high-profile individuals, the risk of identifying your direct quotes, even the following anonymisation, is alike. Therefore, the researcher will take all necessary steps not to publish sensitive direct quotes that can harm you administratively or legally. Most of the time, data will be published only as common themes.

8. Termination of study participation

You may withdraw your consent to participate in this study at any time without penalty or other effect. Please notify me as soon as you decide to withdraw your consent. Your data will be destroyed after that.

9. Clarifications

If you have questions about any of the tests or procedures or require additional information, please ask any of the persons listed below.

Dr Suranji Dahanyake, Senior Registrar in Medical Administration of Ministry of Health and PhD student, University of York, The United Kingdom

Dr Omara Dogar, Assistant Professor Global Health: omara.dogar@york.ac.uk (chief supervisor)

Signed

Dr L C Suranji Dahanayake

Principal Investigator

Mobile -

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Consent Form

Analysing the Smokeless Tobacco Ban 2016 of Sri Lanka

Consent Form

To be completed:

a. By the participant

The participants should complete the whole sheet themselves.

		` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			
		Have you had satisfying answers to all your questions? Have you received enough information about the study?	YES/NO YES/NO		
	5.	Who explained the study to you?			
	6.	Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without any effect in future?	YES/NO		
	7.	All personal details will be treated as STRICTLY CONFIDENTIAL. There are no co-investigators for this research other than the principal investigator. As some of you are high-profile individuals, there is a possibility of identifying you from the direct quotes you make. The researcher will take all the steps to anonymise your selections and not use sensitive direct quotes in the final report. Do you give your permission to proceed?	YES/NO		
		Have you had sufficient time to come to your decision? Do you agree to take part in this study?	YES/NO YES/NO		
		ant's signature Date	dy at any n future? TIAL. There e principal there is a make. The ons and not permission YES/NO YES/NO YES/NO YES/NO YES/NO YES/NO		
	ne (BLOCK CAPITAL)			
b. E	Зу t	he investigator			
l ha part		explained the study to the above participants, and they have indicated a will ate.	ingness to		
Sigr	natu	re of investigatorDate			
Name (BLOCK CAPITALS)					
Version 2 27-03-2021					

Appendix III

Data Extraction Form for Policy Document Review

Title of the document/Document ID (author Date tonic			
ent ty	Title of the document/Document ID (author. Date. topic.		
section I Jocumer Identity	Website.pdf/ Form completion date (dd/mm/yy)/ Full reference		
section I Jocument Identity	with URL		
	Main	Sub-codes	
	code		
	Policy content	Vision, Mission and Aims and means of SLT ban	
		Policy objectives	
		Operational policies aim/ strategic plans	
		implementation plans, action plans	
	Policy	Position/Designation	
	actors	Delegated power by the NATA act	
səpo		Interest in SLT control and prevention	
Section II Data extraction codes	Policy context	Situational factors/triggering factors	
Section II		Economic factors	
ata e		Political factors	
		Sociocultural factors	
		Environmental factors	
		Exogenous factors	
	Policy	Problem Identification	
	Process	Agenda Setting	
		Policy formation	
		Policy Formulation	
		Monitoring and evaluation	

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