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Profile on Implementation of WHO Framework Convention on Tobacco Control in the South-East Asia Region

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Foreword

I am pleased to note that a *Profile on Implementation of WHO Framework Convention on Tobacco Control in the South-East Asia Region* has been developed to commemorate World No-Tobacco Day (WNTD) 2011 on 31 May 2011. The theme for WNTD 2011 is "WHO Framework Convention on Tobacco Control" to highlight the treaty's overall importance, the obligations of the State Parties under the treaty, and the essential and inalienable role of WHO in supporting countries to meet those obligations.

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the world's foremost tobacco control instrument. The first treaty ever negotiated under the auspices of WHO, it represents a signal achievement in the advancement of public health. In force only since 2005, it is already one of the most rapidly and widely embraced treaties in the history of the United Nations, with 172 signatory Parties. An evidence-based treaty, it reaffirms the right of all people to the highest standard of health and provides new legal dimensions for cooperation in tobacco control.

I note with pride and satisfaction that all Member States of the Region have provisions for tobacco control and nine of them have comprehensive tobacco control legislations in line with the WHO FCTC. Most of the legislations have provisions for smoke-free environments although we still need to aim for 100% smoke-free areas since evidence has shown that partial bans do not work. Many countries in the Region have banned tobacco advertising, promotion and sponsorship but there are loopholes in some legislation which were taken advantage of by the tobacco industry. Increasing taxes and levying high taxes uniformly on all forms of smoked and smokeless tobacco products can significantly reduce demand for tobacco, and Member States have been striving for tax increases. Most countries have banned the sale of tobacco to minors but survey findings showed that despite these bans youth in many countries of our Region have easy access to tobacco products. It is of major concern to all that enforcement of tobacco control legislation is still weak and I would like to emphasize that this is one area in which WHO and Member States should prioritize their efforts to curb the tobacco epidemic.

The WHO Regional Office for South-East Asia remains committed to providing technical support to its Member States to effectively implement the provisions of the treaty. I would like to urge tobacco control advocates working ardently with all stakeholders to effectively implement the provisions of the WHO Framework Convention on Tobacco Control. I hope the government's tobacco control efforts would be enhanced through the theme and observance of this year's World No-Tobacco Day.

Dr Samlee Plianbangchang
Regional Director
WHO South-East Asia Region

Executive summary

Tobacco use is one of the leading preventable causes of death in the world. Currently, nearly six million people die each year from tobacco-related diseases. The death toll from the worldwide epidemic of tobacco use could rise to eight million annually by 2030, the greater chunk of which will be from developing countries. It is estimated that, at the current rate of mortality, tobacco use could kill one billion people during the 21st century.

Tobacco use is a serious public health concern in the South-East Asia Region where use of both smoking and smokeless forms of tobacco is prevalent. The Region has nearly 5% of the global land area, almost one quarter of the global population and about one quarter of all smokers in the world. The Region is home to over 240 million smokers and nearly the same number of smokeless tobacco users. Many of them use both forms of tobacco. However, the rising trend of tobacco use among young girls and women, particularly those living in cosmopolitan cities, is of real concern to the Member countries. A case in point is the increasing number of hookah bars in many Member countries where women are also being seen along with men. Also, smokeless tobacco use is prevalent among women, especially in Bangladesh, India and Nepal. India and Indonesia are among the top 10 tobacco-producing countries in the world, and that may invariably increase the availability of tobacco products to people in the Region. Thus, tobacco use is an important public health issue in the Region.

Ten Member countries ratified the WHO Framework Convention on Tobacco Control (WHO FCTC) and Indonesia is going through the process to become a Party to the Convention. In an effort to respond to the provisions of the Framework Convention, Member States have developed comprehensive tobacco control policies, plans and strategies and are dynamically engaged in implementing them for the best outcomes. Nine Member States (Bangladesh, Bhutan, DPR Korea, India, Maldives, Myanmar, Nepal, Sri Lanka and Thailand) in the Region have comprehensive national tobacco control laws. Indonesia has issued a Presidential Decree on Making Cigarettes Less Harmful to Health and the Law of Republic of Indonesia Number 36 enacted in 2009 has some provisions for tobacco control. The legislations of most countries have provisions on smoke-free places, a ban on tobacco advertising, promotion and sponsorship, and a ban on tobacco sales to minors. In conformity with the Regional Committee Resolution (SEA/RC61/R4), all Member countries in the Region have adopted MPOWER policy package as an operational tool to implement tobacco control effectively.

Achieving comprehensive tobacco control in the Region calls for addressing some challenges that range from uniform taxation on all types of tobacco products to making all public places 100% smoke-free and from combating illicit trade in tobacco products to addressing public health interventions and education which covers all segments of people and all kinds of tobacco products. It is also crucial for the Region to strengthen the surveillance system, and have measures in place to counteract any vested interests of tobacco industries. Wide dissemination of public health policy, ensuring earmarked funding, seeking the commitment of all sections of the people and providing for appropriate enforcement infrastructure and roadmaps are important in implementing the legal provisions successfully.

The Region must continue to work meaningfully and synergistically in tandem with different stakeholders in tobacco control such as policy-makers, health practitioners, epidemiologists, economists, government officials, civil society, NGOs, and the media to achieve successful implementation of the provisions of the Convention, and take tobacco control to a higher level of enforcement. The collective and sustained efforts of Member countries are essential to strengthen and advance tobacco control measures in order to fully achieve the objectives of the Framework Convention in the Region.

I. Introduction

Tobacco is a major risk to health and the single largest cause of preventable death globally. Tobacco use kills about 5.4 million people annually and causes another 600000 deaths every year due to exposure to second-hand smoke.[1] Three quarters of these deaths take place in the developing world. Tobacco is the only legally available substance that kills one third to half the number of people who use it. Moreover, tobacco use not only increases the burden of health-care costs for countries but also leads to a colossal degree of lost productivity due to premature deaths and chronic illnesses.

The South-East Asia Region has some of the highest tobacco consuming countries in the world. India and Indonesia are among the ten highest tobacco-consuming countries in the world.[2] In the Region, nearly half of all adult males and two in every five adult females use some form of tobacco. India and Indonesia have the second and third highest number of male smokers in the world.[3] Among students aged 13–15 years, the smoking rate among boys is higher than among girls. However, prevalence of smokeless tobacco use among young girls and women in the Region is on the rise. This could be attributed largely to aggressive female-oriented marketing tactics adopted by the tobacco industry.

There is significant tobacco-related morbidity and mortality in the Region. About 1.2 million deaths occur in the Region every year. A study in 2010 estimated that smoking would lead to around 930 000[4] adult deaths in India alone in that year. Studies have also shown that those women who smoke in India die an average of eight years earlier than their non-smoking peers. The ill-effects of tobacco use in women are also of special concern since tobacco use during pregnancy and the post-partum period[5,6,7] leads to several complications. Given the fact that smoking decreases the body's immune defences and increases susceptibility to opportunistic infections, a major health concern that is inextricably linked to tobacco use is the rising incidence of tuberculosis among smokers in the Region.

Tobacco and poverty are closely linked. Studies have shown that use of tobacco is high among the poorer sections of the population. Member countries of the Region have demonstrated that tobacco users from low-income families spend up to 40% of their income on smoking[8] at the cost of their basic needs which, in turn, thrusts them deeper into a vicious cycle of poverty. The economic cost of tobacco-related deaths imposes a particular burden in developing countries where four out of five tobacco deaths will occur by 2030 and half of all such deaths are likely to occur during the prime productive years. Consequently, the net economic effect of tobacco will thus simply worsen the situation of poverty.

The findings of the Global Adult Tobacco Surveys (GATS) and the Global Youth Tobacco Survey (GYTS) point to an increase in the prevalence of smokeless tobacco use among women and girls in the Region. The tobacco industry's marketing strategies and tactics are influencing these young girls and women. More often than not, women bear the double burden of tobacco use, particularly among those in the disadvantaged groups where they use smokeless tobacco and at the same time are exposed to second-hand smoke at homes of one-room dwellings since the majority of men smoke. In addition, those young girls and women engaged in cultivation and manufacturing of tobacco not only endanger their own lives by getting addicted to tobacco and by suffering from other hazards, they also often become victims of labour exploitation.

One of the main obstacles to tobacco control is interference by the tobacco industry in legislative and policy-making processes through lobbying and partnering with organizations inside and outside of government, as well as asserting and maintaining a direct and indirect influence on policy-makers, political leaders and researchers. It is, therefore, imperative for the governments of the Member countries to recognize that there is a fundamental and irreconcilible conflict between the interests of the tobacco industry and those of public health policy. Ministries of health must be at the forefront in protecting public policy processes from interference by the tobacco industry.

Ever since the WHO FCTC came into force, countries have made tremendous progress in the Region towards improving tobacco control measures. It is noteworthy to observe that tobacco control is increasingly gaining its importance in the political, economic and social arenas of the countries. The ratification of the WHO Framework Convention on Tobacco Control by most of the Member countries in the Region signifies their unparalleled commitment to develop and enforce effective tobacco control policies. Therefore, in line with the objectives of the WHO FCTC, the countries need to fully implement the treaty to protect people from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke. Member countries are urged to place the treaty at the core of their efforts to control the global epidemic of tobacco use, and reduce the burden of tobacco-related diseases and deaths.

The *Profile on the Implementation of the WHO Framework Convention on Tobacco Control* has been developed to mark World No-Tobacco Day (WNTD) 2011 in keeping with its theme for this year. This profile provides an overview of the status of the implementation of the Framework Convention in South-East Asia by country. It takes stock of the major progress made and challenges faced in the last few years while implementing tobacco control measures in Member countries. All countries have reporting mechanisms related to the Framework Convention in place. To evaluate the implementation of the Framework Convention in the Region, the data sources used were from the most recent country reports signed by Member countries; findings from periodic surveys conducted in Member States; research conducted on different indicators and assessments by the Secretariat of the Conference of Parties.

All Member countries of the Region except Indonesia have ratified the Framework Convention during the period 2004–2006, and since then there have been sustained efforts made to accelerate the process of realization of the goals of the Convention. Since this year's theme of WNTD is "WHO FCTC", the profile highlights the major tobacco control measures that have been or are being implemented in each Member country.

II. Regional overview

1. Prevalence of tobacco use

Smoking among men is high in the Region and women usually take to chewing tobacco. The prevalence across countries varies significantly. Smoking among adult men ranges from 24.3 % (India) to 63.1% (Indonesia) and among adult women from 0.4% (Sri Lanka) to 15% (Nepal). The low prevalence of smoking among women is because of the fact that smoking by women is not acceptable in most of the communities in the Region. In contrast to smoking, the use of smokeless tobacco is quite popular among women. The prevalence of smokeless tobacco use among men varies from 1.3% (Thailand) to 51.4% (Myanmar), while for women it is from 4.6% (Nepal) to 27.9% (Bangladesh).

Table 1: Prevalence of tobacco use, by sex, in select Member States of the Region

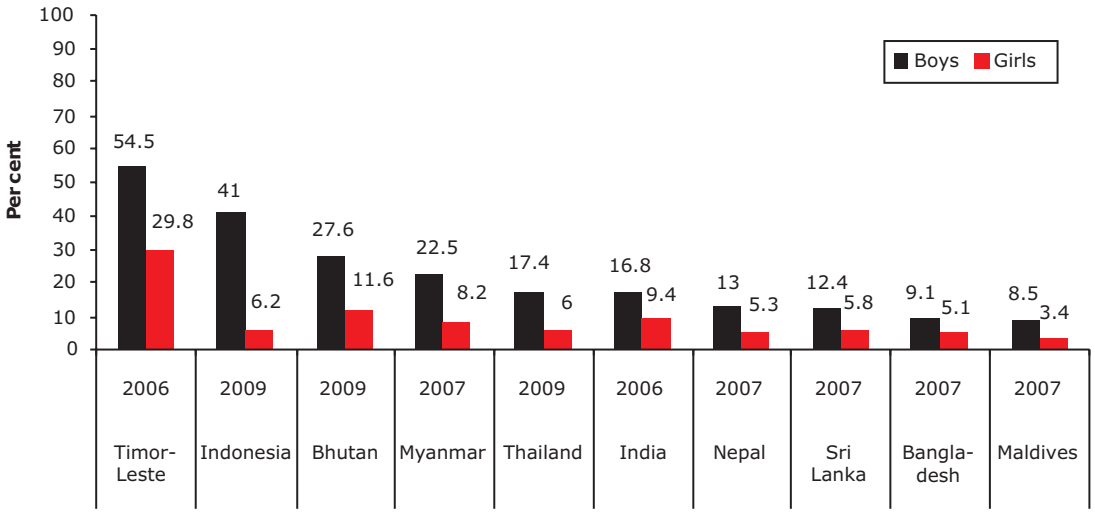
Member Countries	Age	Smoking (%)		Smokeless (%)	
		Male	Female	Male	Female
Bangladesh	15+	44.7	1.5	26.4	27.9
India	15+	24.3	2.9	32.9	18.4
Indonesia	15+	63.1	4.5	N.A.	N.A.
Maldives	25–64	37.5	11.8	N.A.	N.A.
Myanmar	15–64	44.7	7.8	51.4	16.1
Nepal	15–64	34.5	15.9	31.2	4.6
Sri Lanka	15–64	29.8	0.4	24.9	6.9
Thailand	15+	45.6	3.1	1.3	6.3

Source: Bangladesh GATS 2009, India GATS 2009, Indonesia National Socioeconomic Survey 2004, Maldives STEPS Survey 2004, Myanmar STEPS Survey 2009, Nepal Non-Communicable Disease Risk Factor Survey 2008, Sri Lanka STEPS Survey 2006, Thailand GATS 2009.

Overall tobacco use among males is high compared with their female counterparts in all Member countries of the Region. However, the trend of tobacco use among women is on the rise because of aggressive target-oriented marketing tactics of the tobacco industry.

Findings from the Global Youth Tobacco Survey (GYTS) show that the current use of any form of tobacco among students aged 13–15 years ranges from 8.5% (Maldives) to 54.5% (Timor-Leste) among boys and from 3.4% (Maldives) to 29.8% (Timor-Leste) among girls.

Figure 1: Current tobacco use among students (13–15 years) in select Member countries of the Region, by sex



Source: Global Youth Tobacco Survey (GYTS) 2006-2009.

Prevalence of current use of any tobacco product among school personnel ranges from 38% in Bangladesh to 11% in Thailand. Findings from the Global Health Professions Student Survey (GHPSS) reveal that cigarette smoking is more prevalent than use of other forms of tobacco among medical and dental students in Bangladesh, India, Myanmar and Nepal.[9-12, 22-25]

Even though the prevalence of tobacco use among men is higher than women in the Region, its rising trend among women is an increasing cause for concern.

2. Tobacco products and patterns of tobacco use

In South-East Asia tobacco is mainly produced in Bangladesh, India, Indonesia and Thailand. India and Indonesia are among the ten biggest tobacco leaf producing countries in the world. India is not only the second largest producer of tobacco leaf but is also the second biggest consumer of tobacco in the world. The Food and Agriculture Organization of the United Nations (FAO) projected that India would have consumed over half a million tons of tobacco in 2010. Another big consumer in the Region is Indonesia that holds the sixth position among tobacco consumers of the world.[13]

Various types of smoked and smokeless tobacco products are used in the Region. Among smoked tobacco products, low cost indigenous tobacco products such as *bidis* (Bangladesh, India, Nepal and Sri Lanka), *cheroots* (Myanmar), and roll-your-own cigarettes (Thailand) are smoked in the Region, especially by the poorer sections of the populations. Clove cigarettes called *kreteks* are popular in Indonesia. Manufactured cigarettes are the preferred choice of upper class people in the Region. Other forms of smoking products used in Region are *dhumti, chuttas, chillums, hookah, pipes, cigars,* etc.

Some common smoking forms of tobacco products in the Region

Cigarettes	Kreteks	Bidis
Cheroots	Hand-rolled cheroots	Cigars
Hookah	Ye pyaung (Watery tobacco)	Shisha
Chillum*	Hookli*	Chutta*

(*Courtesy: Advocacy Forum for Tobacco Control, Mumbai, India and IndiaMike.com)

Smokeless tobacco products are used in different ways such as chewing, sucking and applying tobacco preparations to the teeth and gums.[14] The commonly used smokeless form of tobacco in the Region is tobacco with betel quid (known as *paan* in India, Bangladesh and Nepal*; kwanya* in Myanmar and s*irih* in Indonesia), which is usually prepared by the user themselves or by vendors in kiosks widely distributed even in communities. Another common tobacco chewing product is tobacco and lime mixture (known as *khaini* or *surti* in India, and *khoinee* in Bangladesh), which is either manufactured or prepared by the user themselves. *Gutkha*, a manufactured tobacco mixed with betel nut and other additives, is popular among youth in India and is now seen throughout the Region. Taking advantage of the misconception about tobacco

being good for oral health, the tobacco industry is producing tobacco products as dentifrice,[15] most common in India and Bangladesh in different forms such as *gul gudaku, bajjar, tapkir, lal dantmanjan,* etc.

Some common smokeless forms of tobacco products in the Region

Betel quid	Manufactured Khaini	Gutkha
Dohra and surti	Creamy snuff in tubes	Gul
Lal dantmanjan (dentifrice)	Tuibur (Tobacco water)	Mishri (dentifrice)
Zarda	Hnatsay (Honey soaked tobacco)	Kiwam

In recent times, the Region has seen an increasing use of smokeless tobacco products among children, youth and women mainly because of lack of adequate knowledge about the addictive and harmful effects of smokeless tobacco, aggressive marketing by the tobacco industry, and lower prices of and easy accessibility to smokeless tobacco products.[16]

3. Status of the WHO Framework Convention Implementation in the South-East Asia Region

The WHO Framework Convention on Tobacco Control (WHO FCTC) was developed in response to the globalization of the tobacco epidemic. It is the first global treaty negotiated under the auspices of the World Health Organization, and it entered into force in February 2005. It has since become one of the most widely embraced treaties in UN history. As of April 2011 there are 172 Parties to the Framework Convention.

South-East Asia is one of the top producers of tobacco products in the world. With significant proportions of the population using some form of tobacco, the effective implementation of supply and demand reduction strategies is a major challenge.

The Framework Convention provides the principles and context for policy development, planning of interventions and mobilization of political and financial resources for tobacco control. The Framework Convention is the supreme global tobacco control instrument, which contains legally binding obligations for its Parties. To address the complex set of determinants for tobacco use, the Framework Convention includes both supply and demand reduction measures.

In the Region, ten Member countries have ratified the Framework Convention and are Parties to the Convention. The ratification of the WHO Framework Convention on Tobacco Control by the Member countries offers an unparalleled opportunity to pass or amend their domestic legislations, and develop and enforce effective policies and programmes. Through ratification of the Framework Convention, all Parties in the Region have an obligation to implement the international regulatory framework to Control Tobacco Use. Currently, Member countries are at various stages of implementation, and the challenge remains for all to move towards complete implementation of the treaty.

Table 2: Ratification of the WHO Framework Convention and comprehensive tobacco control legislations in nine Member countries of the Region

Member countries	Date of signature	Date of ratification	Comprehensive tobacco control legislations
Bangladesh	16 June 2003	14 June 2004	*Smoking and Tobacco Products Usage (Control) Act, 2005*
Bhutan	9 Dec. 2003	23 Aug. 2004	*Tobacco Control Act of Bhutan, 2010*
DPR Korea	17 June 2003	27 April 2005	*Law of the Democratic People's Republic of Korea on Tobacco Control, 2005*
India	10 Sept. 2003	5 Feb. 2004	*The Cigarettes and Other Tobacco Products Act, 2003*
Maldives	17 May 2004	20 May 2004	*Law on Tobacco Control, 2010*
Myanmar	23 Oct. 2003	21 April 2004	*The Control of Smoking and Consumption of Tobacco Product Law, 2006*
Nepal	3 Dec. 2003	7 Nov. 2006	*Tobacco Product (Control and Regulatory) Bill in 2011*
Sri Lanka	23 Sept. 2003	11 Nov. 2003	*National Authority on Tobacco and Alcohol Act, No. 27 of 2006*
Thailand	20 Jun. 2003	8 Nov. 2004	*Tobacco Products Control Act B.E. 2535 & Non-Smokers' Health Protection Act B.E 2536, (1992)*

Table 3: Ratification of the WHO Framework Convention and tobacco control provisions in Indonesia and Timor-Leste

Member countries	Date of signature	Date of ratification	Tobacco control provisions
Indonesia	-	-	*The President of the Republic of Indonesia, Government Regulation No. 19 Year 2003 regarding Making Cigarettes Less Harmful to Health*
Timor-Leste	25 May 2004	22 Dec. 2004	*Ministry of Health Circular* N°5*/2008/IVGC/MS, 2008.* *Degree-Law No. 2006: Health Warning and Tax Control of Manufactured Tobacco Products.*

The Framework Convention had a significant effect on redirecting tobacco control policies at both the regional and national levels. The ratification of the Framework Convention has provided the anti-tobacco coalition in the Member countries with the impetus to combat tobacco. In order to achieve effective implementation of Framework Convention, national tobacco control laws have been developed and passed in nine Member countries. Timor-Leste is in the process of drafting a national legislation on tobacco control.

Effective implementation of the Framework Convention can only be achieved through active engagement of all relevant sectors of the government, nongovernmental organizations and civil society, as well as involving new partners to take action within their political, occupational, social and cultural networks and spheres of influence. The Member countries need to work consistently for complete implementation of the treaty so as to reap the health, social and economic benefits of tobacco control.

Monitoring tobacco use (Articles 20 & 21)

The Region has conducted the Global Youth Tobacco Survey (GYTS) in ten Member countries. It supported the collection of valuable information on the prevalence of tobacco use, knowledge and attitudes towards cigarette smoking, role of the media and advertising, access to cigarettes, exposure to second-hand smoke (SHS) and information on cessation of cigarette smoking. Bhutan, India, Indonesia, Maldives and Timor-Leste have conducted two rounds of national GYTS. Myanmar, Sri Lanka and Thailand have conducted three rounds of national GYTS.

In the Region, nine Member countries have conducted Global School Personnel Survey (GSPS) on a national sample. India, Indonesia, Thailand and Timor-Leste have conducted two rounds of GSPS.

The Global Health Professions Students Survey (GHPSS) was conducted in seven Member countries of the Region. GHPSS for medical and dental students have been conducted in six Member countries. GHPSS for pharmacy students has been conducted in five Member countries, and for nursing students in two countries. The Global Adult Tobacco Survey (GATS) has been conducted in Bangladesh, India and Thailand. A repeat GATS is under process in Thailand.

Table 4: Provisions for smoke-free measures in the Region

Smoke-free public places	BAN	BHU	DPRK	IND	INO	MAL	MMR	NEP	SL	THA	TL
Health-care facilities	√	√	√	√	√	√	√	√	√	√	√
Educational facilities	√	√	√	√	√	√	√	√	√	√	X
Universities	X	√	√	√	√	√	√	√	√	√	X
Government Facilities	X	√	√	√	X	√	X	√	√	√	X
Indoor offices	X	√	√	√	X	√	X	X	√	√	X
Public transport	X	√	√	√	X	√	X	√	√	√	X
Restaurants	X	√	√	X	X	√	X	X	X	√	X
Pubs and bars	X	√	√	X	X	NA	X	X	X	√	X
All other public places	NA	X	√	X	X	NA	NA	NA	X	X	NA
National law requires fines for smoking	√	√	√	√	√	√	√	X	√	√	X
Fines levied on the establishment	X	√	X	√	X	√	X	X	√	√	X
Fines levied on the smoker	√	√	√	√	√	√	√	X	√	√	X
Funds dedicated for enforcement	X	√	X	√	X	X	X	X	√	√	X
Complaint system requires an investigation after a complaint	X	√	X	√	X	√	X	√	X	√	X

Source: Country validated information for Global Tobacco Control Reports (GTCR III, 2011) of SEA Region Member countries (unpublished).

Protection from exposure to tobacco smoke (Article 8)

In keeping with Article 8 of the Framework Convention, Member countries have taken legislative, executive and administrative measures to protect people from exposure to tobacco smoke in indoor places, public facilities and other indoor public places, and on public transport. Almost all Member countries in the Region have banned smoking in health-care and educational facilities. Smoking is banned in government facilities and public transport in six Member countries. Bhutan, Maldives and Thailand have completely banned smoking even in the restaurants. National law in most Member countries envisages fines for smoking in public places (Table 4).

Packaging and labelling of tobacco products (Article 11)

Three countries in the Region have implemented specific health warning labels while few others are in the process of developing strategies and implementing them. Studies have shown that health warning labels have a positive impact in some countries.

- India has implemented graphic health warnings on all kinds of manufactured tobacco products.

- Thailand also implemented ten rotating graphic warnings covering 55% of the front and back surface area of cigarette packets, five rotating graphic warnings on cigar packets covering 50% and two graphic warnings on roll-your-own cigarettes.
- Bangladesh has provisions providing six rotating textual-specific health warnings on smoking tobacco products but has implemented the same only on the packets of manufactured cigarettes.

Education, communication, training and public awareness (Article 12)

Many Member countries in the Region are making efforts in developing IEC materials on tobacco control issues and disseminating them to wider target audience through use of appropriate media. For instance, Bhutan disseminated information on effects of smoking and second-hand smoke through electronic and print media. Similarly, some Member countries also used various media to raise public awareness on smoke-free places (India), quit smoking (Thailand), and cancer and smoking (Nepal). WHO also supported Member countries in developing IEC materials and their dissemination.

Tobacco advertising, promotion and sponsorship (Article 13)

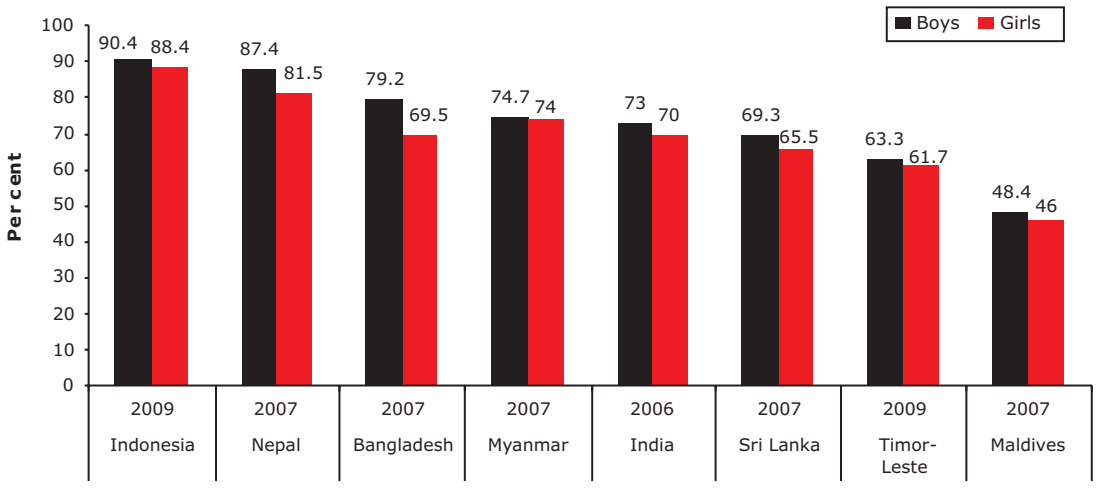
All Member countries (except Indonesia and Timor-Leste) have a policy banning various forms of direct tobacco advertising and promotion on national television, radio, billboards, outdoor advertising and sponsored events. Some countries have even banned tobacco advertising on international TV/radio and in international magazines/newspapers. The indirect bans such as on free distribution, promotional discounts and the appearance of tobacco brands in TV/films are in place in most of the countries. Indonesia has limited provisions, but it restricts free distribution of tobacco products.

Table 5: Bans on tobacco advertising and promotion in the Region

Types of Bans	BAN	BHU	DPRK	IND	INO	MAL	MMR	NEP	SL	THA	TL
Direct bans											
National TV and radio	√	√	X	√	X	√	√	√	√	√	X
International TV and radio	X	X	X	√	X	X	X	√	X	X	X
Local magazines and newspapers	√	√	X	√	X	√	√	√	√	√	X
International magazines and newspapers	X	X	X	√	X	X	X	√	X	X	X
Billboards and outdoor advertising	√	√	X	√	X	√	√	√	√	√	X
Point of sale	X	√	X	X	X	√	√	√	√	√	X
Internet	√	√	X	√	X	X	√	√	√	√	X
Indirect bans											
Free distribution	√	√	X	√	√	√	√	√	√	√	X
Promotional discounts	X	X	X	√	X	X	√	√	√	√	X
Non-tobacco products identified with tobacco brand names	X	X	X	√	X	√	√	X	√	√	X
Brand name of non-tobacco products used for tobacco product	X	X	X	√	X	√	√	√	X	√	X
Appearance of tobacco brands in TV and/or films (product placement)	X	X	X	√	X	√	√	√	√	√	X
Appearance of tobacco products in TV / films	X	√	X	√	X	√	√	√	√	√	X
Sponsored events	√	√	X	√	X	√	√	√	√	√	X

Source: Country validated information for Global Tobacco Control Reports (GTCR III, 2011) of SEA Region Member Countries (unpublished).

Figure 2: Exposure to cigarette advertising on billboards among students aged 13–15 years, by sex, in select Member countries of the Region



Source: Global Youth Tobacco Survey (GYTS) 2006–2009.

One of the major challenges that the Region faces is tackling tobacco advertising. A large proportion of the population, particularly young boys and girls, face high exposure to tobacco advertising and promotion campaigns. The tobacco industry uses tactical and innovative ways to reach its tobacco products to all sections of its targets, including youth and women.

Despite implementing various bans, over two in five young girls and boys are exposed to cigarette advertising on billboards and in print media. one in ten boys and girls have been offered free samples of cigarettes at some point of time and possessed an object (T-shirts, bags, etc.) with a cigarette brand logo on it.

Tobacco cessation (Article 14)

Although there is enough indication that most of the users are willing to quit their tobacco habit, currently Member States are still endeavouring to have adequate facilities and training provisions on cessation services. India has 20 tobacco cessation centres and few community cessation clinics. Thailand has a good network for community health cessation. India and Thailand have developed national tobacco cessation guidelines and recently launched national quitlines and telephonic helplines. India is also trying to establish tobacco cessation at the district level.

WHO-SEARO has developed the following:

(1) Helping People Quit Tobacco: A Manual for Doctors and Dentists

(2) Tobacco Cessation: A Manual for Nurses, Health Workers and Other Health Professionals

(3) Manual on Tobacco Control in Schools

(4) Community Cessation Manual

WHO-SEARO has also supported community cessation programmes in six Member countries. SEARO provided training at the regional level on tobacco cessation and has also supported national tobacco cessation training in many countries of the region.

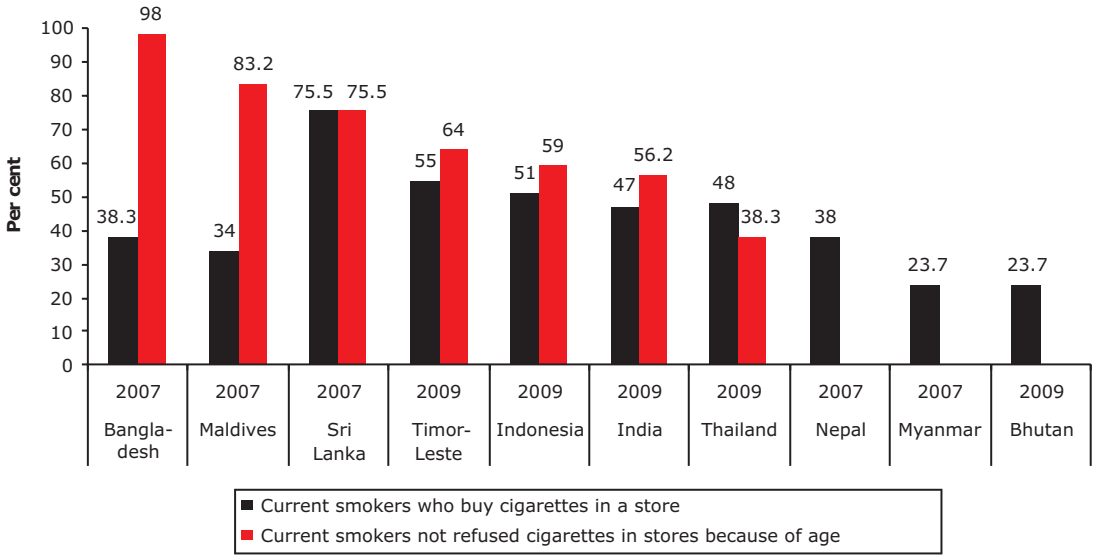
The tobacco control manual for schools has been translated into different languages for use by different Member States. Training of teachers has also been supported in some Member States.

Sales to and by minors (Article 16)

Many young boys and girls can still buy cigarettes from a store in many country of the Region. The percentage of boys and girls who could get cigarettes from a store ranges from a high of 75% in Sri Lanka to 24% in Myanmar. Almost every current smoker among the youth in Bangladesh (98%) can get cigarettes without being refused from sellers on account of their age (Figure 3).

A significant percentage of ever-smokers started smoking at much younger age. For instance, about two to four out of every ten ever-smokers were initiated to smoking before the age of 10 years in the Region. Such information calls for an urgent need to incorporate provisions regulating the sale to minors in the laws of all Member countries as well as ensure effective implementation of enforcement policies.

Figure 3: Access and availability of cigarettes to students aged 13–15 years in select Member countries of the Region

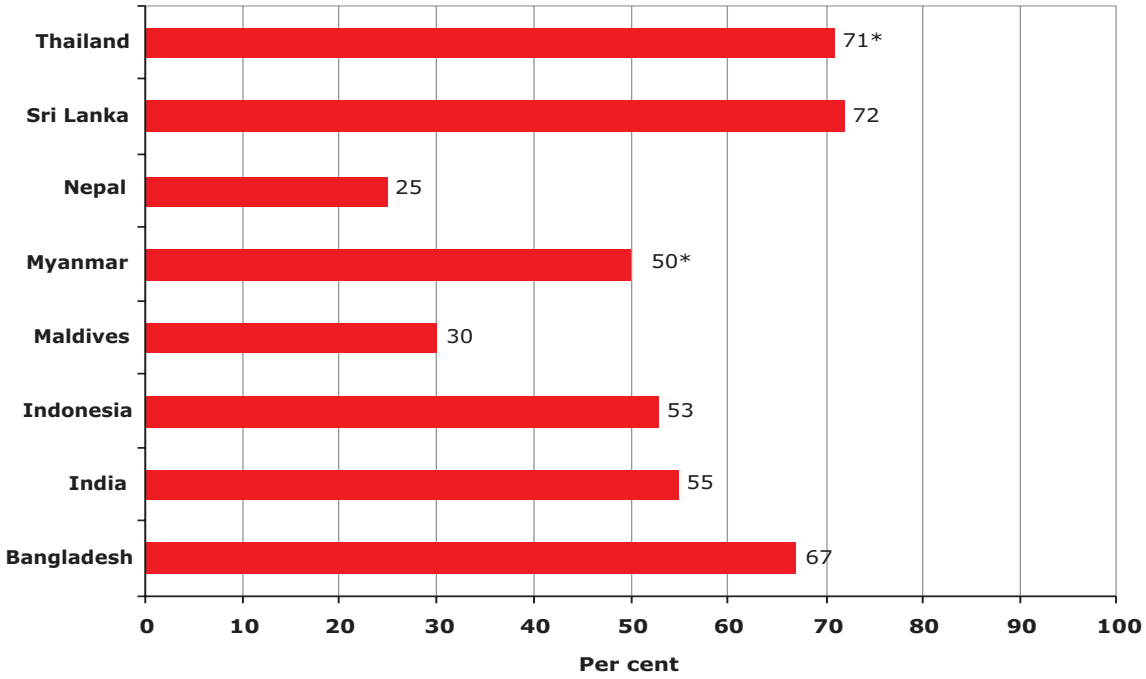


Source: GYTS 2007–2009.

Price and tax measures to reduce the demand for tobacco (Article 6)

According to the Global Progress Report 2010 on FCTC implementation[17], the average price per pack of 20 pieces is US$ 1.13 and the average total tax rate levied on cigarettes is 57.7% in the Region, which is far less than the World Bank's recommended threshold of 67% of the final retail price of cigarettes.

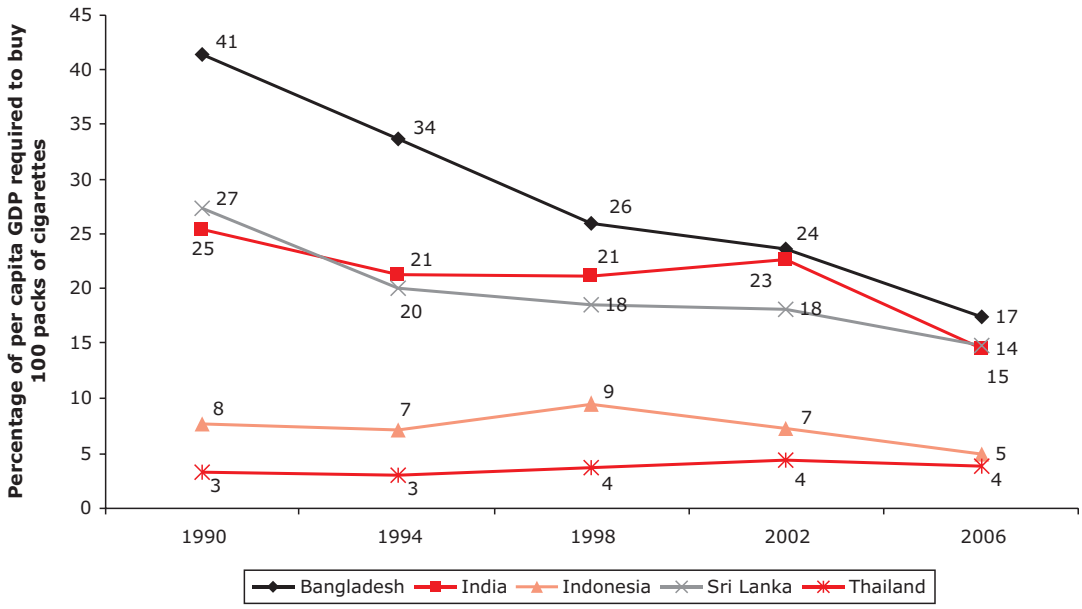
Figure 4: Rates of taxation on cigarettes in select Member countries of the Region



Source: *World Report on the Global Tobacco Epidemic 2009* (*Rates of Myanmar and Thailand updated).

Although countries have increased taxes in every fiscal year, over the last decade cigarettes have become more affordable in many countries in the Region as inflation rates have not been taken into account while raising taxes. Also, the trend of GDP per capita required to buy cigarettes declined over the years, indicating an increase in actual affordability for cigarettes (Figure 5).

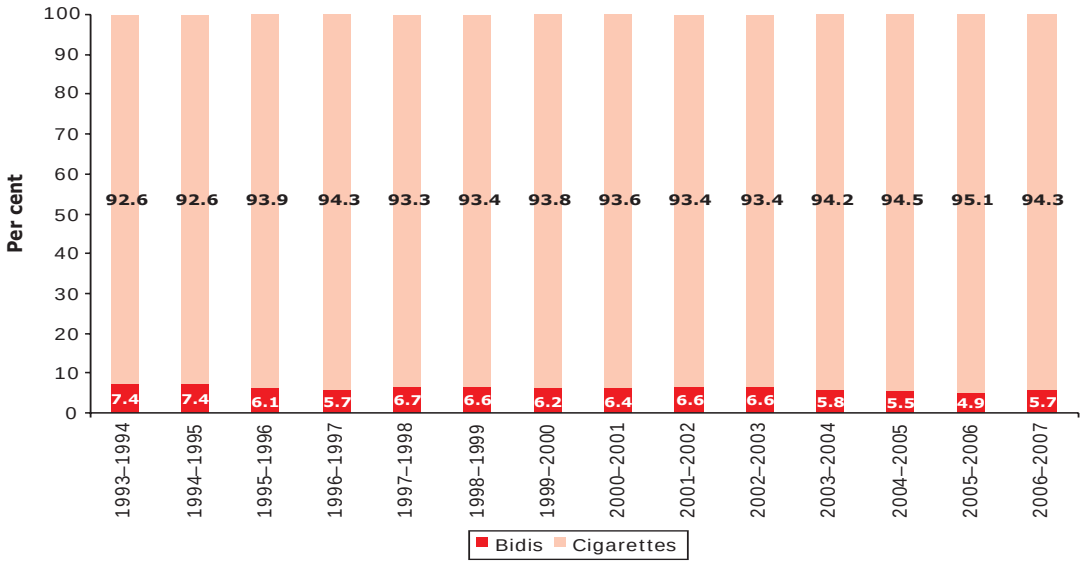
Figure 5: Increasing affordability of cigarettes in select Member countries the Region



Source: *Blecher E, Walbeek C.V. (2008). An Analysis of Cigarette Affordability. International Union Against Tuberculosis and Lung Disease, Paris.*

Taxation on other tobacco products is far less than cigarettes and hence easily affordable to the poor section of the people. For instance in India, the revenue that is generated from *bidis* is insignificant compared with cigarettes indicating a wide disparity of tax application between these two smoking items even though ten *bidis* are smoked for every cigarette consumed. The total percentage of revenue contribution from *bidis* in 2006–2007 was only 5.7% as opposed to 94.3% for cigarettes (Figure 6).

Figure 6: Percentage of excise revenue from *bidis* and cigarettes in India from 1994–2007



Source: *Sunley, Emil M., India: The Tax Treatment of Bidis, 2008.*

To protect the poor from the devastating health and economic impacts of tobacco use, it is important to ensure that tobacco tax on all products are harmonized and meet the standards of the World Bank.

Thailand, India and Nepal set good examples on this in the Region because part of their tobacco taxation revenue is earmarked for health issues.[18]

Cigarettes have become far more affordable in many countries of the Region. By raising the excise tax, Member countries could increase the retail price of cigarettes, and make them less affordable

III. Implementation of the WHO Framework Convention in SEA Region Member States

Bangladesh

Highlights

- Ratified the WHO FCTC in 2004 and enacted the Tobacco Control Act in 2005.
- Declared most public places smoke-free.
- Implementing six health warnings.
- Banned all forms of advertisement for smoking tobacco products.
- Conducting mobile courts to enforce tobacco control law.
- Providing crop substitution subsidy.

Bangladesh has seen a rapid rise of tobacco users over the years. Easy availability of cheap tobacco products, lack of strong tobacco control regulations and weak enforcement of regulations have been attributed to the rise in tobacco use. Prevalence of smoking is 44.7% among men and 1.5% among women whereas the use of smokeless tobacco is 26.4% among men and 27.9% among women.[19] Prevalence of current tobacco use among students aged 13–15 years is 9.1% among boys and 5.1% among girls.[20,27] It is apparent that smoking is largely popular among men whereas smokeless forms are popular among women tobacco-users. Even though the smokeless tobacco use is high, there is no provision for smokeless tobacco control in the legislation.

Major challenges

- Advertisement at point of sale.
- Exposure to SHS in public places.
- Cross-border advertising.
- Uniform taxation on all forms of tobacco.
- Strict enforcement of ban of sale of tobacco products to minors.
- Dealing with tobacco industry.
- Expansion of crop substitution subsidy.

The Smoking and Tobacco Products (Control) Act was passed in 2005. The Act prohibits:[21]

- Smoking in public places such as schools, hospitals, government offices, public parks, shopping malls, cinema halls, children parks, airports, buses, trains, etc.
- Advertisement of tobacco products through any media.
- Installation of automatic vending machines in public places for sale of tobacco products.

Public transport and public places are not 100% smoke-free. Even though smoking in public places is prohibited by law, more than two thirds of men (69%) and one fifth of women (21%) are exposed to second-hand smoke in public places.[19]

The Act mandates that every packet of tobacco product must have any of the six textual health warnings covering at least 30% of the total area of the packet on the front and back sides. However, pictorial health warnings are currently not being used in Bangladesh.

Text of health warnings in Bangladesh:

(a) Smoking causes death.
(b) Smoking causes stroke.
(c) Smoking causes heart disease.
(d) Smoking causes lung cancer.
(e) Smoking causes respiratory problems .
(f) Smoking is injurious to health.

Advertisement of tobacco products at the point of sale is allowed in Bangladesh. Evidently, almost half of male adults are being exposed to cigarette advertisement at the point of sale.[19] Also, there is a huge percentage of youth who are exposed to cigarette advertisement on billboards (79.2% boys, 69.5% girls) and in newspapers/magazines (56% boys, 70% girls).[25]

Mobile courts are a unique feature of the judicial system in Bangladesh that operate to quicken the process of dispensation of justice in non-criminal cases. Violation of tobacco control laws is one of the offences that can be tried by a mobile court.

There is a provision for a crop substitution subsidy in tobacco control legislation. The 2005 Act (Section 12) requires the Government to grant loans on easy terms for the purpose of discouraging the tobacco cultivators from growing tobacco and encouraging the cultivation of alternative cash crops.

Bangladesh conducted the GATS for its adult population in 2009. A subnational GYTS in 2004 and a national GYTS in 2007 were conducted for students aged 13–15 years. The GSPS at the national level was conducted in 2007 and the GHPSS for medical and dental and students in 2006 & 2009.

SEARO supported the dissemination of IEC posters for community clinics in Bangladesh

Cigarette advertisement and display of smokeless tobacco products at the point of sale.

Youth rallying against tobacco in Dhaka.

Bhutan

Bhutan is unique in its tobacco control efforts since it is the only country in the world that completely bans cultivation, production and sales of tobacco and tobacco products in the country. The people of Bhutan had lobbied to ban tobacco products and this community movement led to several districts turning tobacco-free. In the recent past, public movements have changed into administrative action. Smoke-free areas were declared in 2005, and the legislative movement came to fruition with the enactment of the Tobacco Control Act in 2010.

Prevalence of smoking among adults in Thimphu stands at 6.8% and use of smokeless tobacco at 19.4%. More men smoked than women.[26] The prevalence of current tobacco use among students aged 13–15 year was also reported to be high (27.6% for boys; 11.6% for girls).[27] About two in ten men and one in ten women school personnel currently smoke in Bhutan.[28]

Highlights

- Ratified the WHO FCTC in 2004 and enacted Tobacco Control Act in 2010.
- Banned cultivation, production and sale of tobacco products.
- Declared all public places smoke-free.
- Banned advertising on all tobacco products.
- Levied Customs duty and sales tax on imported tobacco products for personal consumption.
- Regular monitoring of tobacco control indicators through GYTS, and GSPS.

The Tobacco Control Act of Bhutan, 2010 has been enacted by Parliament in June 2010. The Act bans:[31]

- Cultivation, harvesting, manufacturing, supplying or distributing and sale of tobacco and tobacco products in the country. A person can import tobacco products for personal consumption as per the quantity approved by the Bhutan Tobacco Control Board. However, imported tobacco products must have the

Major challenges

- Complete enforcement of smoke-free areas.
- Lack of data on adult tobacco prevalence and other tobacco control indicators at national level.
- Limited human and material resources.
- Lack of tobacco cessation services.
- Uniform taxation on tobacco products.
- Cross-border tobacco advertising and illicit trade.

source of origin (country) and with specified health warnings; imported tobacco products are subject to sales tax and Customs duty.

- Smoking in all public places including commercial centres, recreation centres, health facilities, educational institutions, public gatherings/ spaces and public transportation.
- All kinds of advertisement and promotions of tobacco.

Tax is imposed on all imported tobacco products, and imports from third countries are charged 100% Customs duty and 100% sales tax[26] (except importation from India due to the free trade agreement with that country). Taxes on all kinds of tobacco products were doubled in 2004.

To implement the provisions of comprehensive tobacco control legislation effectively, punitive actions are included in the legislation and are being enforced.[29]

The Tobacco Control Board oversees, coordinates and guides the implementation of all tobacco control provisions. The Bhutan Narcotic Control Agency and the Royal Bhutan Police are entrusted with the responsibility of supporting the enforcement measures.

Training to prevent tobacco use is almost nil (school personnel, 6.7%).[28] However, continued efforts are being made in educating and raising public awareness about the dangers of second-hand smoke. The Ministry of Health used both the print and broadcast media to inform and educate people about the health hazards of tobacco use and exposure to tobacco smoke. The Ministry also developed appropriate IEC materials and disseminated them widely.

Bhutan conducted the Global Youth Tobacco Survey (GYTS) in 2006 and 2009, and one round of Global School Personnel Survey (GSPS) in 2009. Both GYTS (2006, 2009) and GSPS (2009) were conducted on a nationally represented sample.

The country also instituted the tobacco control reporting system, and the Ministry of Health had reported regularly to the WHO Framework Convention Secretariat.

Contraband tobacco products seized by police in Thimphu.

A sign in a public place stating a fine of Ngultrum 500 for violation.

(Courtesy: *Kuensel* March 2011)

The Democratic People's Republic of Korea

DPR Korea keenly celebrates World No-Tobacco Day (WNTD) every year and disseminates information about tobacco use and its effect on health. The Government persuades public health institutions and the media to spread the information about the health effects of tobacco and its adverse impact on environmental protection and economic development.

Prevalence of smoking among adult males in DPR Korea was 52.3% in 2002.[30] 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 the Presidium of the Supreme People's Assembly on 22 December 2009.

Highlights

- Ratified the WHO FCTC in 2005 and enacted tobacco control law in July 2005.
- Designated smoke-free areas.
- Prohibition of tobacco promotion.
- Availability of tobacco cessation support.
- Prohibition of sale of tobacco to minors.

The law covers various provisions including packaging, inscription, place of tobacco sale, prohibition of sales to minors, prohibition of tobacco promotion, and smoke-free areas.

Major challenges

- Implementing tobacco control law.
- Enforcing smoke-free policies.
- Improving tobacco cessation coverage.

The Law[31] stipulates that:

- Tobacco products are sold only in designated shops at the price fixed by the State.
- Smoking is forbidden in public transport, schools, hospitals, office rooms, shops, nurseries, kindergartens, theatres, cinemas, culture halls, conference rooms, battle sites, historic places, sidewalks, stations, etc.
- Citizens can smoke in designated places.
- The exterior of the tobacco packet shall specify health warnings and contents of nicotine and tar.
- Institutions, enterprises and organizations shall not carry out any act that promotes the sale of tobacco products.

- Tobacco shall not be sold to minors and the use of vending machines at shops has been prohibited by law.

As per the country information collected for Global Tobacco Control Report 2011, DPR Korea uses one specific health warning that is written in principal language of the country. The pictorial health warnings are also prominently used.

Tobacco cessation support is available in most of the health-care facilities, including at the community level. The cost of the support is partially covered by the national health insurance. Nicotine replacement therapy and pharmacotherapy are not yet available in the country.

A poster exhibition on harmful health effects of cigarette smoking in Pyongyang.

Posters on cigarettes with both textual and pictorial health warnings.

India

India has been producing, consuming and exporting tobacco products for many years. That is why the Act on Cigarettes existed since 1975. But it was not until 2003 that India took major strides in tobacco control. The Central Government passed the Cigarettes and Other Tobacco Products Act (COTPA) applicable to all tobacco products in 2003.

Prevalence of smoking among adults is 14% and of smokeless tobacco use is 26%. Male smokers (24.3%) outnumbered female smokers (2.9%). Similarly, there are more male users (32.9%) of smokeless tobacco than female users (18.4%).[32] However, the trend in the use of tobacco has been on a decline among both men and women over the years.

Highlights

- Ratified the WHO FCTC in 2004 and enacted the Tobacco Control in 2003.
- Declared most public places smoke-free.
- Enforced tax on all tobacco products.
- Health Cess on tobacco to finance National Rural Health Mission.
- Established State Tobacco Control Cells.
- Incorporated tobacco cessation into training for primary health-care providers.
- Initiated pilot project on alternative cropping system.

Major challenges

- Enforcement of smoke-free policies.
- Uniform taxation on tobacco products.
- Tobacco advertising at the point of sale.

The Cigarettes and Other Tobacco Products Act 2003[33-37] and subsequent ministerial orders stipulate that:

- It is a punishable offence to smoke in public places.
  The Smoke-free Rules were revised in 2008 redefining smoke-free places so as to include stadium, railway stations, bus stops, hotels, restaurants, pubs, bars, shopping malls, cinema hall, etc.
- The use of health warnings for tobacco products is mandatory.
- No person shall sell, offer for sale, or permit sale of cigarettes or any other tobacco products to any person who is under 18 years of age, and sale of tobacco within a radius of 100 yards of any educational institution is prohibited.
- The use of two rotating text and pictorial health warnings for smoking tobacco products and one text and pictorial health warning for all smokeless tobacco products.

- Tobacco advertising, promotion and sponsorship (except at the point of sale) are banned.

Pictorial health warnings on smoking and smokeless forms of tobacco products used in India.

The success of displaying the health warnings on packages is clearly shown by the survey results: about 70.8% of cigarette smokers, 62% of *bidi* smokers and 63% of smokeless tobacco users noticed health warnings on the packages of tobacco products.[32] A study shows that students watching anti-smoking media messages were less likely to be current smokers, which was true for both boys and girls.[38]

Compliance to the policy of smoke-free areas is poor in India. Only a partial ban is enforced in restaurants and some public places. It can be seen that a high proportion of both youths (43% boys, 36% girls) and adults (40% men, 18% women) were exposed to second-hand smoke in public places. Common places for SHS exposure were public transport (22% men, 13% women) and workplaces (32% men and 19% women).[32, 39]

India imposes a differential excise tax system and levies a tiered-specific rate. Smoking tobacco products are subject to specific excise taxes while smokeless tobacco products are subject to *ad valorem* excise taxes.[40] The specific excise and *ad valorem* excise imposed per pack of 20 sticks of some of the most popular brands of cigarettes was 27.7% and 16.7% respectively in 2010. There is a 5% tax on each pack of 20 sticks of *bidi*.

However, uniform taxation of tobacco products is a big challenge in India. A Goods and Services Tax (GST) will be introduced by the Government of India in 2011. This GST will be levied on all kinds of tobacco products nationally. In 2005–2006, the Government of India introduced a new dedicated levy called the Health Cess (HC) which applies to the most smoked and smokeless tobacco products. The revenue from this levy is used to help finance the expenditures of the National Rural Health Mission (NRHM) and the revenue from other duty such as National Calamity Contingency Duty (NCCD) for providing calamity relief.

The State Tobacco Control Cells have been established in Ahmadabad, Delhi, Chennai, and Mumbai to undertake smoke-free activities in states for advocacy, information dissemination, surveillance and enforcement of smoke-free policies.

The Government of India established tobacco cessation centres that serve as tobacco control resource centres. Pharmacotherapy and Nicotine Replacement Therapy (NRT) are available in the country. Tobacco cessation is also being integrated into other programmes such as cancer control, NCD, TB, school health, and the district tobacco control programme.

The Ministry of Health and Family Welfare, Government of India, and the Central Tobacco Research Institute (CTRI, Andhra Pradesh) are piloting the alternative cropping system for *bidi* and chewing tobacco in five different regions in the country, with the aim to establish viable and sustainable alternatives to *bidi*/chewing tobacco crops.

India conducted GYTS and GSPS in 2003, 2006 and 2009. The country has conducted GHPSS among medical, dental and pharmacy students in 2009. GATS was conducted in 2009.

A minor exposed to second-hand smoke.

Cigarette advertisement at the point of sale and display of smokeless tobacco products in the capital city of Delhi.

Indonesia

Indonesia is witnessing a rising consumption of cigarettes particularly among men. People are more susceptible to smoking because of their easy access to the cigarette market since Indonesia has the fifth largest tobacco market by volume in the world. It is the home of the cigarette *kretek (*clove cigarettes*)* and the majority (>90%) of smokers in Indonesia use *kretek*. In fact, Indonesia is one of the countries with the highest prevalence of smoking among adults and youth in the South-East Asia Region.

Highlights

- Designated smoke-free zones.
- Enforced tax on tobacco products.
- Implemented health warnings on package.
- Established tobacco cessation clinics.

Prevalence of smoking among adults is 63.1% for men and 4.5% for women. A percentage of daily smoking among men (46.8%) is much higher than women (3.1%).[41] Information on smokeless tobacco use is not available. Tobacco use among students aged 13–15 years is 41% among boys and 6.2% among girls. The use of both cigarettes and other tobacco products among boys has almost doubled from 2006 to 2009.[42]

Major challenges

- Not yet Party to the Convention.
- Enforcing smoke-free policies.
- Low taxation on tobacco products.
- Widespread tobacco advertising and promotion.
- Reduce tobacco sales to youth.

The Government Regulation No.19/2003 titled "Making Cigarettes Less Harmful to Health" was passed in 2003 and reinforced regulations for smoke-free zones. The most recent "Law of Republic of Indonesia Number 36 Year 2009 Concerning Health" termed tobacco to be an addictive substance.

The Government Regulation No.19/2003[43] stipulates that:

- Smoke-f ree zone include health facilities, working places, educational facilities, prayer places, public conveyances and public places.
- One specific health warning in textual form should be displayed on tobacco packages. It also states that the message should be displayed conspicuously on the label part of the packaging in a clear and easy-to-read way on one of the largest panels of the cigarette package with a size no less than 3 mm in height.
- Tar and nicotine content of cigarettes must be disclosed.
- Cigarette producers and importers cannot conduct any promotional activity by giving away cigarette samples as free gifts or by giving other free non-tobacco products branded by cigarette labels.

The regulation does not have any provision on banning tobacco advertising, promotion and sponsorship**.** There is only a restriction on direct tobacco advertising on the electronic media between 9.30 p.m. to 5 a.m. (local time). The regulation prohibits cigarette producers or importers from giving cigarette samples as free gifts or by giving other free non-tobacco products that carry cigarette branding. The exposure of youth to tobacco advertising is high in Indonesia. According to GYTS 2009, about nine out of ten students aged 13–15 years old were exposed to cigarette advertisements on billboards and nearly eight out of ten were exposed to cigarette advertisements in newspapers/magazines. Free samples of cigarettes have been offered to 12.1% of boys and 4% of girls, and 15.7% of boys and 7.5% of girls possessed objects with a tobacco brand logo on it.[42]

There is only one tariff tax, the specific tax for all tobacco products. The excise tariff for tobacco products is determined in rupiah for each piece or gram of tobacco product and the tariff is based on the manufacturer's classification of products and their retail prices. The rate for specific excise, which constitutes the major part of the tax, for 20 sticks of cigarettes in Indonesia was 45.7% in 2010 and it is regarded as one of the lowest in the Region.

Indonesian youths are increasingly exposed to the second-hand smoke (SHS). According to the GYTS 2009, 81.6% boys and 87.9% girls were exposed to SHS in public places and 72.6% of boys and 65.3% of girls exposed to SHS at homes.

Tobacco cessation support is available in limited number of health-care facilities and the cost for it is not covered under the national/federal health insurance scheme.

Youth have easy access to tobacco products at affordable prices due to absence of regulation on tobacco sale to minors. As per the GYTS 2009, 51.1% of the current smokers among the 13-15 years youth could easily buy cigarettes from a store and 59% of them were not refused cigarettes because of their age.

Indonesia has conducted five rounds of subnational GYTS and two rounds of national GYTS (2006 and 2009). The country has conducted two rounds of GSPS (2006 and 2009). GHPSS was conducted among medical students in 2006, dental students in 2007 and pharmacy students in 2009.

Poster on smoke-free homes.

Anti-tobacco campaign countering cigarette advertising in Jakarta

Maldives

The Maldives has taken one big step forward in tobacco control by adopting a Tobacco Control Bill in 2010 that will invariably facilitate the implementation of its WHO Framework Convention on Tobacco Control obligations. The Bill:[44]

- Prohibits advertising of tobacco products.
- Has provisions for tobacco products' labelling and packaging.
- Prohibits cultivation of tobacco.
- Controls imports and exports of tobacco product.
- Monitors how tobacco products are sold.
- Has provisions for the taxation of tobacco products.
- Encourages the implementation of cessation programmes.
- Creates public awareness about the dangers of tobacco use.
- Prohibits smoking in public places, including cinemas, conference halls, mosques, health-care services, sporting facilities, government buildings and educational facilities.

Highlights

- Ratified the WHO FCTC in 2004 and enated Tobacco Control Law in 2010.
- Implementing smoke-free islands.
- Taxation on imported tobacco products.
- Banned point-of-sale tobacco advertising.
- Implemented health warnings.
- Banned sale of tobacco to minors.

Major challenges

- Enforcement of tobacco control law.
- Protecting young people from SHS.
- Enforcing ban on tobacco advertising.
- Scaling up tobacco cessation services.

Prevalence of smoking is 37.5% among men and 11.8% among women in Maldives.[45] There is no information on the smokeless tobacco use. As per the GYTS 2007 conducted among 13–15-year-olds, the prevalence of current tobacco use in Maldives is 8.5% among boys and 3.4% among girls. The GYTS 2003 and 2007 reveals a significant reduction in smoking of cigarettes and use of other tobacco products both among boys and girls.[46]

Maldives has prohibited smoking in public places. The new Act defines public places as mosques, health-care facilities, teaching institution, government institution, cinemas, meeting halls, restaurants, shops, public transport and workplaces. Initiatives are also being taken to make and declare islands as "Tobacco-free Islands".

The law mandates health warnings on tobacco products such as *bidi,* cigars, tobacco sachets and pounded tobacco with the purpose of trade. There has to

be five rotating textual health warnings occupying at least 30% of the front and back of the package.

Tobacco products in Maldives are solely imported. The only tobacco product manufactured locally is the Maldivian *bidi*. The import duty is paid on all tobacco products and all equipment used for consumption of tobacco as per Law No. 31/79. The rate of import duty for a pack of 20 sticks of the most popular brand was 31.6% in 2010.

Text of health warnings in Maldives:

(a) Tobacco paves the way for cancer.
(b) Tobacco blocks the arteries and leads to heart attack.
(c) Tobacco contains several chemicals harmful to health.
(d) Smokers are more prone to have abnormal babies.
(e) Those exposed to second-hand smoke are prone to dangerous health effects.

The GYTS conducted among 13–15-year-olds reveals high exposure to second-hand smoke among boys and girls in both 2003 and 2007 (GYTS). In GYTS 2007, 65.4% boys and 70.6% girls were exposed to second-hand smoke in public places.

Fewer youth are now exposed to tobacco advertising. The percentage of boys who noticed cigarette advertisements dropped from 78.3% in 2003 to 48.4% in 2007 and from 68% to 46% among girls (GYTS, 2003 & 2007).

Maldives has established tobacco cessation clinics in some of the health-care facilities and tobacco cessation services have also been initiated at the community-level. Nicotine replacement therapy is not yet available in the country.

Even though sale of tobacco products to minors is prohibited in the country, a larger percentage of youth can still obtain cigarettes from a store and are not refused because of their age.

Maldives conducted subnational GYTS in 2003 and national GYTS in 2004 and 2007. The STEPS survey was carried out in 2004.

The National Tobacco Control Committee of the country carries out the overall policy coordination for tobacco control, including provisions on tobacco advertising, promotion and sponsorship.

A sticker on exposing children to the second-hand smoke.

Tobacco cessation workshop for health personnel in Male.

Myanmar

Highlights

- Ratified the WHO FCTC in 2004 and enacted tobacco control law in 2006.
- Declared Education and health institutions smoke free.
- Banned direct and indirect advertising.
- Enforced 50% tax on cigarettes.
- Initiated community cessation support programme.

Myanmar has always accorded high priority to tobacco control and has taken numerous initiatives towards reducing tobacco consumption in the recent past. The country enacted the tobacco control law in 2006, which has important provisions, including creating smoke-free areas, prohibition of tobacco advertising, ban on tobacco sale to minors, etc. The implementation of the MPOWER policy package has supported enforcement of the Act's provisions. Myanmar has developed the National Tobacco Control Policy and Plan of Action (2006–2010) in order to make tobacco control plans and activities operational.

Major challenges

- Strengthening the enforcement measures of Tobacco Act.
- Enforcement of smoke-free policies.
- Exposure to SHS among youth.
- Youth still have access to tobacco.
- Low tax rates on cheroots and smokeless tobacco products.
- Increasing trend on use of smokeless tobacco.
- Expansion of tobacco cessation services.

Prevalence of smoking is 44.7% among men and 7.8% among women, whereas the prevalence of smokeless tobacco use is 51.4% among men and 16.1% among women.[47] Among the youth, the prevalence of current tobacco use is 22.5% among boys and 8.2% among girls.[48]

The Control of Smoking and Consumption of Tobacco Products Law was enacted in 2006 and came into effect in 2007. The law:[49]

- Designates non-smoking areas to include health-care facilities, education facilities, universities, sports grounds, public transport, entertainment buildings, marts, stores, market sheds, public rooms, auditoriums, etc.
- Has provisions on packaging and labelling of tobacco products.
- Bans all forms of direct and indirect tobacco advertising, promotion and sponsorship.
- Prohibits sale of tobacco to and by minors (persons below 18 years of age).
- Bans vending machines and the sale of tobacco products within 100 feet of an educational institution.

Although the Law prohibits all forms of direct and indirect tobacco advertisement, the GYTS findings show that exposure to cigarette advertising is very high, particularly among youth. About 75% of boys and 74% of girls saw advertisements for cigarettes on billboards, and 64% boys and 64% girls reported having seen advertisements for cigarettes in newspapers or in magazines. In the same survey, 9.5% of boys and 7.9% of girls were found to have been offered free samples of cigarettes.[50]

Exposure to second-hand smoke is high among youth. About 51% of boys and 42% of girls were exposed to second-hand smoke (SHS) in public places, and 39% boys and 29% girls exposed at home.[50] Regulations for specific health warnings on packages of tobacco products are not yet in place.

Tobacco-Free Schools have been established and the dangers of tobacco have been featured in the "Life-skills" curriculum. Teacher's manual handbooks, pamphlets, posters, post cards, etc have also been published and widely used. Also, the community-based tobacco cessation programme was piloted in a few townships in 2005.

Ad valorem excise of 50% is applied on cigarettes whereas a far lesser tax rate of 10% is applied for cheroots, 20% for cigars and pipes and 25% for betel preparations and pipe tobacco. Hence, there is a huge variation in the taxes on cigarettes and other smoked and smokeless tobacco products in Myanmar. For imported tobacco, there is a tariff of 30% of the Cost, Insurance and Freight (CIF) value. Tax rates have remained the same for decades without being adjusted for inflation. Hence, the price of cigarettes and other tobacco products have become increasingly affordable over the years.

Myanmar conducted the national GYTS in 2001, 2004 and 2007. The 2011 survey is ongoing at the time of going to press. The national GSPS was conducted in 2007 and the GHPSS was conducted among medical, dental and pharmacy students in 2006 and 2009. Sentinel prevalence studies on tobacco use among males and females more than 15 years of age were carried out at sentinel townships in 2001, 2004, 2007 and 2009.

Training of basic health personnel on tobacco.

Community-based tobacco cessation programme.

Nepal

In Nepal, different government, non-government and private sector players and stakeholders are involved in controlling tobacco use. The Ministry of Health and Population actively collaborates with other sectors and ensures that anti-tobacco policies are collectively developed, implemented and monitored.

Highlights

- Ratified the WHO FCTC in 2006 and enacted Tobacco Product & Regulatory Bill in 2011.
- Extended smoke-free zones.
- Enforced tax on tobacco product.
- Implemented health warnings.
- Law ban sale of tobacco to minors and pregnant women.

Prevalence of smoking is 34.5% among men and 15.9% among women. Men smoke twice as much as women. In the case of smokeless tobacco, the use among men is over six times higher than that among women.[51] Tobacco use among students aged 13–15 years is 13% among boys and 5.3% among girls.[52-53]

Parliament of Nepal approved the Tobacco Product (Control and Regulatory) Bill 2010 on 11th April 2011.

The Bill[54] stipulates that:

- Smoking is prohibited in public places, including government facilities, health and educational facilities, workplaces, public transport, hotels, religious places, shopping malls, stadiums, etc.
- Smoking is not allowed in a private house or on transportation if that affects other person.
- Warning messages and pictures must cover at least 75% of the surface area of tobacco products packages.
- Tobacco advertising and sponsorship is prohibited.
- Sale of tobacco products to children under 18 years and pregnant women is prohibited.
- The government to establish health tax fund from the tobacco taxation.

Major challenges

- Implementation of the new Act.
- Enforcing smoke-free policies.
- Protecting youth from SHS.
- Enforcing ban on tobacco advertising.
- Expansion of tobacco cessation services.

It was found that a high percentage of youth was exposed to second-hand smoke. For instance, among students aged 13–15 years, 50% of boys and 45% of girls were exposed to SHS at public places despite the ban on smoking in public places.[52]

Despite the Government's efforts in banning tobacco advertising and sponsorship, the GYTS 2007 reveals a high percentage of Nepali youth exposed to advertising and promotion: 87.6% of boys and 81.5% of girls had noticed advertisements for cigarettes on billboards and 87.6% of them had seen advertisements for cigarettes in newspapers and magazines, and 7.6% boys and 7.9% girls were offered free samples of cigarettes.

Tax has been enforced on all types of cigarettes, cigars, *bidis,* piped tobacco and smokeless tobacco products. Excise tax, health tax and value added tax are levied on manufactured cigarettes. The tax on *bidi* is lower than on cigarettes. Specific tax rates are imposed depending on the length of cigarette sticks. Recently, a recommendation was made to increase the excise tax on tobacco products by more than 66% of the retail price. Nepal imposes a 2 paisa health tax on every manufactured cigarette stick.

Tobacco cessation clinics are available only in some health-care facilities. A tobacco "Quitline" has been established by the Nepal Cancer Relief Society. Nicotine replacement therapy (NRT) is available on prescription in pharmacies.

Nepal has piloted the Practical Approach to Lung Health (PAL) pilot project and has been successful in enhancing tobacco control through tobacco counselling and cessation activities and promoting smoke-free environments.

The GYTS 2007 reveals that 38% of current smokers bought cigarettes from a store indicating an easy access for youth or minors to cigarettes.

Nepal conducted GYTS in 2001 and 2003. But the national GYTS was conducted only in 2007. The subnational GSPS was conducted in 2003 and the national GSPS in 2007. The GHPSS was also conducted among medical and dental students in 2006. The WHO STEPwise approach to noncommunicable disease risk factor surveillance (STEPS) and GYTS were carried out in 2007.

Cigarettes displayed for sale in a shop in Katmandu.

Youth reading IEC materials on the harmful effects of tobacco.

Sri Lanka

Sri Lanka is the first country among the Members States of the Region to ratify the Framework Convention. The country has put in considerable efforts to implement tobacco control measures efficiently ever since the enactment of the National Authority on Tobacco and Alcohol Act in 2006.

Prevalence of the smoking form of tobacco is 15% and that of smokeless tobacco use is 15.8% in Sri Lanka. More men (29.8%) than women (<1%) smoked. Similarly, use of smokeless tobacco is higher among men (24.9%) than women (6.9%).[55]

Highlights

- Ratified the WHO FCTC in 2003 and enacted Tobacco Act in 2006.
- Implemented smoke-free policy in public places.
- Enforced tax on tobacco products.
- Implemented health warnings.
- Strengthened the monitoring system.
- Banned sale of tobacco to minors.

Major challenges

- Effective implementation of the Act.
- Sustained efforts in supporting smoke-free policy.
- Enforcing ban on tobacco advertising.
- Protecting youth from second-hand smoke.
- Expansion of tobacco cessation services.
- Sale of tobacco products to minors.

The National Authority on Tobacco and Alcohol Act, No. 27 of 2006 was passed in 2006. The Act[56] stipulates that:

- Smoking is prohibited within any enclosed public places such as government institution, office premises, health-care facilities, educational centres, universities, museums, cinema halls, supermarkets, public conveyances, etc.
- Non-smoking areas with designated smoking rooms are allowed in airports, hotels (with a capacity of >30 rooms) and restaurants (with a capacity of >30 persons).
- A manufacturer is prohibited to sell tobacco products without having health warnings and tar/nicotine content disclosure displayed on the packages.
- All forms of advertising on national TV and radio, in local magazines/ newspapers, on billboards, through outdoor advertising and the Internet are banned.

- Promotion of all tobacco products and brand names through any means is banned. Also, the tobacco industry's sponsorship of any educational, cultural, social and sporting organization or event is not allowed.
- The sale and promotion of tobacco products to any person below 21 years of age is banned.
- Installment of vending machines to dispense tobacco products is prohibited.

However, Sri Lanka does not have any provision for pictorial health warnings and also allows tobacco advertising inside a place where tobacco products are sold.

In spite of the bans on tobacco advertisements and promotion, a high percentage of boys and girls are exposed to direct advertisement. Among students aged 13–15 years, about 67% noticed advertisements for cigarettes on billboards and 68% in the print media. However, exposure to indirect advertising has been declining over time. For instance, about 8% of boys and 4% of girls in 1999 were offered a free cigarette by a tobacco company representative compared with only about 3% boys and girls in 2007.[57]

Exposure to second-hand smoke in public places is also high in Sri Lanka. Data from GYTS 2007 reveal that more than 65% of students aged 13–15 years have been exposed to second-hand smoke.

Tobacco cessation support is available in most primary care facilities and hospitals. Pharmacotherapy is available with a physician's prescription. However, health insurance does not cover the cost for cessation support.

The specific excise rate on the most popular brand of cigarettes was 59.2%. The government also imposes 12% value-added tax on cigarettes and other taxes constitute 3% of the total retail sale price. However, taxation is not uniform for all tobacco products.

Young boys and girls can buy cigarettes easily from a store even the law does not permit it. About three fourths of smokers among students aged 13–15 years bought cigarettes from a store, and 75% of them were not refused cigarettes because of their age.[57]

Recently, district tobacco control cells have been established in few districts with the purpose of bringing all the relevant stakeholders together and managing the district tobacco control activities more effectively and collaboratively.

Sri Lanka conducted the national GYTS in 1999, 2003 and 2007. GSPS was conducted in 2007. GHPSS was carried out among medical and nursing students in 2006. The WHO STEPwise approach to noncommunicable disease risk factor surveillance (STEPS) was carried out in 2008 among 15–64-year-old adults.

The county is also using the Framework Convention reporting instrument and has been submitting the Global Tobacco Control Report since 2006.

Recently released posters on harmful effect of tobacco use for advocacy and public education

(Courtesy: National Authority on Tobacco and Alcohol (NATA) Office, Colombo)

Thailand

Thailand has some of the world's strongest anti-tobacco legislation instruments in place. Tobacco health warnings existed as early as 1984, and Thailand has been updating the laws with necessary amendments/notifications/regulations to incorporate all the provisions of the Framework Convention. The major tobacco control legislations are the Tobacco Products Control Act, B. E. 2535, 1992, and the Non-Smokers Health Protection Act, B. E. 2535, 1992. The recent notification of the Ministry of Public Health (No. 11) B.E.2549 (2006), No. 19 B.E.2553 (2010) and the 18th MoPH notification further reinforced the tobacco control measures in Thailand.

Highlights

- Ratified the WHO FCTC in 2004 and enacted Tobacco Control Act in 1992.
- Launched 100% smoke-free Thailand.
- Imposed high tax on tobacco products.
- Banned advertisement of tobacco at the point of sale.
- Implemented pictorial health warnings.
- Cessation services widely available.
- 2% tax from tobacco and alcohol is earmarked for health promotion.

Major challenges

- Promotion of smoke-free policies.
- Cross-border advertising.
- Enforcing ban on tobacco sale to minors.
- Finding alternatives to tobacco farming.

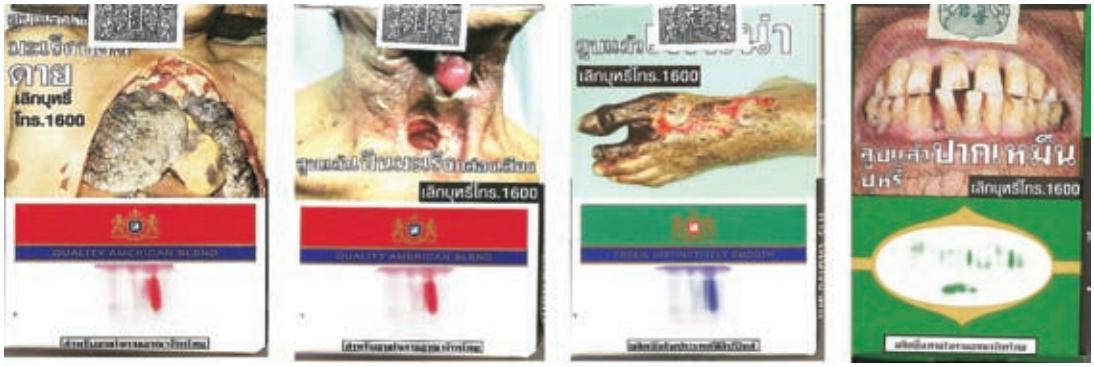
Prevalence of smoking among adults is 23.7% and smokeless tobacco use is 3.9%. The percentage of smoking among men (45.6%) is fifteen times higher than women (3.1%).[58] The current level of tobacco use among school boys is 17.4% and among girls 6%.[59]

The Tobacco Control Act[60-66] and further ministerial orders stipulate that:

- All public buildings, indoor workplaces, indoor public places and public transport are designated smoke-free areas.
- All forms of direct and indirect tobacco advertising, promotion and sponsorship, including at the point of purchase, are banned.
- All cigarette products sold in Thailand should display one out of ten rotating text and pictorial health warnings, and the health warnings should cover at least 55% of the principal display area in front and back sides of the package.
- Two black-and-white text and pictorial health warnings are to be used on any shredded tobacco products.

- Both manufactured and imported cigarettes must have labels displaying names of emitted toxic and carcinogenic substances
- Sale of tobacco products to persons less than 18 years of age is prohibited.

There has been a huge success in the display of health warnings on the cigarette packages. Over nine out of ten cigarette smokers noticed a pictorial health warning on cigarette packets. Also, about two in every ten users of hand-rolled cigarettes and smokeless tobacco noticed health warnings on the packages (GATS 2009).



Pictorial health warnings on packages of tobacco products in Thailand

However, exposure to second-hand smoke (SHS) is high in Thailand. As per GYTS 2009, 68% of boys and 67% of girls were exposed to SHS at public places. GATS 2009 also reveals that 31% of men and 19% of women were exposed to SHS at indoor workplaces, and 43.4% men and 35% women exposed to it at home. Although smoking in restaurants is legally banned, about 11% of men and 7.2% of women were exposed to SHS in restaurants.

Despite the bans on tobacco advertising and promotion in the country, people can still find cigarette advertisements in imported publications or on international TV programmes. About one third of all students aged 13–15 years had seen cigarette advertisements in newspapers and magazines. Few of them even received free samples of cigarettes (7.5% boys, 3.5% girls) (GYTS 2009). As per GATS 2009, 16% of adults had noticed some form of cigarette advertising, promotion and sponsorship.

By 2010, the majority of the primary-care facilities and hospitals had tobacco cessation clinics. Pharmacotherapy is available with a physician's prescription, and non-nicotine tablets are included on the National Essential Drugs List. Nicotine replacement therapy (NRT) is available over-the-counter. Health insurance covers the cost of cessation services either entirely or partially. The national quitline centre was established in 2009. The helpline telephone number is printed on cigarette package labels as well.

Taxes on cigarettes in Thailand include 71% excise tax, 5% customs duty on cigarettes imported from ASEAN countries and 60% on cigarettes from countries under WTO agreement, 2% surcharge tax for the Thai Health Fund,

6.5% value-added tax and other surcharge tax for the Thai Public Broadcasting Service. The roll-your-own tobacco is taxed according to the dual system comprising a 10% *ad valorem* tax plus a specific tax of 0.5 baht per gram of blended shredded tobacco.

Studies on the feasibility and impact of growing other plants to substitute tobacco and on the revenue-cost ratio of farming tobacco and other crops are ongoing. This is aimed at finding some economically viable alternatives for tobacco growers and manufacturers.

Thailand conducted GATS in 2009 and the national GYTS in 2005 and 2009. GSPS was conducted in 2005 and 2009. GHPSS was conducted in 2006 among dental, pharmacy and nursing students.

A Thai shop before the ban on display of tobacco products at the point of sale was enforced.

A Thai shop after the ban on display of tobacco products at the point of sale was enforced.

Timor-Leste

Timor-Leste is deploying multisectoral efforts and employing all possible means to effectively reduce tobacco use among the general population and move closer towards achieving its obligations under the Framework Convention.

Currently, there is lack of adequate data on the prevalence of tobacco use among adults. However, about 23% of school personnel smoked cigarettes, and the prevalence of smoking among men is about thirty times higher than that of women.[67] The cigarette smoking among youth (boys 38.2%, girls 14.6%) and use of other tobacco products (19% boys, 17% girls) are one of the highest in the Region.[68]

Highlights

- Ratified the WHO FCTC in 2004.
- Prohibits smoking in all health facilities and premises.
- Taxation on imported tobacco products.
- Health warnings in local languages.

Major challenges

- Adoption of national tobacco control law.
- Protecting young people from SHS.
- Establishment of tobacco cessation clinics
- Ban on the sale of tobacco to minors.

Timor Leste does not have any comprehensive tobacco control law at present. In 2008, the Ministry of Health Circular Nº5/2008/IVGC/MS[69] prohibited smoking in all health facilities and health premises. Both smoking and use of any tobacco products is banned in hospitals, health centres and sanitary posts, health premises, all vehicles of the Ministry of health, and during any health trainings. All health facilities should have "No Smoking" signs pasted.

The Decree Law No. 2006 mandates five rotating textual health warnings on tobacco products. It states that health warning labels must be individually and visibly printed on both the front and back sides of every cigarette or tobacco box and packet, right below or above the product trade mark, with letters in colour contrasting with that of the background of the box or package and covering a surface equivalent to the size of the producer's trademark. Importers must print health warnings in Portuguese or the local Tetum languages.

Text of health warnings in Timor-Leste:

(a) Smoking kills.
(b) Smoking is a health risk.
(c) Smoking causes cancer.
(d) Smoking while pregnant hurts baby.
(e) Smoking causes sexual dysfunction.

In the absence of any regulation on tobacco advertising, promotion and sponsorship, the tobacco industries have been taking advantage of the situation and using market their tobacco products vigorously in the country. Tobacco companies also sponsor sports and entertainment events targeting the youth. The cigarette manufacturers also give free gifts as part of tobacco product promotion.

According to GYTS 2009, about two thirds of students aged 13–15 years were exposed to cigarette advertisement on billboards and in newspapers/ magazines. A high percentage of boys (24.4%) and girls (21.4%) were offered free samples of cigarettes. Similarly, a high percentage of boys (27%) and girls (19.6%) possessed objects with a brand logo of cigarettes.

The survey in 2009 found that the exposure of youth to second-hand smoke in public places is high (67% boys, 56% girls).[68]

The government levies two types of taxes on tobacco products that are imported, one on the value of imported tobacco and another on the weight of the tobacco products. Manufacture of tobacco products is not allowed.

There is no tobacco cessation support in the country. However, nicotine replacement therapy is available.

As per GSPS 2009, only 20% of school personnel had ever received training to prevent tobacco use by youth and 47.2% of school personnel had access to teaching and learning material on tobacco use prevention.

Timor-Leste has no provision regarding restriction of sales to and by minors. As per GYTS 2009, 55% of the students bought cigarettes from a store and 64% of students were not refused buying cigarettes from a store because of their age.

Timor-leste conducted the national Global Youth Tobacco Survey in 2006 and 2009. The Global School Personnel Survey was also conducted in 2006 and 2009.

Young students at a No-Tobacco Day Rally in Dili.

Indirect advertisement of cigarette brand on a banner.

IV. Conclusion and way forward

As part of continued efforts to reduce the disease burden of tobacco in the Region, it is high time that countries enhance and prioritize national programmes to effectively implement their tobacco control legislation. Countries should align national tobacco control legislation and further regulations in line with the provisions of the WHO Framework Convention on Tobacco Control and implement the same effectively.

Enforcement measures are instrumental to achieve the objectives of any legislation. Public education on the existence and provisions of the national tobacco control laws is crucial. Training of law enforcers and public health professionals and dissemination of existing legislation to the public is an essential tool for the effective implementation of laws.

Since tobacco is a major risk factor for noncommunicable diseases (NCDs), effective implementation of the WHO Framework Convention will ensure great success in prevention and control of NCDs. Being a cross-cutting issue and a public health emergency to be dealt by many stakeholders, interagency collaboration and partnerships must be strengthened at country and regional levels.

WHO will continue to support Member States for effective implementation of the Framework Convention on Tobacco Control to protect present and future generations from the devastating economic and health impacts of tobacco use. WHO will encourage and support Member States to participate in intergovernmental negotiations and protocol development processes under the Convention.

V. References

(1) World Health Organization. *World Report on the Global Tobacco Epidemic, 2009: Implementing Smoke-Free Environments.* Geneva: WHO, 2009.

(2) World Health Organization, Regional Office for South-East Asia. *Implications of the Agreement on South Asian Free Trade Area on Tobacco Trade and Public Health in the SAARC Region*. New Delhi: WHO-SEARO, 2008.

(3) American Cancer Society and World Lung Foundation. *The Tobacco Atlas*. 3rd ed. New York, 2009.

(4) Jha P, Jacob B, Gajalakshmi V, Gupta PC, Dhingra N, Kumar R, Sinha DN, Dikshit RP, Parida DK, Kamadod R, Boreham J, Peto R; RGI-CGHR Investigators. A nationally representative case-control study of smoking and death in India. *N Engl J Med*. 2008 Mar 13; 358(11):1137-47.

(5) England LJ, Kim SY, Tomar SL, Ray CS, Gupta PC, Eissenberg T, Cnattingius S, Bernert JT, Tita AT, Winn DM, Djordjevic MV, Lambe M, Stamilio D, Chipato T, Tolosa JE., Non-cigarette tobacco use among women and adverse pregnancy outcomes. *Acta Obstet Gynecol Scand*. 2010; 89(4): 454-64.

(6) Gupta PC, Subramoney S., Smokeless tobacco use and risk of stillbirth: A cohort study in Mumbai, India, *Epidemiology*. 2006 Jan; 17(1):47-51.

(7) Subramoney S, d'Espaignet ET, Gupta PC., Higher risk of stillbirth among lower and middle income women who do not use tobacco but live with smokers. *Acta Obstet Gynecol Scand*. 2010; 89(4): 5727.

(8) Efroymsona D, Ahmed S, Townsend J, Mahbubul Alam SM, Dey AR, Saha R, Dhar B, Sujon AI, Ahmed K, Rahman O, Hungry for Tobacco: An analysis of the economic impact of tobacco consumption on the poor in Bangladesh. *Tob Control*. 2001;10: 212-17.

(9) Warren WC, Sinha DN, Lee J, Lea V, Jones N, Tobacco use, exposure to second-hand smoke, and cessation counselling among medical students: Cross-country data from the Global Health Professions Student Survey (GHPSS), 2005-2008. *BMC Public Health.* 2011; 11: 72. *http://www.biomedcentral.com/content/pdf/1471-2458-11-72.pdf* - accessed 6 May 2011.

(10) Warren WC, Sinha DN, Lee J, Asma S. Tobacco use, exposure to second-hand smoke, and cessation counselling training among dental students. *J Dent Educ*. 2011; 75(3): 385-405.

(11) Sinha DN, Singh G, Gupta PC, Pednekar M, Warren CW, Asma S, Lee J, Linking India Global Health Professions Student Survey Data to the World Health Organization Framework Convention on Tobacco Control. *Indian Journal of Cancer*. 2010; 47(Suppl 1): S 30-34.

(12) Warren CW, Sinha DN, Lee J, Lea V, Jones N R, Tobacco use, exposure to second-hand smoke, and training on cessation counselling among nursing students: Cross-country data from the Global Health Professions Student Survey (GHPSS), 2005–2009. *Int. J. Environ. Res. Public Health.* 2009; 6(10): 2534-2549. *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2790091/?tool=pubmed* – accessed 6 May 2011.

(13) Food and Agriculture Organization of United Nations (2004). *Higher world tobacco use expected by 2010 – Growth rate slowing down: Number of smokers growing - Production shifting to developing countries. http://www.fao.org/english/newsroom/news/2003/26919-en.html* - accessed 6 May 2011.

(14) Dobe M, Sinha DN, Rahman K, Smokeless tobacco use and its implications in WHO South East Asia Region. *Indian Journal of Public Health*. 2006 Apr-Jun; 50(2):70-5.

(15) Sinha DN, Gupta PC, Pednekar M, Use of tobacco products as dentifrice among adolescents in India: Questionnaire study. *BMJ.* 2004; 328: 323-324. *http://www.bmj.bmjjournals.com/cgi/content/full/328/7435/323* - accessed 6 May 2011.

(16) World Health Organization, Regional Office for South-East Asia. *Brief Profile on Gender and Tobacco in South-East Asia Region*. New Delhi: WHO-SEARO, 2010. *http://www.searo.who.int/LinkFiles/World_No_Tobacco_Day_GenderandTobacco.pdf* - accessed 9 May 2011.

(17) *2010 Global Progress Report on the Implementation of the WHO Framework Convention on Tobacco Control.* Geneva: WHO Framework Convention on Tobacco Control, 2010. *http://www.who.int/fctc/reporting/summaryreport.pdf* - accessed 9 May 2011.

(18) Guindon GE, Perucic AM, Boisclair. *Higher tobacco prices and taxes in South East Asia: An effective tool to reduce tobacco use, save lives and generate revenue*. HNP Discussion Paper-Economics of Tobacco Control Paper No.11. Tobacco Free Initiative. World Health Organization and HNP-World Bank, 2003.

(19) Government of the People's Republic of Bangladesh, Ministry of Health and Family Welfare; World Health Organization, Country Office for Bangladesh. *Global Adult Tobacco Survey: Bangladesh Report 2009. Dhaka, 2009. http://www.searo.who.int/LinkFiles/Regional_Tobacco_Surveillance_System_GATSBAN_ FullReport2009.pdf* – accessed 9 May 2011.

(20) *Report on Global Youth Tobacco Survey (GYTS) and Global School Personnel Survey (GSPS) 2007 in Bangladesh*. New Delhi: WHO-SEARO, 2008. *http://www.searo.who.int/LinkFiles/GYTS_BAN2007.pdf* – accessed 11 May 2011.

(21) Government of People's Republic of Bangladesh, Ministry of Health and Family Welfare. Smoking and Tobacco Products Usage (Control) Act, 2005. In: *National Strategic Plan of Action for Tobacco Control, 2007–2010.* Dhaka: MOHFW, 2009. pp. 29-32. *http://www.whoban.org/pdf/Tobacco_full_book.pdf* – accessed 9 May 2011.

(22) Global Health Professions Student Survey (GHPSS). *Bangladesh 2009 Factsheet (Dental). http://www.searo.who.int/LinkFiles/GHPS_Bangladesh_Dental_FactSheet2009.pdf* - accessed 6 May 2011.

(23) Global Health Professions Student Survey (GHPSS). *Bangladesh 2009 Factsheet (Medical). http://www.searo.who.int/en/Section1174/Section2469/Section2480_14179.htm* - accessed 6 May 20111.

(24) Global Health Professions Student Survey (GHPSS). *Bangladesh 2009 Factsheet (Pharmacy*). *http://www.searo.who.int/en/Section1174/Section2469/Section2480_14179.htm* - accessed 6 May 2011.

(25) Government of the People's Republic of Bangladesh, Ministry of Health and Family Welfare. *Report on Global Youth Tobacco Survey (GYTS) and Global School Personnel Survey (GSPS)*. Dhaka, 2007.

(26) Ministry of Health, Royal Government of Bhutan. *Brief Profile on Tobacco Control in Bhutan*. Thimphu, 2010.

(27) Global Youth Tobacco Survey (GYTS). *Bhutan 2009 Factsheet*. *http://www.searo.who.int/LinkFiles/GYTS_Bhutan_Factsheet2009.pdf* - accessed 6 May 2011.

(28) GSPS. *Bhutan 2009 Factsheet*. *http://www.searo.who.int/LinkFiles/GSPS_Bhutan_2009_Factsheet.pdf* - accessed 6 May 2011.

(29) Royal Government of Bhutan. *Tobacco Control Act of Bhutan 2010*. *http://en.wikipedia.org/wiki/Tobacco_Control_Act_of_Bhutan_2010* - accessed 6 May 2011.

(30) Democratic People's Republic of Korea, Ministry of Health. *Smoking Survey among Male Population.* Pyongyang, *2002.*

(31) Democratic People's Republic of Korea. *Law of the Democratic People's Republic of Korea on Tobacco Control.* Pyongyang, 2005.

(32) Government of India, Ministry of Health and Family Welfare. *Global Adult Tobacco Survey: GATS India 2009–2010. Mumbai, 2010. http://www.searo.who.int/LinkFiles/Regional_Tobacco_Surveillance_ System_GATS_India.pdf* - accessed 6 May 2011.

(33) Government of India, Ministry of Health and Family Welfare. *The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 and related Rules and Regulations – No. 34 of 2003*. New Delhi: MoHFW, 2003. *http://www.whoindia.org/LinkFiles/Tobacco_Free_Initiative_Compilation_of_tobacco_control_laws_rules_notifications.pdf* - accessed 9 May 2011.

(34) Government of India, Ministry of Health and Family Welfare. *Cigarette and Other Tobacco Products (Packaging and Labeling) Rules, 2006. In: The Gazette of India. Extraordinary Part II, Section 3, Sub-section (i).* New Delhi: MOHFW, 2006.

(35) Government of India. Ministry of Health and Family Welfare. *Cigarette and other tobacco products (Packaging and Labeling) (Amendment) Rules, 2007.* The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 and related Rules and Regulations.

(36) Government of India, Ministry of Health and Family Welfare. *Cigarette and Other Tobacco Products (Packaging and Labeling) Rules, 2008. In: The Gazette of India. Extraordinary Part II, Section 3, Sub-section ii.* New Delhi: MOHFW, 2008.14.

(37) Government of India, Ministry of Health and Family Welfare. *Cigarette and Other Tobacco Products (Packaging and Labeling)* (Amendment) Rules, 2009. In: *The Gazette of India. Extraordinary part II, Section 3, Sub-section i.* New Delhi: MOHFW, 2009.

(38) Shah PB, Pednekar MS, Gupta PC, Sinha DN., The Relationship between Tobacco Advertisements and Smoking Status of Youth in India. *Asian Pac J Cancer Prev*. 2008 Oct-Dec; 9(4): 637-42.

(39) Global Youth Tobacco Survey (GYTS) – India 2009 Factsheet.

(40) World Health Organization. *WHO Technical Manual on Tobacco Tax Administration*. India, 2010. *http://whqlibdoc.who.int/publications/2010/9789241563994_eng.pdf* - accessed 9 May 2011.

(41) The Government of Republic of Indonesia, Ministry of Health (2004). *National Socioeconomic Survey*.

(42) *GYTS – Indonesia 2009 Factsheet http://www.searo.who.int/LinkFiles/GYTS_IndonesiaFactsheet2009.pdf* - accessed 9 May 2011.

(43) The President of Republic of Indonesia. *Making Cigarettes Less Harmful to Health*. Government Regulation No. 19 Year 2003. Jakarta: The Government of Republic of Indonesia, 2003.

(44) Government of the Republic of Maldives, Ministry of Health (2010). *Law on Tobacco Control*. *http://www.health.gov.mv/regulations.php*- accessed 9 May 2011.

(45) Government of the Republic of Maldives, Ministry of Health (2004). *WHO STEPS survey*. http://www.health.gov.mv – accessed 9 May 2011.

(46) *Linking Global Youth Tobacco Survey Data to Tobacco Control Policy in Maldives*. *http://www.searo.who.int/LinkFiles/GYTS_MAV_2003_07_.pdf* - accessed 9 May 2011.

(47) Government of Myanmar, Ministry of Health. *Brief Profile on Tobacco Control in Myanmar*. Yangon, 2009. *http://www.searo.who.int/LinkFiles/Tobacco_Free_Initiative_SEA-TFI-27.pdf* - accessed 9 May 2011.

(48) World Health Organization, Regional Office for South-East Asia. *Report on Global Youth Tobacco Survey (GYTS) and Global School Personnel Survey (GSPS) 2007 in Myanmar*. New Delhi: WHO-SEARO. *http://www.searo.who.int/LinkFiles/GYTS_MMR_GYTS_GSPS_2007.pdf* – accessed 9 May 2011.

(49) The Union of Myanmar, State Peace and Development Council. *The Control of Smoking and Consumption of Tobacco Product Law (The State Peace and Development Council Law no. 5/2006. Dated 4th May 2006)*. Yangon: State Peace and Development Council, 2006.

(50) World Health Organization, Regional Office for South-East Asia. *Report on Global Youth Tobacco Survey (GYTS) and Global School Personnel Survey (GSPS) 2007 in Myanmar.* New Delhi: WHO-SEARO, 2007. *http://www.searo.who.int/LinkFiles/GYTS_MMR_GYTS_GSPS_2007.pdf* – accessed 6 May 2011.

(51) World Health Organization, Regional Office for South-East Asia. *WHO NCD Risk Factor Survey (STEPS) in Nepal 2007*(unpublished).

(52) Ministry of Health and Population, Government of Nepal. *Brief Profile on Tobacco Control in Nepal*. Kathmandu: Ministry of Health and Population, 2010. *http://www.searo.who.int/LinkFiles/Publications_ and_Documents_tobacco_control_nepal.pdf* - accessed 6 May 2011.

(53) Pandey MR, Pathak RP, Shrestha S, Saud S. *National Global Youth Tobacco Survey (GYTS) and National Global School Personnel Survey (GSPS) in Nepal 2007*. Kathmandu: Mrigendra-Samjhana Medical Trust, 2007. *http://www.searo.who.int/LinkFiles/GYTS_Nepal_Report_2007.pdf* – accessed 6 May 2011.

(54) Federal Democratic Republic of Nepal. *Tobacco Product (Control and Regulatory) Bill, 2010*.

(55) Ministry of Healthcare and Nutrition, Government of Sri Lanka. *Brief Profile on Tobacco Control in Sri Lanka*. Colombo, 2009.

(56) Parliament of the Democratic Socialist Republic of Sri Lanka*. National Authority on Tobacco and Alcohol Act, No. 27 of 2006*. [Certified on 29th August, 2006]. Colombo, Department of Government Printing, Sri Lanka, 2006. *http://documents.gov.lk/Acts/2006/National%20Authority%20on%20Tobacco %20and% 20Alcohol%20%20 Act%20No.%2027/Act%20No.%2027%20(E).pdf* - accessed 6 May 2011.

(57) Gunasekara PW. *Report of the Global Youth Tobacco Survey (GYTS) and Global School Personnel Survey (GSPS), Sri Lanka*. New Delhi: World Health Organization, Regional Office for South-East Asia, 2007. *http://www.searo.who.int/LinkFiles/GYTS_SRL_GYTS-GSPS_Report_2007.pdf* – accessed 6 May 2011.

(58) World Health Organization, Regional Office for South-East Asia. *Global Adult Tobacco Survey (GATS): Thailand Country Report*. New Delhi: WHO-SEARO, 2009. *http://www.searo.who.int/LinkFiles/Regional_Tobacco_Surveillance_System_GATS_Thailand_2009.pdf* – accessed 6 May 2011.

(59) World Health Organziation, Regional Office for South-East Asia. *Thailand 2009 Factsheet*. New Delhi: WHO-SEARO, 2009*. http://www.searo.who.int/LinkFiles/GYTS_ThailandFactsheet2009.pdf* – accessed 6 May 2011.

(60) Ministry of Public Health, Thailand. *Tobacco Products Control Act B.E.2535 (A.D. 1992)*. Bangkok: MoPH, 1992. *http://www.thpinhf.org/T_Products_Control_Act-text.html* – accessed 9 May 2010.

(61) Ministry of Public Health, Thailand. *Notification of the Ministry of Public Health (No. 10) B.E.2549 (A.D. 2006).Re: : Criteria, Procedures and Conditions for Displaying the Name of Toxic and Carcinogenic Substances on Labels of Cigarettes. Issued under the Tobacco Product s Control Act B.E. 2535*. Bangkok: MoPH, 2006. *http://thaiantitobacco.com/eng/files/tc/announce_moph10_eng.pdf* – accessed 9 May 2011.

(62) Ministry of Public Health, Thailand. *Notification of the Ministry of Public Health (No.11) B.E.2549 (A.D. 2006. Re: : Criteria, Procedures and Conditions for Displaying Pictures or Statements relating to Warning on Harm; Date, Month and Year of Manufacture; Manufacturing Source and Sale only in the Kingdom of Thailand on Labels of Cigarettes and Cigars. Issued under the Tobacco Products Control Act. B.E. 2535*. Bangkok: MoPH, 2006.

(63) Ministry of Public Health, Thailand. *Notification of the Ministry of Public Health (No. 12) B.E.2549 (A.D. 2006). Re: Criteria, Procedures and Conditions for Displaying Words or Statements that may cause Misunderstanding on Labels of Cigarettes, Cigars and Tobacco. Issued under the Tobacco Products Control Act. B.E.2535*. Bangkok: MoPH, 2006.

(64) Ministry of Public Health, Thailand. *Notification of the Ministry of Public Health (No. 13) 2550 (A.D. 2007). Re: Criteria, Procedures and Conditions for Displaying Pictorial Labels and Statements of Warning on Harm of cigars. Issued under the Tobacco Products Control Act B.E. 2535. G/TBT/N/THA/288.* Bangkok: MoPH, 2008.

(65) Ministry of Public Health, Thailand. *Notification of the Ministry of Public Health (No. 14) B.E.2550 (A.D. 2007). Re: Criteria, Procedures and Conditions for Displaying Pictorial Labels and Statements of Warning on Harm of Tobacco. Issued under the Tobacco Products Control Action B.E. 2535 (A.D. 1992).* Bangkok: MoPH, 2007. *http://thaiantitobacco.com/eng/files/tc/announce_moph_eng_tobacco.pdf* - accessed 9 May 2011.

(66) Ministry of Public Health, Thailand. *Notification of the Ministry of Public Health Government Gazette, Vol 126 Special Section 143, Notification of the Ministry of Public Health RE: Criteria, Procedures and Conditions for Displaying Labels and Statements on Labels of Cigarettes B.E. 2552 (A.D. 2009).* Bangkok: Ministry of Public Health, 30 September 2009.

(67) World Health Organization, Regional Office for South-East Asia. *GSPS-Timor Leste 2009 Factsheet*. New Delhi: 2009. *http://www.searo.who.int/LinkFiles/GSPS_EastTimor_2009_Factsheet.pdf* - accessed 9 May 2011.

(68) Kusumawardani N, Rahman K, Warren CW, Jones NR, Asma S, Lee J, Serekai M. *Report on Global Youth Tobacco Survey Timor Leste. Linking Global Youth Tobacco Survey (GYTS) data to the WHO Framework Convention on Tobacco Control: The Case for Timor Leste.* Jakarta: Biomedical and Pharmacy Research Center. *http://www.searo.who.int/LinkFiles/GYTS_TimorLeste.pdf* - accessed 6 May 2011.

(69) Government of Timor Leste, Ministry of Health. *Health Circular 2008; Nº5: IVGC/MS.*

(70) Government of Sri Lanka, Ministry of Healthcare and Nutrition (2006). *WHO STEPS Survey*. Colombo.

(71) Government of India, Ministry of Health and Family Welfare. *Global Youth Tobacco Survey: GYTS India Factsheet 2006*. New Delhi, 2006

(72) World Health Organization, Regional Office for South-East Asia. *Country-validated Information for Global Tobacco Control Reports (GTCR III, 2011)*. New Delhi: 2011 (Unpublished).

(73) BlechervE, van Walbeek C. *An Analysis of Cigarette Affordability*. Paris: International Union Against Tuberculosis and Lung Disease, 2008.

(74) Sunley, Emil M. *India: the Tax Treatment of Bidis. 2008*. *http://www.tobaccofreeunion.org/files/44.pdf* – accessed 9 May 2011.

This *Profile on the Implementation of the WHO Framework Convention on Tobacco Control in the South-East Asia Region* provides an overview of the status of the implementation of the convention in the eleven Member States of the SEA Region.

It highlights some major milestones achieved as well as the challenges faced while implementing tobacco control measures in Member countries.

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