COUNTRY PROFILES on implementation of WHO Framework Convention on Tobacco Control in WHO South-East Asia Region

World Health Organization
Regional Office for South-East Asia

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Abbreviations

ASCI	Advertising standards council of India
COP	Conference of the Parties
COTPA	Cigarettes and other tobacco product act
CSO	Civil society organization
CSR	Corporate social responsibility
GATS	Global Adult Tobacco Survey
GHPSS	Global Health Professions Student Survey
GSHS	Global School-based students Health Survey
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
IEC	Information, education and communication
MOH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MPOWER	Monitor, Protect, Offer, Warn, Enforce, Raise
NATA	National authority on tobacco and alcohol
NBR	National board of revenue
NCCTU	National committee for the control of tobacco use
NCD	Noncommunicable diseases
NRT	Nicotine replacement therapy
NTCC	National tobacco control cell
SEAR	South-East Asia Region
SHS	Seconhand smoke
SIDS	Sudden infant death syndrome
SLT	Smokeless tobacco
STEPS	WHO STEPwise approach to surveillance to Surveillance of NCD risk factors
TTM	Thailand tobacco monopoly
UN	United Nations
VAT	Value added tax
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control
WHO SEARO	WHO Regional Office for South-East Asia

Foreword

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first global health treaty negotiated under the auspices of WHO. It establishes tobacco control as a priority on the public health agenda and provides an evidence-based tool for adoption of sound tobacco control measures. WHO FCTC came into force on 27 February 2005. Ten out of the eleven Member States in the WHO South-East Asia Region are Parties to the WHO FCTC and have tobacco control legislation in line with its provisions. Timor-Leste is in the process of enacting tobacco control law while Indonesia is not a Party to the Convention yet, but has enacted tobacco control laws.

The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of Noncommunicable Diseases (NCDs), 2011, identified tobacco use as one of the four major risk factors for NCDs such as heart diseases, cancer, respiratory diseases, diabetes, etc. The WHO Global action plan for the prevention and control of NCDs 2013–2020 highlighted some effective tobacco control interventions as "best buys" to tackle the NCD epidemic. Measures to ensure reduction in tobacco use include: protecting people from second-hand smoke through national "100% smoke-free" legislation; offering help in quitting tobacco use; warning people about the dangers of tobacco use; enforcing bans on tobacco advertising, promotion and sponsorship; and raising tobacco taxes on all tobacco products.

To reduce the health threat of tobacco, the global target is a 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years and over by 2025 (using 2010 as a baseline). The Global status report on NCDs 2014 reiterated that most countries have already engaged in strengthening their tobacco control measures, leading to the accelerated implementation of WHO FCTC, which would enable them to reach this target. Accelerating implementation of WHO FCTC has been adopted as one of the means to achieve Sustainable Development Goals in the post-2015 development agenda.

However, evidence shows that law enforcement on smoke-free public places is weak in many Member States leading to a high level of exposure to second-hand smoke. The Global Youth Tobacco Survey (GYTS) data points out that more than one third of 13–15 year old students are being exposed to tobacco smoke either at home or in enclosed public places; while the Global Adult Tobacco Survey (GATS) and NCD Risk Factor Survey indicate that a significant proportion of adults (15+ years) are exposed to second-hand smoke in homes as well as in workplaces in many countries of the Region.

The survey reports also affirmed weak enforcement in prohibition of tobacco advertisements, promotion and sponsorship; exposure of children, youth and adults to tobacco advertisements through all forms of media; and non-inclusion of advertising prohibition at point of sale or through the electronic media in the tobacco legislation of most countries.

This profile of Member States in South-East Asia Region reports the implementation of the provisions of the WHO FCTC with highlights on the prevalence of tobacco use, types of tobacco products used, tobacco control legislations and their enforcement, taxation of tobacco products and the tobacco industry interference.

I believe this profile will be of benefit to Member States as a baseline to accelerate the implementation of the WHO FCTC.

Dr Poonam Khetrapal Singh
Regional Director
South-East Asia Region

Executive summary

Background

Tobacco use is the leading cause of preventable deaths in the world. Tobacco-related diseases affect both users and those exposed to tobacco smoke. Currently around 6 million tobacco users and 600 000 nonusers die each year due to tobacco use and exposure to second-hand smoke. Disturbingly, 170 000 of the victims were children. There are around one billion smokers worldwide, with 80% of them living in low- and middle-income countries [1],[2].

Deaths attributable to tobacco include chronic illnesses such as heart disease, lung disorders and cancers. In fact, the morbidity or impairment of health caused by tobacco is more widespread. Loss of income and the psychological effects due to chronic illness are other factors that affect families of tobacco users. It is therefore one of the major causes of loss of quality of life, or healthy years of life lost in the world [3].

Tobacco contributes significantly to the maintenance of the vicious cycle of poverty in many countries – tobacco exacerbates poverty and poverty increases tobacco use. Studies show that the poor smoke more. The poorest tobacco users spend a sizable amount of their income on tobacco, thereby restricting these families to spend on other necessities such as food, education and health care. Additionally, due to health effects, tobacco contributes to malnutrition, illiteracy, higher health-care costs and premature death [4],[5].

In addition to the human toll, the effects of tobacco are felt significantly in the economy of a country. It has shown to intensify the effects of poverty due to loss of income, spending on tobacco and costs of illness.. The World Bank, following extensive studies on the subject, has declared that, when all factors are taken into account, tobacco use is a net loss to an economy [6].

Tobacco smoke pollutes the environment and tobacco growing and curing contributes significantly to deforestation. The leeching of nutrients by the tobacco plant makes the soil infertile. The heavy use of pesticides needed to protect the plant pollutes groundwater [7].

The World Bank estimates that governments need to spend only a few dollars per capita in low-income countries to implement effective tobacco control programmes. This means that the cost for saving a life is miniscule when money is spent on tobacco control compared to other programmes. The Bank concludes that tobacco control in low-income and middle-income countries is likely to be affordable, even in countries where per capita public expenditure on health is extremely low [6]. Such interventions are a cornerstone to achieve the targets set for noncommunicable diseases, for which tobacco is a significant contributor [8].

Therefore, especially in the South-East Asia Region where resources are severely limited, investing in tobacco control is a particularly cost-effective and an affordable means of saving lives and improving health.

WHO is leading the battle against these far-ranging harms of tobacco. The WHO Framework Convention on Tobacco Control (WHO FCTC) entered into force in February 2005. It has become

one of the most widely embraced treaties in the history of the United Nations. Currently there are over 180 Parties [9] covering almost 90% of the world's population. In 2008, WHO introduced a package of tobacco control measures to further counter the tobacco epidemic and to help countries to implement the WHO FCTC. Known by the acronym MPOWER, it outlines practical and cost-effective measures identified as "best buys" and "good buys" in tobacco control. Measures outlined correspond to at least one provision of the WHO FCTC [10].

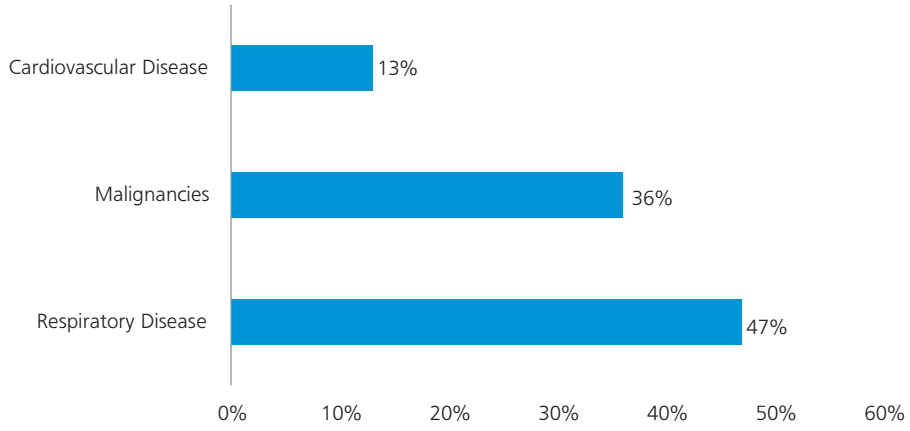
Tobacco use in the WHO South-East Asia Region

Tobacco use is deeply embedded in the culture of South-East Asia. The tobacco industry uses social and cultural beliefs of people to its advantage and markets their products intensively. Smoking by young women was previously not a social norm, as smoking was seen predominantly as adult male behaviour, but the scenario is changing as there is a rising trend of smoking among girls and women [11].

There are many Region-specific issues and challenges in relation to the use and harm from tobacco that need to be specifically addressed.

WHO South-East Asia Region (SEAR) is home to about one fourth of the world's population. It is estimated that there are 246 million smokers and 290 million smokeless tobacco users in WHO SEAR. This means that one fourth of the world's smokers and over 80% of the world's smokeless tobacco users reside in this Region. [12] A total of over 1.3 million die each year in the Region due to tobacco. It is also estimated that 14% of deaths of males of this Region occurs due to tobacco. The proportion of female deaths due to tobacco in the Region was 5% [13].

Figure E.1: Percentage of tobacco attributable male deaths in selected disease categories in Member States of WHO SEAR



Source: WHO Global Report on Mortality Attributable to Tobacco, 2012.

This Region consists of countries with contrasting geographic patterns, weather, populations and a diverse range of political systems, socio-cultural systems, religious beliefs and languages. These distinctions are apparent not only between countries but within countries too. Therefore, it is to be expected that factors such as patterns of tobacco use, community attitudes towards

use, tobacco control measures implemented and difficulties encountered in implementing tobacco control measures, etc., fall within a broad spectrum.

Demographic variations

There are three countries in the Region in which the population exceeds 100 million – India (1.25 billion, Indonesia (250 million) and Bangladesh (156 million)). In three countries of the Region, population is less than 2 million – Timor-Leste (1.78 million), Bhutan (754 000) and Maldives (345 000) [14]. This is one example of the range of contexts to consider when developing and implementing any health-promoting strategies in the Region. For instance, in some cities in the larger countries, populations are larger than in entire smaller countries. Data from 2005 show that around 30% or more of the population was less than 15 years of age in all countries of the Region, except in Democratic People's Republic of Korea, Sri Lanka and Thailand [15]. This includes all the mega-countries of the Region and is bound to have a serious bearing on tobacco control.

Variations in prevalence of tobacco use among adults [16]

In the WHO South-East Asia Region, more than half of adult males and nearly two in ten adult females use tobacco in one form or the other. There are wide ranging differences among countries as within countries in relation to tobacco use – the prevalence, types of tobacco used, gender disaggregation, etc. Tobacco use among adult males ranges from around 34% in Bhutan (2014) to 74% in Myanmar (2014). It was 20% or more among women in Bangladesh (2009), India (2009–2010), Myanmar (2014) and Timor-Leste (2014). The use of smokeless tobacco is widespread. It is discussed in the next section.

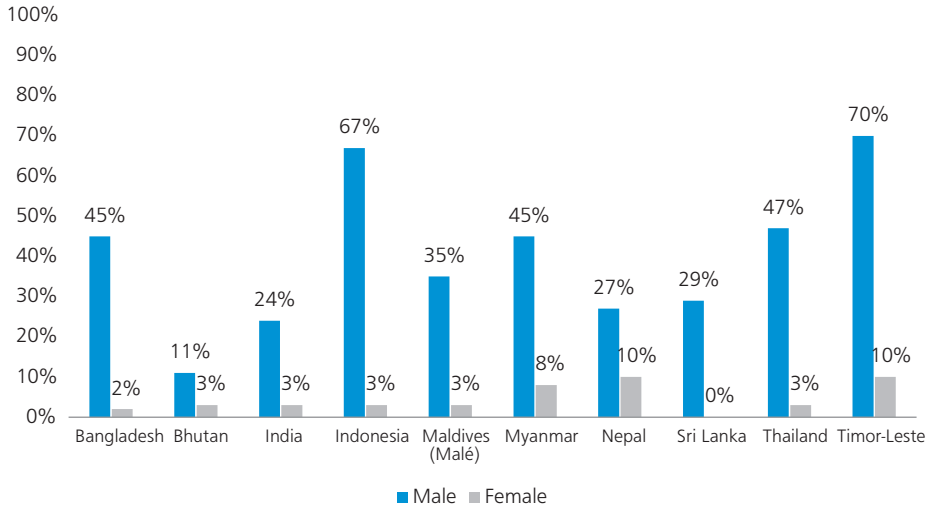
Because countries such as Bangladesh, India and Indonesia have very large populations, even a relatively low prevalence denotes a very large number of individuals using tobacco.

There are wide variations in the prevalence of tobacco use within countries too. The Global Adult Tobacco Survey (GATS) carried out in Thailand found that 58% of males in the Southern Region were current smokers while in the Bangkok region, it was 38%. The current smokers among females ranged from 1% in the North-East to 6% in North Thailand [17]. In India, the overall prevalence of current tobacco use ranged from 67% in Mizoram to 9% in Goa [18].

In most countries of the Region, the most popular form of tobacco use was smoking. Smoked tobacco products ranged from manufactured cigarettes produced by multinational companies (most countries) or large local companies (e.g. Indonesia and Thailand), and hand-rolled bidi manufactured by small local companies and as a cottage industry (e.g. India). Overall, the rates of smoking among males were significantly higher in all countries, and in all age groups.

In Bangladesh, India, Myanmar and Nepal, a sizable proportion of tobacco users are smokeless users. Therefore, in these countries, there is a significant difference between overall tobacco use and the prevalence of smoking.

Figure E.2: Prevalence of smoking among adults by sex in Member States of WHO SEAR



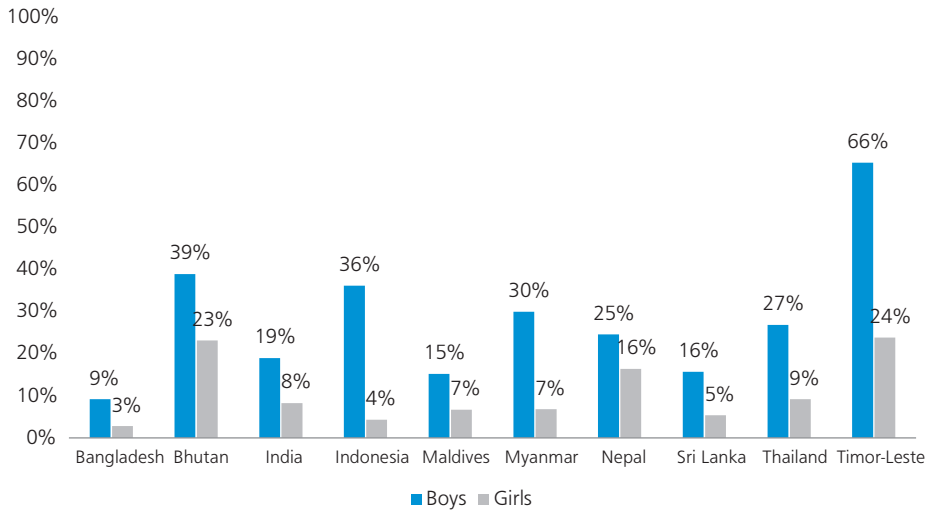
Source: World Health Organization, Regional Office South-East Asia, Monitoring tobacco control among adults in selected Member States of South-East Asia Region – at a glance 2015.

Note: There are national level surveys carried out on later dates in countries (e.g. Indonesia, Thailand), but the prevalence figures of GATS were used for these countries as they were more comparable with the data available from other countries.

Tobacco consumption by youth [19]

Tobacco use among the 13–15 year olds is a major concern in several SEAR countries. Considering the latest available Global Youth Tobacco Survey (GYTS) data, the overall prevalence of tobacco use in this age group was Timor-Leste (42%), Bhutan (30%), Nepal (20%) and Indonesia (20%). The lowest prevalence rates were seen in Bangladesh, Maldives and Sri Lanka. Prevalence rates for boys were significantly higher than for girls in all countries.

Figure E.3: Prevalence of tobacco use in the 13–15 year age group by sex in Member States of WHO SEAR



Source: World Health Organization, Regional Office for South-East Asia, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Considering the population demographics described before, where over one third of populations of many countries are below the age of 15 years, these percentages represent very large numbers. Therefore, tobacco use among children in the Region needs serious attention.

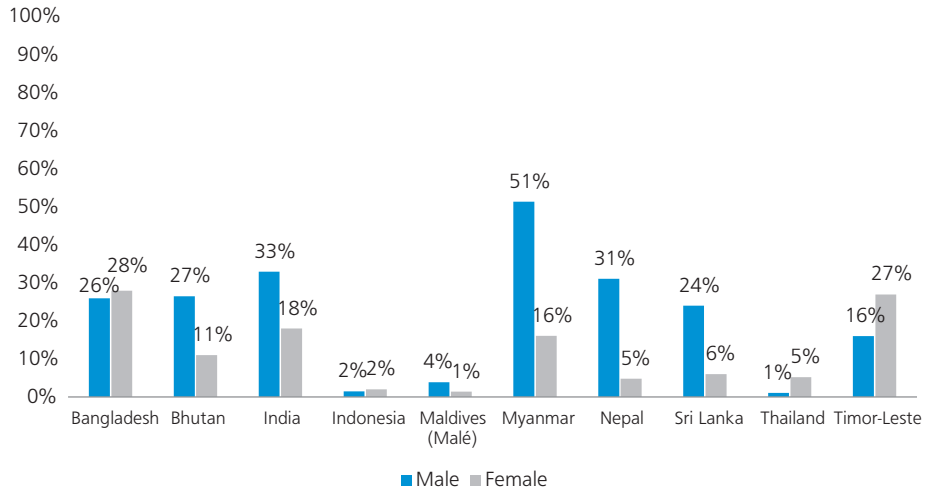
Use of smokeless tobacco among adults

Use of smokeless tobacco (SLT) is a major health issue in the Region. It is estimated that over 80% of the world's smokeless tobacco users live in the WHO South-East Asia Region [12]. India is the biggest producer of smokeless tobacco [21].

Data on prevalence of use of smokeless tobacco use are available from the Global Adult Tobacco Surveys, Noncommunicable disease risk factor (STEPS) Surveys and Demographic and Health Surveys in SEAR countries, except in Democratic People's Republic of Korea. In many SEAR countries, SLT use was higher among males. In Bangladesh, Indonesia, Thailand and Timor-Leste, smokeless tobacco use was higher among females. In males, the prevalence of use ranged from 51% in Myanmar to 1% in Thailand. Among females, the prevalence of SLT use varied from 28% in Bangladesh to 1% in Maldives (Malé).

In all countries, except in Indonesia, Maldives and Nepal, the prevalence of smokeless tobacco use was higher among women than the prevalence of smoking. In two countries – Thailand and Timor-Leste – SLT use in women is higher than in men. Data on SLT use from Democratic People's Republic of Korea is not available. These findings should be considered in utmost seriousness as both Bangladesh and India, which have high prevalence of use, are mega-countries, which mean that the absolute numbers of such users are quite large.

Figure E.4: Prevalence of smokeless tobacco use among adults by sex in Member States of WHO SEAR



Source: World Health Organization, Regional Office South-East Asia, Monitoring tobacco control among adults in selected Member States of South-East Asia Region – at a glance 2015.

Betel quid was the most commonly used product in most countries. Use of *khaini* was practiced most commonly in India. Where analyses were available, SLT is more commonly used in rural areas and among disadvantaged groups.

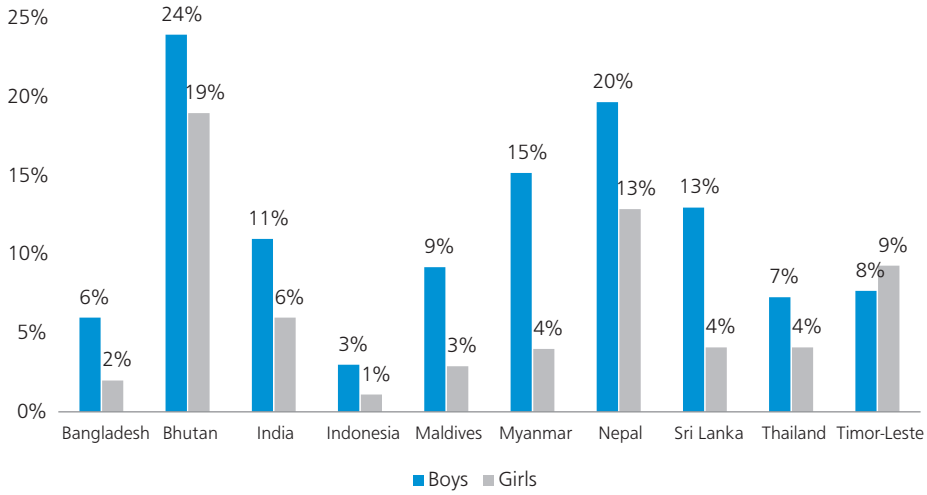
There is very little knowledge of harm of such products among users, which is a major concern. Also there is lack of research on smokeless tobacco-related mortality in the Region, specific risks of different products and economics of smokeless tobacco. Specific policies and strategies aimed to address smokeless tobacco use are also not widely implemented [21].

Use of smokeless tobacco among youths

The GYTS found relatively high use of smokeless tobacco in the 13–15 year age group in Bhutan, Myanmar and Nepal. In all countries, SLT use among boys was higher than among girls.

In Bangladesh, Bhutan, Nepal and Sri Lanka, the overall prevalence of SLT use in this age group of 13–15 years is higher than for smoking. This should be taken seriously as policies and programmes tend to focus on smoking, and SLT use, if unattended to, could become more prevalent.

Figure E.5: Prevalence of smokeless tobacco use among 13–15 year olds by sex in Member States of WHO SEAR



Source: World Health Organization, Regional Office for South-East Asia, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Exposure to second-hand smoke

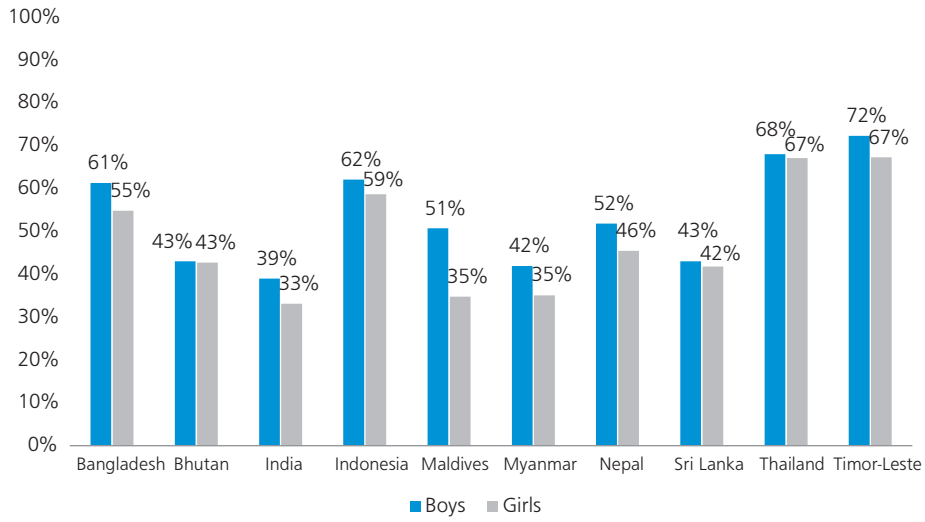
Evidence of harm from second-hand smoke has accumulated over the years [22]. The strongest evidence exists in adults for lung cancer, ischemic heart disease and new cases of asthma. In children, strong evidence exists for low birth weight, childhood chronic respiratory symptoms, lower respiratory illness, new cases of and exacerbation of asthma, middle-ear effusion and infection, reduced pulmonary function and sudden infant death syndrome (SIDS) [2].

Estimates showed that around 60 000 children, 57 000 women and 43 000 men of the WHO South-East Asia Region died due to exposure to second-hand smoke in 2004 [2].

Smoke-free laws have been implemented in almost all countries of the Region. Most of these are relatively comprehensive. Despite this, exposure to second-hand smoke is common in many countries of the Region.

GYTS data show a significant proportion of 13–15 year olds being exposed to tobacco smoke either at home or at enclosed public places. These data can be used to form conclusions on the level exposure of second-hand smoke in overall populations as well. The exposure of this age group to second-hand smoke in enclosed public places was generally high in most countries. Overall, 70% in Timor-Leste, 68% in Thailand, 60% in Indonesia and 59% in Bangladesh have been thus exposed [19]. Therefore implementation and monitoring of implementation of the current smoke-free laws in countries of the Region should receive immediate priority.

Figure E.6: Exposure of 13–15 year age group by sex in Member States of WHO SEAR to smoking in enclosed public places



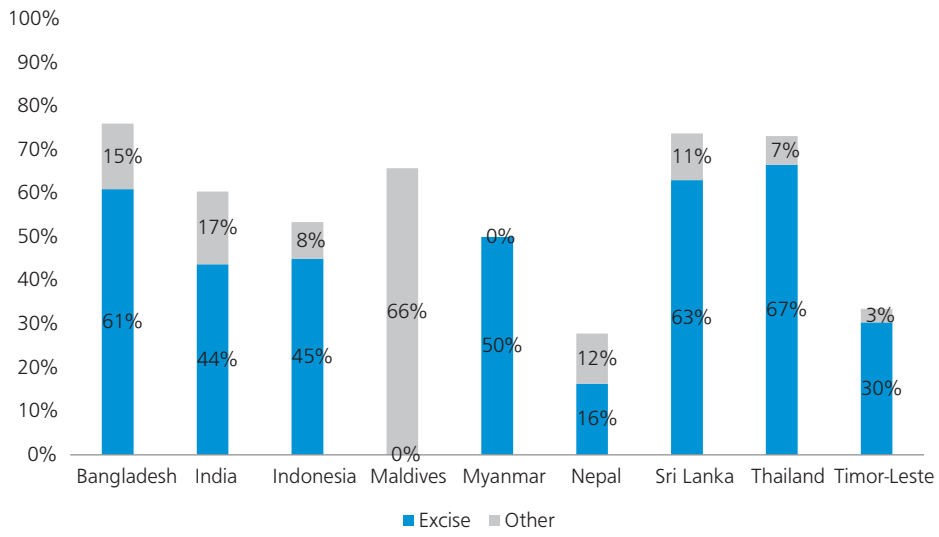
Source: World Health Organization, Regional Office for South-East Asia, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation

Taxation is the most effective measure in tobacco control. It is a tool that can be used by governments to increase its revenue and at the same time decreases tobacco consumption, especially among the poor. Adjusting the tobacco taxes to reduce affordability and increasing taxes across all tobacco products is key in this regard. The total tax share can contribute to higher retail prices of and decreased demand for tobacco products. Most countries in the Region impose lower taxes on tobacco products that are consumed by the poor, such as bidis and hand-rolled cigarettes [23].

The total share of all taxes in the cigarette retail price varies from country to country. Bangladesh, Sri Lanka and Thailand were the only countries in the Region where the share exceeded 70% of the retail price in 2014. It was 28% in Nepal and 33% in Timor-Leste. Bhutan has banned manufacture, sale and trade of tobacco products and data from Democratic People's Republic of Korea were not available [24].

Figure E.7: Taxes as a percentage of selling price of the most widely sold product in Member States of WHO SEAR in 2014



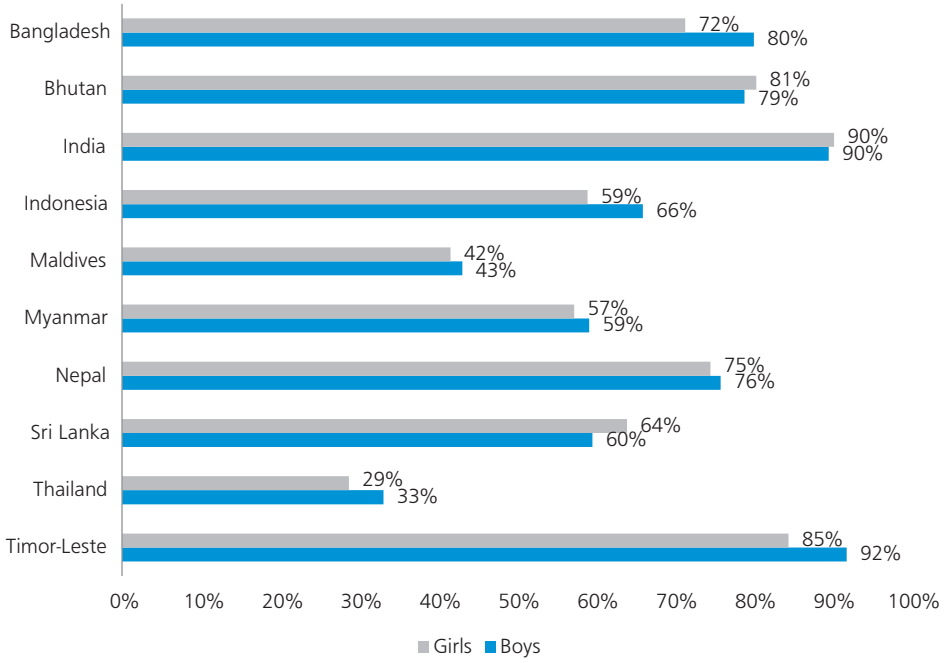
Source: WHO report on the global tobacco epidemic, 2015.

Exposure to tobacco advertising

Robust restrictions on tobacco advertising and promotion are in place in almost all countries. Tobacco advertising is not banned in Indonesia, although sponsorships as banned [24].

Despite such wide-ranging restrictions, a significant percentage of populations of all SEAR countries are exposed to some form of tobacco promotion, according to the GYTS, Global Adult Tobacco Surveys and Noncommunicable Disease Risk Factor Surveys conducted. This is discussed in more detail in the county reports. Most were exposed to pro-tobacco ads in newspapers or on television, video or movies. As most countries have banned direct advertising, it would be safe to assume that most such exposure occurs through television, videos and movies. The lowest exposure was in Thailand where about one third of the 13–15 year olds had been exposed during the past 30 days; it was 43% in Maldives and about 60% or more in all other countries, except Democratic People's Republic of Korea, from where data were not available.

Figure E.8: Exposure of 13–15 year age group by sex in Member States of WHO SEAR to pro-tobacco advertisements



Source: World Health Organization, Regional Office for South-East Asia, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Tobacco and poverty

Relative deprivation and societal deprivations are strongly associated with mortality and health. How tobacco causes, maintains and perpetuates poverty is well documented [5]. At the individual and household levels, money spent on tobacco can have a very high opportunity cost. For the poor, money spent on tobacco is money not spent on basic necessities, such as food, shelter, education and health care. Tobacco users are at much higher risk of falling ill and dying prematurely of cancers, heart attacks, respiratory diseases or other tobacco-related diseases. This deprives families of much-needed income and imposing additional health-care costs. Many tobacco farmers, rather than becoming rich from the crop, often find themselves in debt to tobacco companies. Furthermore, tobacco cultivation and curing can cause serious damage to human health. There are also negative effects on the environment. These factors in turn also affect national economies that can keep entire countries "poor" through macro-economic factors [25].

Surveys in specific SEAR countries have shown that households consuming tobacco were spending many times more on tobacco than on health, education and necessities such as clothing and shelter. Also, expenditure on tobacco as a percentage of income was highest among the lowest income groups [26].

Therefore, given the importance of the issue of poverty in the Region, tobacco control should be considered an important means of tackling overtly and disempowerment in the SEA Region rather than a means of improving health alone.

Tobacco cultivation

Tobacco is cultivated in many countries of the Region. India is the third largest tobacco producer in the world and exports tobacco to over 100 countries [27]; and Indonesia is the fifth largest tobacco producer in the world [28]. Bhutan and Maldives have prohibited tobacco cultivation. Other countries fall within these two extremes. In countries such as Thailand and Sri Lanka, where a significant percentage of the tobacco required for manufacturing of cigarettes is grown within the countries, the most dominant tobacco company (multinational monopoly in Sri Lanka [29] and government monopoly in Thailand [30]) control tobacco growing and purchasing to a large extent.

Implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) and MPOWER measures

Currently, 10 out of 11 countries of the Region are parties to the WHO FCTC. There has been a significant response from Member States in implementing the articles of the WHO FCTC. Most Member States have national tobacco control laws. These laws contain provisions on smoke-free places, bans on tobacco advertising, promotion and sponsorship, health warnings and bans on tobacco sales to minors [24]. Most countries have established national level agencies, committees or appointed focal points for tobacco control.

There are several aspects of implementation of the WHO FCTC in the Region that need to be addressed. One such issue is implementation of the Articles of the WHO FCTC according to the given timelines. Also, implementation of the Articles on areas such as comprehensive smoke-free policies, comprehensive bans on advertising, taxation, health warnings, and surveillance and prevention of illicit trade need further strengthening. The publication of Guidelines on implementation for several Articles of the WHO FCTC by the Conference of Parties [31] has strengthened the impetus for effective implementation of these Articles.

WHO introduced the MPOWER measures, which correspond to one or more articles of the Framework Convention, to assist in reducing the demand for tobacco products at the country level. Following the 2008 Regional Committee Resolution SEA/RC61/R4, all Member States in the Region have adopted MPOWER measures to implement tobacco control strategies more effectively.

Capacity for implementation of policies and laws, and tobacco control programmes

The South-East Asia Region comprises many resource-poor settings. There are shortcomings in infrastructure in many countries. This compounds issues such as large populations and complex geography, for example, large numbers of islands and remote, hilly terrains. Such factors always

have a negative bearing on the capacity for implementing and enforcing policies and laws, not only for tobacco-related issues, but for other issues as well.

Therefore in such contexts, in the competition for attention, health-related policies may lose out to other policies that may be seen or perceived as more important. Unless sustained advocacy is maintained, capacity-building not only for implementation and enforcement but for formulation, development and evaluation of tobacco control programmes may suffer in the competition for resources in SEAR countries. Many SEA Regional Committee Recommendations recognize this situation and emphasize on building capacity at various levels for tobacco control. The Sixty-eighth session of the Regional Committee adopted a resolution which adopted the Dili Declaration on accelerating the implementation of the WHO FCTC.

However, since the advent of the WHO FCTC, structures for the implementation of tobacco control programmes have been established in most countries. These structures are tasked primarily to monitor and facilitate implementation of the tobacco control laws that are in place. Some countries such as India, Myanmar and Sri Lanka have already established subnational structures for tobacco control as well.

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Bangladesh

BANGLADESH

Current prevalence of tobacco use

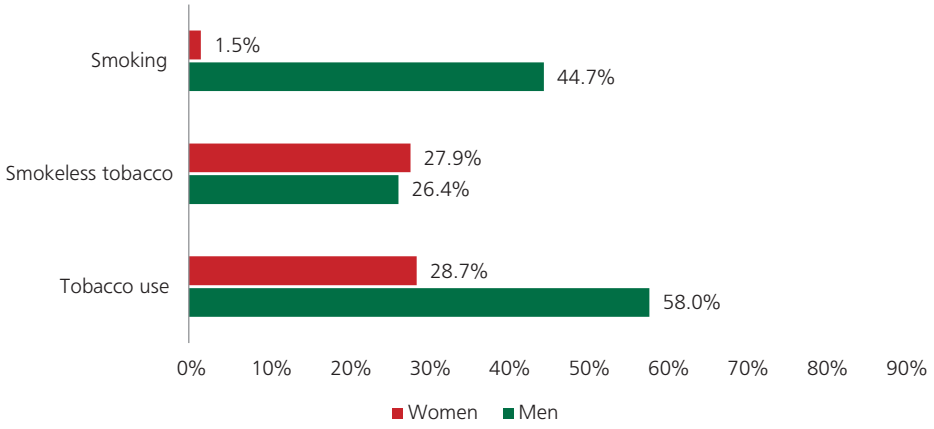
Tobacco use among adults [1]

The WHO Global Adult Tobacco Survey (GATS) 2009 found that in Bangladesh, 58% of men and 28.7% of women who were 15 years and older used tobacco. This made the overall population level use of this age group 43.3%. In general, tobacco use in rural areas (45.1%) was higher than in urban areas (38.1%).

Overall prevalence of smoking was 44.7% among men and 1.5% among women. Prevalence figures are a little higher in rural residences. Among men, the prevalence of smoking was highest (32.4%) among the 45–64 year age group.

Overall consumption of smokeless tobacco was 27.2%. Its use in women (27.9%) was more than in men (26.4%). Consumption was higher in older age groups and this trend was more prominent in women. Smokeless tobacco use was slightly more prevalent in rural areas (28.8%) than in urban areas (22.5%). Smokeless tobacco use was highest (49.3%) in men in the 65+ age group. Among women, it was highest in the same age group, which was 64.1%.

Figure 1.1: Prevalence of tobacco use in the 15+ age group by sex in Bangladesh

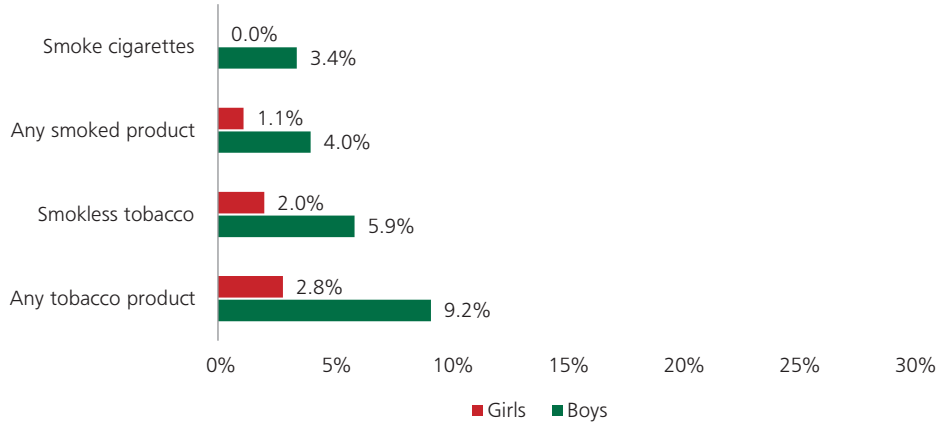


Source: World Health Organization, Global Adult Tobacco Survey (GATS) 2009.

Tobacco use among youth [2]

The Global Youth Tobacco Survey of 2013 showed that the current prevalence of tobacco use among boys was 9.2% while among girls, it was 2.8%. The current prevalence of smoking was 4% among boys and 1.1% among girls. 5.9% of boys and 2% of girls were current users of smokeless tobacco. These figures are relatively low compared with most other countries in the WHO South-East Asia Region.

Figure 1.2: Prevalence of tobacco use among 13–15 year old students by sex in Bangladesh

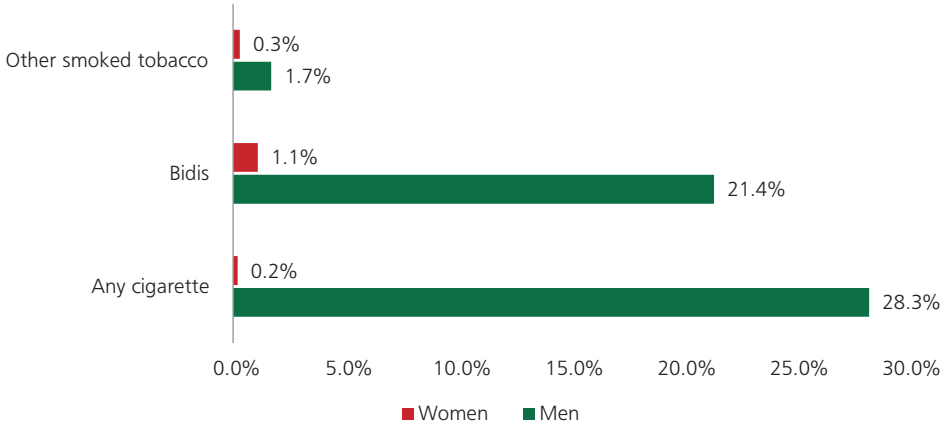


Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used [1]

Smoked tobacco

Figure 1.3: Products used by current smokers 15+ age group by sex in Bangladesh



Source: World Health Organization, Global Adult Tobacco Survey (GATS) 2009.

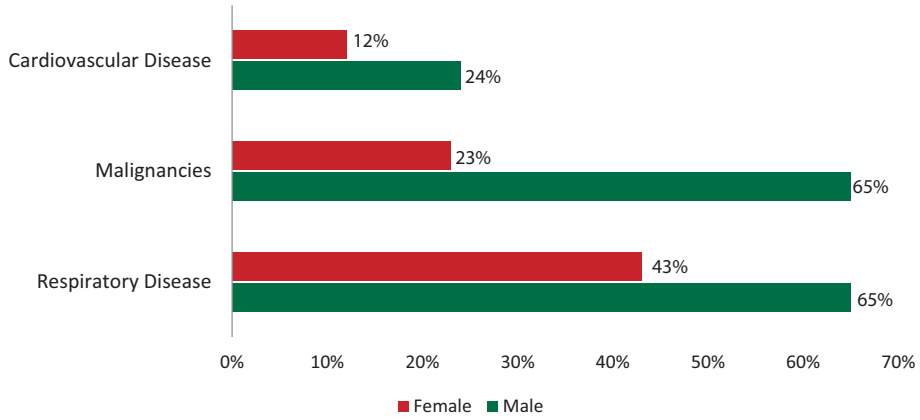
Smokeless tobacco

Jarda/Zarda (which contains tobacco, lime, spices, vegetable dyes, areca nut) was the most commonly used smokeless product by both men and women who use smokeless tobacco. Sadapata (plain dried tobacco leaves) and Gul (which contains tobacco powder, molasses, other ingredient, mostly used to clean teeth) were the other most commonly used products [3], [4].

Mortality attributable to tobacco [5]

Nearly a quarter (24%) of deaths of males over 30 years of age was attributable to tobacco. Among males dying prematurely, more than a quarter of the deaths between the ages of 45 and 59 years and nearly a third of the deaths (31%) between the ages of 60 and 69 years was attributable to tobacco. Overall, 12% of deaths of females above the age of 30 years in Bangladesh is attributable to tobacco use.

Figure 1.4: Percentage of tobacco attributable deaths in adults in selected disase categories by sex in Bangladesh



Source: WHO Global Report. Mortality Attributable to Tobacco 2012.

Economic impact of tobacco use [6]

According to the WHO study entitled "Impact of tobacco-related illnesses in Bangladesh" conducted in 2007, the annual cost of tobacco-related illnesses in Bangladesh attributable to tobacco use, on the one hand, was estimated at 50.9 billion taka including 5.9 billion for second-hand smoking. On the other hand, the total annual benefit from the tobacco sector was estimated at 24.8 billion taka from tax revenue and wages in tobacco production. The cost of tobacco use to the country thus exceeds the benefits by 26.1 billion taka per annum (equivalent to US$ 442 million).

There was almost a one-to-one correspondence in the aggregate from one taka spent on tobacco to one taka needed to treat consequent illness. Accordingly, if tobacco use was eliminated, households suffering from tobacco-related illnesses would have been able to reallocate as much as 10.2% of their total household expenditure for welfare-enhancing purposes.

The out-of-pocket expenditure at the household level is higher for tobacco-related illnesses than for all other illnesses. This may be the reason that only 41% of those who had one of the eight illnesses among the sample households actually sought care.

The total direct cost, hospital system and household out-of-pocket expenditure as attributable to tobacco use, was thus estimated at 56.3 billion taka, if all patients with tobacco-related illnesses sought treatment. In addition, the total loss of income due to tobacco-related illnesses was thus estimated to be 46 billion taka.

Summing direct costs of the hospital system and households to treat ischemic heart disease, stroke, and chronic obstructive pulmonary disease with the indirect costs imposed by these diseases through disability and premature death, second-hand smoke costs society a further 5.9 billion taka every year.

Implementation of the WHO FCTC

Bangladesh signed the WHO FCTC in June 2003 and ratified it in June 2004.

Current tobacco control legislation and regulations

The Bangladesh Government passed the Smoking and Tobacco Product Usage (Control) Act in 2005 and made it effective in the same year. This was amended in 2013. Rules were revised in March 2015.

The amended law includes a comprehensive ban on tobacco advertisement promotion and sponsorship including ban on advertisement at point of sale, rotating pictorial health warnings covering at least 50% of the principal display area of tobacco packages, and a ban on use of misleading descriptors (like 'light' and 'mild') on tobacco packs. List of smoke-free public places has been extended. Through the rule, some public places like hospitals and educational institutions are declared totally smoke-free where no designated smoking area can be identified. Smokeless tobacco products have been brought under the purview of this law as well. Therefore, the regulations will apply equally to smokeless tobacco products. Penalties for the violation of various clauses of the Act have been increased. Sale of tobacco to and by minor has been banned. The owners and managers of public places and public transports are given some responsibilities, and if they fail to fulfil, they will be prosecuted. The Act also states that the government may formulate policy to discourage tobacco cultivation and manufacturing of tobacco products. The Ministry of Health will establish the 'National Tobacco Control Cell (NTCC)', as this cell is currently functioning under an administrative order.

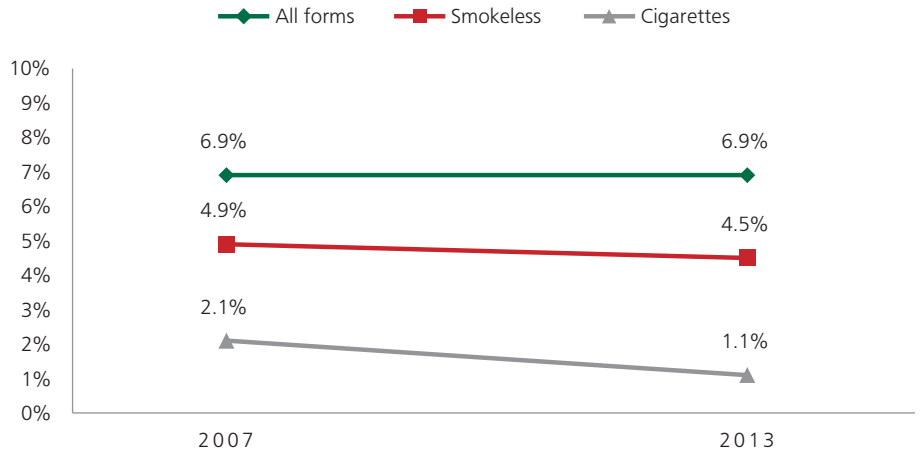
Structures for enforcement of tobacco control legislation

The National Tobacco Control Cell (NTCC) was established in 2007. NTCC is the functional arm of the Ministry of Health and Family Welfare for tobacco control activities in Bangladesh. It has become the hub of national coordination, referral and support centre for all tobacco control stakeholders, including NGOs in Bangladesh. It is headed by the Additional Secretary (Public Health and WHO) of the Ministry of Health and Family Welfare, and day-to-day supervision is conducted by the Coordinator, NTCC.

Its objectives are to coordinate tobacco control activities in Bangladesh on behalf of the Ministry of Health, facilitate implementation and enforcement of law to reduce tobacco use through capacity-building of the tobacco control stakeholders, partnership-building for tobacco control and mobilization of resources, reduce tobacco cultivation and production, monitor tobacco control law implementation, monitor progress on implementation of the WHO FCTC and MPOWER policy, and conduct research and surveys on tobacco and its effects [7].

Surveillance of trends in prevalence of tobacco use

Figure 1.5: Trend in prevalence of tobacco use among 13–15 year old students in Bangladesh



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

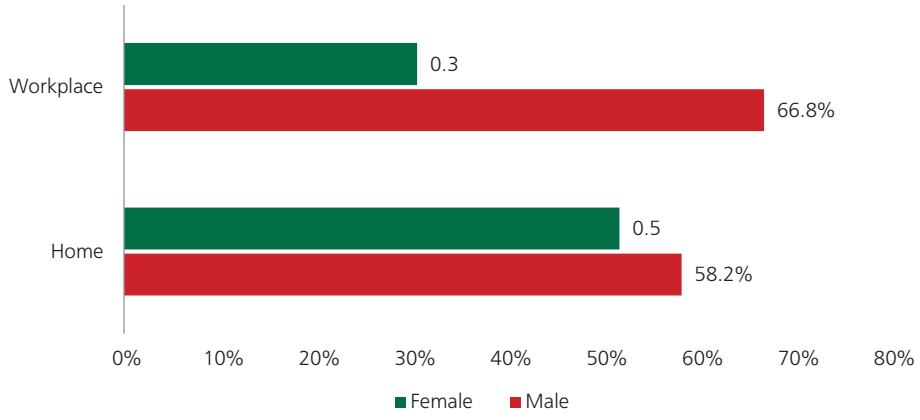
Overall, tobacco use in the 13–15 year age group has remained relatively static between 2007 and 2013. As the Noncommunicable Disease Risk Factor Survey was carried out on a national level sample in 2013, a technically sound baseline figure is available for surveillance.

Protection from exposure to second-hand smoke

Bangladesh has a wide-ranging ban on smoking in public places [8]. It covers educational institutions, government and other offices, elevators, indoor work places, hospital and clinic buildings, court buildings, public transport buildings, public vehicles, cinemas halls, exhibition halls, theatre market buildings, children's parks, etc. and other places accessible for collective use by people.

In the GATS 2009 survey, second-hand smoke exposure in the past 30 days at home was reported by 51.7% of women and 58.2% of men. Exposure to second-hand smoke at the workplace in the same period was reported by 66.8% of men and 30.6% of women [1].

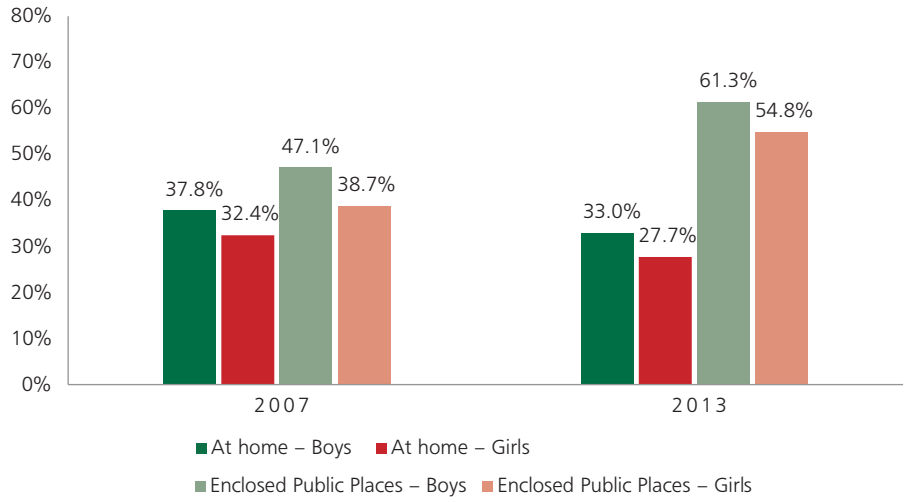
Figure 1.6: Exposure of adults to second-hand smoke by sex in Bangladesh, in the past 30 days



Source: World Health Organization, Global Adult Tobacco Survey (GATS) 2009.

Overall, 31.1% of those in the 13–15 year age group (33% of boys and 27.7% of girls) were exposed to tobacco smoke at home, while nearly 60% (61.3% of boys and 54.8% of girls) were exposed to tobacco smoke in enclosed public places during the last seven days, according the 2013 GYTS Survey [2].

Figure 1.7: Exposure of 13–15 year old by sex and place to second-hand smoke in Bangladesh



Source: World Health Organization Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Health warnings

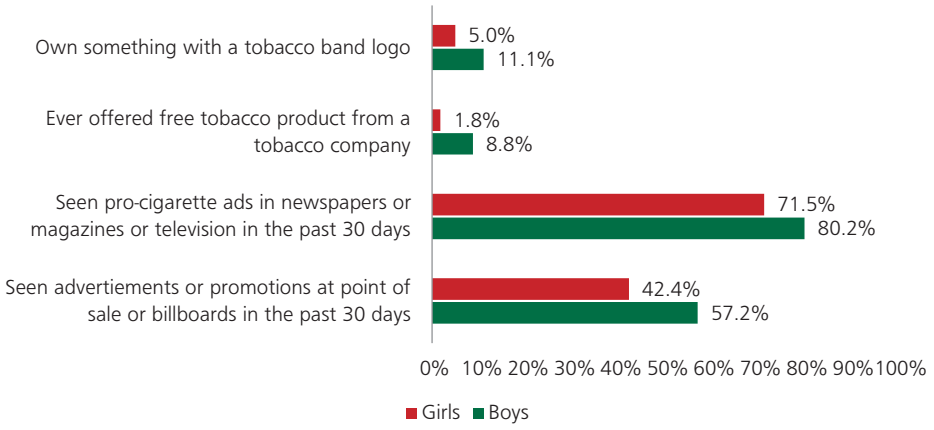
Rotating health warnings covering 50% of total area of the front and back of tobacco packs have been implemented. The warning contains a picture as well as text in the principal local languages. These warnings appear on all cigarette packs, packs of other forms of smoked tobacco and smokeless tobacco. These have to be printed on the top portion of the principal surface. All tobacco products sold in Bangladesh, whether imported or locally manufactured, should display this warning [8].

Enforcement of advertising, promotions and sponsorship ban

The tobacco control law prohibits all forms of tobacco advertisements, promotion and sponsorship. Point of sale displays, Internet advertising and publicity of corporate social responsibility projects of the tobacco industry are prohibited [8].

Despite the laws and structures in place, children are still exposed to tobacco promotions. The exposure was comparatively high in the case of advertisements in newspapers or magazines or television or videos or movies [2].

Figure 1.8: Exposure of 13–15 year old students to tobacco promotions by sex during last 30 days in Bangladesh



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation [9]

Smoked and smokeless tobacco products are taxed in Bangladesh. However, the proportion of tax, of the selling price of bidi is low.

Total tax share as percentage of retail price is 76% (excise tax proportion 61.0% (ad valorem) and VAT 15%). A complex tired ad valorem tax structure results in a substantial difference in excise tax rate both within and across product lines. Excise taxes account for as little as 43% of retail price on the least expensive brand of cigarettes and up to 61% on premium cigarettes while the excise on bidis was 18% of retail price in 2014. Tax stamps are applied on tobacco products.

The National Board of Revenue (NBR) doubled the excise tax on SLT from 30% to 60% in the 2014–2015 National Budget. Additional excise of 1% of the retail price goes to the Ministry of Health.

Cessation services

There is no formal structure or programme established to promote quitting or provide cessation services in Bangladesh. Some primary care clinics and other health clinics offer services to smokers [9].

Among the 13–15 year old boys, 60% of current smokers said that they wanted to stop smoking now [2]. The STEPS Survey [3] found that the proportion of former daily smokers among men was 15.4% and 0.7% in among females. The proportion of former smokers increased with age; the highest proportion (30.4%) being in the eldest age group.

The Global Adult Tobacco Survey [1] found that almost 70% of current smokers plan or think about quitting. Nearly half the smokers (47.3%) made an attempt to quit in the last 12 months. Among those who visited a health-care facility, 56% were asked about smoking, and 52.9% were advised to quit smoking.

Tobacco industry

The two largest companies, one of which is a multinational, have around three fourths of the market share of cigarettes in Bangladesh [10]. The bidi industry is also huge and promotes the image of the bidi industry as a "poor man's industry". The tobacco industry uses bidi workers and farmers as front groups and tries to delay the amendment processes and to lower taxes on bidis and smokeless tobacco products.

Tobacco cultivation

Though tobacco is a minor crop in Bangladesh, tobacco is grown in 123 000 acres of land. This is a sizable amount of land that might otherwise be used to grow rice or other important crops [6].

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Bhutan

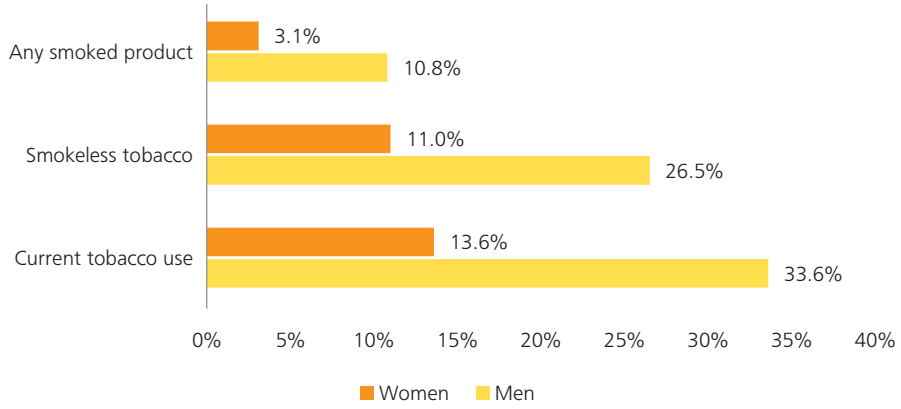
BHUTAN

Current prevalence of tobacco use

Tobacco use among adults

The WHO Stepwise Approach to Surveillance (STEPS) of Noncommunicable Disease Risk Factors Survey of 2014 [1] showed that 10.8% of males and 3.1% of females between the ages of 18–69 years were current tobacco smokers. This makes the overall prevalence 7.4%. In the same age group, 26.5 % of men and 11.0% of women were current users of smokeless tobacco products. The overall prevalence for smokeless tobacco therefore was 19.7%.

Figure 2.1: Prevalence of tobacco use among the 18–69 year age group by sex in Bhutan



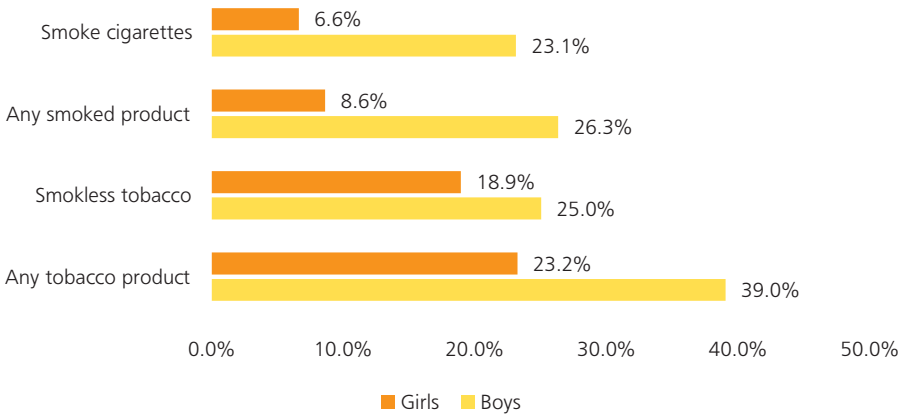
Source: Noncommunicable Diseases Risk Factor Survey (STEPS) Bhutan, 2014, World Health Organization.

According to a survey in four selected districts (Bumthang, Chukha, Thimphu and Trashigang), the prevalence of current tobacco use varied significantly [2] [3]. Of the four districts surveyed, the rate of tobacco use is highest in Chukha (15.8%) – a southern district bordering India, followed by Thimphu (12.5%) – the district with the largest urban centre, and the lowest in Trashigang (2.4%), an eastern district. Tobacco use was highest in the 25–34 year age group (14.4%). It was 9.4% in the 18–24 year age group, 9.3% in the 35–49 year age group, and 9.8% among those aged 50 years and older.

Tobacco use among youth

The Global Youth Tobacco Survey of 2013 [3] showed that the current prevalence of tobacco use among boys was 39.0% while in girls, it was 23.2%. In contrast to the overall (30.3%) rates of tobacco use which are among the lowest in the WHO South-East Asia Region, this was notably high. The current prevalence of smoking was 26.3% among boys, while 25.0% of boys used smokeless tobacco. These figures were also among the highest in the Region. The corresponding rates among girls were 8.6% and 18.9%.

Figure 2.2: Prevalence of tobacco use among 13–15 year old students by sex in Bhutan



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

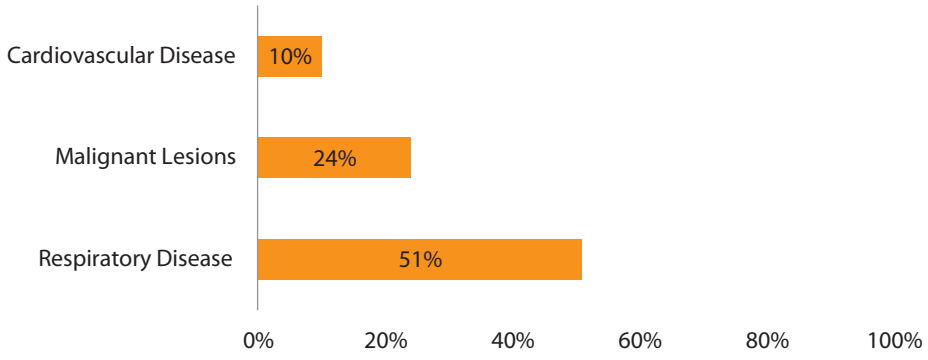
Types of tobacco products used

Cigarettes, biris are used as smoking products; chewing of betel quid with areca nut with or without tobacco is a very common practice.

Mortality attributable to tobacco [4]

The death rate due to tobacco for men over 30 years was 219 per 100 000. The proportion of deaths attributable to tobacco among men was 13.0% while in women, it was 1%. Three fourths of cancers of the trachea, bronchus and lungs, and one fourth of all other malignancies of males of the same age group occurred due to tobacco. Over half who were dying of respiratory diseases of the same age group died from causes attributable to tobacco.

Figure 2.3: Percentage of tobacco-attributable deaths for selected disease categories



Source: WHO Global Report, Mortality Attributable to Tobacco, World Health Organization, 2012.

Economic impact of tobacco use

No study has been done on the economic impact of tobacco use in Bhutan to date.

Implementation of the WHO Framework Convention on Tobacco Control

Bhutan signed the WHO Framework Convention on Tobacco Control on 9 December 2003 and ratified it on 23 August 2004.

Current tobacco control legislation and regulations

The sale of tobacco was banned in Bhutan in 2004 [5]. This was a landmark law in tobacco control globally. The advertising of tobacco products on all the national media channels had been banned since 1995.

Tobacco Control Legislation includes the Tobacco Control Act of Bhutan 2010 and its amendments in 2012 and in 2014. This act was developed in line with the WHO FCTC, and was enacted on 6 June 2010. This act prohibits cultivation, harvesting, manufacture, supply, distribution and sale of tobacco products. Though the sale of tobacco products is banned, consumption is not prohibited except in areas identified as smoke-free zones by the government. Cigarettes, piped tobacco and other tobacco products can be imported for personal consumption under a specific import quantity. Tobacco products cannot be imported for sale [6]. The Act prohibits tobacco advertisements, promotions and sponsorships. The Promotion of Cessation to Tobacco Use and Treatment for Tobacco Dependence is also mandated in the Act.

The law has been amended twice – in 2013 and in 2014, mainly on penalties and the amount of tobacco permitted to carry per person from abroad as duty free allowance for personal consumption.

Structures for enforcement of tobacco control legislation

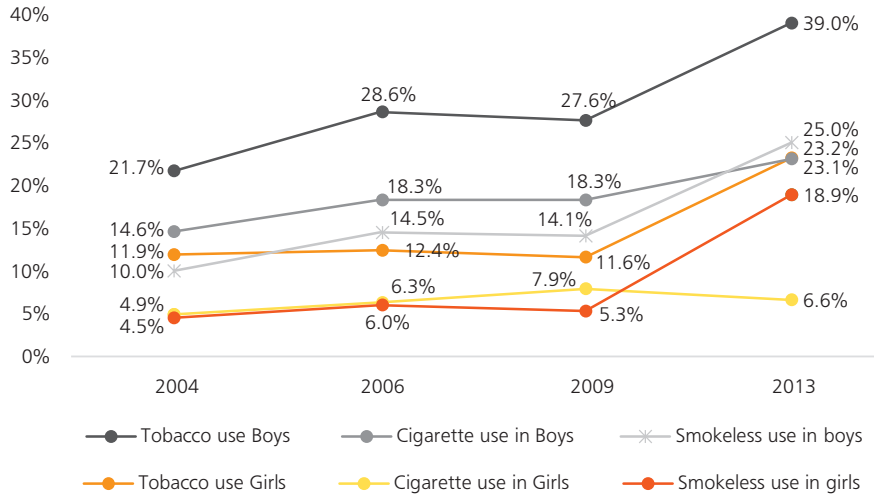
A National Steering Committee on Tobacco Control with representation from all sectors concerned to coordinate and guide the implementation of all tobacco control activities was the coordinating structure before the Tobacco Control Act was established. This committee consisted to representation of all government agencies involved in tobacco control [7].

The Tobacco Control Act of 2010 has established the Tobacco Control Board to take all necessary measures to control tobacco to prevent the people of Bhutan from health, social and environmental consequences of tobacco consumption and exposure to tobacco smoke. The Act also specifies the powers and functions of this board, which include formulation and implementation of the national tobacco control strategy and monitoring the enforcement of the Act. The Act also specifies what the key ministries such as health, economic affairs, finance, education, the police, road safety and transport authority, local government and civil societies should undertake to achieve the aims of the Act.

Rules and regulations to further clarify and implement this Act were issued in 2011 and its amendment was issued in 2013 by the Tobacco Control Board [8]. After the amendment of the Tobacco Control Act, 2014, the Tobacco Control Programme of the Bhutan Narcotics Control Agency is drafting the Tobacco Control Act, 2015, which shall be endorsed by the Tobacco Control Board.

Surveillance of trends in prevalence of tobacco use [9]

Figure 2.4: Trends in prevalence in 13–15 year old age group by sex and by type of tobacco products in Bhutan during 2004–2013



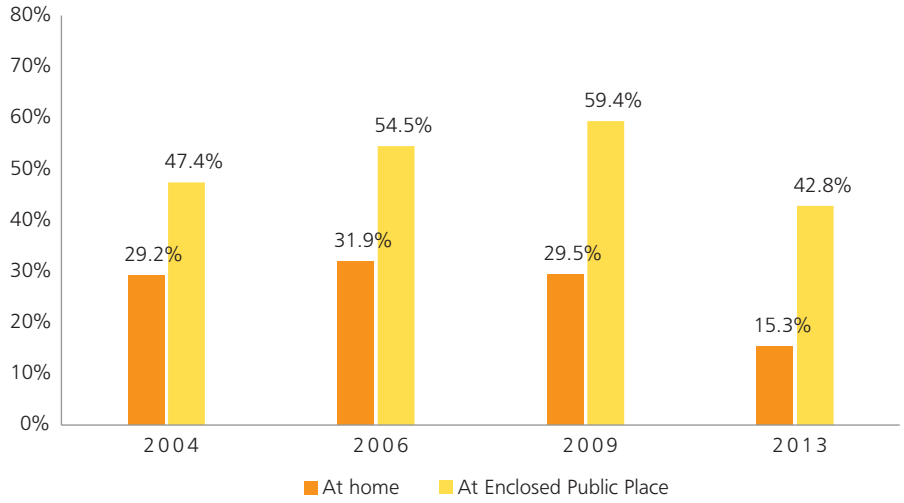
Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

As seen above, there has been an overall increase in all forms of tobacco use in this age group since 2004. The use of smoked and smokeless forms seems to be equally common. The only stable/reducing trend is seen in smoking among girls. All other forms of tobacco use were about 20% or higher. Overall tobacco use among boys, which was 39%, was the second highest in the Region.

Protection from exposure to second-hand smoke

The Global Youth Tobacco Survey 2013 found that 15.3% of those between the ages of 13 and 15 years were exposed to tobacco smoke at home. About 43% of the same age group had been exposed to tobacco smoke in enclosed public places. Among adults, one in five were exposed to tobacco smoke at home while one in four was exposed to tobacco smoke at workplaces [1].

Figure 2.5: Exposure of 13–15 year olds to second-hand smoke in Bhutan – last 7 days



Source: World Health Organization Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Smoking is prohibited in public places by an executive order. Two notifications to this effect were brought out on 8 November 2004 and on 18 February 2005. Smoke-free areas were declared through these notifications with effect from 1 March 2005, and the penalties for violation of the notification have been earmarked. The Royal Bhutan Police has been empowered to enforce and monitor the implementation of smoke-free areas.

The Tobacco Control Act of 2010 has designated health-care facilities, educational facilities, universities, government facilities, indoor offices, recreation centres, shopping complexes, hotels, restaurants, pubs and bars, public transport, public gatherings and all other indoor public places as smoke-free. Smoking is also prohibited in public gatherings such as meetings, festivals, markets, etc. and public institutions [6].

Almost two thirds (65%) of tobacco users reported that smoking is completely banned in their home [2], which shows that a majority of tobacco users are taking steps to protect their families from tobacco smoke in their homes.

Health warnings

As production, manufacture and sale of any type of tobacco product is prohibited in Bhutan, there are no clauses related to health warnings on tobacco control laws. However, the 2010 Tobacco Control Act specifies that all tobacco products imported for personal consumption shall show the country of origin and appropriate health warnings as required by the Ministry of Health [6].

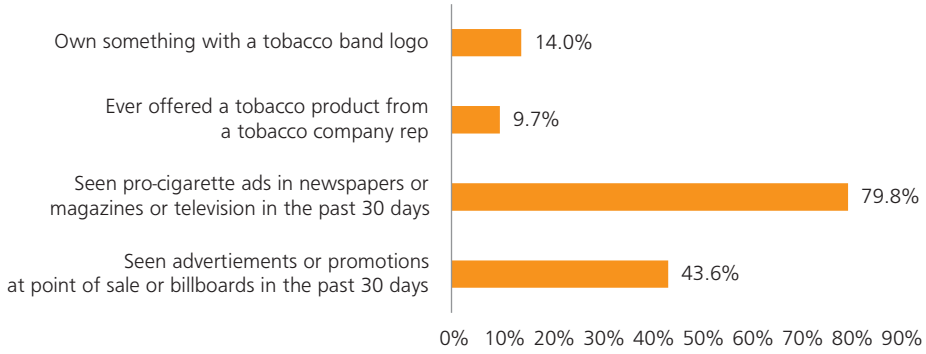
Enforcement of advertising, promotions and sponsorship ban

Advertising of tobacco products on all national media channels has been banned since 1995. However, cross-border advertising through international television and radio channels, cinema and the print media does take place [7].

The Tobacco Control Act of 2010 contains a comprehensive ban on all forms of tobacco advertising, promotions and sponsorships. The few areas it does not cover include appearance of tobacco brands on TV and/or films (product placement) and publicity of Corporate Social Responsibility Programmes of Tobacco Companies [10].

Despite this, a large proportion of those between the ages of 13 to 15 have been exposed to tobacco promotions.

Figure 2.6: Exposure of 13–15 year olds to tobacco promotions in Bhutan, 2013



Source: World Health Organization Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation [8]

Tobacco products are not sold in Bhutan. The import of tobacco for personal use is allowed in the following quantities: 800 sticks of cigarettes or 1200 sticks of Bidis, or 150 pieces of cigar, or 750 grams of other tobacco or tobacco products as per the tobacco control amendment 2014.

A person importing tobacco and tobacco products originating from countries other than India, for personal consumption, shall pay 100 percent sales tax and 100 percent customs duty at present. A person importing tobacco and tobacco products originating from India, for personal consumption, has to pay only the 100 percent sales tax at present. These rates may be revised by the Tobacco Control Board from time to time.

Cessation services

83.1% of smokers between the ages of 13 and 15 attempted to quit smoking during the preceding year, according to GYTS [3]. 81.8% wanted to stop "now". A quarter of current smokers (25.3%) had received help or advice to quit.

According to a survey carried out in four districts, almost one third of smokers (29%) have plans to quit smoking within the next six months. One fourth (25%) of smokers have plans to quit sometime in the future, beyond six months, and almost one half (46%) have no plans to quit. Two thirds (66%) of smokers reported that it would be hard for them to quit smoking. Religious affiliation was seen as a strong motivator with 84.6% of tobacco users stating that

religion is somewhat or very much a reason to think about quitting. This was higher than for health concerns [2].

Widespread and accessible cessation services are yet to be established in Bhutan [10].

According to the Tobacco Control Act, the Tobacco Control Board through the Tobacco Control Office should take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependency.

Regulations on tobacco also specify action such as inclusion cessation into the existing curriculum/programme for medical and health trainees/workers as per the guideline which may be issued by the Ministry of Health; incorporation of tobacco cessation services into primary health-care services; establishment of easily accessible and free quit-line services; and making accessibility of low-cost pharmacological therapy [8].

Tobacco industry

There is no tobacco industry in Bhutan but survey data show that there is the rise in tobacco use among youth, indicating some form of industry interference with tobacco control measures in Bhutan. Cross-border advertising and illicit trade in tobacco products also contribute to the increase in tobacco use.

Tobacco cultivation

Tobacco cultivation does not occur as it is prohibited by the tobacco control law. According to the Tobacco Atlas, less than 100 hectares of tobacco was grown in Bhutan in 2009 [11].

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Democratic People's Republic of Korea

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Current prevalence of tobacco use

Tobacco use among adults

The Adult Tobacco Survey of 2013 [1] showed that 43.9% of males were current tobacco smokers. Female tobacco use was 0%. The NCD Risk Factor Survey in 2008 [2] reported smoking prevalence among males above 25 years of age as 52.3% and 0% among females.

There are no data available on smokeless tobacco use. SLT use is not practiced in Democratic People's Republic of Korea.

Tobacco use among youth

No data are available on youth prevalence. GYTS has not been done to date.

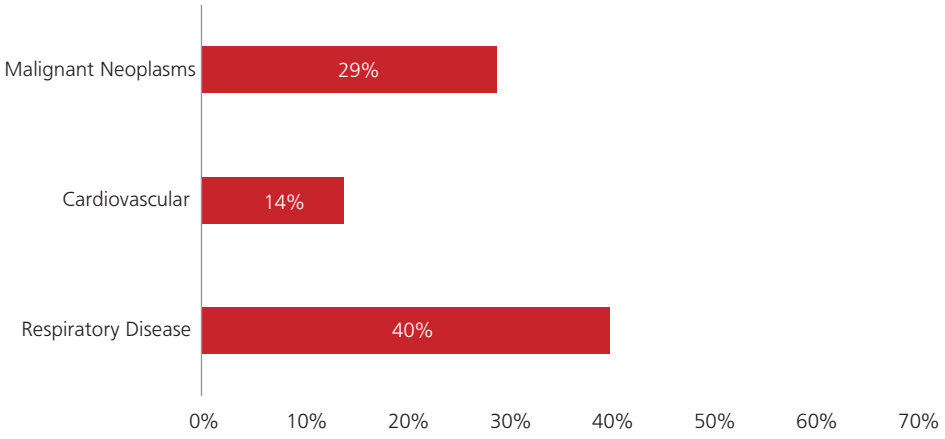
Types of tobacco products used

Manufactured cigarettes are the most common form of tobacco used in Democratic People's Republic of Korea.

Mortality attributable to tobacco [3]

Overall, 13% of deaths of males above the age of 30 years were attributable to tobacco. 14% of deaths were from cardiovascular diseases; 29% of deaths were from all malignant neoplasms; and 40% of deaths for respiratory diseases of males of the same age group were due to tobacco.

Figure 3.1: Percentage of tobacco-attributabe deaths of males above 30 years for selected disease categories



Source: WHO Global Report, Mortality Attributable to Tobacco, World Health Organization 2012.

Economic impact of tobacco use

No study has been done to date on the economic impact of tobacco use in Democratic People's Republic of Korea.

Implementation of the WHO Framework Convention on Tobacco Control

Democratic People's Republic of Korea singed the FCTC on 17 June 2003 and ratified it on 27 April 2005.

Current tobacco control legislation and regulations [4]

The Law of the Democratic People's Republic of Korea on Tobacco Control was adopted by Decree No. 1200 of the Presidium of the Supreme People's Assembly on 20 July 2005 and amended by Decree No. 537 of Presidium of the Supreme People's Assembly in December 2009.

This law covers many aspects of tobacco control such as manufacture, sale, import and export, advertising and promotion of tobacco products, education on harms of tobacco and smoke-free places. It specifies that the State will strengthen tobacco control and will sensitize the people about the harms of tobacco and that institutions, enterprises and organizations should not carry out acts to promote tobacco to facilitate its sale. Only designated shops are allowed to sell tobacco, and tobacco should be sold only at a price set by the state price-fixing organ. Many public places are declared non-smoking places, and students are prohibited from using tobacco.

Structures for enforcement of tobacco control legislation

Article 31 of The Tobacco Control Act has established the Korean Tobacco Association. It consists of officials from the foodstuff and daily necessities industry, public health, customs, foreign trade and tobacco production. Its main function is overseeing the implementation of the government policy on tobacco and the implementation of the tobacco control law.

Protection from exposure to second-hand smoke

The Tobacco Control Act specifically prohibits smoking in public transport, schools, healthcare facilities, shops, schools, nurseries, theatres, cinemas, sidewalks and stations.

Health warnings

Textual warnings appear on the front and sides of cigarette packs. This warning is mandatory for domestically produced or imported cigarettes [5]. The text size had been increased in 2013; graphic health warnings are not yet in place.

Enforcement of advertising, promotions and sponsorships

There is no legal ban on advertising, promotion and sponsorship of tobacco products. However, since all industries in Democratic People's Republic of Korea are state-owned, commercial advertisement, promotion and sponsorship do not exist in Democratic People's Republic of Korea.

Taxation

The government sets the price of cigarettes. Specific tax percentages within this price are not available [5].

Cessation services

Smoking cessation support is available in most health clinics, primary care facilities and hospitals [5].

Tobacco industry

The tobacco industry is state-owned. No data are available.

Tobacco cultivation

No data are available.

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India

INDIA

Current prevalence of tobacco use

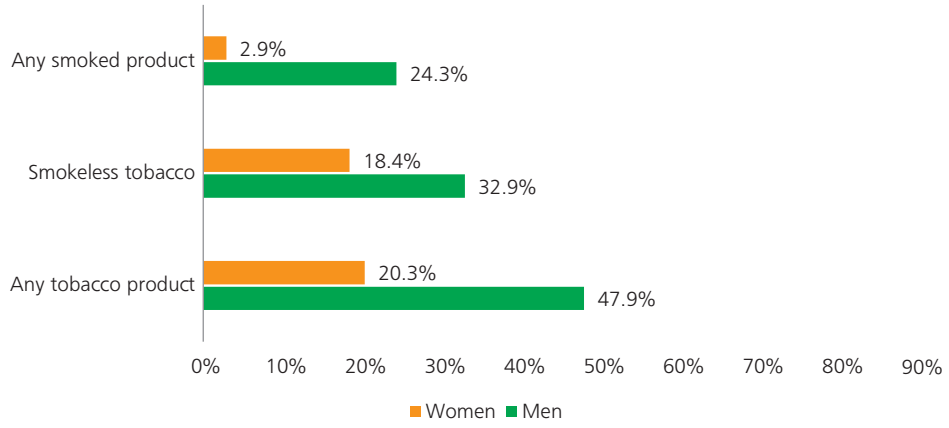
Tobacco use among adults [1]

The Global Adult Tobacco Survey showed that the prevalence of tobacco use among males was 47.9% and among females, it was 20.3%. This meant that overall 34.6% or over one third of adults in India use some form of tobacco.

Prevalence of smoking among males is 24.3%, and 2.9% among females. Therefore the overall adult prevalence of smoking was 14.0%. One third (32.9%) of males and 18.4% of females used smokeless tobacco products, making the overall adult prevalence 25.9%. 38.4% adults in rural areas and one in four (25.3%) adults in urban areas used tobacco in some form.

Based on the above, it was estimated that the number of tobacco users in India was 274.9 million. This comprised 163.7 million using only smokeless tobacco, 68.9 million using tobacco only in smoked form and 42.3 million using both smoking and smokeless tobacco.

Figure 4.1: Prevalence of tobacco use in the 15+ age group by sex and type of tobacco products in India

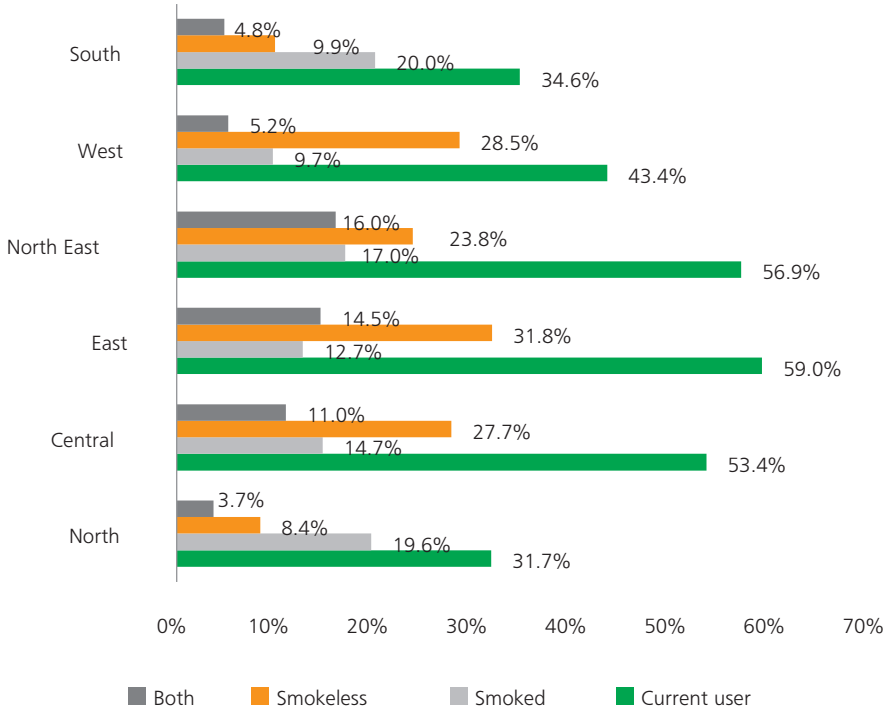


Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

The highest prevalence of overall tobacco use (48%) was in the 65+ age group, while the lowest (18%) was in the 15–24 year age group.

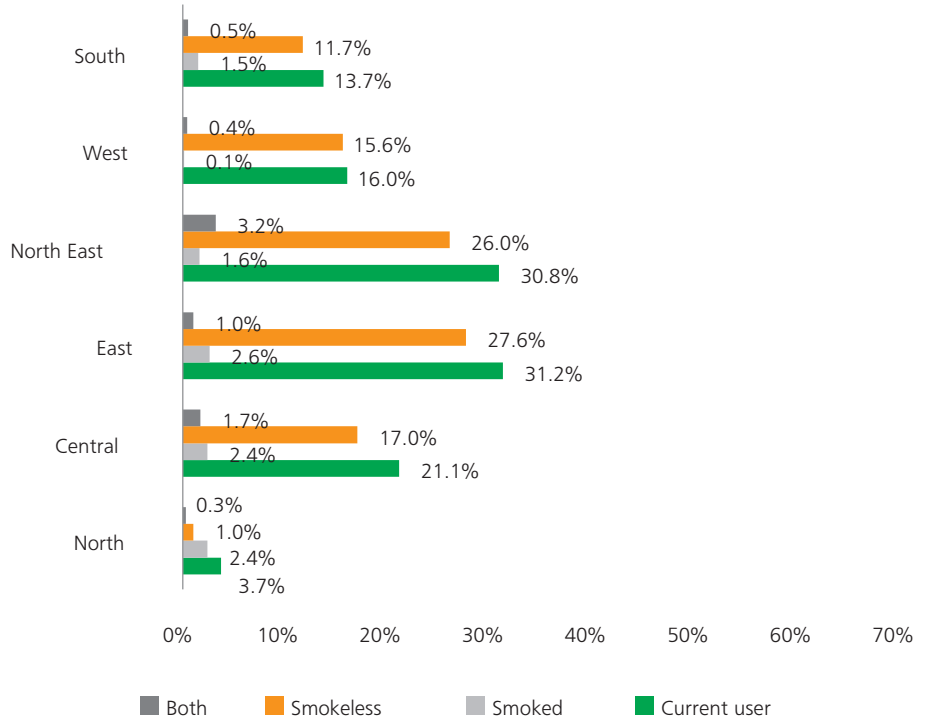
There were differences in tobacco use by Region as well. In general, the prevalence of use was high in the North-East, East and Central Regions while it was comparatively low in the North and South. Where smoking prevalence was high, the use of smokeless tobacco was low.

Figure 4.2: Tobacco use among adult males in India by Region



Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Figure 4.3: Tobacco use among adult females in India by Region

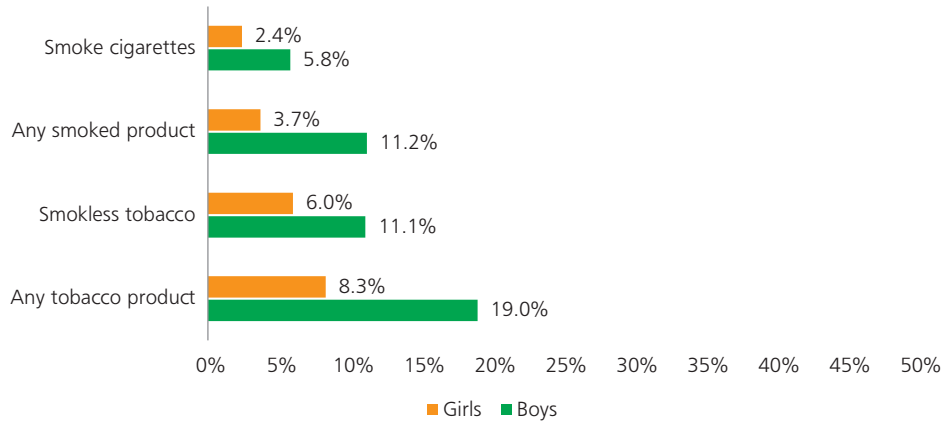


Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Tobacco use among youth

The Global Youth Tobacco Survey of 2009 [2] showed that the current prevalence of tobacco use among boys was 19.0% while in girls it was 8.3%. The current prevalence of smoking was 11.2% among boys and 3.7% among girls. 11.1% of boys and 6% of girls used smokeless tobacco.

Figure 4.4: Prevalence of tobacco use among 13–15 year old students by sex in India



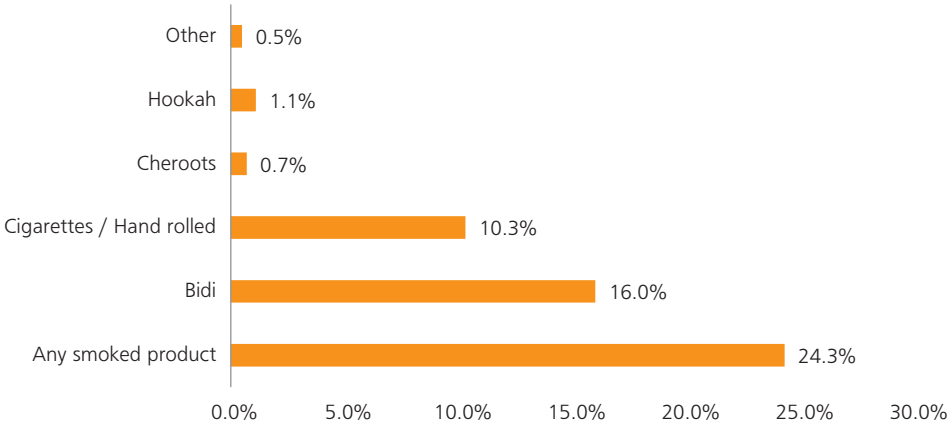
Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used [1]

Smoked tobacco

The overall prevalence of daily smoking among men was 24.3%. The vast majority of them used bidi. The prevalence of smoking among females was low (2.9%). The types of products used were similar to those of men.

Figure 4.5: Prevalence of smoking among adult males in India by products used



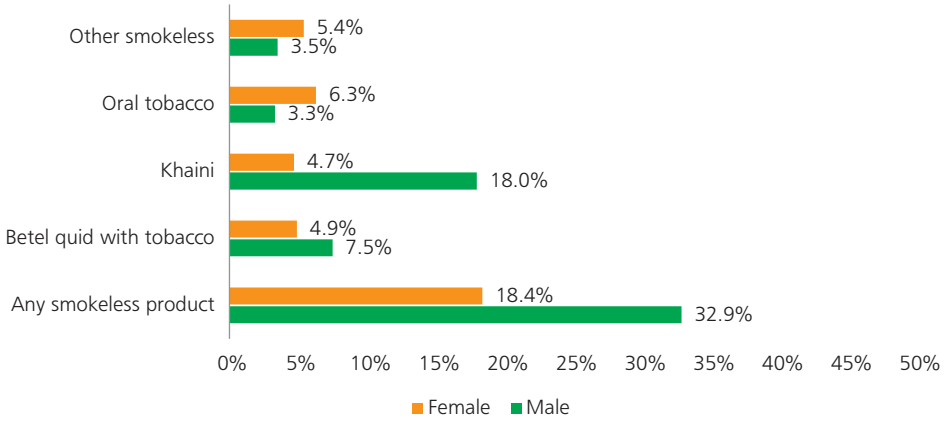
Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Smokeless tobacco

Betel quid with tobacco (*Khaini* - tobacco and lime mixture), *Gutkha* (tobacco, lime, areca-nut mixture), oral tobacco (as *snuff*, *mishri*, gul or *gudakhu*) were the most commonly used products by both men and women.

Overall, smokeless tobacco was used by 32.9% of men and 18.4% of women.

Figure 4.6: Prevalence of smokeless tobacco use among adults in India by products used and by sex

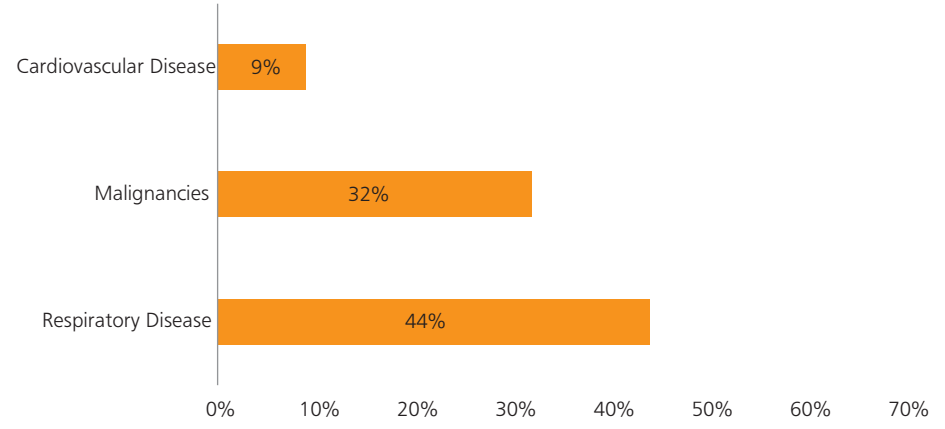


Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Mortality attributable to tobacco [3]

12% of deaths of males in India over 30 years of age were attributable to tobacco. Among males dying prematurely, 14% of deaths between the ages of 45 and 59 years and 17% of deaths between 60 and 69 years were attributable to tobacco. The proportion of female deaths attributable to tobacco was significantly lower.

Figure 4.7: Percentage of tobacco-attributable deaths of adult males in selected disease categories in India



Source: WHO Global Report. Mortality Attributable to Tobacco, 2012.

Economic impact of tobacco use

The study on Economic Burden of Tobacco Related Diseases in India [4] found that in 2011, total economic costs attributable to tobacco use from all diseases in India for persons aged 35–69 years amounted to Rs. 1 04 500 crores (US$ 22.4 billion). 84 percent of this cost consisted of indirect costs. Males were responsible for 91% of the total economic burden. However, for smokeless tobacco, females were responsible for almost 30 (29)% of the burden.

The direct medical costs were Rs.16 800 crore (US$ 3.6 billion). The associated indirect morbidity cost was Rs. 14 700 crore (US$ 3.1 billion). The costs of premature mortality was estimated to be Rs. 73 000 crores (US$ 15.6 billion).

Cardiovascular diseases (Rs. 3600 crores), respiratory diseases (Rs.2800 crores), tuberculosis (Rs.2300 crores) and cancers (Rs.1400 crores) were the major contributors to the direct medical and indirect morbidity costs on account of tobacco use. Among these four diseases, the female share of the economic burden of disease was highest (38%) for cancers. The cost of premature mortality was highest in the age group of 40–44 years for both males and females.

This study was carried out in 13 States. Uttar Pradesh had the highest (28%) of the estimated health-cost burden followed by West Bengal (13%) and Andhra Pradesh (12%).

Implementation of the WHO Framework convention on Tobacco Control (FCTC)

India signed the WHO FCTC in September 2003 and ratified it in February 2004.

Current tobacco control legislation and regulations [5]

The Cigarettes and Other Tobacco Products Act (COTPA) 2003 was formulated to discourage tobacco use and protect the youth and masses from the harmful effects of tobacco use and second-hand smoke.

It includes Articles on prohibition of smoking in public places, prohibition of direct and indirect advertising, promotion and sponsorship of cigarette and other tobacco products, prohibition of sale of cigarette and other tobacco products to a person below the age of 18 years, prohibition of sale of tobacco products within a radius of 100 yards of educational institutions, mandatory depiction of statutory warnings, including pictorial warnings on tobacco packs, and display of tar and nicotine contents on tobacco.

Several gazette notifications on smoke-free places and pictorial warnings have been since issued under this Act.

Structures for enforcement of tobacco control legislation [6]

The National Tobacco Control Programme was launched by the Ministry of Health and Family Welfare, Government of India in 2007–2008. The programme was launched in 21 States covering 42 districts in a phased manner.

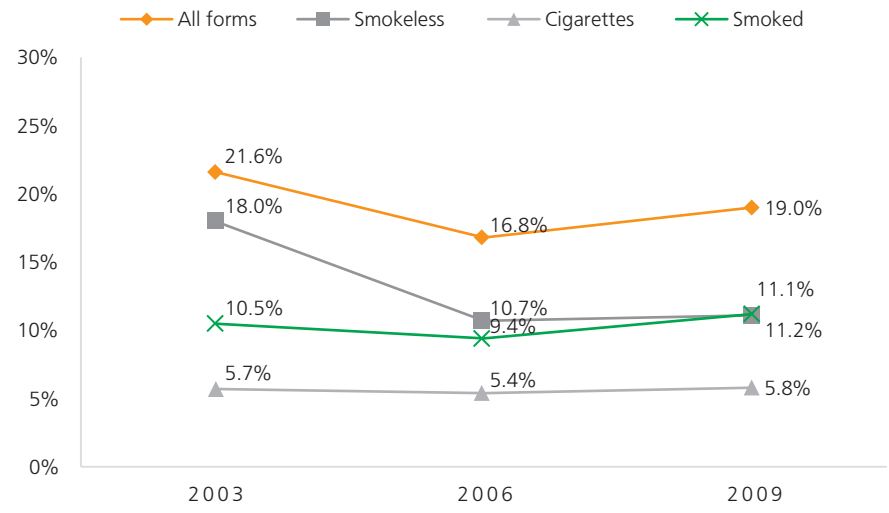
National Tobacco Control Cell: The National Tobacco Control Cell (NTCC), Ministry of Health and Family Welfare, is responsible for overall policy formulation, planning, monitoring and evaluation of the different activities envisaged under the National Tobacco Control Programme. It is supported by consultants in specific areas of tobacco control such as Policy, Legal, National Coordination and IEC and Advocacy. State and District Tobacco Control Cells have been established and linked to the NTCC.

Inter-ministerial Task Force: The multifaceted nature of the tobacco epidemic in India calls for greater involvement of various stakeholder ministries/departments. Hence, an Inter-Ministerial Task Force has been constituted at the national level under the Chairpersonship of Secretary (Health) to enhance Inter-ministerial/Inter–departmental coordination. The task force consists of representatives from 12 departments of the Government of India. In addition, representatives from 7 State governments and 2 from civil society organizations are special invitees to the task force.

Steering Committee: A national-level Steering Committee has been constituted under the Chairpersonship of Secretary (Health) to look into specific instances of violation of the Article on Advertising of COTPA, which consists of representatives from 3 departments of the Government of India. Included are also representatives from the Press Information Council of India, the Press Information Bureau, Advertising Standards Council of India (ASCI), and civil society organizations.

Surveillance of trends in prevalence

Figure 4.8: Trends in prevalence of tobacco use among 13–15 year old boys in India



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Overall, tobacco use in the 13–15 year age group has remained relatively static between 2003 and 2009. There is a clear drop in consumption on smokeless tobacco in this age group.

The Global Adult Tobacco Survey that was carried out at the national level in 2010 provides a technically sound baseline figure for surveillance of tobacco use among adults as well.

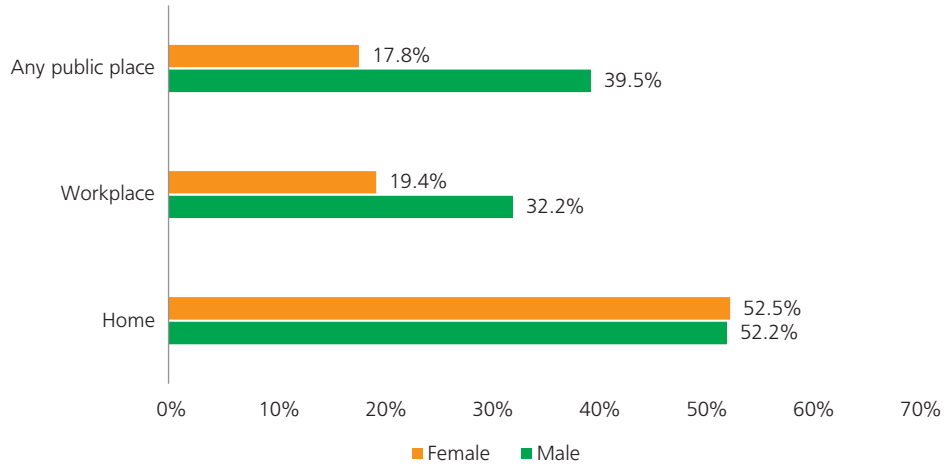
Protection from exposure to second-hand smoke

Public transport, health facilities, all educational institutions, government facility restaurants, auditoria and all indoor workplaces and other enclosed places that the public has access to have been declared smoke-free [5].

In the Global Adult Tobacco Survey, second-hand smoke exposure during at least one day in the past 30 days at their homes was reported by over half the men and women. Exposure at the workplace in the same period was reported by 32.2% of men and 19.4% of women. Almost 39.5% of men and 17.8% of women reported that they were exposed to second-hand smoke at public places during the last month [1].

Overall, 21.9% of those in the 13–15 year age group (24.1% of boys and 18.8% of girls) were exposed to tobacco smoke at home while 36.6% (39.0% of boys and 33.1% of girls) were exposed to tobacco smoke in enclosed public places during the last seven days, according the 2009 GYTS Survey.

Figure 4.9: Exposure of adults to second-hand smoke in India

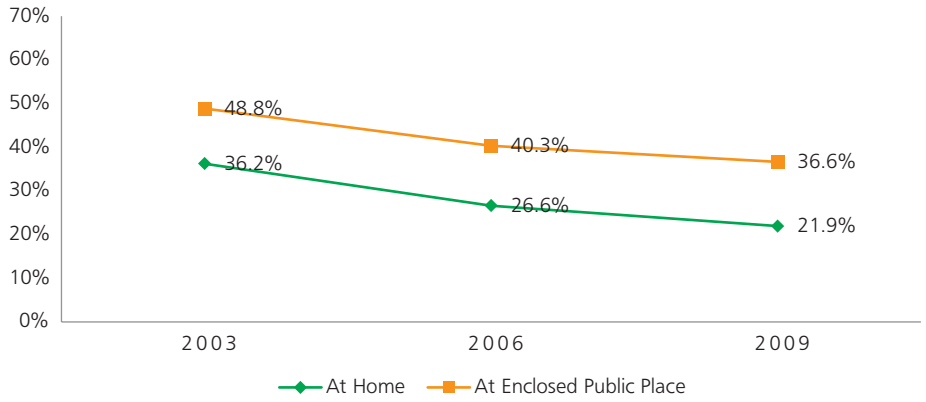


Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Health warning

Regulation for rotating health warnings covering 85% of the total area of the front and back of tobacco packs was adopted in 2013. The warning contains a picture as well as text in the principal local languages. These warnings must appear on all cigarette packs, packs of other forms of smoked tobacco and smokeless tobacco. These have to be printed on the top portion of the principal surface. All tobacco products sold in the country, whether imported or locally manufactured should display this warning. The implementation of the 85% graphic health warning has been delayed. Currently 40% pictorial health warnings on front surfaces appear on cigarette packs as well as SLTs.

Figure 4.10: Exposure of 13–15 year olds to second-hand smoke at home and at enclosed public places in India



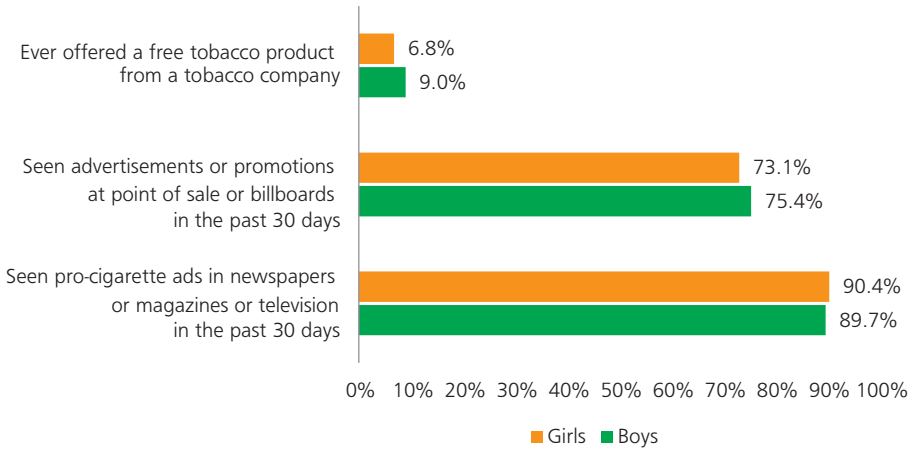
Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Enforcement of advertising, promotions and sponsorship ban

The tobacco control law prohibits all forms of tobacco advertisements, promotion and sponsorship. Product placements and brand stretching are prohibited. Free distribution and promotional discounts are banned [5].

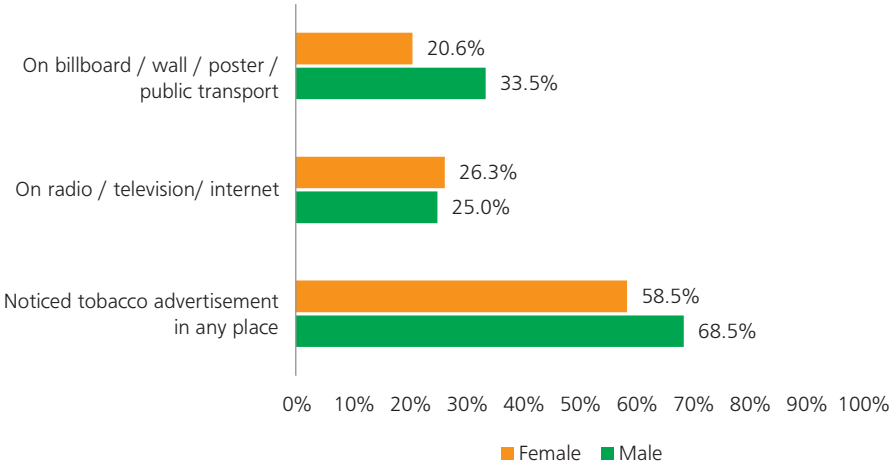
Despite the laws and structures in place, children are still exposed to tobacco promotions. The Global Youth Tobacco Survey found that about 90% of those between 13 and 15 years old were exposed to some form of tobacco promotion (ads in newspapers or magazines or on TV, videos, or movies) during the preceding 30 days. The exposure was comparatively high in the case of advertisements in newspapers or magazines or television or videos or movies [2]. The Global Adult Tobacco Survey found that adults too are commonly exposed to some form of tobacco promotion.

Figure 4.11: Exposure of 13–15 year old students to tobacco promotions in India



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Figure 4.12: Exposure of adults to tobacco promotions by sex in India



Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Taxation [7]

India levies tiered specific excise taxes on cigarettes, with seven brackets of Basi Excise Duty (BED) based on cigarette length and whether or not there is a filter; Additional Excise Duty (AED), national calamity duty (NCCD) and VAT. Tax share of retail price for cigarettes is 60.39% (+ excise tax 43.73% and VAT 16.67%). A specific amount for all tobacco products (varies by product), except bidis, goes to the Health Cessation Fund, and an amount levied on bidis goes to the Bidi Worker's Welfare Fund, which also includes medical care for workers in the bidi industry.

Cessation services

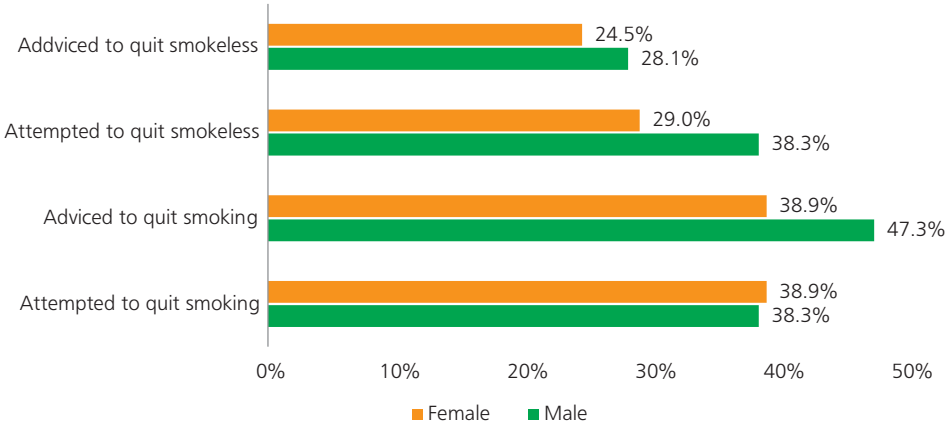
There is no formal structure or programme established to promote quitting or provide cessation services in India. Some primary care clinics and other health clinics offer services to smokers [7]. A pilot project set up 19 tobacco cessation clinics in government health facilities beginning in 2002. Evaluation of the results of these clinics shows promising results [8]. A pilot project on mHealth on tobacco cessation started in early 2015 and nationwide mHealth cessation services were launched in October 2015.

According to the Global Adult Tobacco Survey [9], 38.4% have made an attempt to quit in the last 12 months. During the past 12 months, almost 40% of female smokers and 47.3% of male smokers were advised to quit by a health-care provider.

38.9% of male and 29.0% of female smokeless tobacco users have attempted to quit during the past year. About one fourth of males (28.1%) and females (24.5%) among the smokeless tobacco users were asked to quit by a health-care provider.

Two thirds (67.2%) of current smokers among the 13–15 year age group had attempted to quit last year, which is a relatively high proportion. 66.1% of current smokers of that age group stated that they wanted to stop smoking "now". 94.3% smokers in that group had received help or advice from a programme or a professional to stop smoking [2].

Figure 4.13: Attempts to quit among adult tobacco users and advice on quitting during the past year, India



Source: Global Adult Tobacco Survey India 2009–2010, Ministry of Health and Family Welfare, World Health Organization.

Tobacco industry [10]

Though bidis is the most commonly used tobacco product in India, its production is fragmented. As most brands of bidi are hand-rolled in individual homes on a small scale, the bidi industry is considered to be a cottage industry. The bidi manufacturing industry is divided into two different sectors: organized and unorganized. The organized sector is factory-based and production is increasingly mechanized. The production of 80% of bidi is considered be in the cottage industry. It is also estimated that no individual company or brand has more than 5% of the market share of bidi.

The smokeless tobacco industry in India is controlled by a few large national companies and many different regional players. The top five companies are estimated to account for about 31% of sales.

The market share of the manufactured cigarette industry is relatively smaller than that of other products. The cigarette market in India is controlled by four locally established companies, but most companies also have close ties to international tobacco companies.

India had gone through several litigations by the tobacco industry for smoke-free public places, smoke-free movies, and graphic health warnings. An example is the delay in implementation of the regulation on 85% graphic health warning, which is clearly due to the interference of the tobacco industry.

Tobacco cultivation [11]

India is a leading exporter of tobacco, exporting tobacco to more than 100 countries. It is the third largest producer of tobacco. China and Brazil occupy the first and second positions, respectively.

Presently, tobacco is being cultivated in an area of about 493 000 hectares (0.24%) of total arable land in the country. Different types of tobacco are grown for cigarettes, bidi, chewing tobacco, hookah, cheroots, cigar wrappers, cigar filler, etc.

The overall annual production is about 800 million kg. Out of the total production, about 50% is cigarette-type and 50% is non-cigarette type of tobacco. Out of this, about 265million kgs is flue-cured Virginia tobacco (FCV), which is produced in an area of 217 000 hectares, mainly in the States of Andhra Pradesh and Karnataka. Bidi tobacco is cultivated in an area of about 102 000 hectares, mostly in the States of Gujarat and Karnataka, with an annual production of nearly 204 million kg. [12]

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Indonesia

INDONESIA

Current prevalence of tobacco use

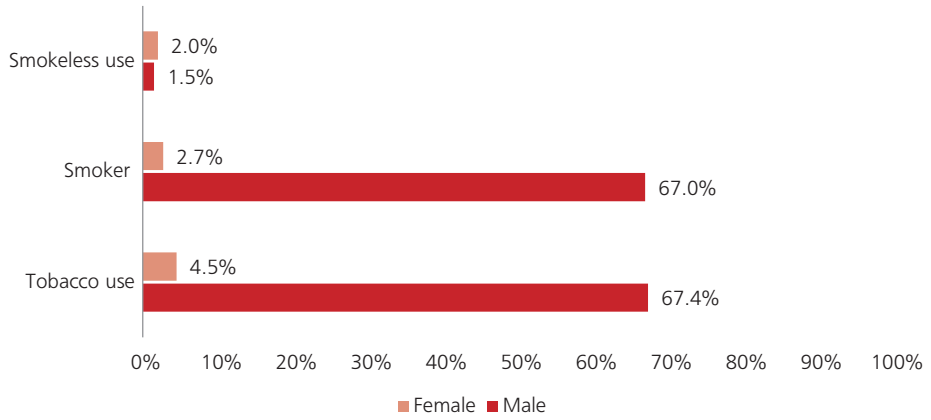
Tobacco use among adults [1]

Indonesia is the fourth-largest cigarette consuming country. Two thirds of men (67.4%) and one in 20 (4.5%) women use tobacco. The overwhelming majority of tobacco users are smokers. The overall prevalence rate of current smokers is 34.8%. It is high among men (67.0%), which is about 30 times the prevalence rate of women (2.7%). Current smokeless tobacco use is low, with an overall prevalence rate of only 1.7%.

The overall estimated number of current smokers who smoke various tobacco products is 59.9 million persons. 57.6 million of them are men. This indicates a very high national burden of tobacco use in Indonesia. The vast majority of them, 54.3 million persons, smoke *kreteks*. The number of hand-rolled cigarette users (8.1 million) is higher than the number of white cigarette users (3.8 million). Around half a million smoke other products such as pipes, cigars, shisha and others.

The 25–44 year age group has the highest number of smokers – 29.2 million. 26.9 million of them are *kretek* users. Hand-rolled cigarette users, however, show a higher prevalence in the 45–64 year age group.

Figure 5.1: Prevalence of tobacco use in over 15-year age group by sex in Indonesia

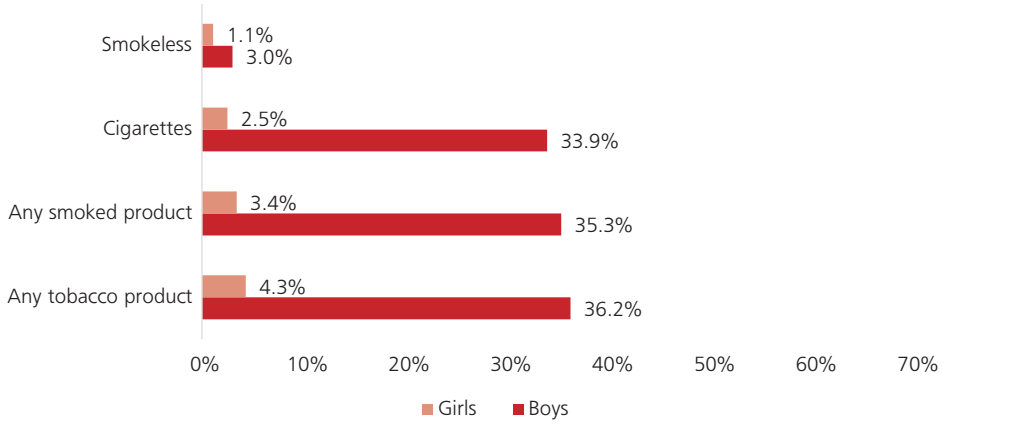


Source: Global Adult Tobacco Survey Indonesia 2011. World Health Organization.

Tobacco use among youth

The Global Youth Tobacco Survey of 2014 [2] showed that the current prevalence of tobacco use among boys was 36.2% while in girls it was 4.3%. The current prevalence of cigarette smoking was 33.9 % among boys, while only 3 % of boys used smokeless tobacco. The corresponding rates among girls were significantly lower.

Figure 5.2: Prevalence of tobacco use among 13–15 year old students by sex in Indonesia in 2014



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used [1]

Smoked tobacco

Among current tobacco users, 95.1% use smoked tobacco only, 2.6% use smokeless tobacco only and 2.3% use both smoked and smokeless tobacco [1].

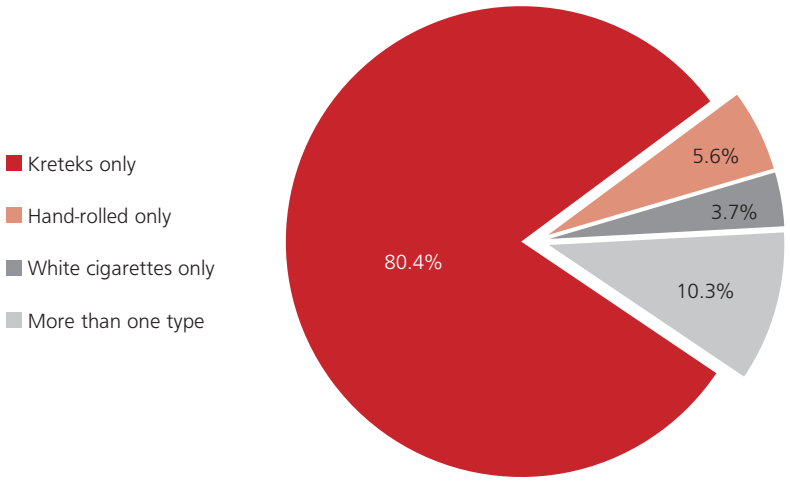
Kreteks or clove cigarettes are the most popular tobacco product in Indonesia. White cigarettes, hand-rolled cigarettes are also used, but to a significantly lesser extent. Even a lesser number uses pipes, cigars and shisha.

There are two types of manufactured cigarettes in Indonesia – kreteks and white cigarettes. Kreteks are clove cigarettes, and typically contain a mixture consisting of tobacco, cloves and other additives. There is also a major market for non-factory made cigarettes, which are clove cigarettes that may be either filtered or unfiltered. The kretek (clove-blended) cigarette dominates the market in both the machine-made and hand-rolled categories.

Smokeless tobacco

Use of smokeless tobacco is not very common in Indonesia; only less than 2.6 % reported to use SLT in 2011 [1].

Figure 5.3: Types of smoked tobacco products used in Indonesia



Source: Global Adult Tobacco Survey Indonesia 2011. World Health Organization.

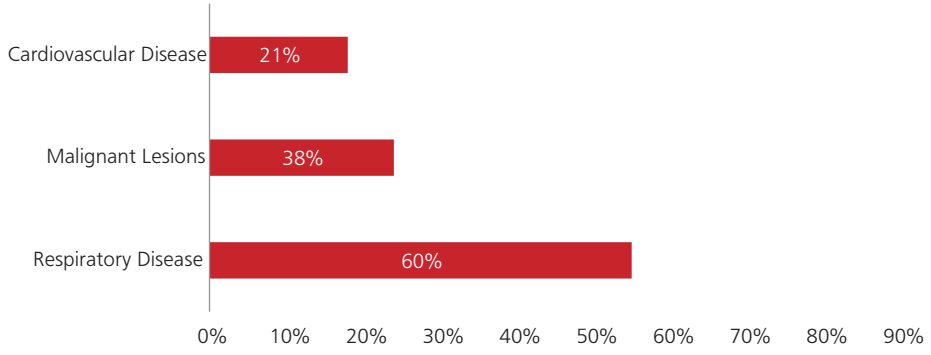
Mortality attributable to tobacco

Standardized machine-smoking analyses indicate that kreteks deliver more nicotine, carbon monoxide and tar than conventional cigarettes. Kretek smoking is associated with an increased risk of acute lung injury, especially among susceptible individuals with asthma or respiratory infections. Research shows that regular kretek smokers have 13–20 times the risk of abnormal lung function compared with non-smokers [1].

Among those dying prematurely, (16%) between the ages of 45 and 59 years was attributable to tobacco. Tobacco was responsible for 21% of all noncommunicable disease-related deaths, and 12% of all communicable disease-related deaths of those over 30 years [3].

One fifth (20%) of deaths of those males above the age of 30 years in Indonesia is attributable to tobacco use. This was significantly higher than that for women of the same age group, which was 12%.

Figure 5.4: Percentage of tobacco-attributable deaths of males over 30 years of age due to selected disease categories



Source: WHO Global Report. Mortality Attributable to Tobacco, 2012.

Overall, 38% of all male deaths from malignant lesions, 21% deaths from cardiovascular conditions and 60% of deaths from respiratory diseases occurred due to tobacco.

Economics of tobacco use [1]

Based on the Baseline Health Research 2010, an average of 12 cigarettes sticks is consumed per person per day, at an average price of IDR 600.00 per stick. Therefore, the expenditure for tobacco per person per day was IDR 7,200.00 or IDR 216,000.00 per person per month. This expenditure is larger than the Conditional Cash Transfer (CCT) programme for poor families, which was IDR 100,000.00 per family per month.

The total medical expenditure on selected major diseases (629 017 hospitalized cases) attributed to tobacco use in 2010 was IDR 1.85 trillion; these included chronic obstructive pulmonary disease, coronary heart disease, selected neoplasms/cancers and perinatal disorders. It is estimated that there were 1 258 034 ambulatory cases of tobacco-related diseases. With the average expenditure per patient per visit (without subsidy) of IDR 208 337, the total expenditure for ambulatory services in 2010 was IDR 0.26 trillion.

Implementation of the measures of the WHO Framework Convention on Tobacco Control (FCTC)

Indonesia is yet to become a signatory to the WHO FCTC. But the Government of Indonesia has pledged it support to implement MPOWER policies [4].

Current tobacco control legislation and regulations

The Government of Indonesia enacted the tobacco control regulation entitled "Regulation of Government of Indonesia No. 109 of 2012: Control of materials that contains addictive substances in tobacco products in the interest of health" in 2012. This regulation covers production and import, distribution, special protection for children and pregnant women, and smoke-free zones.

It specifies measure to restrict advertising and sponsorship, protection from second-hand smoke, establishes health warnings and provides guidance on crop diversification. Selling to those under 18 and vending machines are prohibited through this regulation. It prohibits the use of misleading terms such as "light" and "mild" in tobacco packs. This regulation also specifies the responsibilities of different government agencies and local authorities in implementing the Articles of this Regulation.

The Ministry of Health issued the regulation implementing the pictorial health warnings in 2013, to implement the Articles of Regulation on health warnings [5].

Structures for enforcement of tobacco control legislation

The Tobacco Control Regulation of 2012 [6] states that "Guidance and oversight by the Minister of Health, the relevant ministers and the Head of the Food and Drug Control Agency on the administration of efforts at controlling tobacco products in the interests of health shall be

conducted in the various areas of responsibility in accordance with their respective duties and functions". This Regulation also specifies agencies responsible for implementing and overseeing the different functions relating to tobacco control such as smoke-free places, advertising and crop diversification.

The Indonesian Ministry of Health has also appointed a Tobacco Control Focal Point at the Directorate General of Disease Control and Environmental Health to coordinate technical activities and prepare regulations on tobacco control [1].

Surveillance of trends in prevalence

Comparable recent trend data are not available for national level prevalence of tobacco use. However, as both the Global Youth Tobacco Survey (2014) and the Global Adult Tobacco Survey (2011) have been completed, there is a technically sound baseline for future surveillance.

Protection from exposure to second-hand smoke

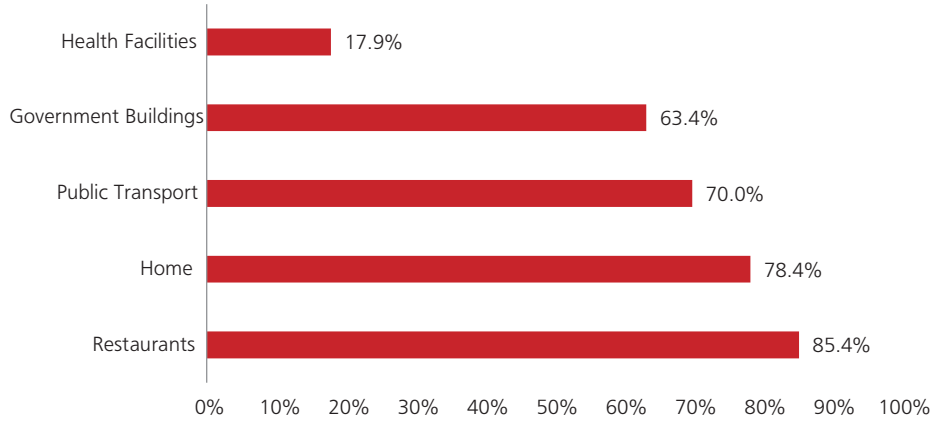
Health-care facilities, public transport and educational facilities, including universities, are smoke-free. Other locations have not been declared as smoke-free yet. There are several subnational laws on smoke-free environments as well, covering and declaring almost the same locations as smoke-free [7].

The Global Adult Tobacco Survey 2011 [1] found that a vast majority of those over the age of 15 years were exposed to second-hand smoke at various places during the past 30 days. Overall, 51.3% of workers are exposed to SHS at indoor workplaces. This means that overall, 14.6 million workers are exposed to SHS in the indoor areas of their workplaces. More male workers are exposed to SHS than female workers. Workers in rural areas were exposed more than were urban workers.

Overall, 78.4% of adults aged 15 years and above were exposed to SHS at homes. This means that 133.3 million adults aged 15 years and over are exposed to SHS at home. Exposure at home does not differ substantially by gender or age group. People living in rural areas have a higher prevalence of exposure to SHS at home (88.2%) than those who live in urban areas (68.5%). Adults with a lower educational level have the highest prevalence of exposure to SHS at home (84.5%) and those with college and university level of education have the lowest, which was also a substantial 57.2%.

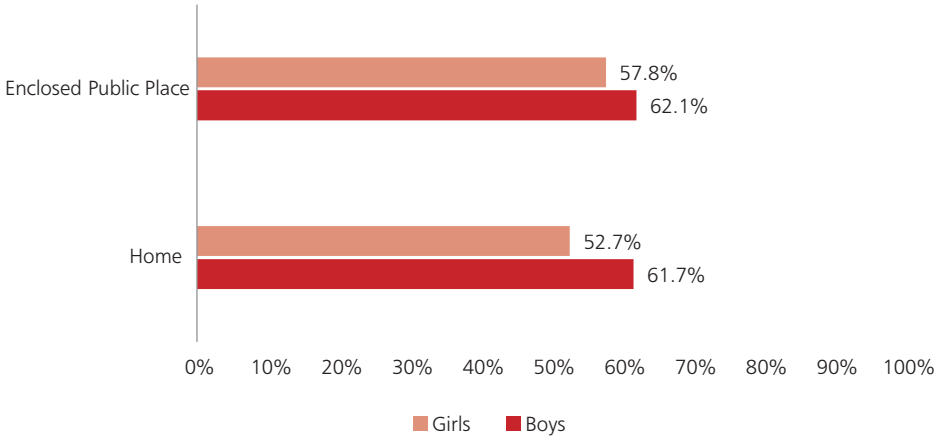
Overall, 57.3% of those in the 13–15 year age group were exposed to tobacco smoke at home and 60.1% were exposed to tobacco smoke in enclosed public places during the last seven days, according the 2014 GYTS Survey [2].

Figure 5.5: Exposure to second-hand smoke of those above 15 years in Indonesia



Source: Global Adult Tobacco Survey 2011, Indonesia, World Health Organization.

Figure 5.6: Exposure of students between 13 and 15 years to second-hand smoke by sex in Indonesia



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Health Warnings

A rotating pictorial warning covering 40% of both the front and back, on the top of the wide faces of the packaging is in place since 2013 [5]. This warning has to appear on all packages of smoked and smokeless tobacco. The text should appear in the principal languages of the country. This law applies to both domestically produced and imported tobacco products.

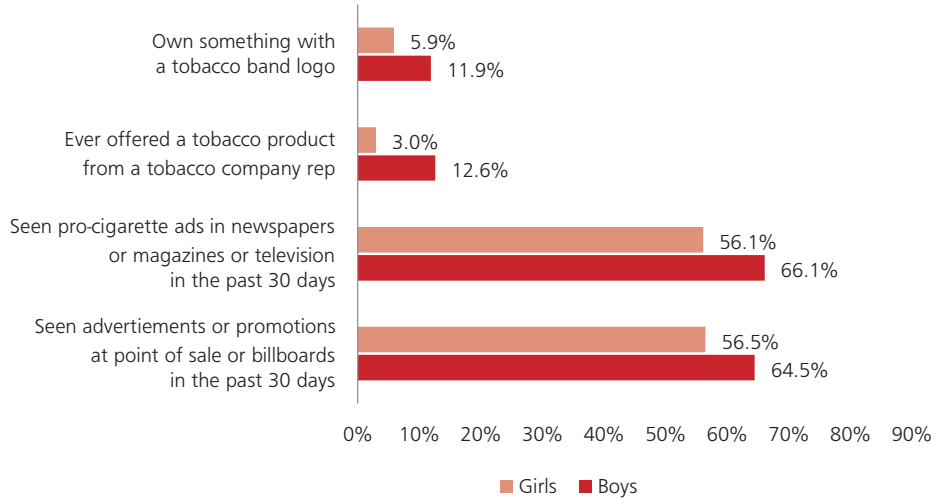
Enforcement of advertising, promotions and sponsorship ban

Currently there is no comprehensive ban on tobacco advertising and promotion. There is a prohibition on free samples; gifts or discounts are prohibited as is the use of tobacco brands or logos with other products or events. There are no comprehensive restrictions on tobacco

advertising and promotions through television, radio, billboards, newspapers, magazines and the Internet. The Tobacco Control Regulation places several restrictions on the content of tobacco advertisements. Some such restrictions include not using children or cartoon characters, not claiming health benefits, and not being contrary to community norms. A health warning covering 10% of the duration of the advertisement or 15% of its surface area is required for all advertisements [6].

A large proportion of both children and adults are exposed to tobacco marketing strategies in Indonesia as the following two graphs indicate.

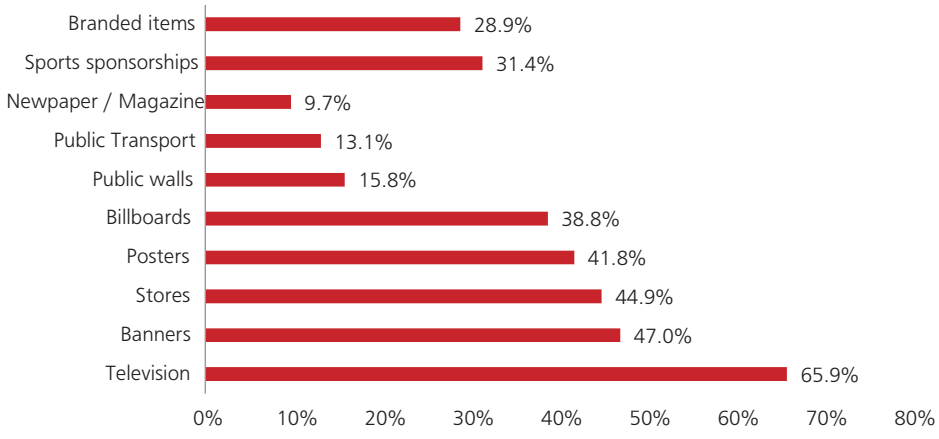
Figure 5.7: Exposure to tobacco promotions of 13–15 year old students by sex in Indonesia



Source: Global Youth Tobacco Survey 2014, Indonesia, World Health Organization.

The percentage of those above the age of 15 who noticed any kretek cigarette advertisement, sponsorship or promotion was 84.2%. Men, people in the younger age group (15–24 years) and people living in urban areas were more likely to notice kretek cigarette marketing [1].

Figure 5.8: Exposure to kretek marketing of those over 15 years of age during last 30 days in Indonesia



Source: Global Adult Tobacco Survey Indonesia 2011, World Health Organization.

Taxation [7]

Different types of tobacco products are taxed differently. The tax share is 53.4% of retail price of cigarettes (excise tax is 45.% and VAT 8.4%). 10% surcharge is imposed on tobacco excise. 2% from tobacco excise revenue is allocated to regional governments as revenue sharing as per Indonesian Law number 39 of 2007 on excise duty. Of this, at least 50% of cigarette tax (regional tax) revenue is allocated for health programmes and for law enforcement.

Cessation services

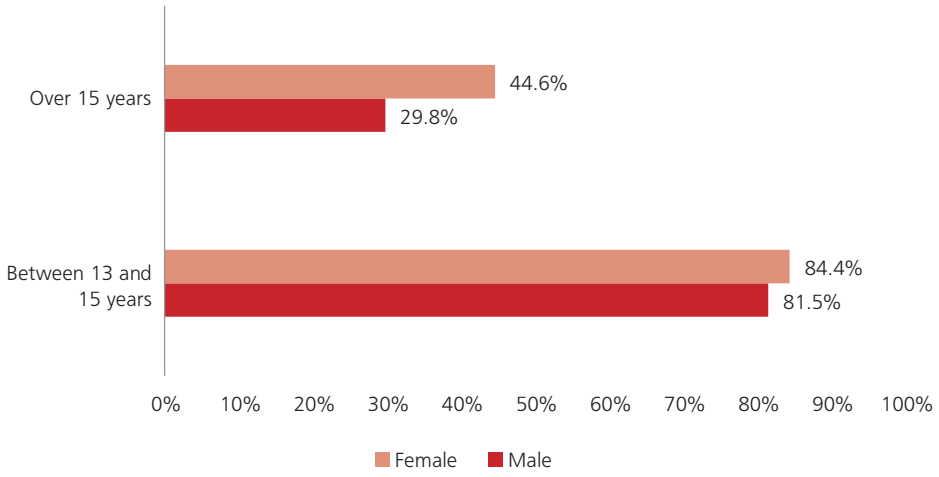
Almost 81.5% of the boys and 84.4% of girls between the ages of 13 and 15 attempted to quit during the preceding year, according to GYTS [2]. This is a very important finding, which shows that services for this age group are urgently needed. The Global Adult Tobacco Survey found about 29.8% of male and 44.6% of female respondents over 15 years of age attempted quit smoking during the last year.

The rate was highest in the 15–24 age group (36.5%) and lowest in the 65+ age group (25.7%). When the level of education was taken into account, the most quitting attempts were in the highest education category (39.4% in the college and university segment), while it was lowest in the lowest education category (23.7%) (primary school or less) [1].

Of those who had successfully quit, a very high proportion of smokers reported quitting on their own (70.7%). Of the other successful quitters, 13.6% used other methods and counselling was used by 7.0%. The cessation method that was least used was prescription medication, which had helped only 0.4% of successful quitters.

Of current smokers, almost 50% are planning or are thinking about quitting.

Figure 5.9: Smokers attempting to quit over the preceding 12 months



Sources: Global Youth Tobacco Survey 2014 Indonesia and Global Adult Tobacco Survey 2011 Indonesia, World Health Organization.

Although there is no national level structure established for cessation services, some pharmaceutical cessation aids are available and can be obtained without a prescription from pharmacies. Currently there is no national level quit line. Smoking cessation support is available

in some hospitals and primary health-care clinics. Some health professionals provide such support as well. The cost of such support is not covered by the national health system or by health insurers [7].

On the positive side, 40.5% of smokers who visited a health-care facility were asked about their history of tobacco smoking, and 34.6% were advised to quit smoking [1].

Tobacco industry

Indonesia is the world's third largest cigarette market by volume excluding China. Since 2005, the Indonesian market has shifted from being solely dominated by local manufacturers to a market where the number one, four and six spots are controlled by Transnational Tobacco Companies. These companies have about 40% of the market. The large local companies also hold a significant market share [8].

The presence of mega industry in Indonesia poses a huge challenge to implementing tobacco control in Indonesia. The industry uses tobacco farmers as front groups and raises objections to all efforts in acceding to the WHO FCTC.

Cultivation of tobacco

Indonesia is the world's fifth-largest producer of tobacco leaf [1], but a net importer of tobacco [9]. There are around 689 000 tobacco farmers in Indonesia, but it consists of only 0.6% of total employment. About 216 000 hectares of tobacco is cultivated. It is found mainly in East Java.

Indonesia Law No. 39 of 2007 was enacted to support the tobacco farmers. The law prescribed that 2% of the excise tax on tobacco products should be used for:

(1) improvement of the quality of raw materials;

(2) development of the tobacco industry;

(3) social development;

(4) dissemination of excise regulations; and

(5) law enforcement on illicit tobacco products.

Crop diversification in tobacco growing areas has been implemented as a government policy. Indonesia shifting to other activities includes the inclusion of livestock rearing, such as goat/sheep [9].

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Maldives

MALDIVES

Current prevalence of tobacco use

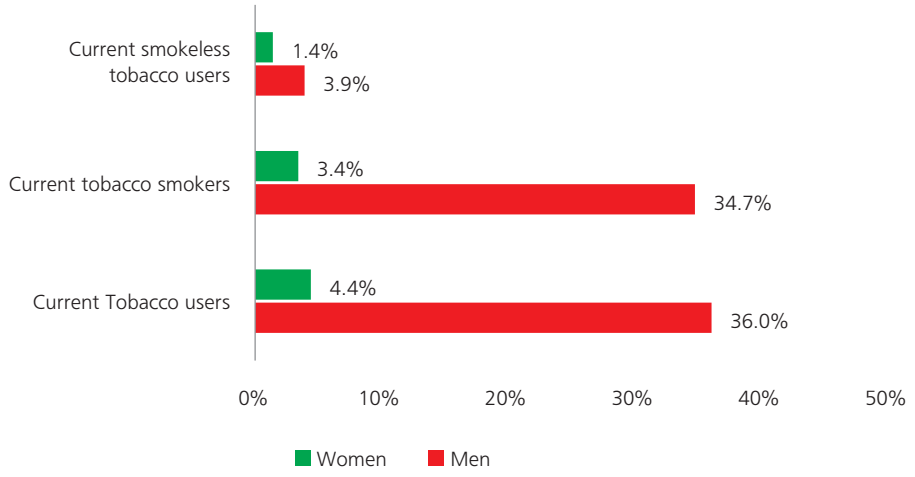
Tobacco use among adults

The WHO STEP-wise approach to Surveillance of NCD Risk Factors (STEPS) Survey of 2011 [1] showed that 34.7% of males and 3.4% of females between the ages of 15 and 64 years were current tobacco smokers. This means that there are 10 male smokers in this age group for every 1 female smoker.

Nearly all tobacco users were tobacco smokers. Over 82.4% of tobacco smokers were daily smokers, and 93.9% of these daily smokers used manufactured cigarettes. Therefore, the vast majority (about four fifths) of tobacco users in Maldives were users of manufactured cigarettes.

The highest current prevalence of 45.9% was seen in males between the ages of 25 and 34 years. The highest prevalence for females was 9.7% in the 55–64 year age group. The prevalence of smoking is a good indicator of tobacco use in Maldives and the prevalence of smokeless tobacco use is relatively low [1].

Figure 6.1: Prevalence of tobacco use in 15–64 year group by sex in Maldives



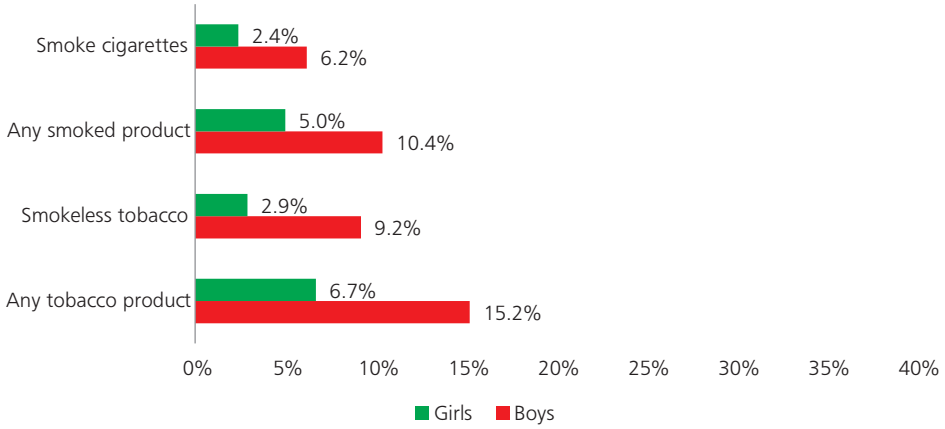
Source: Noncommunicable Diseases Risk Factor Survey Maldives, 2011, Subnational, World Health Organization.

3.9% of men and 1.4% of women between the ages of 15 and 64 years were current smokeless tobacco users. Men between the ages of 55 and 64 had the highest rate of prevalence, which was 16.2%, while in women the highest current prevalence was also in the same age group, which was 7.3%. The prevalence of use increased with age. Only 1.7% of male and 0.4% of females in the 15-24 age group used tobacco, which is a positive finding.

Tobacco use among youth

The Global Youth Tobacco Survey of 2011 [2] showed that the current prevalence of tobacco use among boys was 15.2% while in girls it was 6.7%. The current prevalence of cigarette smoking was 6.2% among boys, while 9 2% of boys used smokeless tobacco. The corresponding rates among girls were significantly lower.

Figure 6.2: Prevalence of current tobacco use in 13–15 age group by sex in Maldives



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used

Smoked tobacco

As shown in the above section, the vast majority of tobacco users use manufactured cigarettes, which are imported to Maldives. Smokeless tobacco use is also prevalent. Tobacco cultivation and production of tobacco products using tobacco leaves in Maldives is prohibited [3].

Smokeless tobacco

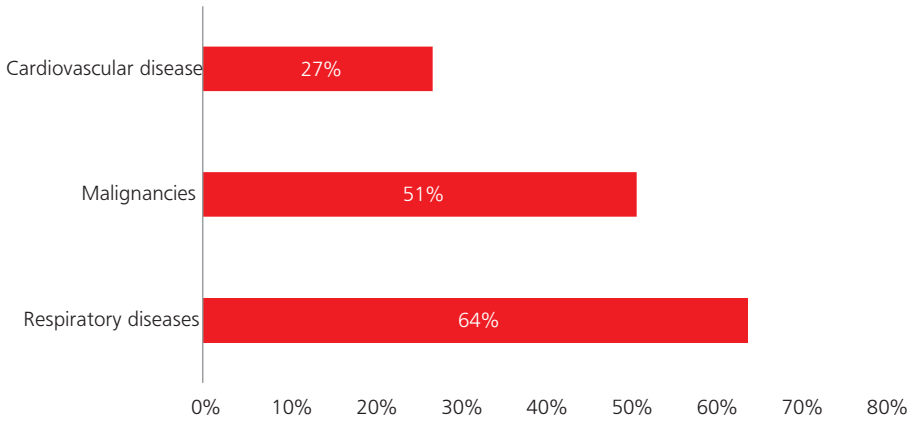
About 4% of males and 1.4% of females use SLT. [1].

Mortality attributable to tobacco [4]

It is estimated that over one fourth (27%) of deaths of those above the age of 30 years in Maldives is attributable to tobacco use.

21% of deaths among men aged between 45 and 59 and 35% of deaths of men aged between 60 and 69 occurred due to tobacco. Tobacco was responsible for 32% of all noncommunicable disease-related deaths, and 16% of all communicable disease-related deaths of males over 30 years.

Figure 6.3: Tobacco attributable deaths of males over 30 years of age in Maldives



Source: WHO Global Report, Mortality Attributable to Tobacco, World Health Organization 2012.

Of all deaths of males above 30 years of age due to tobacco, more than one half (51%) were from malignant lesions; more than one fourth (27%) were from cardiovascular conditions; and almost two thirds (64%) were from respiratory diseases.

Economic impact of tobacco use

No study has been done till date on the economic impact of tobacco.

Implementation of the WHO FCTC

Maldives signed the WHO FCTC on 17 May 2004 and ratified it on 20 May 2004.

Current tobacco control legislation and regulations [3]

The Tobacco Control Act No. 15 /2010 was enacted by the Government of the Republic of Maldives with several stated objectives. These include prohibiting growing tobacco and advertising tobacco products, regulation of import, export, sale of tobacco products, packaging, and labelling, regulation of taxation of tobacco products, protection from second-hand smoke and cessation support and are aligned with the provisions and Party obligations under the WHO FCTC.

Structures for enforcement of tobacco control legislation [3]

The Tobacco Control Act established the multisectoral statutory body to advise the government on tobacco control. The "Tobacco Control Board" is appointed by the President. The Minister of Health presides over the Board. Members of this Board consist of representatives from relevant government ministries, experts on tobacco control, experts on public health, consumer protection advocates and representatives from civil and business associations.

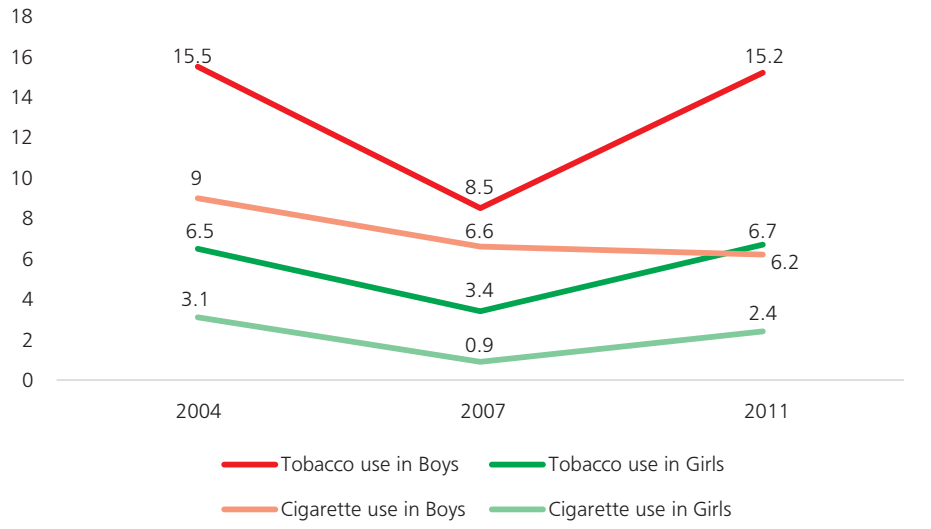
This entity should submit a report to the cabinet on an annual basis, giving its recommendations on issues related to tobacco control.

Among its functions are conducting research, issuing regulations required under the Act, monitoring the effectiveness of this Act and recommending amendments, determining actions to be taken for tobacco control on a national level and coordinating activities conducted by ministries, government authorities and non-profit organizations against tobacco.

The Health Protection Agency (HPA) is the focal Department in the Ministry of Health for tobacco control as well as the secretariat of the Tobacco Control Board.

Surveillance of trends in prevalence [5]

Figure 6.4: Trend in tobacco use among 13–15 year olds by sex in Maldives



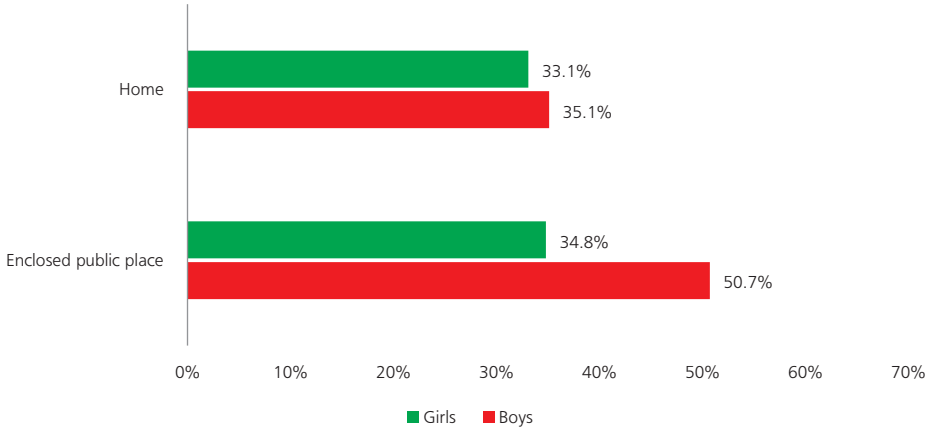
Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Unlike the findings for adults, use of tobacco products other than cigarettes is proportionately larger in this age group. In 2011, the current use of smokeless tobacco was almost similar among boys and girls of this age group. In adults, the prevalence of smoking was several times higher than the prevalence of smokeless tobacco use [1].

Protection from exposure to second-hand smoke

The STEPS survey found that nearly 23% of male respondents and 20% of female respondents were exposed to tobacco smoke in their home daily. There were no significant variations in the exposure to tobacco smoke across age groups and by gender [1]. It also found that during the preceding 30 days, 20.3% of males and 11.4% of females were exposed to tobacco smoke in their workplace [1].

Figure 6.5: Exposure of 13–15 year olds to second-hand smoke during by sex in Maldives



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Overall 34.5% of those in the 13–15 year age group were exposed to tobacco smoke at home and 43.0% were exposed to tobacco smoke in enclosed public places during the last seven days, according the 2011 GYTS Survey.

The Tobacco Control Act of 2010 declared many areas as smoke-free [3]. These include total smoking bans in cinemas and auditoriums, mosques, health service providers, educational facilities, childcare and child education facilities, rehabilitation facilities, buildings where government authorities are housed, and sports courts, fields, and stadiums including open areas and buildings within their premises as well as a 10-feed radius of the entries and exits to these premises. Smoking is completely or partially banned as prescribed under relevant regulations in public transport vehicles or vessels, eateries, cafes, restaurants and open public areas or at gatherings.

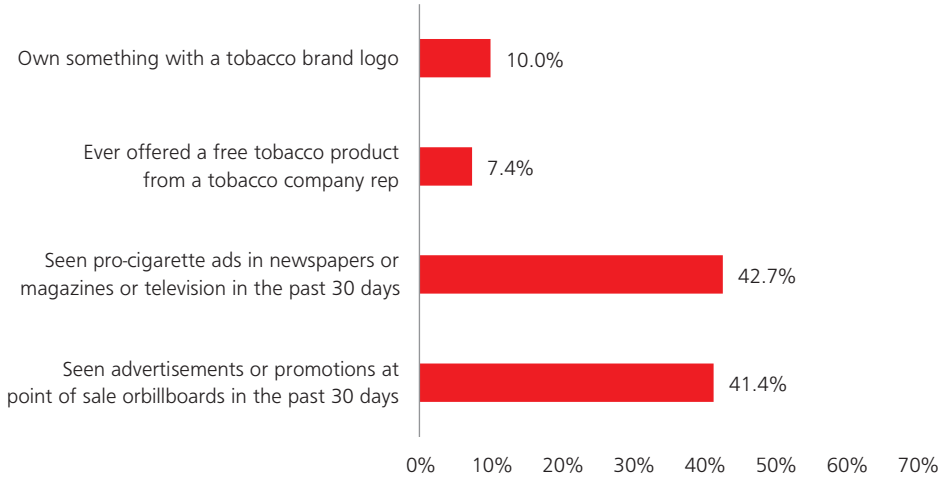
Health warnings

The Tobacco Control Act has a provision for introduction of health warning on outside packaging of tobacco products, through relevant regulations. The law gives this authority to the Ministry of Health, and with the enactment of the Tobacco Control Act, and until new regimes for Health Warning are introduced, the prevailing requirement for 30% textual warning on both the front and the rear of tobacco packages has been reinstated and is being implemented.

Enforcement of advertising, promotions and sponsorship ban

The tobacco control law prohibits all forms of tobacco advertisements, promotion and sponsorship. Point of sale and Internet advertising and product placements are prohibited as well. Free distribution of tobacco products, promotional discounts and Internet sales and vending machines are banned as well [7]. Despite the laws and structures in place, children are still exposed to point of sale tobacco advertising and promotional displays as is the case in many other SEAR countries.

Figure 6.6: Exposure of 13–15 year olds to tobacco promotions in Maldives



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation

There is an import duty on tobacco products. This is the only tax applied currently to tobacco products. Taxes such as value added tax (VAT), specific taxes and excise duties are not applied; as of 2014, 65.8% of the selling price of the largest selling brand of cigarettes consisted of tax (import duties)(WHO Comparable Estimate) [7]. With the limited tax increase that came into effect in 2015, the tax incidence on the retail value of a cigarette currently amounts to 62.5% (retail price of a cigarette = MVR2.00 and tax levied is MVR1.25).

Cessation services

The STEPS Survey found that 38.6% of males and 43.6% of females among current smokers attempted to quit during the last 12 months [1]. Cessation services are not formally established within the health system at present; however, a pilot cessation service is being tested in the capital Male' at the Urban Primary Health Centre (Dhamana Veshi), a government facility.

Tobacco industry

There is no tobacco production in Maldives as the Tobacco Control Act prohibits producing tobacco from tobacco leaves. Maldives being a net importer, the tobacco industry is present to the extent of importers, distributors, wholesalers and retailers in the supply chain.

Cultivation of tobacco

The Tobacco Control Act of Maldives prohibits cultivation of tobacco [3].

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Myanmar

MYANMAR

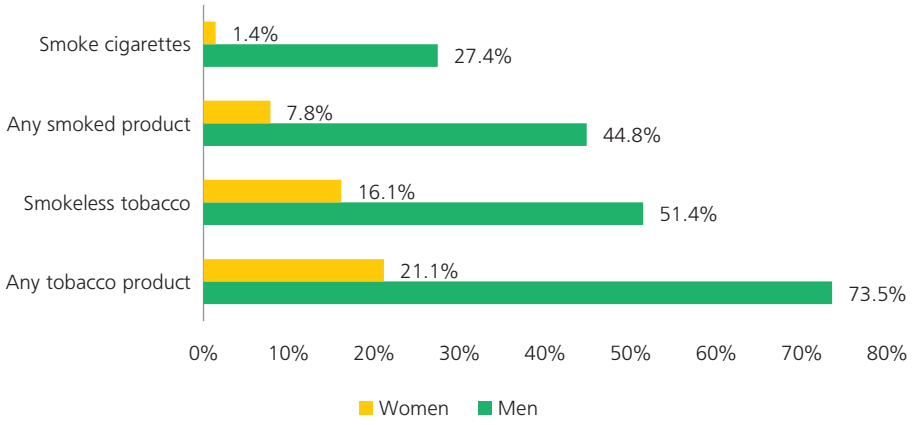
Current prevalence of tobacco use

Tobacco use among adults

The WHO Noncommunicable Disease Risk Factor Survey of 2009 [1] showed that 73.5% of males and 21.1% of females between the ages of 15 and 64 years were current tobacco users. The highest current prevalence of 80.3% was seen in males between the ages of 25 and 34 years.

44.8% of men and 7.8% of women of the same age group were current users of smoked tobacco products. The overall mean age of initiation for men was 20.3 years while for women, it was 22.3 years. Of the smokers, 75.1% of men and 78.5% of women smoked daily. Among daily smokers, only 27.4% of men and 1.4% women used manufactured cigarettes, while cheroots and cigars were more widely used.

Figure 7.1: Tobacco use among 15–64 year age group by sex in Myanmar



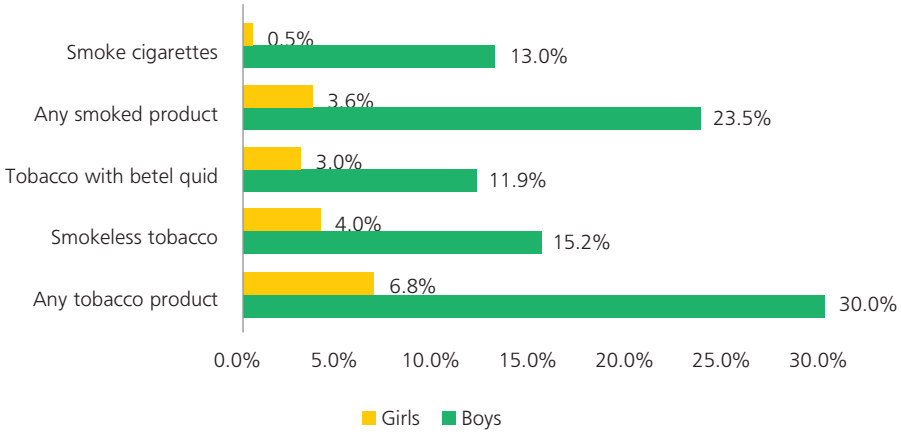
Source: Noncommunicable Diseases Risk Factor Survey Myanmar, 2009, World Health Organization.

This survey also showed that 51.4% of men and 16.1% of women between the ages of 15 and 64 years were current smokeless tobacco users. Oral and nasal use of snuff, chewing tobacco and betel quid chewing was almost equally seen. Men between the ages of 25 and 34 had the highest rate of prevalence, which was 63.0%, while in women, the highest current prevalence was in the 45–54 age group, which was 32.1%. In comparison with many other countries in the Region, these figures are cause for concern.

Tobacco use among youth

The Global Youth Tobacco Survey of 2011 [2] showed that the current prevalence of tobacco use among boys was 30.0% while in girls, it was 6.8%. The current prevalence of cigarette smoking was 13.0% among boys, while 15.2% of boys used smokeless tobacco. The corresponding rates among girls were significantly lower.

Figure 7.2: Prevalence of tobacco use among 13–15 year olds by sex in Myanmar



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used [3]

People of Myanmar consider that *Kun* or *kun-ya* (betel leaf, betel nut and condiments), *hsey* (cigarettes/cheroots with tobacco) and *lahpet* (fermented tea leaves) are the essential delicacies to be served to the guests coming to their homes, weddings and any other ceremonious occasions. It is felt that it would be impolite to refuse the three delicacies when offered as a token of friendship and hospitality, particularly in rural areas.

Smoked tobacco

About 60–80% of tobacco smokers used locally-produced cheroots, produced commercially by local cottage industries or hand-rolled and home-made. Myanmar cheroot is usually 4–6 inches long, hand-rolled, thinly wrapped with a cured leaf of a *thenatphet* tree – a local variety of the cordia family (cordia myxa) (mostly grown in Shan State), and the roll contains cured Myanmar tobacco mixed with other ingredients, mainly soft wood chips. It is quite different from *bidi*, as at one end, it has a filter made out of a small roll of corn-husks.

Foreign brands and new local brands, which are produced by joint-venture private companies, have dominated the domestic cigarette market. In 2009, the age and sex-standardized adult daily smoking prevalence in Myanmar was 18% [4].

Smokeless tobacco

The most common product of smokeless tobacco in Myanmar is raw and cured tobacco (known as hsey or hsey-ywet kyee). A few widely available products are: dried raw tobacco leaves (hsey or hsey wah), cured and roasted tobacco leaves (hsey me'), tobacco leaves treated with alcohol and honey (hsey paung or hnut hsey), scented tobacco soaked in honey, lime juice and water (hsey paung yay or black water), and other varieties of tobacco mixture added with fragrances (hsey hmwe). While most tobacco products are produced locally, a few popular SLT products such as 92, Signal 350, Parijat, Queen, and Baba brands are imported from India and Bangladesh [5].

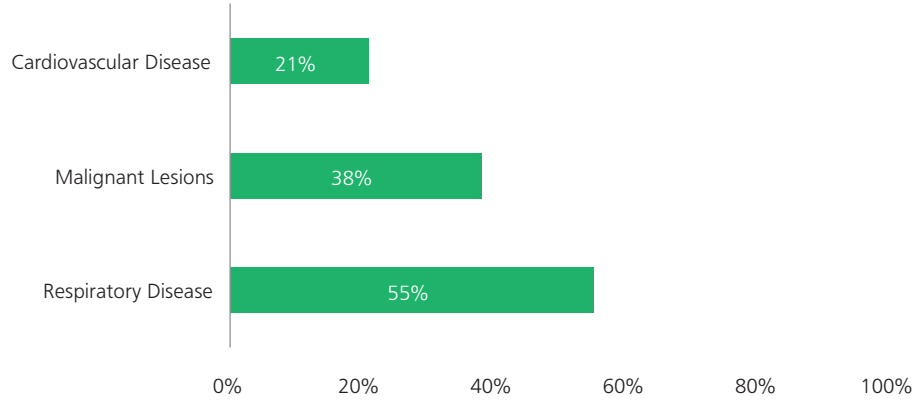
Between 2007 and 2011, SLT use increased from 6.5% (boys – 10.3%, girls – 2.7%) to 9.8% (boys – 15.2%, girls – 4.0%) [6].

Mortality attributable to tobacco [7]

Among those dying prematurely, one in four deaths between the ages of 45 and 59 years was attributable to tobacco (24%). Tobacco was responsible for 25% of all noncommunicable disease-related deaths, and 9% of all communicable disease-related deaths of those over 30 years.

It is estimated that almost one fifth (19%) of deaths of those above the age of 30 years in Myanmar is attributable to tobacco use. Unlike many other countries in the Region, this percentage was almost equal among men (19%) and women (18%).

Figure 7.3: Percentage of tobacco attributable deaths of selected disease categories



Source: World Health Organization. WHO Global Report. Mortality Attributable to Tobacco, World Health Organization, 2012.

About 52% of all male deaths from malignancies were due to tobacco. Overall, 38% of all deaths from malignant lesions and 21% of deaths from cardiovascular conditions and 55% of deaths from respiratory diseases occurred due to tobacco. Available data show that of total deaths in Myanmar, a staggering overall 39.3% among men and 40.1% among women were attributed to NCDs of which a substantial avoidable part may be due to SLT use.

Data of the Proceedings of a Forum on Cancer in Myanmar indicated that tobacco-related cancers were more common in men. Gender differences were highly significant for cancers of the lung, larynx, esophagus, bladder and stomach. As regards risk factors, chewing of the BQ containing tobacco was significantly associated with the occurrence of oral and oropharyngeal cancer, particularly the cheek, where the risk was more than 10 times higher in chewers compared with non-chewers. The risk increased with the number of quids chewed per day and was higher in chain-chewers, prolonged chewers, and in those who started chewing at an early age. It was four times higher in persons who kept the quid in the mouth overnight compared with those who did not. [8].

Economic impact

Several studies in Myanmar showed that poor families would benefit greatly if they shifted their tobacco expenditure to essential food and clothing. Rough estimates showed that with the amount of money spent on a pack of 20 cigarettes, the family could buy two kilograms (one *pyee* or eight condensed-tin measures) of rice, which could feed five members of the family for a day; and this could add 1100 calories per person a day, which is nearly half the daily requirement. Alternatively, nearly 300g of cooking oil, 300g of fish, chicken or beef, 6 eggs and 3 kg of lentils could be bought with the money spent on the tobacco products for a day [3].

Implementation of the WHO FCTC

Myanmar signed the WHO FCTC in October 2003 and ratified it in April 2004.

Current tobacco control legislation and regulations

With the objectives of protecting and reducing the dangers of tobacco among the community and based on the provisions of the WHO FCTC, "The Control of Smoking and Consumption of Tobacco Product Law" was enacted in May 2006 and came into effect in May 2007 [9].

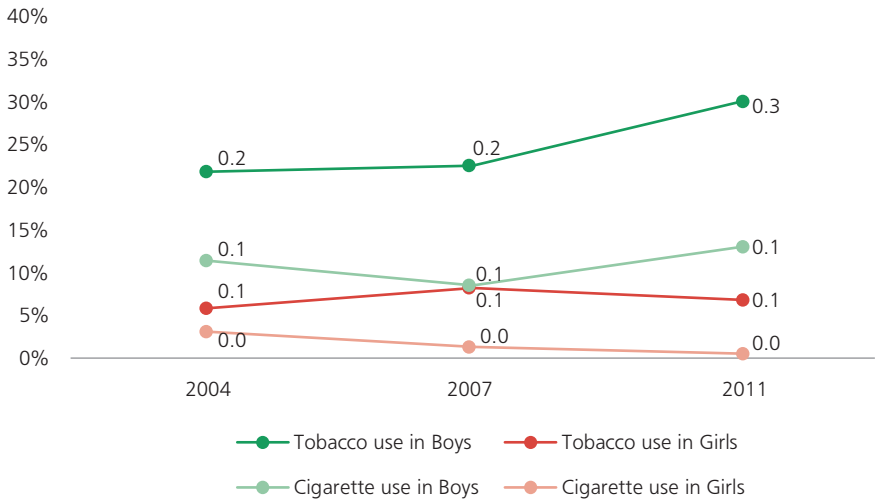
This legislation covers areas such as designation of smoke-free areas, limitation on sale of tobacco and tobacco products to minors (below 18 years old), establishment of warning labels, ban on tobacco advertisement in public media such as TV, newspapers, billboards, etc., ban on sponsorship, and promoting tobacco cessation programmes [10].

Structures for enforcement of tobacco control legislation

Supervisory bodies to implement the tobacco control act have been established at the State, District and Township levels, through the act itself [9]. This act also sets up the Central Board of the Control of Smoking and Consumption of Tobacco Products under the Chairmanship of the Minister of Health and consists of members from the Ministry of Health, other relevant government organizations and experts from other government departments. The main role of the Board is for policy guidance and coordination of intersectoral activities.

Surveillance of trends in prevalence [11]

Figure 7.4: Trends in prevalence in 13–15 year age group in Myanmar 2004-2011



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Overall, tobacco use among boys has increased since 2004, with one third becoming current tobacco users by 2011. Among girls, overall use as well as cigarette smoking has decreased, which is a positive trend. Although smokeless tobacco use data are not available for 2004, use of smokeless tobacco has increased between 2007 and 2011 – from 10.3% to 15.2% among boys and 2.7% to 4.0% among girls.

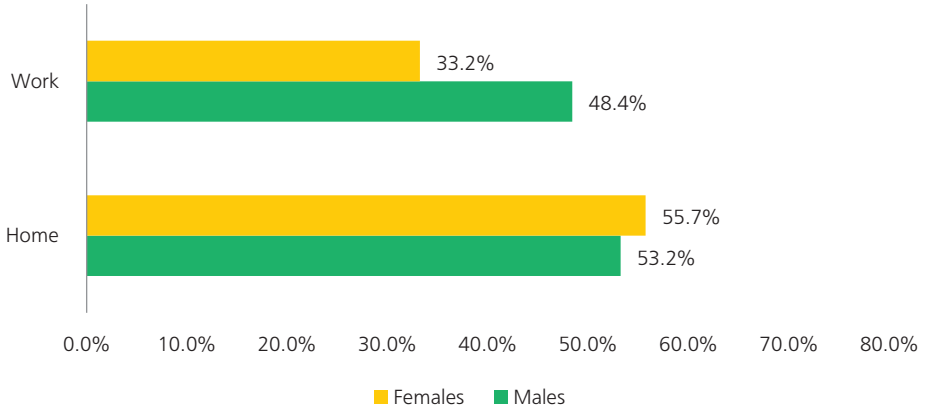
Protection from exposure to second-hand smoke

The NCD Risk Factor Survey found that nearly (53.2%) 54% of male respondents and (55.7%) 56% of female respondents had been exposed to tobacco smoke in their home during the preceding seven days. The prevalence of exposure to tobacco smoke was not significantly different across age groups and by gender [1]. It also found that during the preceding seven days, nearly 48.4% of male respondents and 33.2% of female respondents had been exposed to tobacco smoke in their workplace.

32.2% of those in the 13–15 year age group were exposed to tobacco smoke at home and 38.4% were exposed to tobacco smoke in enclosed public places during the last seven days, according to the 2011 GYTS Survey.

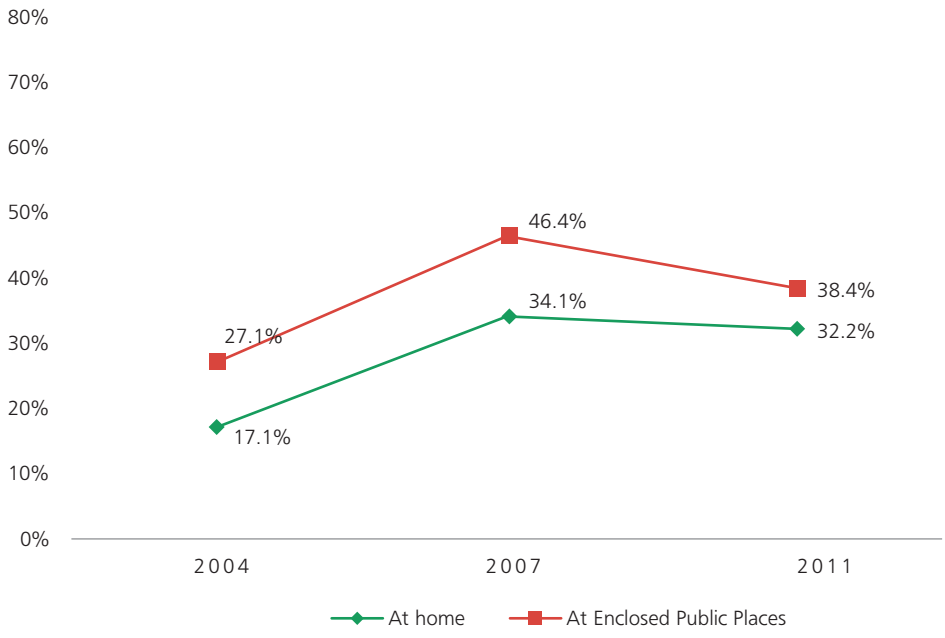
In order to protect the community from exposure to tobacco smoke, the tobacco control law has designated many no-smoking areas, including in public places, public transport, health facilities and educational institutions [10].

Figure 7.5: Exposure to second-hand smoke of those 15 years and older by sex in Myanmar



Source: Noncommunicable Diseases Risk Factor Survey Myanmar, 2009, World Health Organization.

Figure 7.6: Exposure of 13–15 year olds to second-hand smoke in Myanmar



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

In 2011, the President's office also made the decree that all governmental office buildings and compounds must be tobacco-free. The Ministry of Health reminded the public on no-smoking areas as defined in the law through newspapers and television channels. In March 2014, the Ministry of Health issued two notifications, defining the signage of no-smoking areas to be put at every smoke-free place defined by the law, and also defining the criteria for designated smoking areas [9].

Health warnings

Pictorial warnings covering 75% of total area of tobacco packs have been approved by the National Health Committee of Myanmar and are in the process of being implemented. Textual warnings are already in place [12].

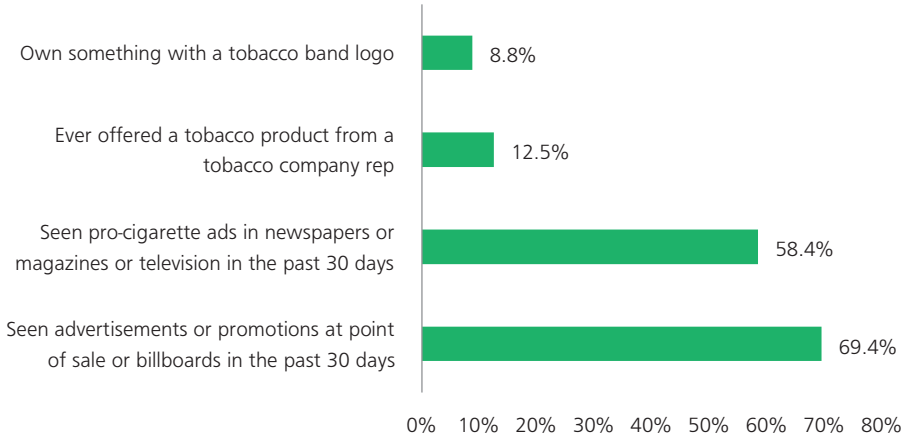
Enforcement of advertising, promotions and sponsorship ban

The tobacco control law prohibits all forms of tobacco advertisements, promotions and sponsorships. Although the law prohibits tobacco advertisements, various forms of advertising like vinyls, stickers, calendar, tissue box, ash tray, menu card, T-shirts, etc. and promotions are still made by the tobacco industries.

A regular monitoring and reporting system relating to advertising from Townships to respective State/ Region and then to the Central level has been in effect since July 2013. The Ministry of Health has also been reporting to the Government's office monthly since then [9].

Despite the laws and structures in place, children are still exposed to tobacco promotions, as is the case in many other SEAR countries.

Figure 7.7: Exposure of 13–15 year olds to tobacco promotion in Myanmar



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation

The Ministry of Health held coordination workshops with the involvement of related sectors for raising tobacco taxes harmoniously across all forms of tobacco products. Previously, the commercial tax levied on cigarettes was 50% of sales price, and 10%, 20% and 25% on cheroots, cigars and smokeless tobacco, respectively. Since April 2012, it was increased to 100% on cigarettes and 50% on other tobacco products such as cheroots [9]. As these prices are applied to the base price of a stick, 50% of the price of a cigarette and 33% of the price of a cheroot consist of tax [13]. At present, taxation on tobacco and tobacco products is included under items for taxation of commodities of commercial values as shown in the Annexure of the Commercial Tax Law in Myanmar. Under the Union Taxation Law of 2014, a taxation structure for local or

imported tobacco products remained at 100% commercial tax on cigarettes, and 50% on raw tobacco, cheroots, cigars and other tobacco products. While there is no taxation on locally-produced areca nuts, there is a commercial tax of 5% for imported ones. The total tax share is 50% of retail price in 2014 [13] (uniform excise tax: ad valorem). In 2015, the commercial tax on cigarettes was increased to 120% and to 60% for all other forms of tobacco products [14].

Cessation services

Almost (89.1) 90% of smokers between the ages of 13 and 15 attempted to quit during the preceding year, according to the GYTS [2]. The NCD Risk Factor Survey found that 10% (9.8) of the over 2800 male respondents had quit smoking, and this percentage increased with age. A similar pattern was observed among females [1].

Community-based cessation activities were started at pilot townships in 2004 in Myanmar. Since 2012, health professionals were trained for counselling and assisting people for cessation of tobacco use in both community-based and institution-based settings. But, as in other ASEAN countries, Nicotine Replacement Therapy (NRT) is still expensive and less accessible in Myanmar [9].

Dental GHPSS - over 88% of students thought that dentists had a role in giving advice or information on smoking cessation to patients – the highest being in Indonesia (98.7%) and the lowest in Myanmar (88.8%). Except for Myanmar (69.3%), over 80% in all countries thought that health professionals should get specific training on smoking cessation techniques.

Medical GHPSS - less than 25% of students reported having ever received some kind of formal training in their professional school on cessation approaches to use with their patients in all sites with the exception of Myanmar (43.7%) [4].

Tobacco industry

About 60–80% of tobacco smokers used locally-produced cheroots, produced commercially by local cottage industries or hand-rolled. Cigarette production is dominated by joint-venture private companies with major tobacco multinationals such as Phillip Morris, British American Tobacco, Japan Tobacco, and Hongyun Honghe Group – China's second-largest tobacco company [3]. The tobacco industry has tried to delay implementation of graphic health warnings.

Cultivation of tobacco

The total land area used to grow tobacco has decreased from 80 000 acres in 1990 to 54 000 acres in 2005, while the land used for Virginia tobacco remained the same – around 10 000 acres. The land used for *thenatphet* tress (used for cheroots) was about 5000 acres, and the production of *thenatphet* leaf remained static. Although a lesser land area is being used for Virginia tobacco, the yield has been doubled. There are no government loans or subsidies for tobacco cultivation in Myanmar. While the government has restricted imports of manufactured cigarettes, there is no limitation of imports of tobacco or other raw material for local production of cigarettes [3].

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Nepal

NEPAL

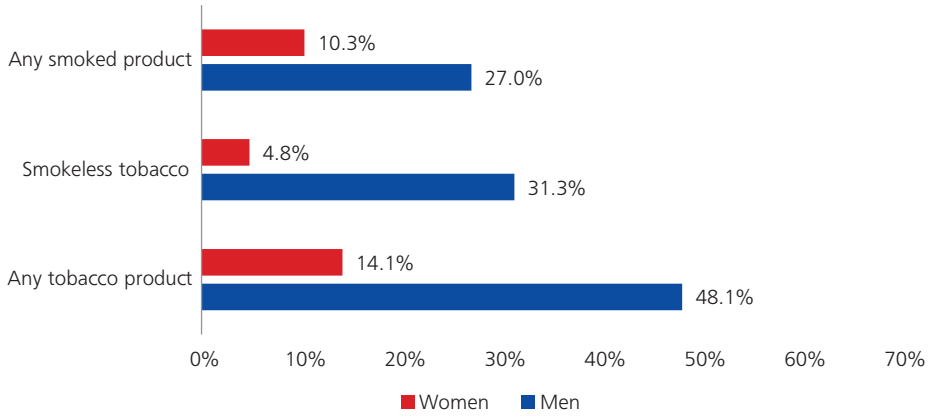
Current prevalence of tobacco use

Tobacco use among adults

The WHO Stepwise Approach to Surveillance (STEPS) of Noncommunicable Disease Risk Factors Survey of 2013 [1] showed that almost half (48.1%) of the men consumed either smoked or smokeless tobacco. Among women, the overall percentage of current use of tobacco was 14.1%.

Among men, the prevalence was highest (61.8%) among the 45–69 year age group, followed by 30–44 year olds (56.6%) and 15–29 year olds (35.3%). Among women, the highest prevalence of use (29.8%) was among 45–69 year olds, followed by 30–44 year olds (16.5%). It was less (3.8%) among 15–29 year old women.

Figure 8.1: Prevalence of tobacco use in the 15–69 age group by sex in Nepal



Source: Noncommunicable Diseases Risk Factor Survey Nepal, 2013, World Health Organization.

The prevalence of current smoking was 27.0% for men and 10.3% for women. Among men, the highest prevalence of current smokers (34.5%) was among the oldest age group (45–69 years) and lowest (20.7%) among the younger age group (15–29 years). Among women, it was 22.7% among the 45–69 year age group and 2.4% among 15–29 year olds.

84.8% of current daily smokers smoked manufactured cigarettes. The proportion was higher among men (89.9%) than among women (73.5%).

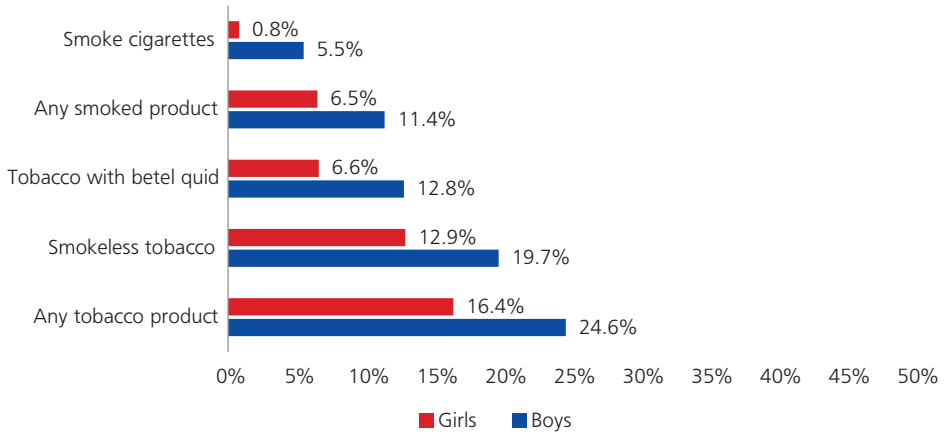
Among men, the prevalence of tobacco use (smoking and smokeless) was highest (61.8%) among the 45–69 year age group, followed by 30–44 year olds (56.6%) and 15–29 year olds (35.3%). Among women, the highest prevalence of use (29.8%) was among 45–69 year olds, followed by 30–44 year olds (16.5%). It was less (3.8%) among 15–29 year old women.

The prevalence of smokeless tobacco use was 31.3% for men and 4.8% for women. Almost 40% and 38.6%, respectively, of males in the age groups 30-44 and 44-69 used smokeless tobacco.

Tobacco use among youth

The Global Youth Tobacco Survey of 2011 [2] showed that the current prevalence of tobacco use among boys was 24.6% while in girls, it was 16.4%. The current prevalence of smoking was 11.4% among boys and 6.5% for girls. 19.7% of boys and 12.9% of girls were current users of smokeless tobacco, which was higher than most other countries in the WHO South-East Asia Region. 12.8% of boys and 6.6% of girls chew tobacco with betel quid. *Pan masala* with *zarda* was consumed by 9.3% of boys and 6.3% of girls.

Figure 8.2: Prevalence of tobacco use among 13–15 year age group by sex in Nepal



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used

Smoked tobacco

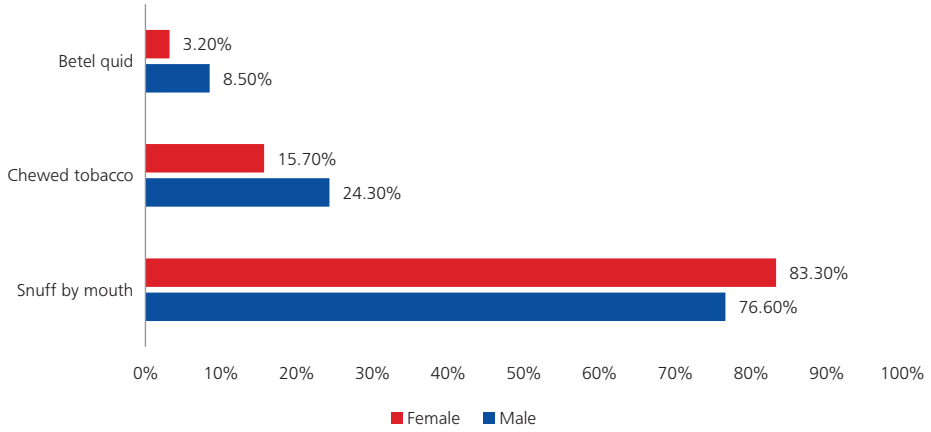
Almost 90% of men and nearly three fourths of women (73.5%) who smoke daily used manufactured cigarettes. Hand-rolled cigarettes were used by 18.5% of current male smokers while it was used by 31.2% of women [1]. The other types of smoking forms are *bidi, hookah, sulfa* and *chillum* or *kankad* [3].

Smokeless tobacco

Betel quid (mixture of betel nut, areca nut, slaked lime and catechu), khaini or surti (dried tobacco leaves and lime), gutka (commercially manufactured containing powdered tobacco, areac nut, slaked lime, areaca nut, catachu and sweet flavouring), zarda (flavoured tobacco in small packs or tins), pan masala (areca nut, catechu, slaked lime and condiments with or without tobacco), snuff (ground or pulverzed tobacco leaves for inhalation) and gul (commercially prepared oral tobacco powder which may contain molasses and other ingredients) are the types of smokeless tobacco used in Nepal [4].

Oral snuff was the most commonly used smokeless product (76.6%) by smokeless tobacco users. Use of snuff by nose was very uncommon (0.7%).

Figure 8.3: Products used by smokeless tobacco users in 15–69 year age group by sex in Nepal

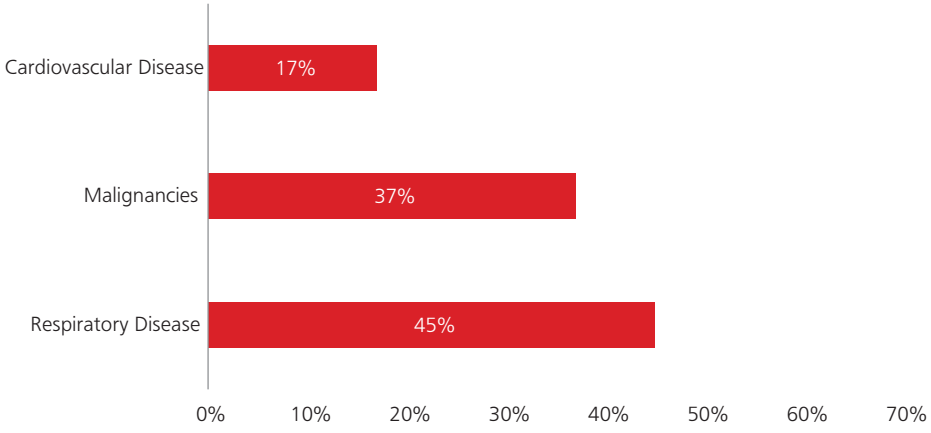


Source: Noncommunicable Diseases Risk Factor Survey Nepal, 2013, World Health Organization.

Mortality attributable to tobacco [5]

Among males dying prematurely, one in five deaths (19%) between the ages of 45 and 69 years was attributable to tobacco. Overall, 15% of deaths in males and 2% of deaths in females above the age of 30 years in Nepal is attributable to tobacco use.

Figure 8.4: Percentage of tobacco attributable deaths of males in selected disease categories



Source: WHO Global Report. Mortality Attributable to Tobacco 2012.

Economic impact of tobacco

No study has been done to date on the economic impact of tobacco in Nepal.

Implementation of the WHO FCTC

Nepal signed the WHO FCTC in December 2003 and ratified it in November 2006.

Current tobacco control legislation and regulations [6]

The Tobacco Product Control and Regulatory Bill, 2010, was approved by Nepal's Constituent Assembly on 11 April 2011.

Among the provisions of this legislation are a total ban on tobacco advertisements, promotion and sponsorships and a complete ban on smoking in public places, workplaces and public transportation. It also bans the sale of individual cigarettes, unlicensed vendors from selling tobacco products, and tobacco sales to minors (under 18 years of age) and pregnant women. It requires display of pictorial warnings covering 75% of cigarette and other tobacco product packs. The law also introduces a health tax on tobacco products, and the law supports the provision of punishments and penalties for violation of these new regulations. In addition, the law established a tobacco control committee under the chairmanship of the health secretary, comprised of relevant stakeholders.

One regulation and one directive were issued under the Act to implement its provisions: (1) The Tobacco Products (Control and Regulation) Regulation – 2068 (2011) and (2) the Directive for Printing and Labelling of Warning Message and Graphics in the Boxes, Packets, Wrappers, Cartons, Parcels and Packaging of Tobacco Products. Pictorial health warnings were implemented in April 2014, following an unsuccessful challenge by the tobacco industry initiated in 2011. Months later, the government issued a directive increasing the size of the pack warnings to 90% of the front and back of all tobacco product packaging beginning 15 May 2015. In 2014, the government introduced further tobacco product regulations, including stricter restrictions on tobacco advertising, promotion, and sponsorship and FCTC Art. 5.3 provisions, which will take effect at a date set by the Ministry.

Structures for enforcement of tobacco control legislation

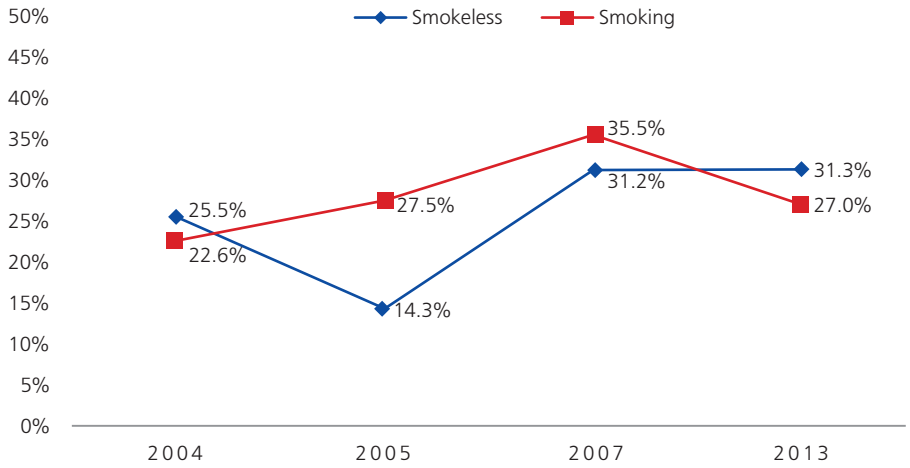
The Tobacco Control Act of 2010 established a national level Committee to formulate policies regarding control and regulation of tobacco products. It is chaired by the Secretary, Ministry of Health and Population. The Director, National Health, Education, Information and Communication Centre is the Vice chairman. The other members include one nominee by the Ministry from government health organizations involved in the prevention and control of cancer and diseases related to lungs and heart, two nominees, including one woman nominated by the Ministry from among the persons from the nongovernmental and private sector health organizations, and one social worker. The Legal Officer of the Ministry of Health and Population will be the Secretary.

This committee has been given the power to invite experts to its meetings when necessary. The Ministry of Health and Population will be the Secretariat of the Committee.

Among its functions are recommendations with regard to policy and law to be adopted for control and regulation of tobacco products; to launch awareness programmes on tobacco to discourage use; implement measures to help people quit smoking, monitor and evaluate the work and activities of inspectors; and to conduct necessary actions for reduction of import, production, sales, distribution and consumption of tobacco products.

Surveillance of trends in prevalence

Figure 8.5: Trend in prevalence of tobacco use among men in Nepal during 2004–2013



Sources: WHO STEPS Survey Nepal. 2004 (age group 25–64, Kathmandu Metropolitan Area), 2005 and 2007 (age group 25–64, Ilam, Tanahu and Lalitpur Districts), 2013 (age group15-69 National).

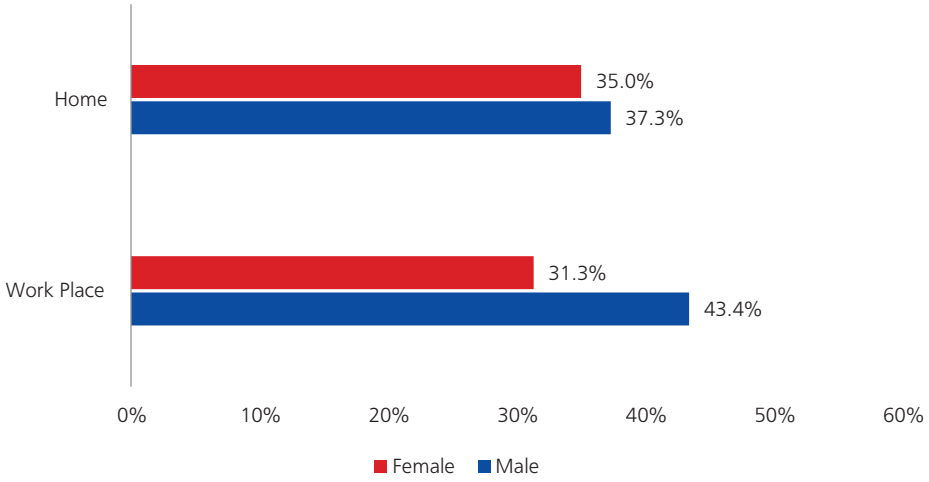
Overall, tobacco use among men has remained static, with smoked and smokeless tobacco use being almost equal at present. Caution should be exercised in interpreting this graph as selection of age groups and the coverage of the STEPS survey have differed in different years.

Protection from exposure to second-hand smoke

Nepal has a wide-ranging ban on smoking in public places. Public transport, health-care facilities, universities and other educational facilities, government facilities, indoor offices, indoor workplaces, cinemas, theatres, restaurants and cafes have been declared as smoke-free places. Penalties for smoking in in such places have been declared and enforced [7]. However, as in most other countries of the Region, a significant percentage of children and adults were exposed to second hand smoke either at home, at workplaces or public places.

The STEPS survey (2013) found that about 35% of both male (37.3%) and female (35.0%) respondents were exposed to tobacco smoke in their home during the preceding 30 days. The prevalence of exposure to tobacco smoke was not significantly different across age groups and by gender [1]. It also found that during the preceding 30 days, nearly 43.4% of male respondents and 31.3% of female respondents were exposed to tobacco smoke in their workplace.

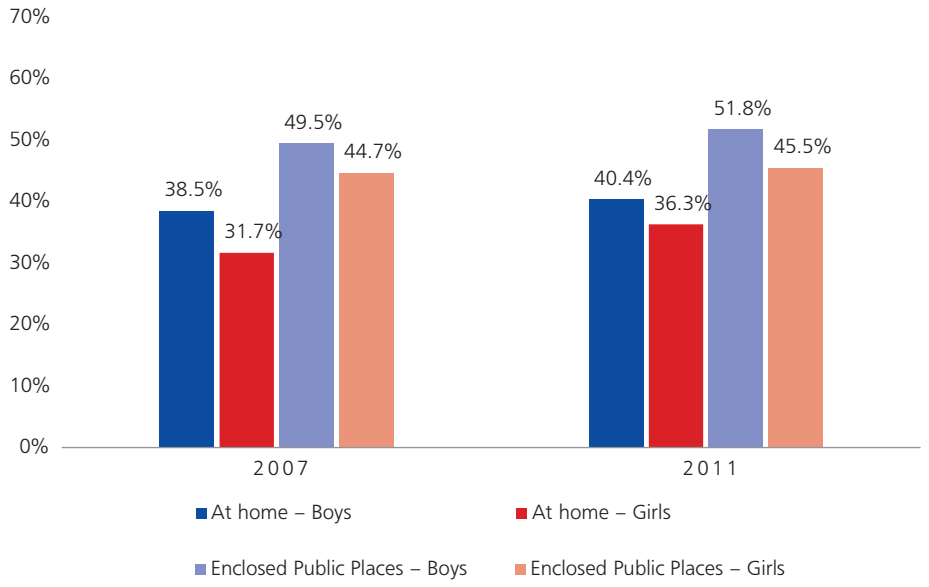
Figure 8.6: Exposure of 15–69 year olds to second-hand smoke in Nepal, last 30 days



Source: Noncommunicable Diseases Risk Factor Survey Nepal, 2013, World Health Organization.

Almost 40% (38.4%) of those in the 13–15 year age group were exposed to tobacco smoke at home while nearly 50% (48.6%) were exposed to tobacco smoke in enclosed public places during the last seven days, according the 2011 GYTS survey. There was no significant change in exposure to second-hand smoke in this age group since the 2007 GYTS survey.

Figure 8.7: Exposure of 13–15 year olds to second-hand smoke in Nepal



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Health warnings

Rotating health warnings on the front and back of tobacco packs have been implemented. These warnings will be increased to 90% (70% for pictorial warning + 20% of text warning) from 15 May 2015 [8]. At the time of the report in July 2015, it was yet to be implemented due to tobacco industry interference, but the Ministry of Health and Family Welfare is committed to its implementation.

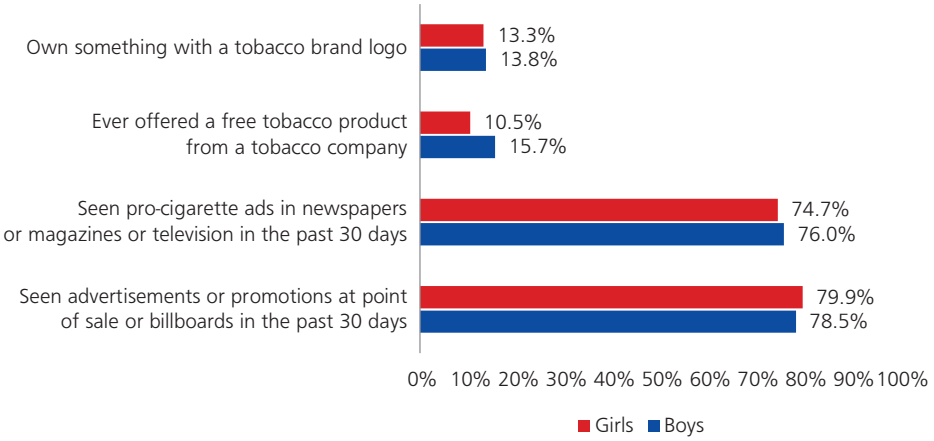
The warning contains a picture as well as text in the principal local languages. These warnings appear on all cigarette packs and on packs of other forms of smoked tobacco and smokeless tobacco. These have to be printed on the top portion of the principal surface. All tobacco products sold in Nepal, whether imported or locally manufactured, should display this warning [7].

Enforcement of advertising, promotions and sponsorship ban

The tobacco control law prohibits all forms of tobacco advertisements, promotion and sponsorship. Product placements and display of tobacco products in films and television is banned. Point of sale displays and publicity of corporate social responsibility projects of the tobacco industry are prohibited.

Despite the laws and structures in place, children are still exposed to tobacco promotions, as is the case in many other SEAR countries.

Figure 8.8: Exposure to tobacco promotions of 13–15 year old students in Nepal during the last 30 days



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation [7]

Smoked and smokeless tobacco products are taxed in Nepal. However, the proportion of tax of the selling price of tobacco products in Nepal is among the lowest in the Region. In the largest selling brand of cigarettes, it is only 27.8%. It is still lower at 20.8% on bidis and 20.6% on chewing tobacco. Total tax share of retail prices on cigarettes was 27.8% (16.3% excise and 11.5% VAT) in 2014.

Cessation services

There is no formal structure or programme established to promote quitting or provide cessation services. Some primary care clinics and other health clinics offer services to smokers.

The STEPS Survey found that around one fourth of both male (27.4%) and female (22.5%) smokers in the 15–69 age group had attempted to quit. 23% male smokers and 20.5 female smokers who smoke currently had been advised by doctors during the past 12 months to quit smoking [1].

Tobacco industry

There are several private tobacco companies in Nepal. The industry has sued governments when they have attempted to implement life-saving tobacco control measures. There had been 11 lawsuits filed by the industry and its allies against the Nepalese Government's move to strictly enforce tobacco control laws; the Supreme Court decision favoured the government.

Tobacco cultivation

In 2010, land devoted to tobacco growing was 0.06% of agricultural land.

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Sri Lanka

SRI LANKA

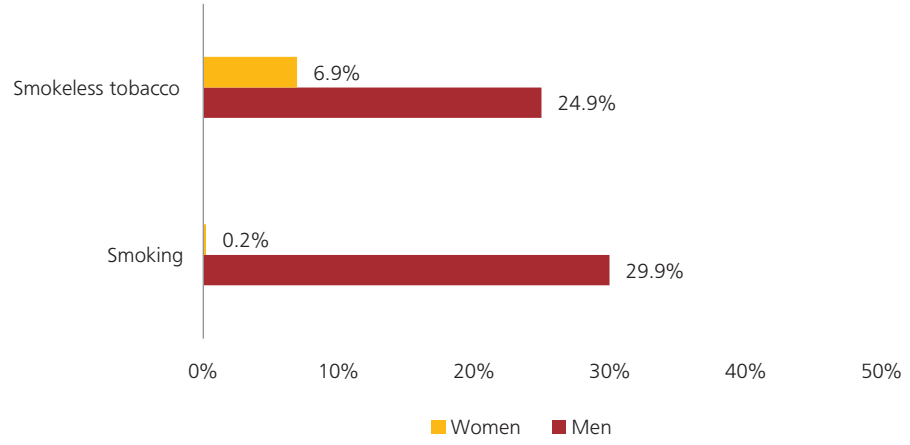
Current prevalence of tobacco use

Tobacco use among adults

The WHO Stepwise Approach for Surveillance (STEPS) Survey [1] on showed that the prevalence of smoking use among males was 29.1% and that among females, it was 0.4%. Therefore, 15% of adults in Sri Lanka were tobacco smokers.

Around one fourth of adult males (24.9%) used smokeless tobacco. Among adult females, the prevalence of smokeless tobacco use was 6.9%.

Figure 9.1: Prevalence of tobacco use among adults by sex in Sri Lanka

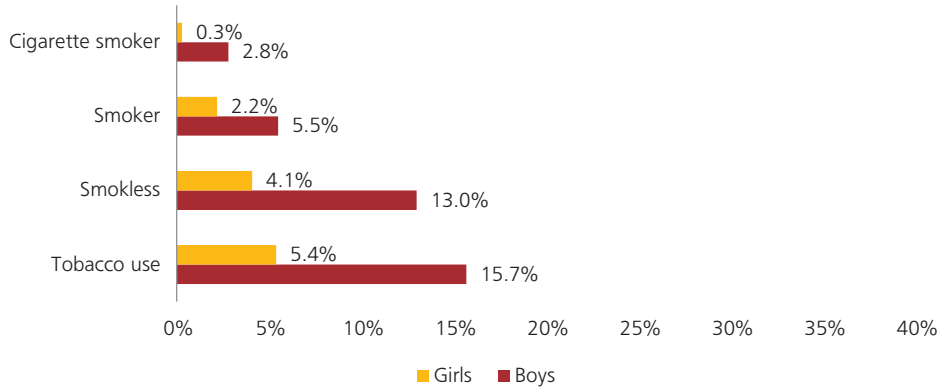


Source: National Noncommunicable Disease Risk Factor Survey Sri Lanka 2006, Ministry of Health and Nutrition.

Tobacco use among youth [2]

Current tobacco use is 15.7% among 13–15 year old boys and 5.4% among girls. 13% of boys and 4.1% of girls used smokeless tobacco. 5.5% of boys and 2.2% of girls were smokers.

Figure 9.2: Prevalence of tobacco use in the 13–15 year age group by sex in Sri Lanka



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used

Smoked tobacco

Among smokers, manufactured cigarettes were used by over 85% of both male (85.7%) and female (85.8%) smokers [1].

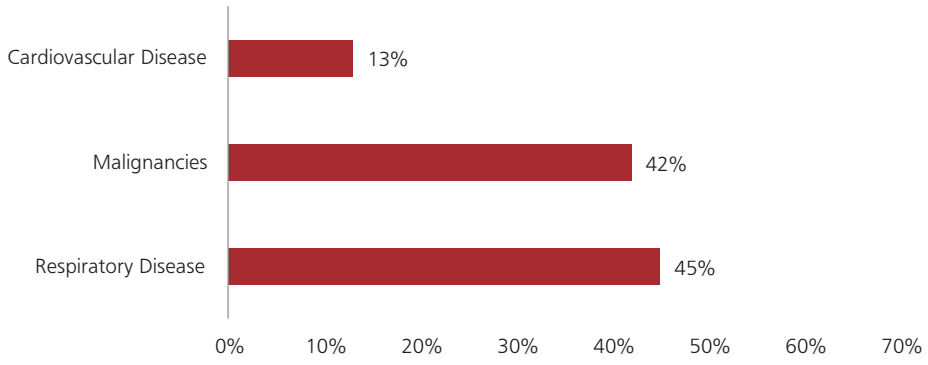
Smokeless tobacco [2]

The prevalence of smokeless tobacco use in Sri Lanka is relatively high, especially among rural and disadvantaged groups. Several types of smokeless tobacco products are widely available and also affordable. The level of awareness about health risks related to the consumption of smokeless tobacco products was low. Different forms of smokeless tobacco products, some of them imported, are used. At the national level, the overall prevalence of use was 15.8% and its use is three times higher among men (24.9%) than among women (6.9). About (8.5%) of youth are current users of smokeless tobacco. Betel quid is the most widely used traditional form. Manufactured products that are used include pan parag/pan masala, mawa, red tooth powder, khaini, tobacco powder, and zarda.

Mortality attributable to tobacco [3]

It was estimated that 13% of deaths of males in Sri Lanka over 30 years of age were attributable to tobacco. Among males dying prematurely, 15% of deaths between the ages of 45 and 59 years and 17% of deaths between 60 and 69 years were attributable to tobacco. The proportion of female deaths attributable to tobacco was zero.

Figure 9.3: Percentage of tobacco attributable male deaths in selected disease categories in Sri Lanka



Source: WHO Global Report on Mortality Attributable to Tobacco, 2012.

Economic impact of tobacco

No study has been done on the economic impact of tobacco in Sri Lanka.

Implementation of the WHO Framework Convention on Tobacco Control

Sri Lanka signed the FCTC in September 2003 and ratified it in November 2003, becoming one of the first few countries in the world to do so.

Current tobacco control legislation and regulations

The Parliament of Sri Lanka approved the National Authority on Tobacco and Alcohol Act in 2006 [4]. The objectives of the Act in relation to tobacco have been stated as identifying the policy on protecting public health for the elimination of tobacco-related harm through the assessment and monitoring of production, marketing and consumption of tobacco products and to make provisions for discouraging persons, especially children, from smoking by curtailing their access to tobacco products.

This law contains articles on banning advertising, sponsorships and other types of promotions, prohibition of smoking in public places, prohibition of sale of cigarettes and other tobacco products to persons below the age of 21 years, banning vending machines and mandatory depiction of statutory warnings on tobacco packs. It also established the office of the National Authority on Tobacco and Alcohol (NATA), a multisectoral government agency responsible for addressing harm from tobacco and alcohol in Sri Lanka.

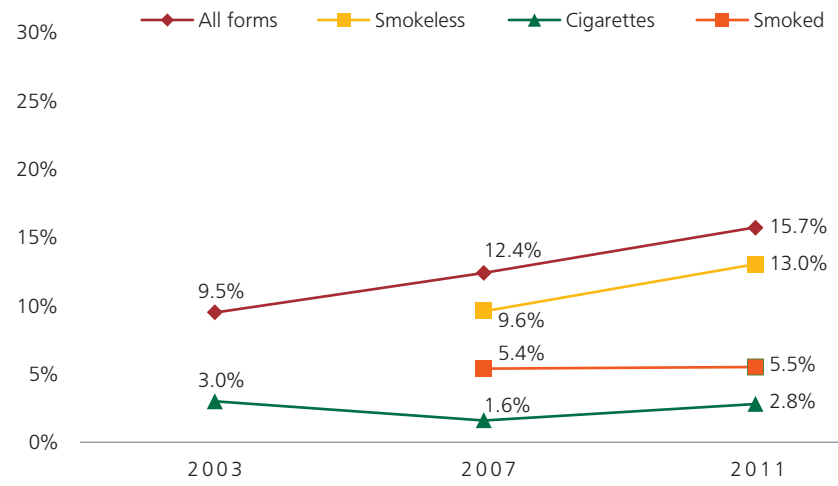
Structures for enforcement of tobacco control legislation

NATA is governed by a board which consists of high-level representatives of government agencies such as the Ministries of Justice, Education, Health, Media, Trade and Commerce, Sports and Youth Affairs and the Departments of Excise and Police. In addition there are five members who are appointed, based on their expertise on the subject [4]. Its tasks related to tobacco include advising the government of the implementation of the Act, recommending measures to minimize harm from tobacco, health promotion initiatives through media in communities, recommending legal, taxation and administrative measures to implement the Act, evaluating impact of policy measures, encouraging research and monitoring production, consumption and marketing.

Tobacco Control Cells have been established by the Ministry of Health in all 26 Health Districts of the country. This project was launched by the President of Sri Lanka in 2009 [5]. These cells operate through a multisectoral decision-making body consisting of the highest ranking district level public administration, health and law enforcement officials.

Surveillance of trends in prevalence

Figure 9.4: Trend in prevalence of tobacco use among 13–15 year boys by sex in Sri Lanka



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

The overall tobacco use and the use of different forms of tobacco among girls is low (5.4% in 2011) and has declined since 2003. The exception was smokeless tobacco use, which has shown a marginal increase (3.9% to 4.1% between 2007 and 2011). Among boys there is a clear increase in use, driven by a significant increase in smokeless tobacco use. Cigarette use too has shown a slight increase.

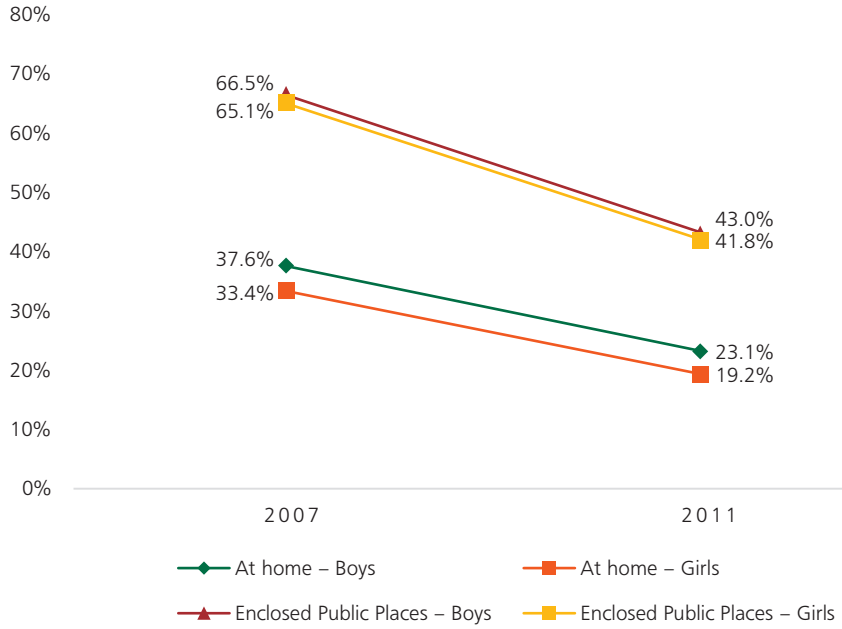
The STEPS survey was completed in 2006 and the 2014 survey is in the pipeline. The Global Health Personal Survey (2006) and the Global School Personal Survey (2003, 2006) have also been conducted once [5]. Therefore, there is technical strong baseline for surveillance.

Protection from exposure to second-hand smoke

Smoking is banned in any government department, statutory authority or board or public institution, office premises, bank, court house, auditorium, sports complex, hospital, clinic, dispensary, laboratory, school, university or other educational institution, library, museums, places of worship, hotel, guest house, lodge, hostel, restaurant, club, Internet cafe, cinema, theatre, supermarket, airport, a waiting room in a railway station or bus terminal, any public conveyance, building, any built in area and lifts [4].

The Global Youth Tobacco Survey found a significant drop in exposure of 13–15 year olds to second-hand smoke between 2007 and 2011 [6]. Second-hand smoke exposure in the past seven days at their homes was reported by 23.1% of the boys and 19.2% of girls, which was a total of almost 20 million people in 2011. Exposure at the workplace in the same period was reported by 43.0% of boys and 41.8% of girls.

Figure 9.5: Trend of exposure of 13–15 year olds to second-hand smoke in Sri Lanka



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Health Warnings

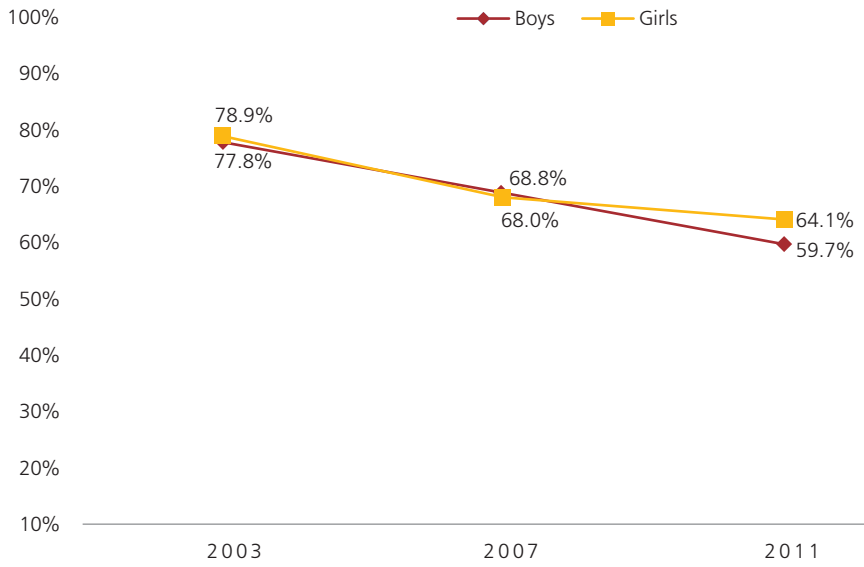
Rotating pictorial health warnings covering 80% of total area of the front and back of cigarette packs has been in place from 1 June 2015 [7]. Before that date, the size of the pictorial warning was 60%. These have to be printed on the top portion of the principal surface, and different warnings should appear on the front and back of each pack. The warning contains a picture as well as text in the principal local languages. All tobacco products sold in the country, whether imported or locally manufactured, should display this warning [8].

Enforcement of advertising, promotions and sponsorship ban

The tobacco control law of Sri Lanka prohibits all forms of tobacco advertisements, promotion and sponsorship. Free distribution and promotional discounts are also banned [4].

Despite the laws and structures in place, children are still exposed to tobacco promotions. The Global Youth Tobacco Survey found that about 59.7% of boys and 64.1% of girls between 13 and 15 years noticed pro-cigarette advertisement or promotions in "newspapers or magazines or television, video or movies" during the preceding 30 days [8]. As tobacco is not allowed to be advertised, this exposure would have been mainly on television, video or movies. Although there seems to have been a dip in such exposure since 2003, the levels in 2011 were still significant. Only a very small proportion reported that they were offered free tobacco products (2.9%) or that they own something with a tobacco logo (4.6%).

Figure 9.6: Exposure of 13–15 year olds to pro-cigarette promotions in Sri Lanka



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation

Manufactured cigarettes are dominant tobacco products in Sri Lanka. Tax consisted of about 73.8% of the selling price (63.1% excise and 10.7% VAT) in 2014 [9].

In Sri Lanka, excise taxation divides tobacco products into two categories – both categories have specific rates that are imposed. Cigarettes are taxed per stick, based on the length. The rates for other smoking products are applied based on weight (per kg). When rates are actually applied for these products, which are mainly consumed by the poor, it is much less than that applied to cigarettes [10].

Cessation services

A national quitline has been established. Services for tobacco users are available in health-care institutions. All such services are free [9].

Tobacco industry

One multinational-owned tobacco manufacturer holds the monopoly for manufactured cigarettes in Sri Lanka. Bidi manufacture is mainly a cottage industry with a few small companies operating. The industry has challenged tobacco control measures frequently, including the court case for the graphic health warning.

Tobacco cultivation

Tobacco cultivation and purchasing is controlled by the monopoly multinational cigarette manufacturer in Sri Lanka [11].

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Thailand

THAILAND

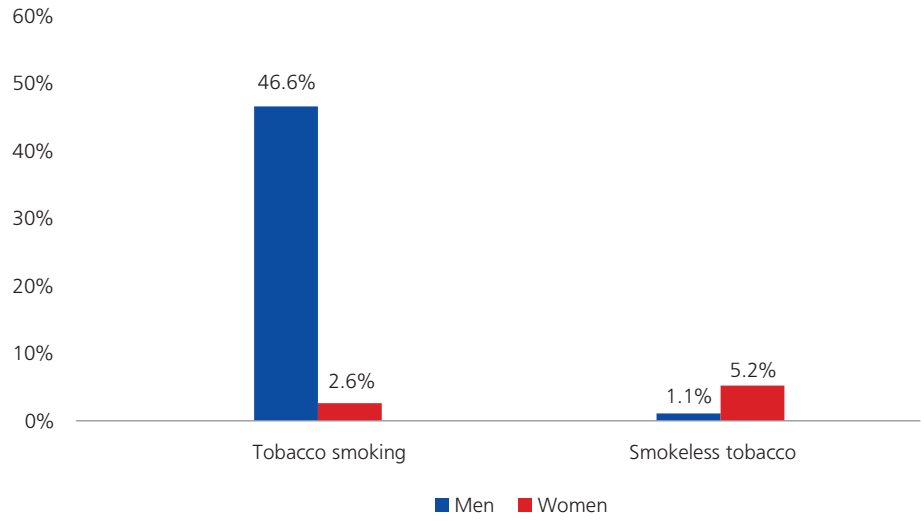
Current prevalence of tobacco use

Tobacco use among adults

The Global Adult Tobacco Survey Thailand 2011 [1] showed that the prevalence of smoking tobacco among males was 46.6% and that among females it was 2.6%. This meant that overall, 24% of adults in Thailand were tobacco smokers.

Sale of smokeless tobacco is banned in Thailand. Its overall use was only 3.2%.

Figure 10.1: Prevalence of tobacco use among adults by sex in Thailand, 2011

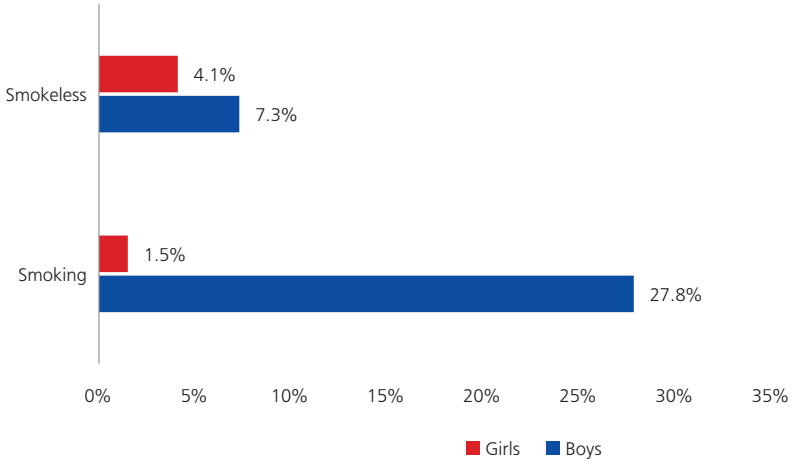


Source: Global Adult Tobacco Survey Thailand 2011, Ministry of Health and Family Welfare, World Health Organization.

Tobacco use among youth

Smoking among 13–17 year old boys was 27.8%, while among the girls of the same age group, it was 1.5%. According to the findings of the Global Youth Tobacco Survey 2009, 7.3% of boys and 4.1% of girls used smokeless tobacco [2].

Figure 10.2: Prevalence of tobacco use among youth (13–15 years) by sex in Thailand



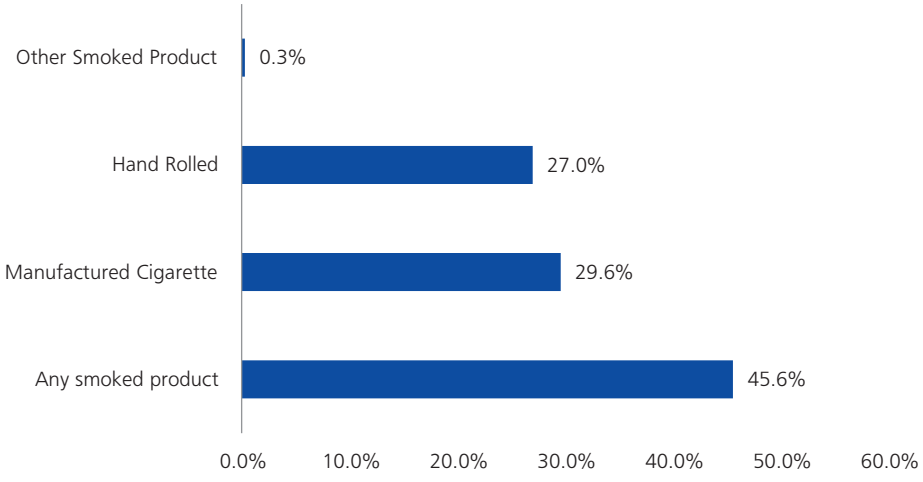
Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used [1]

Smoked tobacco

Among smokers, manufactured cigarettes and hand-rolled cigarettes were used in almost equal amounts. Other forms of tobacco smoking were uncommon.

Figure 10.3: Prevalence of smoking among adult males in Thailand by products used



Sources: Global Adult Tobacco Survey Thailand 2011, Ministry of Health and Family Welfare, World Health Organization.

Smokeless tobacco

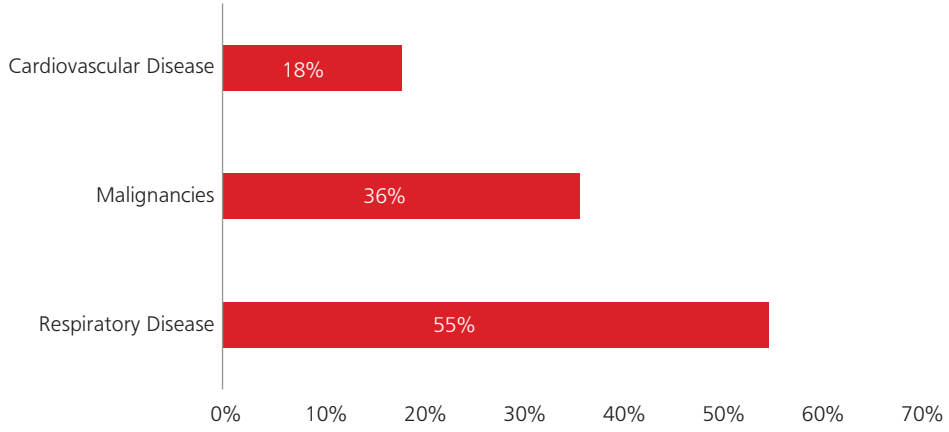
The sale of smokeless tobacco in Thailand is banned. Smokeless tobacco use was more prevalent in adult women (5.3%) than in males (1.1%). The highest prevalence was seen in the over-60 age group with 15% of females and 13% of males using smokeless tobacco. It was lowest in

the 15–24 age groups with an overall prevalence of 0.1%. Betel quid with tobacco was the most common form used followed by oral snuff. The use of other types of smokeless tobacco was far less common.

Mortality attributable to tobacco [3]

16% of deaths of males in Thailand over 30 years of age were attributable to tobacco. Among males dying prematurely, 15% of deaths between the ages of 45 and 59 years and 22% of deaths between 60 and 69 years were attributable to tobacco. The proportion of female deaths attributable to tobacco was 11%.

Figure 10.4: Percentage of tobacco attributable male deaths in selected disease categories in Thailand



Source: WHO Global Report. Mortality Attributable to Tobacco, 2012.

Economic impact of tobacco

A study in 2003 showed that Thais spent almost 3% of total expenditures on cigarettes [4]. The direct and indirect costs of treating lung cancer and chronic obstructive pulmonary disease, both strongly associated with smoking, were estimated. For 1999, this was computed at about US$ 6 million – approximately 0.1% of Thailand's total health-care expenditure for that year [4].

Implementation of the WHO FCTC

Thailand signed the FCTC in June 2003 and ratified it in November 2004.

Current tobacco control legislation and regulations

Thailand's tobacco control acts were pioneering efforts. Tobacco Products Control Act B.E. 2535 (1992) and the Non Smokers' Health Protection Act B.E. 2535 (1992) constitute the legal framework for tobacco control in Thailand [5]. Thailand is in the process of adopting a new legislation – 'The Tobacco Products Law' – to cover all provisions of the WHO FCTC.

The existing laws contain articles on banning advertising, sponsorships and other types of promotions, prohibition of smoking in public places, prohibition of sale of cigarettes and other tobacco products to a person below the age of 18 years, banning vending machines and mandatory depiction of statutory warnings on tobacco packs.

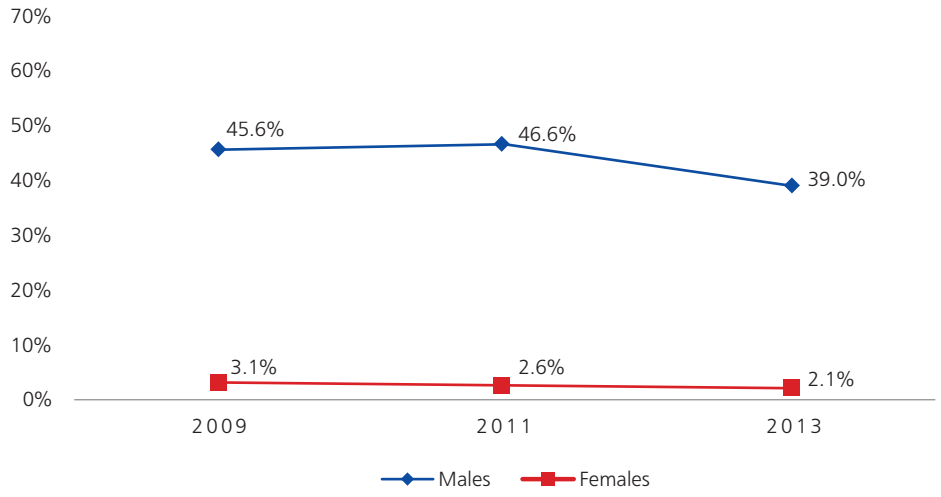
Structures for enforcement of tobacco control legislation

The National Committee for the Control of Tobacco Use (NCCTU) was established in 1989 to formulate public policy and guidelines for tobacco consumption control. NCCTU was responsible for drafting draft legislation to protect non-smokers' health and to control tobacco products [6].

The committee is chaired by the Ministry of Health. Its membership consists of members from the ministry of finance, education, public relations, interior, independent experts in tobacco control, as well as media representatives. Members from any ministry or other agency with a potential conflict of interest, such as representatives from the tobacco industry, ministry of trade or industry or farmers' representatives are excluded. The Bureau of Tobacco Control within the Department of Disease Control, Ministry of Health, is the secretariat of this Committee [7].

Surveillance of trends in prevalence

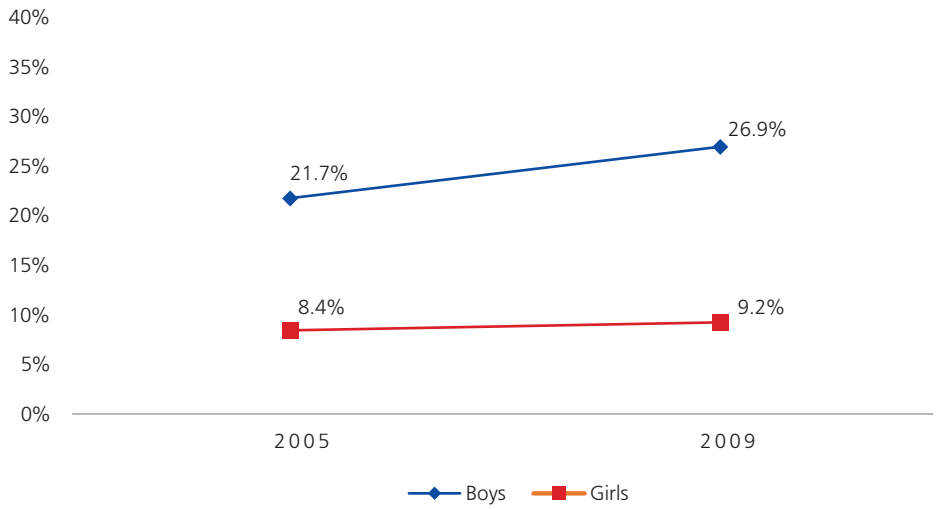
Figure 10.5: Trend in prevalence of smoking among adults in Thailand



Sources: World Health Organization, Global Adult Tobacco Surveys Thailand, 2009 and 2011; National Statistics Office Health and Welfare Survey 2013, Government of Thailand.

Overall, the smoking rate for females has been low, while smoking among males has shown a downward trend. As the Global Youth Tobacco Survey has also been conducted in 2005 and 2009, a technically sound baseline is available for surveillance of tobacco use among the younger age groups as well.

Figure 10.6: Trend in prevalence of smoking among 13–15 year olds by sex in Thailand



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

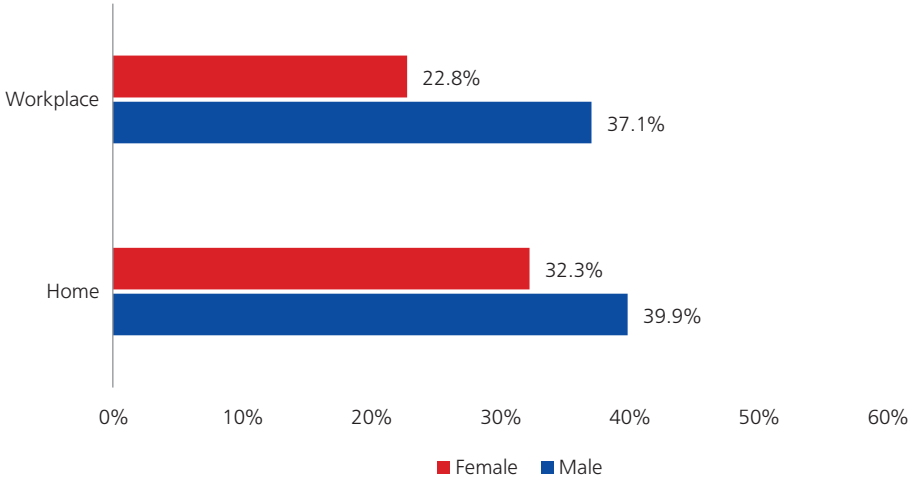
Protection from exposure to second-hand smoke

There is a comprehensive list of smoke-free places declared in Thailand. Public transport, health facilities, all educational institutions, government facility restaurants, cafes, and all indoor workplaces and offices have been declared smoke-free [8].

However, the Global Adult Tobacco Survey, second-hand smoke exposure in at least one day in the past 30 days at their homes was reported by 40 (39.9)% of men and 32.3% of women, which was a total of almost 20 million people. Exposure at the workplace during the same period was reported by 37.1% of men and (22.8)23% of women.

A quarter of adults were exposed to second-hand smoke in public transport and over two thirds were exposed at markets during the past month [1].

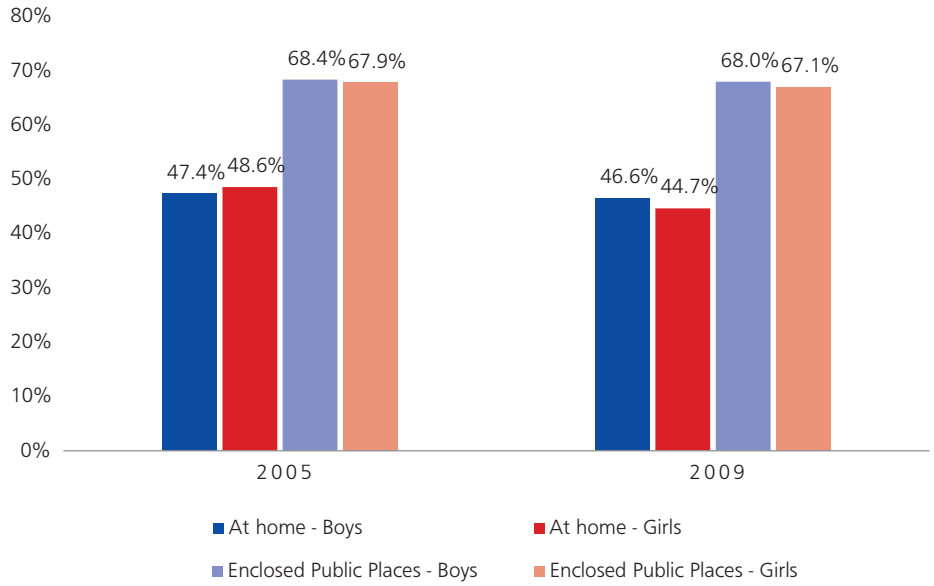
Figure 10.7: Exposure of adults to second-hand smoke by sex in Thailand



Sources: Global Adult Tobacco Survey Thailand 2011, Ministry of Health and Family Welfare, World Health Organization.

Overall, 45.7% of those in the 13–15 year age group (46.6% of boys and 44.7% of girls) were exposed to tobacco smoke at home while 67.6% (68% of boys and 67.1% of girls) were exposed to tobacco smoke in enclosed public places during the last seven days, according the 2009 GYTS Survey.

Figure 10.8: Exposure of 13–15 year olds to second-hand smoke by place and by sex in Thailand



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Health warnings

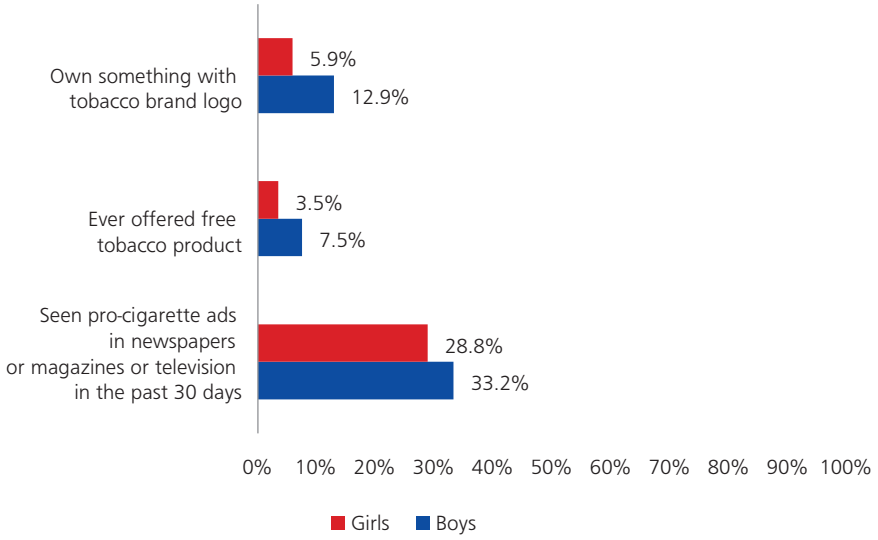
Rotating pictorial health warnings covering 85% of the total area of the front and back of cigarette packs have been implemented. These have to be printed on the top portion of the principal surface. The warning contains a picture as well as text in the principal local languages. For products other than cigarettes, the size of the warning is 50% for cigars and 55% for roll-your-own in both front and back. All tobacco products sold in the country, whether imported or locally manufactured, should display this warning [9].

Enforcement of advertising, promotions and sponsorship ban

The tobacco control law of Thailand prohibits all forms of tobacco advertisements, promotion and sponsorship. Product placements, point of sale advertising, free distribution and promotional discounts are banned [5].

Despite the laws and structures in place, children are still exposed to tobacco promotions. The Global Youth Tobacco Survey found that about 33.2% of boys and 28.8% of girls between 13 and 15 years noticed pro-cigarette advertisement or promotions during the preceding 30 days [2].

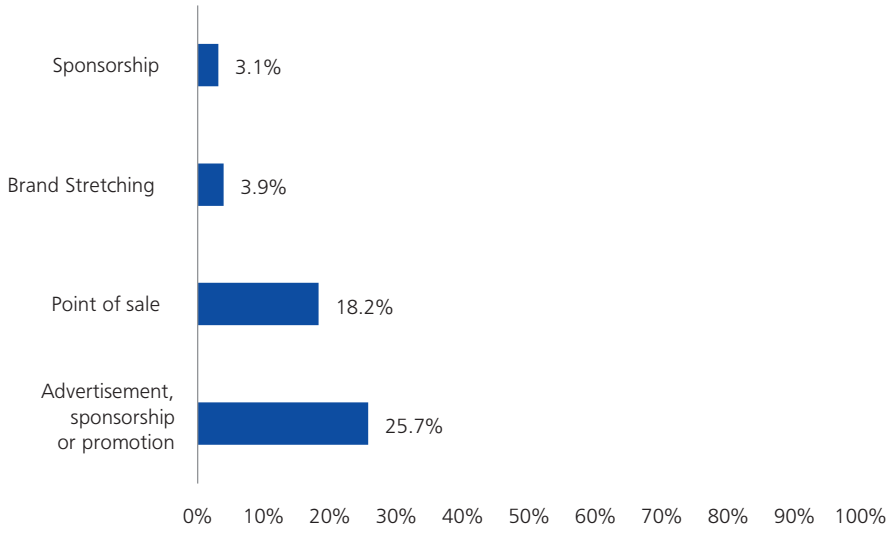
Figure 10.9: Exposure of 13–15 year old students to tobacco promotions by sex in Thailand



Sources: Global Adult Tobacco Survey Thailand 2011, Ministry of Health and Family Welfare, World Health Organization.

The Global Adult Tobacco Survey found that adults too are commonly exposed to some form of tobacco promotion.

Figure 10.10: Exposure of adults to tobacco promotions during last 30 days in Thailand



Sources: Global Adult Tobacco Survey Thailand 2011, Ministry of Health and Family Welfare, World Health Organization.

Taxation [9]

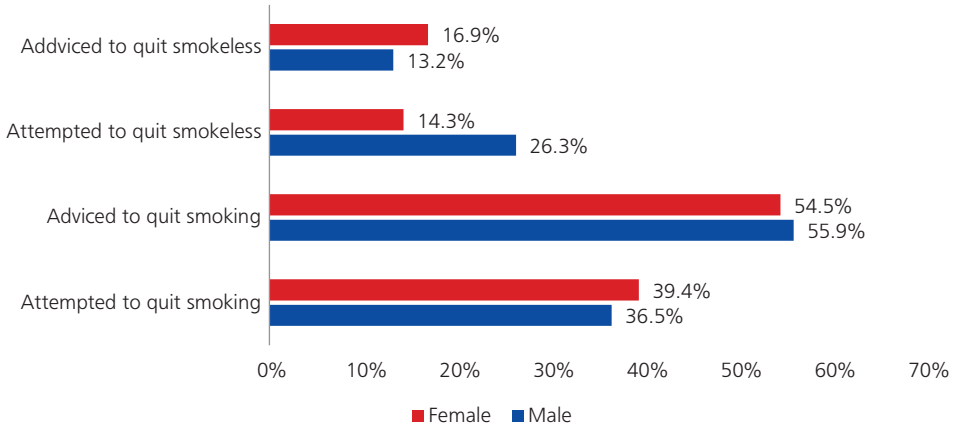
Cigarettes are a dominant tobacco product in Thailand. In 2014, the tax share consisted of about 73.13% of the selling price of the most-sold cigarette brand. A surcharge tax of 2% on tobacco and alcohol goes to the Thai Health Fund; a public broadcasting tax of 1.5% is also applied to each stick of cigarette sold. As sales of smokeless tobacco are banned, no taxes are applied to such products.

While cigarette taxes have increased over time, the excise on roll-your-own tobacco has remained consistently low. In addition, roll-your-own products using so-called indigenous tobacco leaves are exempt from the excise system. As a consequence, the prevalence of roll-your-own cigarettes increased from 2009 to 2011 [1].

Cessation services

Thailand has fairly widespread services to smokers. A national quitline is in operation. Services for users are available in most health-care settings. The costs of such services are borne by the government or the health insurance system [9].

Figure 10.11: Attempts to quit among adult tobacco users and advice to quit, by sex, Thailand



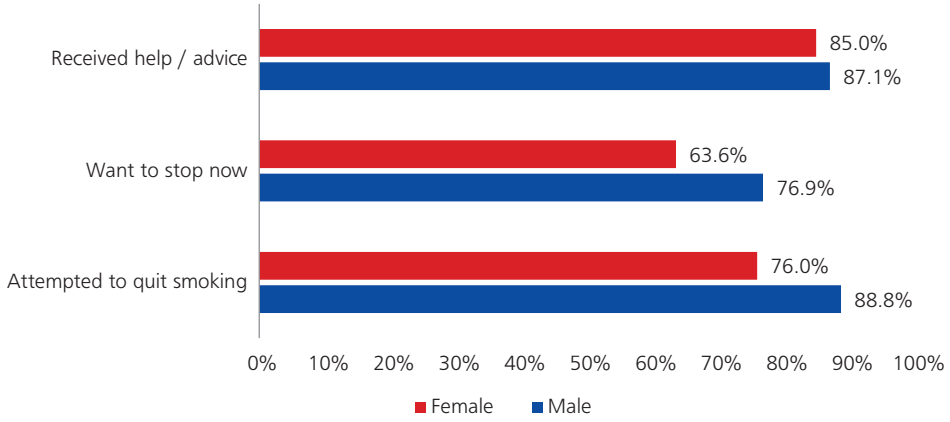
Sources: Global Adult Tobacco Survey Thailand 2011, Ministry of Health and Family Welfare, World Health Organization.

According to the Global Adult Tobacco Survey [1], over one third of smokers made an attempt to quit during the last 12 months. During the past 12 months, over half of all male and female smokers were advised to quit by a health-care provider.

Quit attempts were less among smokeless tobacco users. Less than 20% of all male and females smokeless tobacco users were asked to quit by a health-care provider.

A significant proportion of current smokers (89% of boys 78% of girls) in the 13–15 year age group had attempted to quit last year. 75% of the current smokers of that age group stated that they wanted to stop smoking "now". 87% the smokers in that group had received help or advice from a programme or a professional to stop smoking [2].

Figure 10.12: Attempts to quit among 13–15 year old smokers and advice on quitting, last year, Thailand



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014, Findings from the Global Youth Tobacco Survey, 2003–2014.

Tobacco industry

The government-owned Thailand Tobacco Monopoly (TTM) is the dominant tobacco company in Thailand. TTM is the only manufacturer and distributor of cigarettes in the country and controls 74% of the market share of cigarettes [10].

International tobacco companies are allowed to invest and open their own markets in the country. TTM sells products that attract customers with low- to-middle-income, while international companies cover premium and niche market segments [11].

The tobacco control efforts in Thailand had gone through several litigations by the tobacco industry. Thailand successfully protects warning label requirements from legal challenges on the 85% graphic health warning in 2013. The new Tobacco products Law also faces legal challenges.

Tobacco cultivation

Thailand has a little less than 50 000 tobacco growers and tobacco was grown in just over 28 000 hectares of land in 2011 [12]. The Thailand Tobacco Monopoly (TTM) exerts controls in the tobacco cultivation and procurement as it is the dominant player in the tobacco market as well as the only cigarette manufacturer in Thailand. Though it is a government organization, it promotes tobacco cultivation, supports and educates the tobacco farmers. It also plans and controls costs of tobacco leaf production [10].

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Timor-Leste

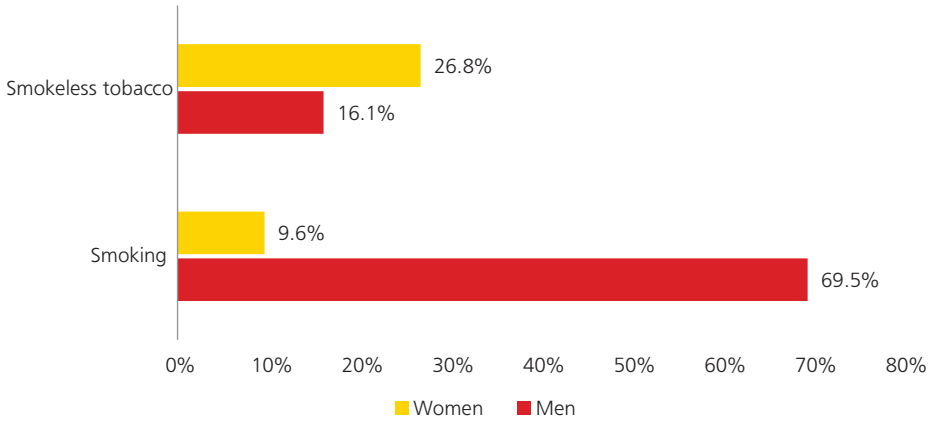
TIMOR-LESTE

Current prevalence of tobacco use

Tobacco use among adults

The WHO STEP-wise approach to Surveillance of NCD Risk Factors (STEPS) Survey of 2014, conducted nationally, showed that the prevalence of tobacco use among males was 69.5% and among females 9.6%, in the 18–69 age group [1].

Figure 11.1: Prevalence of tobacco use among adults (18–69) by sex in Timor-Leste

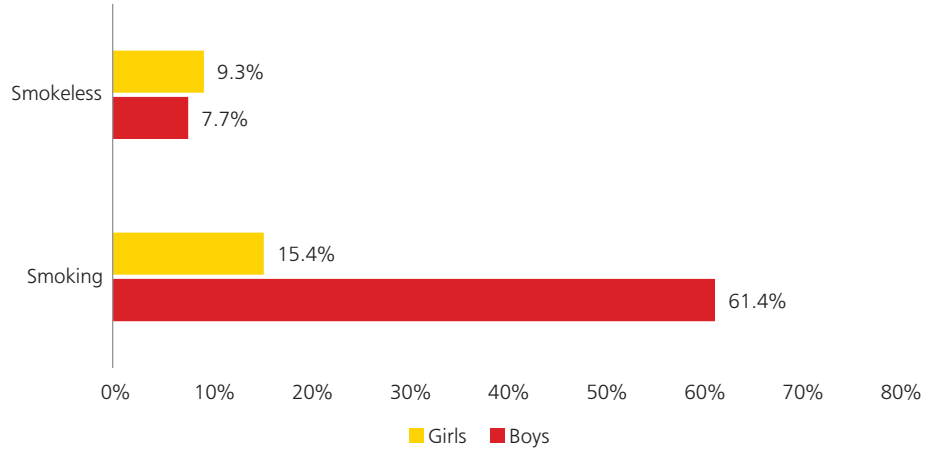


Source: Noncommunicable Diseases Risk Factor Survey Timor-Leste, 2014, World Health Organization.

Tobacco use among youth

Smoking among 13–15 year old boys was 61.4% while among girls of the same age group, it was 15.4%. These figures are the highest in the Region. 7.7% of boys and 9.3% of girls used smokeless tobacco [2].

Figure 11.2: Prevalence of tobacco use in 13–15 age group by sex in Timor-Leste



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Types of tobacco products used [3]

Smoked tobacco

Over 65% of men smoke manufactured cigarettes while just 2.9% of women used cigarettes in the age group 18–69 years [1].

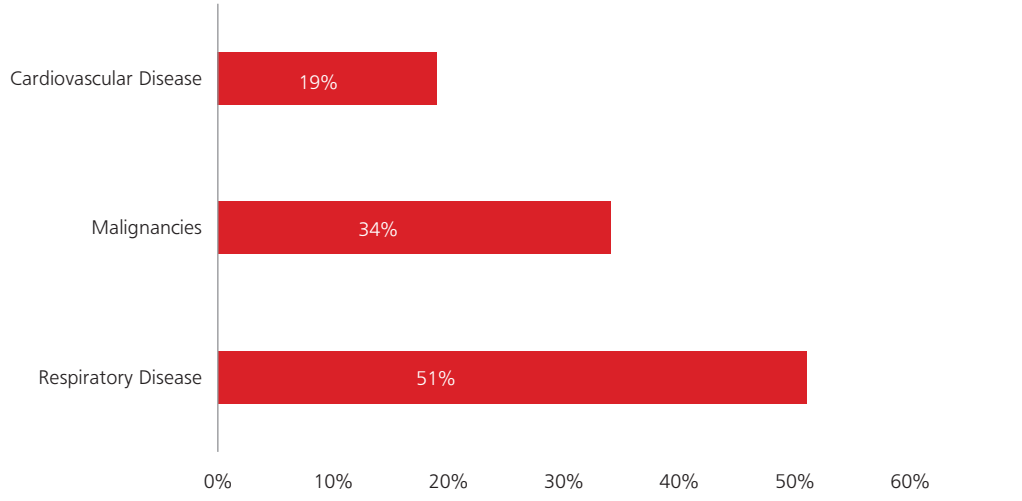
Smokeless tobacco

Smokeless tobacco among both men and women are 16.1% and 26.8%, respectively. The most common form used by men was snuff, while women mostly used chewing tobacco [1].

Mortality attributable to tobacco [4]

About 17% of deaths of males over 30 years of age in Timor-Leste were attributable to tobacco. Among males dying prematurely, 22% of deaths between 60 and 69 years of age were attributable to tobacco. The proportion of female deaths attributable to tobacco was 8%.

Figure 11.3: Percentage of tobacco attributable male deaths in selected disease categories in Timor-Leste



Source: WHO Global Report. Mortality Attributable to Tobacco, 2012.

Economic impact of tobacco

No study has been done on economic impact of tobacco in Timor-Leste.

Implementation of the WHO FCTC

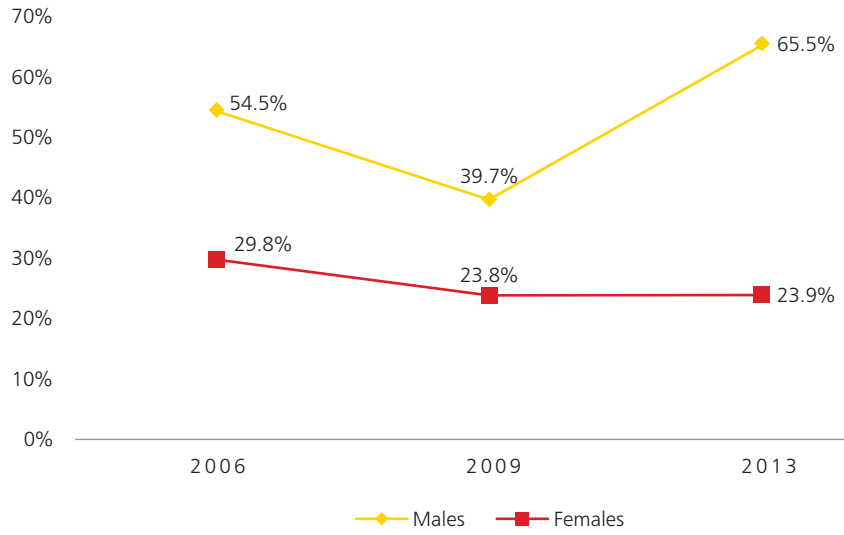
Timor-Leste signed the WHO FCTC in May 2004 and ratified it in December 2004.

Current tobacco control legislation and regulations

Timor-Leste is in the process of adopting national tobacco control legislation at the time of the report.

Surveillance of trends in prevalence

Figure 11.4: Trend in prevalence of tobacco use among 13–15 age group by sex in Timor-Leste



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Tobacco use in the 13–15 year age group in Timor-Leste is the highest in the Region. The vast majority of tobacco users are smokers. This makes prevalence of smoking of this age group in Timor-Leste the highest in the Region. Prevalence of tobacco use remains high over the years both among boys (54.5% in 2006 and 65.5% in 2013) and girls (29.5% in boys and 23.9% in 2013) [2].

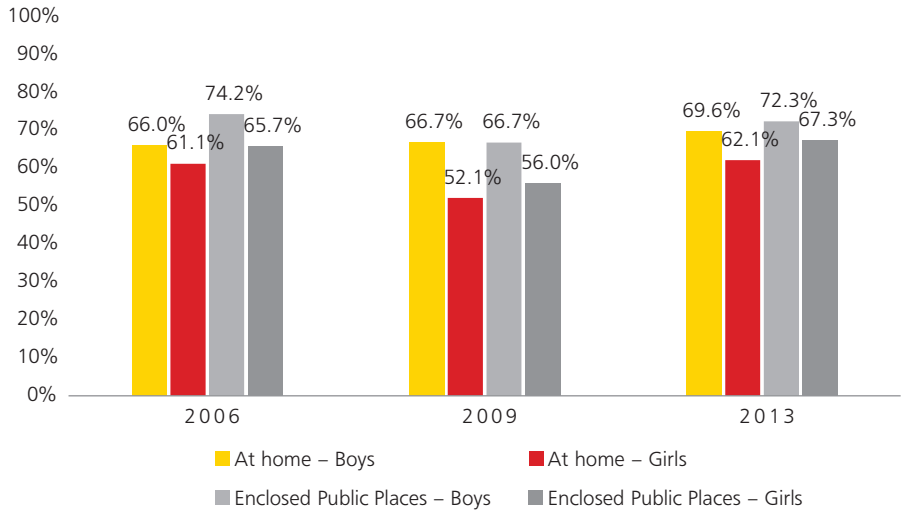
Protection from exposure to second-hand smoke

Smoking is not allowed in health facilities, premises and vehicles of the Ministry of Health [5]. Other areas have not been declared smoke-free [6].

The Global Youth Tobacco Survey of 2013 showed that the vast majority of boys and girls in the 13–15 age group had been exposed to second-hand smoke either at home or at an enclosed public place during the past seven days [2].

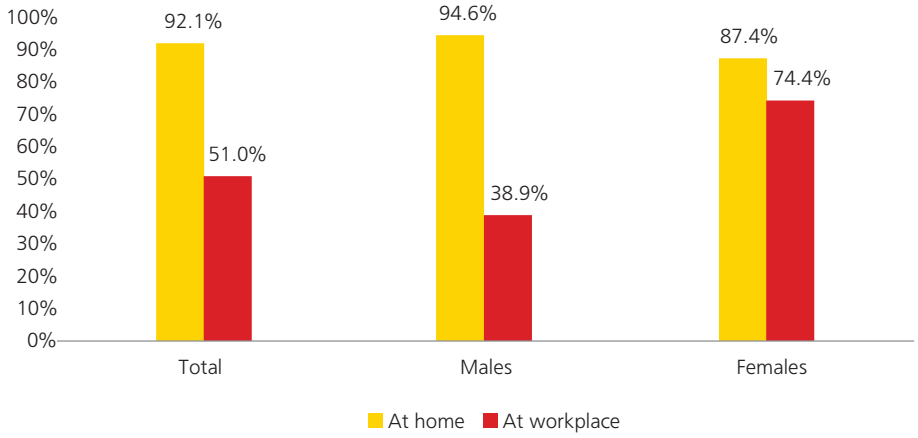
NCD STEPS 2014 also showed that the majority of person in the 18–69 age group were exposed to second-hand smoke either at home or at the workplace in the past 30 days [1].

Figure 11.5: Exposure of 13–15 year olds to second-hand smoke by sex and by place in Timor-Leste



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Figure 11.6: Exposure to second-hand smoke among adults (18–69 years) by sex and by place in Timor-Leste in 2014



Source: Noncommunicable Diseases Risk Factor Survey Timor-Leste, 2014, World Health Organization.

Health warnings

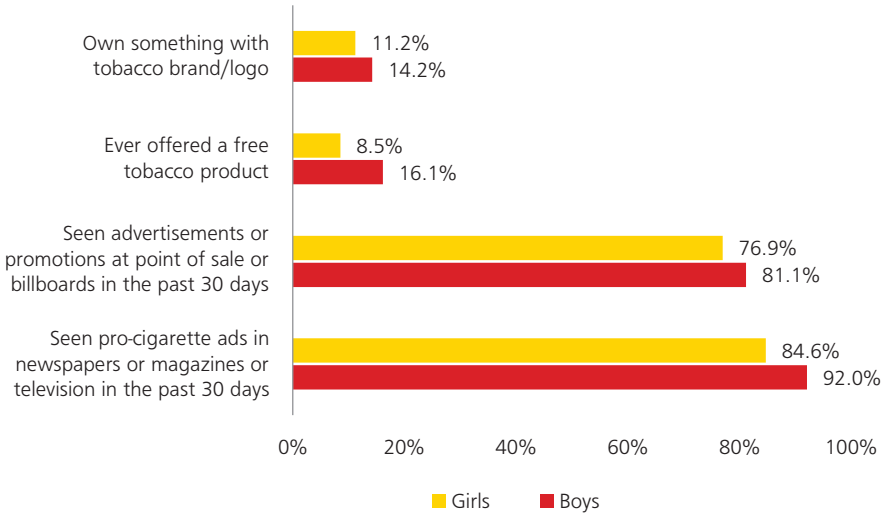
Rotating textual health warnings in local languages on the front and back of cigarette packs have been implemented. Five such warnings have been prescribed [7]. All tobacco products sold in the country, whether imported or locally manufactured, should display this warning [6].

Enforcement of advertising, promotions and sponsorship ban

There are no restrictions on tobacco advertising in Timor-Leste.

The Global Youth Tobacco Survey 2013 found that youth are commonly exposed to tobacco advertising and promotions.

Figure 11.7: Exposure of 13–15 year old students to tobacco promotions by sex in Timor-Leste



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

Taxation [6]

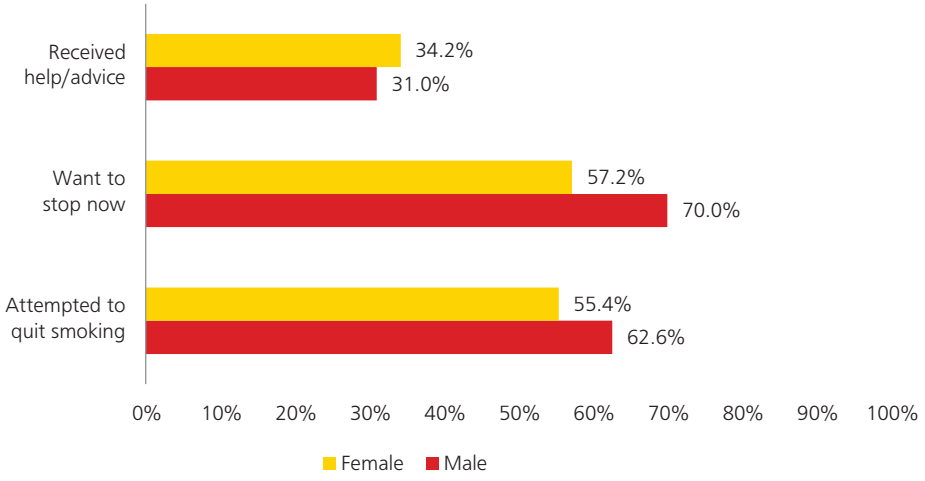
Manufactured cigarettes are taxed whereas roll-your-own cigarettes, which are used by 20% of smokers, are not taxed. The tax share is 33.5% of the price of the largest selling brand of cigarettes (31.4% excise, 2.44% VAT and 0.6% import tariff).

Cessation services

There are formal cessation services available for smokers.

A large proportion of current smokers (62.6% of boys, 55.4% of girls) in the 13–15 year age group had attempted to quit last year. 67.8% of current smokers of that age group stated that they wanted to stop smoking "now". 31.5% of smokers in that group had received help or advice from a programme or a professional to stop smoking [2].

Figure 11.8: Attempts to quit among 13–15 year old smokers adviced to quit, by sex in Timor-Leste



Source: World Health Organization, Monitoring tobacco control among youth in countries of the South-East Asia Region: 2014: Findings from the Global Youth Tobacco Survey, 2003–2014.

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WHO South-East Asia Region (SEAR) is home to about one fourth of the world's population. Studies show that more than half of adult males and nearly two in ten adult females use tobacco in one form or another. There are wide-ranging differences among countries as within countries in relation to tobacco use: the prevalence, types of tobacco used, gender disaggregation, etc. Types of tobacco used and prevalence of tobacco use for adults and youth is documented in this profile by age and sex groups based on available survey data.

Member States of WHO South-East Asia Region have been implementing tobacco control measures in line with the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC). They are in various stages of adopting legislations, enforcing them and enhancing tobacco control measures. Since the advent of WHO FCTC, structures for the implementation of tobacco control programmes have been established in most countries. These structures are tasked primarily to monitor and facilitate implementation of the tobacco control laws that are in place. The tobacco control infrastructure as well as existing tobacco control legislations, health warnings, taxation on tobacco products, tobacco industry and tobacco agriculture are also documented in this profile.

At the Sixty-eighth Session of the Regional Committee, Member States unanimously adopted the Dili Declaration to accelerate implementation of WHO FCTC. This profile will be of benefit to Member States to monitor their tobacco control activities while accelerating the implementation of WHO FCTC.

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