JOINT NATIONAL CAPACITY ASSESSMENT ON THE IMPLEMENTATION OF EFFECTIVE TOBACCO CONTROL POLICIES IN THAILAND
Joint national capacity assessment on the implementation of effective tobacco control policies in **Thailand**
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## Abbreviations

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<tr>
<td>AFTA</td>
<td>Asian Free Trade Agreement</td>
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<td>ASH Thailand</td>
<td>Action on Smoking or Health Foundation, Thailand</td>
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<td>BMA</td>
<td>Bangkok Metropolitan Administration</td>
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<tr>
<td>CIF price</td>
<td>Cost, Insurance, Freight, or the cost of import at the destination (i.e. land border or port of entry)</td>
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<td>DDC</td>
<td>Department of Disease Control</td>
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<td>WHO FCTC</td>
<td>WHO Framework Convention on Tobacco Control</td>
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<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>NCCTU</td>
<td>National Committee for the Control of Tobacco Use</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>RYO</td>
<td>roll-your-own (tobacco)</td>
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<td>SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
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<td>SEATCA</td>
<td>Southeast Asia Tobacco Control Alliance</td>
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<td>ThaiHealth</td>
<td>Thai Health Promotion Foundation</td>
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<td>THPI</td>
<td>Thai Health Promotion Institute</td>
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<td>TRC</td>
<td>Tobacco Control Research and Knowledge Management Centre at Mahidol University</td>
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<td>TTM</td>
<td>Thailand Tobacco Monopoly</td>
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<td>UC</td>
<td>Universal Coverage health care scheme</td>
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<td>VAT</td>
<td>value added tax</td>
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Executive summary

A group of 38 national, international and World Health Organization health experts assessing the country’s tobacco control work conducted more than 80 interviews between 2 and 13 November 2008. The assessment team found that Thailand has a distinctive tobacco control model based on close cooperation between the Ministry of Public Health (MoPH), the Thai Health Promotion Foundation (ThaiHealth) and a very active coalition of tobacco control nongovernmental organizations guided by a unique generation of creative civil society leaders.

This model has allowed Thailand to implement a number of strong policy measures to protect the Thai population from the dangers of tobacco. Such measures include key approaches to reducing tobacco consumption, particularly in the areas of packaging and labelling, advertising bans and smoke-free public areas. As a result of these measures, the prevalence of smoking has steadily decreased over time among both sexes, and exposure to second-hand smoke among households has declined.

Despite decreasing trends, however, challenges persist. Smoking rates remain high among adult men. A higher proportion of younger women are now smoking compared with their predecessors. Exposure to second-hand smoke remains unacceptable.

The tobacco control achievements in Thailand have created a perception of success in Thai society and government. The leadership of the tobacco control movement in the governmental and nongovernmental sectors is well aware of the challenges ahead, but this awareness does not necessarily exist outside this group. Complacency in some sectors of government and civil society may blur the magnitude of the tasks remaining to be done in tobacco control in Thailand.

To ensure the sustainability of current initiatives and further progress, the following recommendations are offered.

1. **Continue to increase tobacco prices through taxation in line with inflation, and substantially increase taxes on “roll your own” cigarette tobacco.**
   Cigarettes have become more affordable over the years as per capita income has been increasing more rapidly than tobacco taxes. An estimated 50% of tobacco consumed in Thailand is “roll your own,” which is taxed at a very low level and often bypasses tax collection and has minimal price incentives for consumers.

2. **Ensure 100% smoke-free indoor environments in all indoor public places and workplaces, including non-air-conditioned spaces, to provide universal and equal protection for all workers and the public from exposure to second-hand smoke.**
   The current law permits certain smoking areas in public places, and is not completely compliant with Article 8 (protection from second hand-smoke) of the WHO FCTC. Enforcement of the law could be further strengthened.
3. **Provide cessation support for all tobacco users through brief cessation interventions within the primary care system.**

Priority should be given to developing and promoting brief cessation interventions that can be routinely incorporated into existing health care delivery networks, especially within the primary care system. As a minimum, this should include encouraging attempts to quit through the identification of tobacco use among all health care users, the delivery of brief advice to quit to all tobacco users and active referral, especially of priority and vulnerable population groups, to treatment services. This will require the establishment and implementation of national cessation guidelines. The sustainability of the Thai tobacco control model depends on three factors: the continued leadership of civil society, with the incorporation of new leaders and new organizations into tobacco control; the strengthening of the Government’s role in tobacco control; and the continued flow of funds to tobacco control. For these reasons, there follow two additional recommendations.

4. **Strengthen and enhance the Thai tobacco control model by:**
   - identifying and developing future leaders in tobacco control within both government and civil society;
   - strengthening the National Committee for the Control of Tobacco Use;
   - reinforcing the capacity of government to lead policy changes, coordinate multisectoral tobacco control planning and implement tobacco control strategies in a sustainable manner (this will require a well-staffed tobacco control cluster, more funds from the regular budget of the MoPH, and closer attention to effective enforcement of tobacco control laws);
   - maintaining and potentially expanding local funding mechanisms for tobacco control, particularly using earmarked tobacco and alcohol taxes for ThaiHealth; and
   - building and sustaining capacity within the tobacco control workforce at all levels.

5. **Give priority to creating a national plan of action for tobacco control, engaging multiple stakeholders, and identifying strategies and activities to have a comprehensive national tobacco control programme, including a system for monitoring the plan’s implementation and outcomes.**

6. **Improve efforts for rising public awareness through effective mass media campaigns.**
1. Introduction

Thailand has implemented a number of strong policy measures to control the tobacco epidemic. As a result, the prevalence of smoking has steadily decreased over time among people of both sexes. In addition, the average number of cigarettes smoked per day by males has declined over time, from 12 per day in 1991 to 10 in 2007. For females, however, the number has slightly increased, from 7 per day in 1991 to 8 in 2007.

Despite steady decreases, smoking prevalence is still high among males
Despite decreasing trends, smoking rates remain high among men. For adults, the major source of smoking data is the national surveys conducted by the National Statistical Office of the Ministry of Public Health (MoPH) since 1976. Over the past 16 years, the number of current smokers decreased from 12.3 million in 1991 to 10.9 million in 2007, resulting in the decreasing of current total smoking prevalence from 32.0 % to 21.2 %. The smoking prevalence among men decreased from 59.33 % in 1991 to 41.7% in 2007 and among women from 4.95 % in 1991 to 1.9% in 2007.

A higher proportion of girls than women are smokers
Although the smoking prevalence is low among adult women, the proportion of young people that smoke is higher than in preceding generations. The survey conducted in 2004 revealed that 5.2% of females aged 13-15 years were current smokers (more than double the adult female prevalence) and that 10.0% of never-smoking girls indicated that they were likely to take up smoking in the coming year. In addition, almost half of girls surveyed possessed an object with a cigarette logo, a strong predictor of becoming a regular smoker later in life. All these data indicate that the smoking prevalence among females may increase rapidly if nothing is done to prevent it.

Exposure to second-hand smoke has decreased but remains high among both young people and adults
Data from national surveys conducted in 2001, 2004 and 2007 show declines in exposure to second-hand smoke among households, from 86% in 2001 to 59% in 2007. This shows that despite improvements, exposure to second-hand smoke is still high. Other surveys also show a high level of exposure. Among third-year students in the health field, 63% were exposed to second-hand smoke in schools and other public places. Moreover, close to half of young people aged 13-15 years (47.8%) are exposed to second-hand smoke at home and almost 70% are exposed outside of their homes.

Tobacco use takes a significant toll on the health of the population and its economy
Two of the three leading causes of mortality – circulatory diseases (18.6%) and cancers and tumours (16.2%) – are tobacco-related. The third leading cause of death is infectious diseases (15.5%), among which tuberculosis is the second most common and which cigarette smoking may exacerbate. Data on economic burden of some tobacco related diseases are available, but there are currently no recent data on total tobacco-specific health expenditures. In 2005, total expenditure on health by the Thai Government was some 248 000 million baht, or about 3.5% of gross domestic product (GDP).

Given that smoking rates are highest among the poor; this represents a significant proportion of family income diverted from such essentials as food, education and health care. Data show that the poorest households in Thailand spend approximately 8% of their household income on tobacco.
Most of the population smoke products made in Thailand
Half of smokers, mostly in rural areas, use roll-your-own (RYO) tobacco locally produced by small businesses, a segment of the market that remains largely fragmented and unregulated. The other half smoke cigarettes mainly produced by the government-owned Thailand Tobacco Monopoly (TTM), which controls about 75% of the market for manufactured cigarettes.

Thailand has permitted the importation of cigarettes since 1991. As a result, TTM’s share of the market has subsequently shrunk, from 99% in 1991 to 75% in 2007. Overall, duty-paid sales of cigarettes remained stable between 1991 and 2007 at approximately 2000 million packs. The extent of non-duty-paid sales, including smuggled products (counterfeit or otherwise) may be as much as 20%.

Assessing the national capacity to reverse the tobacco epidemic in Thailand
In this context, a mission led by WHO performed a joint assessment of the national capacity of Thailand to implement WHO MPOWER package of selected demand reduction tobacco control measures in support of the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC), to which the country has been a Party since November 2004. At the request of the Thai Government, WHO, through its country office in Thailand and the WHO Regional Office for South-East Asia (SEARO), worked together with the Bureau of Noncommunicable Diseases of the MoPH to organize and conduct the joint capacity assessment.

From 2 to 14 November 2008, a group of 30 national, international and WHO health experts reviewed the current status and development efforts of key tobacco control policies, conducting more than 80 interviews with key informants. The group also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control; programme management; inter- and intra-sectoral partnerships and networks; and human and financial resources and infrastructure. Finally, the expert group made recommendations based on the key findings of their analysis to further the development of the following tobacco control policies: Monitor tobacco use and interventions, Protect people from tobacco smoke, Offer help to quit tobacco use, Warn about the dangers of tobacco, Enforce bans on tobacco advertising, promotion and sponsorship, Raise on taxes tobacco and Develop sustainable alternatives to tobacco growing.

For each policy, the report comprises the following three sections.
• Policy status and development. A brief introduction is given on the present status and future development of the policy in question, based on a thorough review of all documents made available by the coordinating team of the capacity assessment prior to the country visit (Tobacco Control Country Profile, the WHO report on the global tobacco epidemic, 2008, legislation in force, results and conclusions of previous studies and reports, etc.) and interviews.

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1 The WHO FCTC provides the principles and context for policy development, planning of interventions and mobilization of political and financial resources for tobacco control. Parties to the WHO FCTC have committed themselves to protecting the health of their populations by joining the fight against the tobacco epidemic. To help countries fulfill the promise of the WHO FCTC and turn this global consensus into a global reality, the MPOWER policy package builds on the measures of the WHO FCTC that have been proven to reduce smoking prevalence. The package is an integral part of the WHO Action plan for the global strategy for the prevention and control of noncommunicable diseases endorsed at the 61st World Health Assembly in 2008.

2 See list of institutions and key informants in Annex 2.
• **Key findings.** A summary is provided of most important facts discovered by the assessment team after conducting the visits and interviews. This is based on an analysis of key factors for the success in implementing present policies and developing future ones, such as political will, programme management and coordination, partnerships and networks for implementation, provision of funds, and human resources.

• **Key recommendations.** A summary of actions required to improve the design, implementation and enforcement of the policy examined.

WHO is grateful to the Government and the tobacco control nongovernmental organizations (NGOs) in Thailand for once again leading the way by carrying out the second pilot of the WHO tobacco control capacity assessment mission. Many other WHO Member States will follow and benefit from the lessons learnt in this pilot mission.

Fig. 1. Map of Thailand:
2. Coordination and implementation of tobacco control interventions: the Thai model

2.1. POLICY STATUS AND DEVELOPMENT

Thailand has a distinctive tobacco control model based on close cooperation between the MoPH, a very active coalition of tobacco control NGOs and the Thai Health Promotion Foundation (ThaiHealth), a quasi-governmental agency devoted to the funding of health promotion projects, including tobacco control. This model has been developed in a context whereby the main manufacturer of cigarettes, TTM, is owned by the Government and has a market share of manufactured cigarettes of 75%.

2.1.1. The role of government

The Kingdom of Thailand is a unitary state wherein health policy is approved at the central level and implementation of health interventions is transferred and to some extent decentralized to provincial administrations. The capital, Bangkok, is an exception as it has an autonomous governance system.

Three formal governmental structures were examined during the mission. The first is the MoPH, which approves the national tobacco control policy and implements and enforces tobacco control laws through its regional and provincial levels. The second and the third are policy coordinating mechanisms chaired by the MoPH: the National Committee for the Control of Tobacco Use (NCCTU), a multisectoral group with representatives from the different sectors of the Government and civil society; and the National Committee for International Implementation (NCII) comprising some members of the NCCTU and experts on the tobacco control provisions of various treaties.

Intra- and inter-sectoral national coordination

The NCCTU was established in 1989 and has an advisory role in policy development. The Director-General of the Department of Disease Control (DDC) is Secretary of the NCCTU with the support of the tobacco control cluster in his or her department. The members of the NCCTU consist of the Permanent Secretaries of related ministries, representatives of civil society and prominent tobacco control experts. The NCCTU is responsible for drafting policy and guidelines on tobacco control; cooperating with other organizations concerning tobacco control activities; and accelerating, controlling, monitoring and evaluating the legal enforcement of notifications issued by the MoPH. Its role also includes revising existing laws and regulations as well as MoPH notifications; promoting, supporting and reviewing academic papers and research articles; disseminating information to the general public; and appointing sub-committees and working groups for certain specific tasks.

The NCII is chaired by the Permanent Secretary of Health and has an advisory role in the development of the country’s position concerning the international aspects of the WHO FCTC. It is assisted by six informal working groups related to WHO FCTC provisions. This committee has appointed several working groups for the preparation of Thailand’s position on proposed guidelines for WHO FCTC implementation.
In 1989, the MoPH created a unit in charge of tobacco control and more recently, in 2002, it established a Tobacco and Alcohol Control Cluster under the Bureau of Noncommunicable Diseases, which reported to the Director-General of the DDC. Following legislation in May 2008 mandating the establishment of an alcohol control unit, the tobacco control component of the Tobacco and Alcohol Control Cluster was created as a cluster under the Bureau of Noncommunicable Diseases while the alcohol component was transformed into the Office of the Alcohol Beverage Control Committee directly under the DDC. The administrative separation of both components was still under way during the mission.

The newly formed Tobacco Control Cluster under the DDC is responsible for developing tobacco control plans and implementing and monitoring activities in coordination with relevant organizations within and outside the MoPH (Fig. 2.1).

Within the MoPH, the Tobacco Control Cluster works with:
- the Office of the Alcohol Beverage Control Committee of the DDC;
- the Department of Medical Services and the Department of Mental Health, MoPH, which provide treatment for drug, alcohol and tobacco addiction;
- 12 regional offices for disease prevention and control; and
- the Office of the Permanent Secretary, which supervises 75 provincial health offices, regional, provincial and community hospitals, district health offices and health centres all over the country.
Outside the MoPH, the Tobacco Control Cluster works in coordination with:

- the government sector, which includes:
  - the Excise Department, Ministry of Finance, responsible for collecting tax on cigarettes and other tobacco products;
  - the Customs Department, Ministry of Finance, responsible for collecting tax on imported cigarettes and other tobacco products and enforcing the law on cigarette smuggling;
  - the Office of the Royal Thai Police, Office of the Prime Minister, responsible for preventing and controlling cigarettes smuggling and enforcing tobacco control legislation;
  - the Department of Special Investigation, Ministry of Justice, responsible mainly for taking legal action against smuggling and evasion of customs duty according to customs legislation;
  - the Public Relations Department, Office of the Prime Minister, which deals with the broadcast media on tobacco control;
  - The Ministry of Education, responsible for implementing smoke-free schools according to the non-smoker’s health protection act;
  - provincial administrative organizations under the Ministry of the Interior, responsible for implementing policies and activities at provincial and district levels;
  - the Council of State, responsible for clarifying the text of legislation and checking conflicts with other laws; and
  - the Office of Narcotics Control;

- autonomous organizations under governmental supervision, including:
  - ThaiHealth (described below); and
  - the Bangkok metropolitan administration, which, in coordination with the MoPH, is responsible for all health programmes (including tobacco control) within Bangkok; and

- NGOs working in tobacco control, such as the Action on Smoking or Health Foundation, Thailand (ASH Thailand), the Thai Health Promotion Institute (THPI), the Southeast Asia Tobacco Control Alliance (SEATCA), the Thai Health Professional Network Against Tobacco and the Teachers Network Against Tobacco. The Tobacco Control Research and Knowledge Management Centre (TRC) at Mahidol University is responsible for developing a database for the monitoring and surveillance of tobacco control, supporting research activities and evaluating tobacco control programmes and projects.

**National implementation**

The implementation of tobacco control policies is undertaken through the MoPH infrastructure (Fig. 3.1). The current structure involves 75 provincial health offices, provincial and community hospitals, district health offices and health centres. Programme policies and strategies are transferred to provincial staff through the training of provincial and district focal points by the technical staff of the 12 regional disease prevention and control centres. Besides tobacco control, these technical staff also look after the non-communicable diseases control programme. The staff in the regional Disease Prevention Centres do not implement programmes but rather monitor and supervise provincial staff after their training. Training is provided to raise awareness on tobacco control laws and on enforcement aspects and to support communication and education campaigns.
The provincial hospitals and provincial health offices are supervised directly by health inspectors of the office of the Permanent Secretary of the MoPH. Health inspectors have a checklist for monitoring priority programmes within the MoPH. Tobacco control is included in the health inspectors’ checklist. Each provincial health office is headed by a Provincial Chief Medical Officer, who is responsible for public health programmes in his/her jurisdiction. A Provincial Noncommunicable Diseases Coordinator, who is also responsible for the tobacco control programme, is appointed to each provincial health office. There is considerable variation in the level of staffing for noncommunicable diseases control across provinces, in terms of the number of staff and time allocated for noncommunicable diseases and tobacco control. Under the health service reform policies, the budget authority for public health services has been shifted to the Contracting Unit for Primary Care, which is located at the district level.

A District Noncommunicable Diseases Coordinator working at the District Health Office is responsible for coordinating tobacco control activities in the district and works in close collaboration with the regional disease prevention and control centre. The implementation of health service reform policies has weakened the role of the District Health Office, as planning and budget authority for the district public health services now rests mainly with the district hospitals, for clinical services and with Local Administration for disease prevention and health promotion.

The Bangkok Metropolitan Administration (BMA) has played an important role by developing the “five days five hours” smoking cessation programme in BMA hospitals. Also, it has developed a four-way approach to smoke-free hospitals, a successful programme that was eventually adapted to all nine BMA hospitals.

Two private–public partnerships can be mentioned as playing some role. The first is the Green Leaf Foundation, which focuses on smoke-free policies and conducts studies and research in environmental conservation, develops environmental quality standards for the tourism industry, and runs workshops for the promotion of environmental technology. The foundation is also running a “Smoke Free Hotel Project” in which currently 336 hotels are participating and among these 220 have been accredited as passing the minimal standard criteria of “Smoke Free Hotel”. Founder organizations comprise the Tourism Authority of Thailand, the Thai hotels Association, the United Nations Environment Programme, the Electricity Generating Authority of Thailand, the Association for the Development of Environmental Quality and the Metropolitan Waterworks. The second is Denla Kindergarten, which has developed a smoke-free programme using schools’ own funds for campaigns.
2.1.2. The role of NGOs
NGOs play a very active role in advocating for policy change in tobacco control and implementation of tobacco control interventions. The main NGOs are the following.

- ASH Thailand plays an important role in launching media campaigns against tobacco, particularly in the areas of smoke-free environments, empowering young people and providing help-line support for tobacco cessation;
- The THPI advocates for tobacco policy and law and provides information to the general public about the strategies of the tobacco industry;
- The Thai Health Professional Network Against Tobacco encourages health professionals to be role models for a smoke-free, healthy life and to be active advocates of the anti-smoking campaign;
- The Teachers Network Against Tobacco supports teachers to build up their capacity to initiate tobacco control activities; and
- SEATCA, focusing on seven south-east Asian countries, was created to share Thai tobacco control experience with other countries and is funded by the Thai Health Promotion Fund, the Rockefeller Foundation and, more recently, the Bloomberg Grants Fund through the Union. Areas of work include technical assistance for policy change, monitoring of the tobacco industry, research, study tours, sharing of best practices, regional/country workshops, fellowships, and seed grants for national capacity building.

2.1.3. The role of ThaiHealth
ThaiHealth was established by law as an autonomous governmental organization in 2001. It is governed by a board presided over by the Prime Minister, assisted by two vice-presidents. One is the Minister of Public Health and the other is an academic or a civil society representative. There is a manager who runs the day-to-day operations. ThaiHealth is funded by an earmarked 2% of tobacco and alcohol taxes, which in 2007 amounted to approximately US$ 60 million, about one third of which came from tobacco taxes. Its mission is to support and develop health promotion interventions leading to improvements in the health of the Thai people through 12 programmes, one of which is tobacco control. Almost 10% of the Thai health budget was devoted to funding tobacco control projects in 2008. About 30% of the ThaiHealth project funding is provided to grantees through an open proposal request programme and the rest through a proactive search programme. Selection of proposals is based on merit.

2.2. KEY FINDINGS

2.2.1. Leadership

2.2.1.1. The Thai model has produced important achievements in tobacco control.
This model has allowed Thailand to implement a number of strong policy measures to protect the Thai population from the dangers of tobacco, particularly in the areas of packaging and labelling, advertising bans and smoke-free public areas. As a result, the prevalence of smoking has steadily decreased over time among both sexes, and exposure to second-hand smoke within households has declined. Nevertheless, despite these decreasing trends, challenges persist: smoking rates remain high among adult men; higher proportions of young women are now smoking compared with those in preceding generations; and the level of exposure to second-hand smoke remains unacceptable.
2.2.1.2. These achievements might be creating some complacency that may delay progress in tobacco control.

The tobacco control achievements in Thailand have created a perception of success in Thai society and government. Although the leadership of the tobacco control movement in the governmental and non-governmental sectors is well aware of the challenges ahead, the mission found that such awareness does not necessarily exist outside this group. Complacency in some sectors of government and civil society may blur the magnitude of the tasks remaining to be done in tobacco control in Thailand. Some NGOs not involved in tobacco control, for example, did not see the need to become involved since they perceived the situation to be under control.

2.2.1.3. Achievements are mainly the result of the initiative and drive of NGOs and professional groups.

The Thai tobacco control model has been possible owing to a unique generation of creative civil society leaders that have built a strong partnership among NGOs and with government and the media. A “core group” of NGO leaders is driving the tobacco control policy agenda, thanks to its strong links to the Thai Health Promotion Fund and its connection to governmental decision-makers.

2.2.1.4. The sustainability of this model depends on three factors.

These factors are: the continued leadership of civil society with the incorporation of new leaders and new organizations; the strengthening of the role of government in tobacco control; and the continued flow of funds for tobacco control.

2.2.2. Funding

2.2.2.1. Funds for tobacco control come mostly from ThaiHealth.

Most of the funds supporting tobacco control activities in the governmental and nongovernmental sectors come from ThaiHealth [about 200 million baht per year]. The Tobacco Control Cluster received about 37 million baht from ThaiHealth in 2008, mainly to fund law enforcement activities. In addition, the Government allocates about 10 million baht a year from the regular budget of the MoPH, mostly to support educational campaigns; this does not include salaries. Recently, the MoPH received a Bloomberg grant of about US$ 1 million for smoke-free environments.

After the introduction of the health service reforms, all services at health facilities are now financed through the Universal Coverage (UC) scheme and provincial jurisdictions receive lump sums to provide a package of health care and public health services, calculated on the basis of fixed per capita rates. Training, supervision and monitoring activities are financed through a non-UC budget available through the DDC. Most tobacco control activities outside the Thai Health Promotion Fund are financed through non-UC funds channelled directly by the DDC to the tobacco and alcohol teams in the noncommunicable diseases units of DDC regional departments, mostly for training provincial teams in tobacco law enforcement and for regular monitoring of compliance with the law. There is no evidence that these funds are channelled to the provincial level nor any clear evidence that significant UC funding is provided for tobacco control at any level.

Some additional funding, predominantly for NGOs, comes from the Rockefeller Foundation, the private sector, and governmental organizations such as the Office of Narcotics.
2.2.2.1. Funding for tobacco control is insufficient, especially for governmental activities. The overall current level of funding and the funding mechanism for tobacco control seem to be satisfactory only for the current level of tobacco control activities at central level. The overall level of funding at local and regional levels is not satisfactory. The funding support for MoPH governmental tobacco control activities from the health regular budget is still very low for both the central and the provincial levels.

2.2.3. Coordination

2.2.3.1. National coordination for tobacco control relies heavily on informal processes.
Even though there are governmental structures to provide the advice needed for decision-making at the highest levels, tobacco control policies rely on informal processes. Owing to the instability of the political situation and frequent changes of Minister of Health, the two most important high-level policy committees – NCCTU and NCII – do not seem to be very active. The plenary of the NCCTU met in January 2008 and the NCII met in June 2007, although the subcommittees of the NCII recently met to prepare the third WHO FCTC meeting of the Conference of the Parties, held in October 2008. Despite the existence of these committees, an informal core group of tobacco advisers to ThaiHealth plays a central role in coordinating all national tobacco control activities. This core group represents NGOs and, although the MoPH has a permanent seat, it is not regularly represented. The NGOs have good access to decision-makers in the MoPH and have created a “parallel” national tobacco control programme that has great influence in successfully creating and implementing national tobacco control policy. This NGO network is located mostly in Bangkok and includes ASH Thailand, the THPI and SEATCA.

2.2.3.1. Government capacity for coordinating tobacco control is not strong.
Despite the evident advances in tobacco control in Thailand, the government tobacco control capacity is not very strong and the structure is still unstable and requires continuous support from NGOs and other partners. The governmental sector has played a less leading role in coordination with NGOs. The Tobacco Control Cluster is currently under transition and restructuring. This points to a need to strengthen the governmental sector while retaining strong links with NGOs.

2.2.3.2. The Government has begun to develop a national plan of action.
A committee was recently established to develop a national policy and plan for tobacco control. This plan will try to set with clear objectives, goals and timetable and will aim better coordination of stakeholder efforts. It is structured around seven main objectives: a) to reduce initiation of tobacco use, b) to increase cessation among tobacco users, c) to minimize the toxic effects of tobacco products, d) to reduce exposure to tobacco smoke, e) to improve tobacco control legislation and compliance, f) to strengthen national capacity for tobacco control, and g) to monitor interference by the tobacco industry. A small working group has been assigned to develop strategies and action plan around each of these objectives.

2.2.3.3. Coordination mechanisms exist at provincial level but mostly rely on informal communication.
Coordination of tobacco control implementation activities at provincial and district levels is agreed on through the Multisectoral Provincial Committee, chaired by the Provincial Governor or Vice-Governor. There is however, less coordination at implementation level. An exception is made under the Office of the Permanent Secretary of the BMA, where the Deputy Permanent Secretary for Health is responsible for delivering its own health policy, as well as the MoPH through 68 health centres and nine hospitals. Municipalities and other local bodies also coordinate with health staff in implementing tobacco control activities.
2.2.4. Infrastructure and human resources

2.2.4.1. *The government Infrastructure for tobacco control is weak.*

There are critical issues concerning the quantity of experienced manpower in tobacco control, both at the central and at the regional level. The Tobacco Control Cluster of the MoPH is currently in transition and understaffed. The training and capacity for tobacco control in the MoPH and other related ministries is inadequate. There is a lack of specific funding and training for tobacco control. This is compounded by a high turnover of senior government officials, which may hamper tobacco control activities.

At central level, the Tobacco Control Cluster uses non-UC funds for organizing national training courses, and supervises the implementation of programmes. Owing to limited funds, only a few training courses can be arranged and no annual meeting for tobacco control is organized. At regional level, the non-UC funds are used for regional training and for supervision at provincial level.

2.2.4.2. *The infrastructure of NGOs is insufficient.*

The number of persons working full time with NGOs is very limited. In some cases, the heads of NGOs are volunteers or work part time. There is a clear need to groom new political champions.

2.2.5. Implementation

2.2.5.1. *There is high level of awareness and acceptance of the smoke-free environment policy for government offices in the MoPH and many government sectors.*

All government offices visited understood and implemented smoke-free environment policies. This followed the signing of agreements, such as memoranda of understanding, between the MoPH and all other ministries. The policy is appreciated by most government staff. Compliance with the policy is, according to anecdotal reports, very high but still to be measured systematically.

2.2.5.2. *Law enforcement is suboptimal.*

Enforcement of tobacco control laws is consistently raised as a problem at all levels. The mission was informed of non-compliance with the smoke-free law and the mandate to conceal tobacco products from the public’s view at point of sale. The mission observed instances of both types of non-compliance. Key informants believe that the Government’s efforts in law enforcement are inadequate. Authorities are hesitant to use coercive means to enforce the law without a previous effort to raise social awareness. Clearly, the Royal Thai Police, the only institution with power to use these coercive means, do not consider it a priority. Nevertheless, attempts to proactively raise social awareness about the need to comply with the law, especially outside Bangkok, are clearly insufficient. At present, efforts by the MoPH are reactive to complaints from the public. The Tobacco Control Cluster has a permanent 24-hour complaints hot-line supported by funding from ThaiHealth. The line is not toll-free and receives between 10 and 50 calls a day, mainly from Bangkok and its environs. It is not clear how many of these calls are potential violations of the tobacco control laws. Within two-four days of the call, inspectors are sent to assess the complaint and proceed to inform the police if coercive action is needed. In the last two years, no fines have been administered for non-compliance with tobacco control laws. A staff of 10, including telephone operators and inspectors, runs the complaints hotline.
2.2.5.3. Implementation of NGO activities at grassroots level has been limited.
NGOs have been successful in political and media lobbying but have not yet paid enough attention to building a grassroots movement, especially outside Bangkok. There is a need for all existing NGOs working in tobacco control to recognize the need to expand and set a clear strategy that involves reaching out to new stakeholders at country level – mostly NGOs working on environmental and other non-health issues. In addition, NGOs working in the provinces need more help from the provincial MoPH staff; current links are tenuous.

2.3. KEY RECOMMENDATIONS

2.3.1. Strengthen the leadership role of government and civil society and enhance its synergies.
The sustainability of the Thai tobacco control model depends very much on two factors.
• The continued leadership of civil society with the incorporation of new leaders. Key NGOs, with the assistance of ThaiHealth, need to consider a long-term plan to groom and mentor new leaders in civil society.
• The strengthening of the government leadership role in tobacco control. Authorities at all levels of the MoPH should play a more active and leading role in tobacco control. While the present model of informal coordination of tobacco control stakeholders remains, the highest MoPH authority possible needs to participate actively and regularly. Although Thailand faces many and important health challenges, the control of the tobacco epidemic requires their intense attention and priority. In addition, the mission recommends that the policy visibility of the Tobacco Control Cluster be enhanced, including its placement at a higher hierarchical level than at present and directly reporting to the Director-General of the DDC.

2.3.2. Reinforce the capacity of government to direct policy changes, formulate tobacco control strategies and coordinate multisectoral tobacco control planning.
The two main policy national coordinating committees, the NCCTU and NCII, should be activated. Informal coordination mechanisms, especially the so-called “core tobacco control advisory group” of ThaiHealth have played and will play an important role in coordinating the key tobacco control stakeholders. Nevertheless, the MoPH has a responsibility to set in motion the full potential of the existing formal coordination mechanisms. Improving coordination between different intra-governmental structures and between all relevant tobacco control partners is urgent. For the sake of sustainability and future advancement, this coordination needs to be regular and based on the existing formal structures.

Priority should be given to the creation of a national plan of action for tobacco control. The Tobacco Control Cluster should take the lead, engaging the various stakeholders in a meaningful way to guarantee broad support. The plan should identify concrete strategies and activities and be structured around the specific obligations of the WHO FCTC, paying special attention to those related to MPOWER and including a system for monitoring the plan’s implementation and outcomes. It should identify which stakeholder(s) and which level of governmental structure should play the lead role in implementing each activity and with what funds. It is strongly recommended that the plan be approved at the highest level of the MoPH as a national plan and included in the National Health Development Plan; this ensure a regular budget allocation for tobacco control.
2.3.3. Enhance the implementation capacity of NGOs and the Government.

NGOs working in tobacco control need to broaden their implementation capacity at the grassroots level by bringing new organizations to the field. NGOs should immediately contact and engage other NGOs not yet involved in tobacco control. NGOs already working in health, such as the Thoracic Society of Thailand, are natural partners, but those working with environmental, development, human rights and other non-health issues should also be contacted.

The MoPH needs to substantially increase its capacity to implement tobacco control interventions and programmes, involving dedicated structures and personnel at regional, provincial and district levels. The Tobacco Control Cluster should include among its role and functions the implementation of interventions and programmes at provincial and other levels. One specific implementation function that needs to be prioritized immediately is the enforcement of existing tobacco control legislation. Following the Thai tradition of increasing social awareness about the law before implementing coercive measures, the Government needs to create a substantial group of officers that can oversee compliance with the law according to a focused and structured plan of visits. Their function would be to hand out warnings to offenders and to educate them "on the spot". The current role for enforcement belongs to the officers from the Royal Thai Police. Additionally according to the law there are several institutions that are in charge with appointing "operational officers" who should monitor compliance within their area of work and collaborate closely with the police officers. Thus, new posts do not need to be created: the function of inspection can be delegated temporarily to specific government officers within and outside the health sector across all jurisdictional levels, paying particular attention to provincial and district levels.

2.3.4. Increase staff numbers and capacity and the financial resources fully devoted to tobacco control.

The limited capacity of qualified staff to face the tobacco control challenges of the country is a severe problem across many organizations and sectors.

- In the governmental sector, the number of staff at central level is clearly insufficient to face the tobacco control challenges of the country. If the MoPH has to take a renewed role in leading, coordinating and implementing tobacco control measures, the number of staff of the Tobacco Control Cluster must increase. In addition, the qualifications of the staff must provide a multidisciplinary approach to tobacco control as a health and development issue, including the communicational, legal, social and economic aspects of tobacco control. At subnational level, government staff at regional, provincial at district levels need to be trained adequately to face the tobacco control enforcement challenges of the country.
- In the area of tobacco control research, there is a need to develop a long-term plan in coordination with key universities to create a base of researchers.

The ThaiHealth model of financial support to tobacco control should continue but with certain provisos.

- The amount of money allocated by ThaiHealth for tobacco control in the immediate future needs to be revised and probably increased. The checks and balances in ThaiHealth and the focus on funding known and trusted individuals has been an excellent strategy as it ensures performance and transparency. There is, however, a need to open up this funding to new organizations that wish to get involved in tobacco control as a core function of their work. This will ensure even broader support in Thailand for tobacco control.
- The regular budget from MoPH needs to be substantially increased to strengthen its role and functions in the areas outlined above.
- Additional sources of funding should be explored in order to expand local funding mechanisms for tobacco control.
3. Monitoring and evaluation

3.1. POLICY STATUS AND DEVELOPMENT

In Thailand, apart from prevalence of tobacco use, the monitoring and evaluation system includes collection of data on the number of cigarettes smoked per day, the age of smoking initiation and exposure to second-hand smoke. The institutions involved in the monitoring system are the Bureau of Noncommunicable Diseases of the MoPH, the National Statistical Office under the Ministry of Information and Communication Technology, and Mahidol University through the TRC. The Policy and Strategy Bureau of the Office of the Permanent Secretary of the MoPH collects mortality data.

The TRC is also involved in evaluating the impact of policy interventions. The main responsibility for monitoring tobacco control policies lies with the DDC.

Monitoring the activities of the tobacco industry is carried out in Thailand by a team belonging to the Tobacco Industry Surveillance Network, established in 2006 by SEATCA. In addition, THPI and ASH Thailand monitor industry activities in order to plan and develop advocacy actions and recommendations for policy changes. They monitor the industry by regularly checking the news media as well as television programmes (THPI only). For the moment, these activities are carried out only at national level.

The main sources of information are the following.

- National surveys conducted regularly by the National Statistical Office since 1976. In these surveys, data on both smoking and alcohol consumption are collected among those aged 15 years and over (approximately 51 000 people). The results of the surveys are made public. The last three surveys included data on the prevalence of exposure to second-hand smoke at home. During the study period of 16 years [1991–2007] the prevalence of smoking dropped among both sexes and the number of cigarettes smoked as well as smoke exposure in the home decreased.

- Behavioural risk factor surveillance, initiated by Bureau of Noncommunicable Diseases in 2002, was completed at the provincial level and involved some 200 000 people. The survey was repeated at regional and zonal levels in 2005 and 2007, covering around 130 000 and 65 000 people, respectively.

- The GYTS in 2004, funded by WHO and conducted by the DDC and the Faculty of Public Health, Mahidol University; and the Global Health Professionals Survey (GHPS) in 2006, funded by the TRC and conducted by various health professional networks. A second GYTS is planned for 2009.

- A national survey conducted in 2007 by Mahidol University among female adolescents and young adults aged 13–25 years (n = 3093) in schools.

- Recently, the MoPH assigned the TRC and NSO as main implementing agencies in implementing the Global Adult Tobacco Survey (GATS). The full survey will start in mid January 2009.
3.2. KEY FINDINGS

3.2.1. Sustainability of the epidemiological surveillance of tobacco use, incorporating an international surveillance system, has not yet been fully achieved.

The three main tobacco surveillance initiatives (GYTS, GHPS in Thailand and GATS) are not fully funded by national sources. For the GATS, for example, which is being prepared, 100% of the funds come from international sources. The Thai Government has not yet set out plans to change this situation, which might limit the sustainability of these essential surveys. Nevertheless, efforts to monitor the tobacco epidemic at national level are being made through national surveys conducted by the National Statistical Office, as well as a behavioural risk factor surveillance funded by the Government. The mission considered that, even though the current national system ensures a good level of sustainability, incorporation of an international surveillance system may not be guaranteed.

3.2.2. Epidemiological surveillance of the tobacco epidemic is conducted, in response to requests from international initiatives, without a consolidated plan of action.

Various institutions perform epidemiological surveillance activities in tobacco control, without a general plan and depending on available national and external funding.

3.2.3. Monitoring of tobacco control activities is fragmentary and limited.

Owing to insufficient funds, the Bureau of Noncommunicable Diseases has limited capacity to monitor tobacco control activities at national and provincial levels. In response to this situation, ThaiHealth is funding the TRC, which was established about three years ago. The TRC uses the SimSmoke model to evaluate the effectiveness of specific policies in reducing the prevalence of smoking in Thailand. Analysis carried out in 2006 showed that increasing taxes was 61% effective in reducing the prevalence of smoking, whereas other policies were less than 25% effective. However, not even the TRC has the capacity to analyse large-scale epidemiological studies, to determine the risk associated with tobacco use or to compute tobacco-attributable deaths in the country. It lacks epidemiologists and researchers to take up research projects. Evaluation of the TRC’s performance in the first three years indicated that it needs a full-time director in order to perform much more effective tobacco control research.

3.2.4. Monitoring of tobacco industry activities is not conducted by governmental structures.

The Government does not regularly or formally monitor those activities of the tobacco industry that are designed to undermine public health. Some NGOs conduct some of these types of activity, for example THPI and ASH Thailand by regularly checking the news media.

3.2.5. Epidemiological surveillance and monitoring at regional and provincial levels are limited.

Since tobacco surveillance data are mainly from the national survey, there is limited regular surveillance activity at regional and provincial levels. Although monitoring of the programme is under the supervision of the regional disease prevention and control centres, there is limited capacity for monitoring and evaluation of tobacco control.

3.2.6. Important academic institutions do not consider tobacco use a priority for research.

Mahidol University is a leader among academic institutions in prioritizing tobacco research. It also analyses data collected in national surveys, builds capacity to analyse data from future projects, and disseminates the results of studies on tobacco control activities. Apart from a few other universities, however, academic institutions do not consider research in the tobacco field to be a priority.
3.3. KEY RECOMMENDATIONS

3.3.1. Create an integrated national surveillance and monitoring system under the coordination of one single body that includes:

- existing surveillance efforts, such as GYTS and the GATS, as well as current national surveillance efforts made by the MoPH, the National Statistical Office and Mahidol University; and
- new components in order to:
  - monitor regularly the efforts of the tobacco industry to undermine public health and to integrate the scant and disparate NGO monitoring and research activities on this topic to avoid duplication of work;
  - monitor progress in enforcing tobacco control policies and interventions pertaining to key articles of the WHO FCTC according to existing guidelines of the Conference of the Parties; and
  - assess the economic impact of problems created by tobacco use and of the benefits of implementing tobacco control measures.

3.3.2. Increase the human capacity for conducting research on monitoring and surveillance activities by establishing a regular training programme for professionals already involved.

3.3.3. Ensure regular funding from ThaiHealth and the Government to conduct the activities of the integrated national surveillance and monitoring system in a sustainable fashion, including repeating full surveys every three-four years.

3.3.4. Develop a tobacco surveillance plan of action to define:

- essential surveillance and monitoring indicators;
- data collection, storage, analysis and dissemination procedures;
- links with policy-making processes and decisions; and
- institutional responsibilities and roles in performing the different functions of the system at all levels of jurisdiction.
4. Smoke-free environments

4.1. POLICY STATUS AND DEVELOPMENT

Smoke-free environments in Thailand are regulated by the Non-Smoker’s Health Protection Act (B.E. 2535) of 1992. This creates a progressive approach to turning indoor workplaces and public places 100% smoke-free by (a) establishing three types of space (non-smoke-free, partially smoke-free and 100% smoke-free) and (b) authorizing the MoPH progressively to move workplaces and public areas from the non-smoke-free to the 100% smoke-free category by a simple ministerial executive order, also known as ministerial notifications.

Since 1992, 18 different executive orders have been promulgated under the Act. Today, the main categories of indoor workplaces and public places considered 100% smoke-free under the law are: governmental offices and public places with an air-conditioning system (including air-conditioned workplaces, some restaurants, bars, etc.). Outdoor places such as sports stadiums, children’s playgrounds, outdoor exercise or sports grounds, public parks, zoos, botanical gardens and teaching/learning facilities have also been declared 100% smoke-free. The latest executive order established that all food shops, restaurants, pubs, bars and markets with air-conditioning must be smoke-free zones, although non-air-conditioned food shops could provide a smoking area in the shop.

Violation of the 1992 Act and its ensuing executive orders is considered a criminal offence. Thus only the Royal Thai Police are entitled to prosecute offenders or apply coercive methods for its enforcement, including fines. The law establishes fines for individual smokers that violate the law, and for owners of businesses where the law is broken, of 2000 and 20 000 baht, respectively.

There is no unified, coordinated effort for executing any form of common policy for implementing smoke-free laws. The various ministries, departments and stakeholders are not always involved at the policy development or decision-making level, and thus effective enforcement of smoke-free laws is sometimes limited. Many private and government institutions have their own piecemeal smoke-free policies, which are followed voluntarily on the basis of individual perceptions.

4.2. KEY FINDINGS

4.2.1. Workplaces and public places declared 100% smoke-free under the law are numerous. Recently, many governmental offices, mainly at central level, became 100% smoke-free.

In most government offices, mainly within the central institutions, there is a strong sense of respect for smoke-free provisions and a general perception of a high level of compliance with the law. At regional and provincial levels of government, however, there is still limited implementation of smoke-free environments. Some governmental institutions are ahead of others in implementing the smoke-free policy mandated by the law. One example is the project for “smoke-free police stations” involving collaboration between the MoPH and the Royal Thai Police, which followed two years of campaigning within the local communities before implementation.
4.2.2. Despite important progress in the protection of people from exposure to tobacco smoke, the proportion of people exposed to second-hand smoke remains unacceptable.

Data from national surveys conducted in 2001, 2004 and 2007 showed declines in exposure to second-hand smoke among households, from 86% in 2001 to 59% in 2007. These figures show that, despite improvements, exposure to second-hand smoke remains unacceptably high. There are two reasons for this. First, the legislation is not yet at the stage of declaring all workplaces and public places 100% smoke-free, as recommended in Article 8 of the WHO FCTC Guidelines, and so is not ensuring universal and equal protection to all workers and the public. Second, implementation of the law is far from perfect, as indicated in the next point.

4.2.3. Compliance with the 100% smoke-free provision of the law is suboptimal.

A poll was conducted in 2005, three years after MoPH Notification No. 10, 2002, which indicated the criteria, procedures and conditions for displaying the name of toxic and carcinogenic substances on labels of cigarettes. It sampled 1696 people over 18 years of age. The results showed that the places in which the law is most violated were public toilets, public phone booths, and places of worship (78.7%, 71.3% and 71.0%, respectively). A second survey conducted in 2006 showed that only 39.2% of smokers aged 15 years or more said that they complied strictly with the law and never smoked in non-smoking areas. The reasons for poor compliance are multiple. It is cumbersome for the public, inspectors and enforcers to follow the legal provisions as an extensive list of workplaces and public places is progressively moved through the different categories of protection from second-hand smoke afforded by the law and its executive orders. Other important reasons are described in the following three key findings.

4.2.4. Present efforts to foster self-enforcement are insufficient.

There is a general perception that punitive or coercive measures are not culturally appropriate and, as such, awareness-raising is preferred in order to foster compliance (i.e. self-enforcement). However, the nature and magnitude of such efforts are insufficient. The result is that emphasis is placed on complying with the smoke-free laws and on informing the public about the dangers of exposure to second-hand smoke. Other educational aspects, such as empowering non-smokers to defend their right to health are usually not included.

The mission recognizes the important contribution of NGOs to building political awareness and public support for smoke-free environments. They are instrumental in securing funding and implementing smoke-free campaigns targeting various communities and sectors within the country (smoke-free schools, hospitals, workplaces, restaurants, hotels, temples, etc.). An example is the project for a “smoke-free Royal Thai Military” as a component of a larger health promotion initiative substantially funded by ThaiHealth and implemented by the Royal Thai Military. This project, which covers almost half of the armed personnel in Thailand, resulted in a decrease of smoking prevalence in the military forces from 40% to 20%.

The mission also recognizes the efforts of the MoPH to inform government workers about the smoke-free provisions in government offices, and past campaigns to inform the public through media campaigns about the entry into force of some executive orders. All in all, however, the educational work in Thailand is not commensurate (a) with the importance that Thai society seems to bestow on self-enforcement, or (b) with the scope, frequency and intensity of efforts that this approach needs to reach key groups, such as business owners or the broader public, in an effective manner.
4.2.5. The power of government to inspect facilities and warn violators is underutilized.
Short of coercive measures, government has extensive powers to foster self-enforcement as a preferred approach in Thailand. These powers are at least two: inspecting facilities to assess compliance with the law and extending “on the spot” warnings to violators.

Public health officers from regional and provincial health departments monitor compliance through planned regular inspections in accordance with existing national inspection guidelines (e.g. the tobacco and alcohol team from a regional department could carry out around 700-900 inspections per year). Inspection plans must comply with annual indicators for work performance as required by the MoPH. Nevertheless, the number of inspections is too small to have an effect on self-enforcement. The law authorizes the appointment and empowerment of staff of various government institutions as “operational officers” to inspect and monitor compliance. However, there is no evidence that these provisions are used regularly to extend the limited staff devoted to inspection and warning.

Furthermore, although various efforts to train regional and local public health inspectors exist throughout the country under the authority and funding of the MoPH, a nationally coordinated and standardized training strategy and curriculum, inclusive of all inspectors, has yet to be developed. The aim of these training programmes is to increase the knowledge of the enforcers and the community about the provisions of the law that could eventually result in an increase in law enforcement. However, the fact that the trainers do not use a standardized integrated curriculum for these programmes can result in uneven levels of training and limit the capacity of these programmes to be evaluated.

Also, the existing system for monitoring compliance and enforcement is limited, so that the successes and challenges of enforcement cannot be recorded and evaluated, in order to identify where adjustments should be made to ensure compliance. For example, violations reported by inspectors are not yet integrated and coordinated within a systematic enforcement and monitoring system, and no relevant communication is established among these staff, the licensing authorities and the police enforcers. Mass media campaigns are not currently focused on the enforcement system and communication channels within this system.

4.2.6. Coercive measures to fine or prosecute violators are rarely used.
The Royal Thai Police is the only institution responsible for enforcing the provisions of the law on smoke-free environments and its executive orders by fining and prosecuting violators. However, due to the police’s perception of competing priorities, coercive measures are rarely used proactively or in reaction to individual complaints or DDC reports. This is shown by the gap between the already small number of violations recorded by the public health officers within their inspection activities and the action or lack thereof taken by police officers.

In addition, procedures for fining are complicated. The police can be called directly by any citizen or by the operational officers (public health inspectors or the officers appointed by institutions, as appropriate). Any call should result in a police officer being sent to where the violation took place, but owing to conflicting priorities this does not always happen. Moreover, once the police officer arrives at the place, he cannot give a summons or fine on the spot. According to the law, he can only invite the violator to the nearest police station where he/she could eventually pay a fine (usually within the limits of the cash available). Therefore, most police officers prefer to give a simple warning to the violator on the spot.
4.2.7. A national steering committee for the management of the Towards 100% Smoke-free Environments in Thailand project has recently been established. This is an externally funded joint project of the MoPH and multisectoral partners that aims to strengthen the national tobacco control programme, with emphasis on preventing second-hand smoke through the implementation of a 100% smoke-free environment policy.

4.3. KEY RECOMMENDATIONS

4.3.1. Ensure universal and equal protection for all workers and the public from exposure to second-hand smoke by enacting, implementing and enforcing a national 100% smoke-free law in Thailand with no exceptions.

The progress made in Thailand and the level of exposure to second-hand smoke indicates that this is possible and necessary. It is the only way to fully protect workers and the public from tobacco smoke according to WHO policy recommendations and WHO FCTC guidelines. According to global best practices, a complete smoking ban in all indoor public places and workplaces ensures better self-enforcement and a more effective enforcement, as it provides a simple and unequivocal message to government agencies and the public where is it possible to smoke and where it is not.

4.3.2. Increase efforts directed at self-enforcement.

4.3.2.1. Where possible, empower the local and other authorities to conduct inspection and monitoring of compliance.

There is an urgent need to increase the number of existing inspectors by delegating the inspection power to other authorities. The creation of this small army would allow the scaling-up of the activities and resources available for inspection and of “on the spot” warning to violators, and therefore raise the level of compliance. This approach requires the establishment of a national coordinating mechanism to ensure a consistent approach nationwide.

4.3.2.2. Increase the scope, frequency and intensity of efforts to educate the public and target audiences, in order to mobilize community support for smoke-free environments and increase self-enforcement.

The existing efforts of NGOs on the dangers of smoking and exposure to second-hand smoke should be complemented with public education campaigns. The collaboration of the government sector with the voluntary sector and the mass media will maximize the outreach of public campaigns and secure community support for implementation of the law. Education should also focus on empowering the public to claim their right to clean air and health. Social monitoring of compliance is possible if citizens are encouraged to make formal complaints. This will broaden the impact of the work of the health agencies without a drastic increase in resources. Although the toll-free phone number for reporting violations by the public has been disseminated, it is still not printed on the mandatory “no smoking” signs. This single measure would facilitate the complaints mechanism.
4.3.3. Increase pro-active enforcement.

4.3.3.1. Although reliance on self-enforcement will remain the focus of compliance efforts in Thailand, this will not work completely without a credible threat of punitive action for potential violators.

Discussions must take place at the highest level between the MoPH and the Royal Thai Police to agree on a common strategy.

4.3.3.2. Enforcement procedures need to be simplified.

Burdensome administrative procedures such as “verbal summoning” and fining only at the police station need to be streamlined. The MoPH should start consultations with relevant government agencies to identify simple, standard procedures that will result in more consistent and effective law enforcement in accordance with the provisions of the Criminal Procedure Code. If appropriate, such consultations can explore the possibility of establishing simple and clear procedures for enforcing the law to allow a quicker ticketing system for violations, such as on-the-spot fines.

4.3.4. Establish a coordinated, multisectorally integrated and systematic system based on an overall enforcement plan, both for surveillance of outcomes, monitoring compliance and for prosecuting violators.

4.3.4.1. While no further research and evaluation is needed to justify smoke-free policy implementation, an evaluation strategy will be very useful to monitor the success of implementation, public support for the law and the health and economic impacts. In this way, ongoing public and political support for the need for stronger enforcement of legislation can be sustained.

4.3.4.2. Measuring outcomes, such as exposure to second-hand smoke in workplaces and public places, should be part of the monitoring system.

4.3.4.3. Compliance can be monitored using one or more of the mechanisms already in place for inspecting business premises (food, alcohol inspectors, etc.) and workplaces (labour inspectors, safety officers, etc.) and integrating compliance inspections into business licensing inspections, health and sanitation inspections, inspections for workplace health and safety, fire safety inspections and similar programmes.

4.3.4.4. Establish a regular mechanism for communicating the impact of law enforcement to the public.

This effort is particularly important because the tobacco industry sometimes encourages and publicizes violations as part of its effort to create the impression that the law is not being respected.

4.3.5. Reinforce, integrate and coordinate the work of the MoPH with the work of the Steering Committee of the Towards 100% Smoke-free Environments in Thailand project.

Appropriate synergy between the work of this committee and the current efforts of the MoPH, in collaboration with all other relevant governmental institutions and NGOs, could create the favourable momentum for Thailand to achieve the 100% smoke-free environments goal. The coordinated action of the MoPH and the project steering committee would formally benefit from inclusion of key institutions in the smoke-free policy implementation (such as the Royal Thai Police, the Royal Thai Armed Forces, the Ministry of Education and other ministries).
All above-mentioned measures should be applied, regardless of how long it takes to enact the new legislation, because preparations will also build support for approval of the new law. In addition, the changes suggested above will not be possible without adequate training and funding.

4.3.6. Establish a multisectoral strategy for effective training of police officers and inspectors.

4.3.6.1. Police officers and inspectors of the MoPH and of the eight different governmental structures that are mainly responsible for monitoring compliance and reporting violations, and any others with an inspection and monitoring role, should be trained to inspect businesses and workplaces, warn them as necessary and report to the monitoring mechanism.

4.3.6.2. Training should comprise a standard programme and guidelines. A national curriculum for training law enforcers and inspectors for monitoring compliance, as well as for the training of trainers, should be developed and made available to all the agencies involved in training.

4.3.7. Provide adequate funds for implementation.

Complementary to the regular funds that are allocated through various projects and grants by ThaiHealth and are instrumental in increasing the implementation of the smoke-free policy, dedicated government funds for advocacy (that could include regular mass-media campaigns) and enforcement will be necessary. These should be planned and allocated in a regular and sustainable manner in order to build political support and increase enforcement activities. Procedures should be evaluated regularly to ensure that appropriate levels of enforcement and resources are maintained.
5. Offer help to quit tobacco use

5.1. POLICY STATUS AND DEVELOPMENT

The management of tobacco dependence comprises four elements: treatment clinics in health care settings, a management approach including pharmacological therapy, quit line services, and the Thai Health Professional Network Against Tobacco.

5.1.1. Health care settings with treatment services.
Surveys conducted by the DDC revealed that in 2003, a total of 430 government and private health care facilities provided some form of tobacco treatment service. Another survey showed that there were 1120 smoking treatment clinics, 127 in Bangkok and 993 in the provinces. Most of them were in government settings. In the private sector, smoking treatment services are available in outpatient clinics rather than hospitals. Most tobacco treatment clinics have multidisciplinary teams.

5.1.2. Management approach.
Behavioural and pharmacological approaches are used alone or in combination. Pharmacology includes nicotine replacement therapy in the form of chewing gum or patches, both of which may only be bought from a pharmacy, and non-nicotine preparations such as amfebutamone and nortriptyline. The latter is included in the National Essential Drug List, so those covered by the UC insurance scheme might be able to obtain it free of charge, though this is not consistent throughout the country and it is not a first-line drug. All other medications for treating tobacco dependence must be paid for by the patient. The UC system covers basic health services for some 76.6% of the population, with an additional 12.7% covered by the Social Security Fund/Workmen’s Compensation Fund.

5.1.3. Quit lines.
Since 1993, ASH Thailand has had a quit line telephone number to give advice and assistance on smoking cessation. The number of calls increased from 1200 in 1994 to 4798 in 2006. The cessation rate increased from 2% in 2002 to 18.5% in 2006. There are other quit lines, in hospitals and NGOs, though with very limited manpower and demand. There is no systematic strategy to promote quit lines. The MoPH quit line is integrated into hotlines for other substance abuse counselling, which uses different approaches and techniques for giving treatment advice. ThaiHealth, the National Health Security Office and other members of the network are developing national smoking cessation services and setting up a national quit line, although the planning remains in the preliminary stages. The phone number of this quit line will also appear on the labels of cigarette packs.
5.2. KEY FINDINGS

While there are several tobacco treatment and management service providers and programmes in both the public and private sectors, these are operated in isolation and are fragmented in service delivery. The MoPH encourages provincial hospitals to provide tobacco treatment and management services but they do not have the budgetary provisions to support this. Further, the tobacco treatment and management services are not covered under national insurance schemes; thus, institutions that choose to offer these services must fund them independently. Overall, the population reach of these services is low because they rely on self-referral and are often clinic- or hospital-based. The actual coverage and reach of existing services is undetermined because no systematic monitoring and evaluation are in place.

5.2.1. A national, systematic, multilevel treatment and management system, integrated into the primary health care system, does not exist.

The existing model is generally clinic-based. There is general interest in tobacco treatment and management within the hospital systems, as demonstrated by site visits conducted in Bangkok, Chiang Mai and Songkhla. Here, there were individual protocols for the treatment and management of tobacco dependence and dedicated staff to carry out the services. However, the available treatment and management services are generally not coordinated, there being, for example, no peer review and limited linkages and referrals between inpatient and outpatient services. The services are often driven by the individual interests of health professionals and institutions (universities, hospitals and primary health care facilities). In many places, there is no systematic follow up mechanism of cases who are discharged from the clinics and assessment of effectiveness of treatment may not be possible.

5.2.2. The MoPH gives a lower priority to the management of tobacco dependence than to other tobacco control strategies.

Tobacco dependence is not considered a critical risk reduction strategy for disease prevention and management.

5.2.3. Tobacco dependence management is not funded under either the UC insurance or the social security fund.

Most clinics are funded from the institutions’ own regular budgets and some charge patients a fee for service. Drugs must be purchased by the patient.

5.2.4. Utilization of current services is low.

At present, treatment services rely on self-referral; active referrals occur only in isolated cases. There are no targeted services for special populations such as young people, remote populations, or those who are heavily addicted or have chronic diseases.

5.2.5. The tobacco dependence management approach utilizes a predominantly medical model.

A public health perspective for risk reduction at the population level is lacking. The existing range of technical treatment guidelines focuses on treating individual smokers using more intensive interventions. Clinics use mainly behavioural counselling supplemented with drugs.

5.2.6. First-line drugs for treating tobacco dependence, such as nicotine replacement therapy, are not included in the list of essential drugs.

The various guidelines are several years old, are not always consistent with each other, and may not include a population health approach.
5.2.7. Training in tobacco cessation is done by a network of health professionals with resources from ThaiHealth, but no national standardized training model exists.

There is no national standardized training model, resulting in different content and approaches in training from the Bureau Noncommunicable Diseases, pharmacists, etc. Training is driven primarily by the networks of health professionals, with most funding coming from ThaiHealth. Funding is based on grants, mostly through a competitive process, which may bias the likelihood of funding towards those institutions with higher skills and a greater capacity to write proposals. ThaiHealth requires all grant recipients to have smoke-free campuses, but there is no requirement for recipients to provide support to staff who need help to quit smoking.

5.2.8. Limited information is available for monitoring and evaluation cessation efforts.

There is no systematic way of monitoring the efficiency, impact and cost-effectiveness of the current services. Some clinics collect their own data, but the indicators, methodologies and benchmarks are specific to each site and results are not routinely shared with the local health department or the national tobacco control programme.

5.2.9. Quit lines exist but they need to be coordinated within a single national quit line.

There are several independent local quit lines that are underutilized and generally unaccompanied by a strategic promotional effort. A national quit line is under development to address these issues. While the plan is still preliminary, it represents a positive step towards increasing efficiency.

5.3. KEY RECOMMENDATIONS

5.3.1. Advocate for a systems approach for managing tobacco dependence.

Evidence on treatment delivered as a population health service (systems approach) needs to be gathered to convince policy-makers and funders to pay more attention and allocate greater resources to treatment.

5.3.2. Give priority to the development of brief treatment interventions integrated into the health care delivery network (especially within primary care).

As a minimum, this should include the identification of tobacco users among all who come to any health service for any reason, the delivery of brief advice on quitting and active referral to treatment services or a quit line, with appropriate quality improvement processes. This would ideally be incorporated into the national tobacco control plan.

5.3.3. Fund tobacco dependence management.

Managing tobacco dependence, including the entire package of tobacco treatment and management interventions, must be considered an important component covered by health insurance schemes, specifically the UC insurance and the Social Security Fund/Workmen’s Compensation Fund. First-line medications should be incorporated into the national essential drug list and covered by these insurance schemes.

5.3.4. Update and consolidate current practices into national guidelines on the treatment and management of tobacco dependence.

All relevant stakeholders should be engaged in this task and designating the national tobacco control programme at the MoPH should be designated as the focal point. The guidelines should reflect a balance between individual clinical interventions and the population-based approach. They should also include a package of interventions.
5.3.5. **Establish a national quit line.**
This should replace the existing multiple, uncoordinated quit lines.

5.3.6. **Promote attempts to quit.**
A promotional strategy needs to be developed in order to increase the number of people attempting to quit and demand by smokers for cessation services. This strategy should be directed to smokers through the media and existing health care services by promoting the referral of smokers to the appropriate services. Consideration should also be given to means of reaching populations that may be hard to contact using conventional promotional methods.

5.3.7. **Monitor services.**
A monitoring and evaluation strategy should be developed to assess the utilization, efficacy, cost-effectiveness and impact of treatment and management services. Results of monitoring and evaluation should be disseminated to all stakeholders.
6. Warn people about the dangers of tobacco

6.1. PACKAGING AND LABELLING

6.1.1. POLICY STATUS AND DEVELOPMENT

Thailand has been a world leader in implementing strong and effective pictorial health warnings. Thailand’s tobacco control legislation and regulations for packaging and labelling are quite comprehensive. Cigarette and cigar packaging must include warnings occupying at least 50% of both sides of the pack or carton. The warning must be any one of an assortment of different types of pictorial label and statement (nine different warnings for cigarettes, five for cigars), printed in four colours, with a specified size and typeface according to standard templates. The notification (2007) states that roll-your-own (RYO) tobacco packaging must include one of two designated black and white pictorial health warnings.

According to the law, the names of certain chemicals contained in the smoke (i.e. cyanide, carbon monoxide) must be displayed on at least 50% of the side of cigarette packaging.

Notification 2549 (2006) addresses the ratio with which the different types of pictorial warning must be printed on packaging (for example, a ratio of 1 type per 5000 cigarettes). However, there are no similar ratios mandated for the list of toxic ingredients that must be printed on the side of the package.

It is forbidden to use misleading words such as “mild” or “light” on cigarette, cigar or shredded tobacco packaging.

The MoPH is responsible for enacting legislation and also has the authority to issue an inquiring letter or summon violators. The TRC and other NGOs collaborate with the MoPH in evaluating the impact of health warnings and make recommendations for future adaptations. The Royal Thai Police is responsible for enforcing the law on packaging and labelling.

The MoPH is responsible for developing health warnings on all tobacco packaging (including RYO tobacco), with a requirement that these be changed every two years.

According to excise legislation, the tax stamp is required to be on top of the pack. However, there is no specific wording specifying exactly where on the top it must be placed, nor is there specific wording prohibiting the stamp from obscuring the health warning.

There is very preliminary discussion among key tobacco control advocates in Thailand to move towards plain packaging of tobacco products.
6.1.2. KEY FINDINGS

6.1.2.1. There is no specific mandate for conducting research on health warning labels.
The TRC has conducted some research on the effectiveness of warnings on cigarette packages, but not for specific subpopulations. No pre-testing of the warnings has been carried out.

6.1.2.2. Compliance with the packaging and labelling regulations of all tobacco products is uneven.
There is high level of compliance with the health warnings on cigarette packaging, though RYO compliance is very low. RYO tobacco packaging does not generally carry health warnings, even though it is required by law. The tax stamp is sometimes placed horizontally on the top half of the front of cigarette packs in a manner that obscures part of the health warnings. There is a lack of clarity as to precisely how the warnings should rotate.

6.1.2.3. Enforcement agents (police officers) are not fully aware of all packaging and labelling regulations.

6.1.2.4. The mission explored the issue of packaging of “fewer than 20 cigarettes” but insufficient information was provided to clarify whether there was a law banning the placement on the market of these packages. If so, better enforcement is required.

6.1.3. KEY RECOMMENDATIONS

6.1.3.1. Policies on health warnings should be progressively harmonized so that all tobacco products contain the strongest possible health message, including RYO tobacco.
For example, this would ensure that warnings on RYO tobacco packaging are also in colour, as is currently required for cigarettes, as well as adding additional pictorial health messages (rather than just the two that are currently required). Also, the addictive nature of nicotine can be included in the warnings. The possibility of plain packaging could continue to be pursued.

6.1.3.2. A specific mandate should be given to an institution to conduct research on health warning labels.
The TRC appears to have some capacity to conduct research on health warnings on all tobacco products, and could therefore be given responsibility for conducting research on warnings in the general population and also in specific target groups such as adolescents, women and lower-income smokers.

6.1.3.3. The excise authorities should insist that the stamp on cigarette packages should be placed away from the health warning labels.
This regulation should be strongly enforced.

6.1.3.4. The MoPH should increase its collaboration with enforcement agencies in order to improve awareness among enforcers.

6.1.3.5. Until health warnings are uniformly implemented on all tobacco products, existing warnings on RYO tobacco packaging should be better enforced.
6.2. PUBLIC AWARENESS AND MASS-MEDIA CAMPAIGNS

6.2.1. POLICY STATUS AND DEVELOPMENT

Raising awareness about tobacco use through anti-tobacco messages and advocating for policy change are driven by a core group of NGOs (particularly ASH Thailand and the THPI) in partnership with government institutions.

Public awareness and mass-media campaigns are supported by ThaiHealth.

6.2.2. KEY FINDINGS

6.2.2.1. Coordination within the tobacco control community to raise awareness and conduct mass-media campaigns, and mechanisms to evaluate the success and impact of these efforts, are still lacking.

A core group of committed NGOs is doing effective work in the country through grassroots communications and national educational campaigns, focusing on the health risks of tobacco consumption and, to a lesser degree, on advocating for policy change. This has resulted in a high level of public awareness on the harmfulness of tobacco and a general perception that current tobacco control efforts are already sufficient.

Health messages are still not reaching the population at the provincial and district levels, and campaigns at the district level are not evaluated.

The MoPH has no formal agenda for developing mass-media campaigns and relies on the work of NGOs.

Most of the media institutions (print and broadcast) are interested in using specific media methods for raising awareness and promoting tobacco control policies through, for example, news reports, public service announcements, features and broadcasts on various aspects of tobacco. The coverage is concentrated mostly around World No Tobacco Day and in support of policy implementation. The media’s main source of information on tobacco control is a core group of NGOs. Use of the mass media is limited, however.

The Ministry of Education is responsible for developing educational materials on tobacco control and implementing other educational activities for young people in collaboration with the MoPH and ensuring its integration into regular school curricula. In general, there is emphasis only on health risks. Public education campaigns cover most schools in urban areas.

6.2.3. KEY RECOMMENDATIONS

6.2.3.1. A nationally coordinated media strategy should be developed with sustained funding and with the goal of educating the public on tobacco control issues.

This strategy would emphasize increased collaboration within the tobacco control community to avoid duplication of efforts and materials, and would be more cost-effective. The strategy could benefit from a variety of specific interventions, such as:

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• developing a set of tested and proven, hard-hitting messages for an ongoing mass-media campaign (television and radio spots), including information on the upcoming national quit line number to be aired during prime time on the national and private networks;
• developing workshops for the media on tobacco control, including tobacco industry tactics, which should result in increased and diversified news coverage on the issue;
• including media institutions in the process of policy implementation and enforcement in relation to strategic communications plans; and
• monitoring and evaluating mass-media campaigns by the appropriate institution (i.e. TCR) to ensure maximum effectiveness and impact.

6.2.3.2. The educational activities implemented by the Ministry of Education should extend their present focus on the health risks to more strategic information on tobacco industry tactics and consider better outreach of educational campaigns, especially in rural areas.
GYTS data should be used for the development of the educational campaigns, both in urban and rural areas. However, in planning these activities, the authorities should bear in mind that the evidence of the effectiveness of schools programs remains inconclusive.
7. Enforce bans on advertising, promotion and sponsorship

7.1. POLICY STATUS AND DEVELOPMENT

Under the Tobacco Product Control Act (1992), most forms of advertising, sponsorship and promotion, including brand stretching, are banned in Thailand. Also, a recent amendment mandates a ban on the display of cigarette packages, signs or logos at points of sale. The following should be noted.

- Corporate social responsibility programmes are widely used by the tobacco industry, including in relation to young people, educational and environmental activities and awards.
- Cross-border tobacco advertising and promotion exists in such forms as televised sporting events.
- The sale and promotion of tobacco products on the Internet still exists and is currently not covered specifically by the law.
- A ministerial notification is currently under development that would ban cross-border advertising.

7.2. KEY FINDINGS

7.2.1. Although bans on direct advertising enjoy a high level of compliance, the ban on indirect advertising is still not well enforced.

Law violations are due either to deliberate action or to misperceptions among retailers as well as law enforcement officers about what the law covers (e.g. lighters and T-shirts with a tobacco brand name and logo, displaying of cigars at points of sale, etc.).

7.2.2. Particularly in the provinces, there is limited understanding among health and police officers of the ban on indirect advertising.

7.2.3. The present law has some loopholes.

For example, the Thai Tobacco Monopoly, which owns a football club with the company name, displays this name and its logo at sport events. It also supports some sport events. The Government is planning to close this loophole.

7.2.4. Because the corporate social responsibility programmes of the tobacco industry are still not prohibited by law, the tobacco companies make full use of it.

For example, the industry sponsors the ASEAN Art Award, fellowships for journalists, and environmental activities run by schools.

7.2.5. The law banning the display of tobacco products at point of sale is frequently violated.
7.2.6. Civil society organizations have taken some of the responsibility for monitoring advertising, marketing and sponsorship by the tobacco industry. Examples of such organizations are ASH Thailand, SEATCA and THPI. In addition, the TRC at Mahidol University, which is supported by ThaiHealth, is responsible for monitoring and evaluating the effectiveness of the ban on tobacco advertising, promotion and sponsorship.

7.2.7. The IT Regulation Bureau under the Ministry of Information and Communications Technology is currently responsible for monitoring Internet content, but has no focus on tobacco advertising and sales.

7.3. KEY RECOMMENDATIONS

7.3.1. The existing law, which is reasonably strong, should be made more comprehensive. This will provide additional protection for Thai population from the tactics of the tobacco industry and enhance the leading role of Thailand in global tobacco control.

7.3.1.1. Tobacco advertising through live broadcasts, the Internet and printed material from abroad should be restricted, even if it is claimed that it does not aim to advertise specifically in Thailand.

7.3.1.2. Until Thailand is able to completely ban cross-border advertising, there are interim measures that can be taken. For example, during the broadcasting of international sports events that include tobacco advertising, there should be strongly worded anti-tobacco messages scrolled on the screen.

7.3.1.3. No tobacco company trade name and business identity should be allowed to be associated with any form of non-tobacco products, services, activities and events.

7.3.2. The use of corporate social responsibility programmes by the tobacco industry should be prohibited by law.

7.3.3. The IT Regulation Bureau under the Ministry of Information and Communications Technology should be mandated to include tobacco advertising and sales in its current work in monitoring Internet content.

7.3.4. The provincial and district levels should increase their capacity for enforcing the law. This should be achieved through better dissemination of information to the public aimed at eventually increasing the reporting of law violations. In addition, more training programmes for enforcement officers and the local media should be organized, focusing on indirect advertising, in order to improve monitoring of compliance with the law and its enforcement.

7.3.5. A coordinated mechanism for collaboration in law implementation and enforcement should be put in place between the MoPH and other government institutions.
8. Raise tobacco taxes and prices

8.1. POLICY STATUS AND DEVELOPMENT

Taxes applicable to cigarettes.
Six taxes apply to cigarettes in Thailand: (a) import duty (on imported cigarettes only); (b) excise tax; (c) tax earmarked for the Heath Promotion Fund; (d) television tax; (e) provincial tax; and (f) value added tax (VAT). All taxes are levied by the Excise Department of the Ministry of Finance, including VAT. The tax base for all taxes except the provincial tax and VAT is the ex-factory price of tobacco (or CIF price plus import duty in the case of imported cigarettes). The VAT is based on the maximum retail sales price. The most important tax in terms of revenue is the excise tax. It is estimated that the final retail price of widely available hypothetical packs of local and international cigarettes consists of the following (see Annex 1 for the exact price structure).

<table>
<thead>
<tr>
<th>Item</th>
<th>Local</th>
<th>Imported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base or import price</td>
<td>5.98</td>
<td>(0.17)</td>
</tr>
<tr>
<td>Tariff</td>
<td>0.00</td>
<td>(0.00)</td>
</tr>
<tr>
<td>Statutory tax inclusive of excise tax</td>
<td>23.92</td>
<td>(0.68)</td>
</tr>
<tr>
<td>Tax for the Health Promotion Fund</td>
<td>0.48</td>
<td>(0.01)</td>
</tr>
<tr>
<td>Television tax</td>
<td>0.36</td>
<td>(0.01)</td>
</tr>
<tr>
<td>Provincial tax</td>
<td>1.00</td>
<td>(0.03)</td>
</tr>
<tr>
<td>Profit margin</td>
<td>10.32</td>
<td>(0.29)</td>
</tr>
<tr>
<td>VAT</td>
<td>2.94</td>
<td>(0.08)</td>
</tr>
<tr>
<td><strong>Final retail price</strong></td>
<td><strong>45.00</strong></td>
<td><strong>(1.29)</strong></td>
</tr>
</tbody>
</table>

The final retail price might not be the exact sum of all components because of rounding.

The exchange rate used for all calculations in this report is 35 baht per US dollar.

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3 The ex-factory price generally refers to the price (or in this case deemed price) in a transaction between the manufacturer and an independent counterpart (distributor or retailer), i.e. the price charged by the manufacturer.
4 CIF = Cost, Insurance, Freight, or the cost of import at the destination (i.e. land border or port of entry).
5 The maximum retail sales price is a retail value that is used by the Excise Department to collect VAT at the same time as other taxes, thereby eliminating the cumbersome task of collecting VAT at retail level.
**Tobacco monopoly and industry structure for cigarettes.**

All locally produced cigarettes are manufactured by TTM at a single plant in Khlong Toei. TTM comes under the jurisdiction of the Ministry of Finance. It is directly supervised by the Excise Department, with which it has a close relationship: the Director-General of the Excise Department is President of the Board of TTM. The main TTM brands together account for around 75% of the licit Thai cigarette market, and include Krong Thip, Wonder and Falling Rain. The market share of the tobacco monopoly remained almost unchanged at over 95% until the end of the 1990s, when retail agreements between the multinational Philip Morris and local retailers’ networks as well as the Asian Free Trade Agreement (AFTA) contributed to boosting the market shares of imported cigarettes to current levels. The most widely sold imported brands are L&M and Marlboro, both produced by Philip Morris.

<table>
<thead>
<tr>
<th>Brand and manufacturer</th>
<th>Estimated market share (2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Krong Thip (TTM)</td>
<td>34.6%</td>
</tr>
<tr>
<td>Wonder (TTM)</td>
<td>26.9%</td>
</tr>
<tr>
<td>L&amp;M (Philip Morris)</td>
<td>17.9%</td>
</tr>
<tr>
<td>Falling Rain (TTM)</td>
<td>12.1%</td>
</tr>
<tr>
<td>Marlboro (Philip Morris)</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95.6%</strong></td>
</tr>
</tbody>
</table>

It is TTM that determines the ex-factory price that is provided to the Excise Department and that is used to calculate all taxes except the ad valorem tax. In the case of imported cigarettes, the declared CIF price plays the same role. These prices are not publicly available.

**Taxes applicable to RYO tobacco.**

RYO tobacco is taxed according a dual system comprising a 10% ad valorem tax plus a 0.05 baht per gram. It is made exclusively from the lower-quality leaves produced by local tobacco growers (higher-quality leaves are sold to TTM to produce cigarettes and to some private companies for trade). The leaves are sold to various shredding companies, which process them and sell the resulting tobacco along with the paper with which to roll cigarettes. Very low taxes have resulted in high affordability of RYO tobacco, and it is roughly estimated that the cost of a RYO cigarette is about one tenth that of a manufactured cigarette.

**Tax administration.**

Fiscal policy for tobacco is decided jointly by the Fiscal Policy Office and the Excise Department (both in the Ministry of Finance), with the latter also being in charge of tax collection. Registration for taxes is based on a system of compulsory licences for all those involved in the manufacture or sale of tobacco. This system is managed by the Excise Department and includes tobacco growers, cigarette manufacturers, RYO tobacco manufacturers, importers and retailers. It appears that the system does cover all participants in the tobacco industry, enabling good control of taxpayers and good access to the tax base.

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6 Tobacco growers are generally under contract with TTM and have to produce a certain quota for sale to TTM. Beyond this quota, growers can sell their own leaves themselves, within the limits of their licence, or sell them to shredding companies.
Illicit trade.

It is estimated that illicit trade could account for as much as 20% of the overall Thai tobacco market, but many estimates are lower. Although the evolution of illicit trade is difficult to track for obvious reasons, the value of fines for smuggling increased from 91 million baht (US$ 2.6 million) in 2003 to 228 million baht (US$ 6.5 million) in 2008. Most illicit trade occurs along the border with Malaysia, but is also present along the borders of Cambodia and Myanmar. There is no specific policy to fight the illicit trade in tobacco products other than standard tax evasion procedures. Legal procedures for smuggling cases are complicated, and contradictory information was obtained from various sources. In addition, inconsistencies between various laws were reported to result in low levels of enforcement.

In general, the smuggler is sent to court only if he/she does not confess to smuggling. Sentences in court seem to be heavier and increase with the number of convictions. If an individual is caught smuggling any amount of tobacco, the smuggled product is seized and the individual is fined to an amount based on the market value of the smuggled product (inclusive of all taxes). Based on some sources, the fine can be calculated as follows, although it was not possible to obtain consistent information from all authorities concerned:

- 10 times the market value in the case of amounts for personal consumption;
- 15 times the market value and confiscation in the case of smuggling for commercial purposes.

There is only very minimal coordination between government agencies on smuggling and no coordination on tobacco control with the authorities in Cambodia and Malaysia, from which most smuggled and counterfeit cigarettes come. Once safely across the border in Thailand, few illicit products are ever confiscated at the retail level. The police at national level claimed to have no mandate to deal with tobacco counterfeiting and smuggling. Both the provincial police and the Provincial Office of Disease Control conduct operations to find counterfeit and smuggled cigarettes on the market, but only the police can make arrests and impose fines. Collaboration on illegal sales between the district police and customs and excise officials is informal, and often based on personal relations.

Diversification programmes.

The Ministry of Agriculture is currently in discussions with the TRC on a two-year pilot of crop diversification programmes for tobacco farmers in eight northern provinces. The first phase of the planned pilot will see the convening of focus groups to identify viable alternatives. With objectives aligned closely to those of the MoPH, the Ministry of Agriculture does not currently collaborate with TTM in any area of its operations, including information sharing and technology transfer.

Earmarking.

In 2001, the Government introduced a special earmarked tax to finance ThaiHealth. The tax stands at 2% of tobacco and alcohol taxes, which together amounted to approximately 2 billion baht (US$ 60 million) in 2007. Only about 10% of the budget is dedicated to tobacco. In 2008, ThaiHealth is expecting to spend 183 million baht (US$ 5.2 million) on tobacco control. The rest of the budget is spent on other noncommunicable diseases. In 2008, ThaiHealth financed tobacco control campaigns (105 million baht or US$ 3 million), smoke-free projects (38 million baht or US$ 1.08 million) and other tobacco control projects, as well as research (40 million baht or US$ 1.14 million).

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7 It was reported that under the excise laws, possession of smuggled cigarettes is prosecutable, while the public health law demands a witness to a transaction in illicit cigarettes before prosecution can take place.
8.2. KEY FINDINGS

8.2.1. In spite of past tax increases, cigarettes have become more affordable over the past years.

At 51.6% of the retail price, excise taxes on cigarettes in Thailand are relatively high by world standards, and all taxes combined add up to 64.3% of the retail price. Prices inclusive of excise duty have also increased broadly in line with inflation, through increases in the statutory rate of excise duty, despite the TTM ex-factory price remaining relatively stable and the CIF price of imported cigarettes tending to decrease for many years.

However, per capita income in Thailand has been increasing rapidly and the affordability of cigarettes has therefore increased accordingly. Between 1998 and 2008, the price of a pack of Krong Thip increased by 73% from 26 to 45 baht, whereas the nominal income per capita grew by 83%. Such changes are particularly significant for individuals in lower-income and less educated groups, who are also most likely to take up or increase smoking as a result of a higher level of disposable income.

Furthermore, efforts to reduce the affordability of tobacco products through tax increases are undermined by illegal sales of single cigarettes. Thai law officially prohibits the sale of cigarettes individually or in small packets, but the capacity assessment team encountered several infractions of this law in the markets of Bangkok.

8.2.2. The imbalance between the tax on cigarettes and that on RYO tobacco is a major source of revenue loss and probably explains the higher prevalence of tobacco use in rural areas.

The low taxes on and price of RYO tobacco has prevented a fall in tobacco consumption in rural areas, where most of it is consumed (especially in the north). Indeed, the prevalence of tobacco use in municipal areas is 16.4% compared with 23.4% in rural areas. Given the large populations in rural areas, it is therefore estimated that about half of the tobacco consumed in Thailand is RYO and is therefore almost untaxed. The impact for revenue collection is clear and, although it is doubtful that RYO tobacco will ever generate as much tax revenue as cigarettes, the gap is substantial.

Although this is a concern among the agencies interviewed, taxation of the sector is at a very preliminary conceptual stage and some fundamental questions have not been answered (e.g. at what stage of production taxes should be levied and how, and whether farmers will be affected and if so how they should be helped). Some officials have nevertheless outlined two conditions that such a new tax would need to meet: (a) no taxation of the farmers themselves; and (b) the tax increase should be gradual.

Overall, officials expressed the need for a much more complete body of knowledge to support the development of tax policy in this area. The data to be used for such analyses appear to be available from the Excise Department, however, since this department is in charge of the entire sector (the exact extent to which data are available was not discussed). Indeed, the presence of farmers that both grow and shred tobacco makes it difficult to tax formal RYO tobacco companies, which would risk diverting all tobacco shredding to the farmers themselves.
8.2.3. The base used in the calculation of the ad valorem tax is probably underreported, resulting in a potential tax gap.

Ad valorem taxation systems are heavily dependent on the definition of a clear and transparent market value of transactions. This is lacking in Thailand, both for imports and for local production. For local production, the ex-factory price is provided by TTM to the Excise Department. Although an external audit of TTM’s financial statements and pricing practices is provided to the Department, the ex-factory price has not changed for many years despite fluctuations in input prices as well as macroeconomic and market conditions. This suggests that an in-depth investigation of pricing practices might be needed to restore the credibility of the stated ex-factory price as a true measure of market price.

The tax base for imported cigarettes suffers from similar issues. An overwhelming proportion of imported cigarettes come from the Philippines, where Philip Morris has set up a factory to export cigarettes to Thailand. These cigarettes are imported by a group of 11 importers, who obtained their licence from the Excise Department. In all interviews, the national authorities were not in a position to confirm either the identity of these importers or their links with their trade counterpart in the Philippines; it has therefore been impossible for this mission to establish the nature of these transactions. Since the CIF price serves as the direct (e.g. import duties) or indirect (e.g. excise duty, etc.) base for all taxes except VAT, the potential difficulties in determining whether import prices are true market prices opens the door to contestation of taxes applied to imported cigarettes. As a result of these difficulties, Thailand has at times replaced the declared import price by an assessed price that it deems closer to the market price. In turn, Philip Morris, through the Government of the Philippines, has lodged a complaint at the World Trade Organization.

8.2.4. Licence fees for tobacco-related activities are extremely low.

Licences and related fees generally serve three main purposes: (a) registration for taxation at a later stage (i.e. taxpayer registration and identification of non-filers, with licence fees counting as a proxy for the cost of licensing); (b) registration for technical controls and support (e.g. application of various tobacco control provisions at the point of sale); and (c) barriers to entry and ensuing taxation of rent (e.g. cell phone operators, various monopolies). In this respect, the licensing system currently applied to the entire tobacco industry in Thailand (from leaf production and imports to processing, manufacturing and retailing) is a highly valuable administrative asset at the disposal of the Government. Although it remains possible that some tobacco-related activities remain outside the current licensing system (notably those of growers), few developing countries have achieved such a strong administrative control of the industry. Licence fees have not increased for the past 42 years, despite increases in prices and general economic growth.

Nevertheless, leveraging the current licensing system towards the three objectives defined above can be improved. Regardless of technical controls that mainly concern the application of tobacco control laws (mostly at the retail level), the licensing system probably barely covers its implementation costs given the extremely low fees levied. In addition, licensing participants to the RYO industry does not result in high revenues from other taxes at the production or retail stages (excise duty in this case). Hence there are concerns regarding the capacity of the RYO licenses to result in tax revenue, and the real benefit of the licensing system for the Government. Finally, license fees are so low that they cannot be assimilated into a system of rent taxation (most strikingly in the case of the tobacco monopoly).
In addition, the potential of licensing as a means of managing the structure of an industry to allow for easier taxation has probably not yet been fully explored. By imposing a (potentially high) fixed fee to selected participants in an industry, licences can play the role of barriers to entry. This in turn creates important economies of scale and a strong incentive to increase the average size of manufacturing units, hence more formal organizations and easier monitoring for tax purposes. Very high licence fees also help discipline the management of firms by taxing the rent, thus preventing dissipation of that rent in inefficiencies that typically characterize industries with a high level of concentration.

8.2.5. Current sentences for smuggling are not an effective deterrent.
In the case of importers of smuggled products, smugglers are rarely identified. They employ drivers of rented vehicles to bring goods across the border. Goods are confiscated and destroyed, but vehicles are often returned to their owners.

In the case of retailers of smuggled products, even if (after identifying an infraction and bringing in the district police before sellers themselves are alerted) arrest is successful, the courts rarely hand down the full fine allowed by law.

8.2.5.1. Coordination among the various agencies involved on tobacco taxation is suboptimal.
A symptom of the lack of coordination on tobacco taxation is a deficient administrative mechanism to develop and enforce a joint strategy on smuggling and the sale of single cigarettes or small packages. The most relevant stakeholder agencies are the customs and excise authorities. The Office of Disease Control and the police at the national, regional and provincial levels.

8.2.5.2. The lack of collaboration between the Ministry of Agriculture and the Ministry of Finance may result in challenges for crop diversification programs at the local level.
The Ministry of Finance has an interest in the tax revenue implications of crop diversification. Furthermore, at the local level, it is not impossible that farmers chosen for the pilot will have some land devoted to alternative crops and some that will continue to be devoted to tobacco growing.

8.3. KEY RECOMMENDATIONS

8.3.1. Move towards increasing the tax rate on RYO tobacco, beginning with an analysis of the RYO sector and a proposal to bring RYO taxes in par line cigarette taxes.
Increasing taxes on RYO tobacco is the most pressing concern for tobacco taxation in Thailand. Higher taxes will most likely result in a reduction in smoking prevalence (especially in rural areas). It is far from clear, however, how one should proceed to increase taxes on RYO tobacco, and a major study on the sector and new ways to tax it should be started immediately by the Ministry of Finance in coordination with other agencies and organizations, including the Ministry of Agriculture. A few guidelines should be followed in carrying out this study.

8.3.1.1. To make new or increased taxes administratively feasible, the sector will probably need to undergo a certain level of restructuring.
This will entail redefining licences and changes in licence fees, pointing to a better separation of tobacco growing and processing.
8.3.1.2. The Ministry of Finance should collaborate with the Ministry of Agriculture, in the context of the pilot project described earlier in this report, to assist farmers that might be affected by a decrease in the demand for lower-grade tobacco to move away from tobacco production. To this end, the Ministry of Finance should work actively and constructively with Ministry of Agriculture and the MoPH on their two-year pilot project in eight northern provinces to identify and test likely alternatives. The Ministry of Finance could contribute with projections and analyses of the revenue and tax revenue implications of these alternatives. To minimize any potential for conflict of interest, the contributing Ministry officials should not be within the department or on the board of TTM.

8.3.2. Make the base for excise tax more transparent by changing to an ad valorem system based on final retail value or by converting the ad valorem excise duty to an amount-specific excise tax. Administration of the current ad valorem tax, based on the CIF or ex-factory price, is very difficult and doubts are likely to remain about alignment of the base price with market prices, both for imports and for local production. Consequently, the Government should either use retail prices as the tax base and print the pre- and post-VAT price on the packs, or completely change the system to an equivalent amount-specific system automatically indexed to consumer prices and growth in annual per capita income.10

8.3.3. Licence fees for all tobacco-related activities should be increased. The licensing system is a valuable asset that the Government should make full use of. This means that licence fees should be increased to take into account the real value that they had when the system was inaugurated. The Government should also drastically increase the fee for the licence issued to TTM which, at 10 000 baht, is very low. The Government should also consider using licensing as a means of restructuring the RYO tobacco sector, although the exact nature of changes should be studied in detail in a dedicated study (see above). The new licence fee should also be adjusted periodically (e.g. every five years according to inflation).

8.3.4. A multisectoral and interministerial strategy on smuggling should be developed. This could include:

- a specific budget for joint activities in support of common objectives, especially at the regional/provincial level;
- designated focal points at all levels (national, regional/principal and district) and organizations;
- greater legal support from the centre to the provinces for court cases;
- higher fines in the case of conviction; and
- other relevant elements and provisions of the Protocol on Illicit Trade in Tobacco Products currently being negotiated by the Intergovernmental Negotiating Body established by the Conference of the Parties to the WHO FCTC.

In order to put this strategy into operation at provincial level, the coordinating structures of the Offices of the Governors should be employed for local coordination, and the Joint Committees of Border Provinces for international coordination, including information sharing across borders (e.g. with Indonesian and Malaysian counterparts). Joint training and training of trainers should be considered for promoting networking between these groups and establishing appropriate structures for sustained information exchange. A lead agency should be appointed for pursuing this coordination, and a budget allocated for joint activities.

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8 Determining what an equivalent system would be is beyond the scope of this report and should be performed by relevant national authorities so that neither tobacco prices nor tax revenues fall.

9 Automatic adjustments should be built into the law so that the increase can be implemented as a simple administrative measure by the relevant tax authorities.

10 Some countries already use a maximum retail price set by the manufacturer as the basis for calculating customs duty and require that the price is printed on the pack to facilitate enforcement at the retail level.
Annex 1. Tobacco price structure

Calculation is based on the following formula:

\[ P^c = \left( P^0 \times (1 + t_r) \times \left[ 1 + \frac{(1 + h + k) t_e}{1 - t_e} \right] + t_f + m \right) \times (1 + t_v) \]

Where:  
- \( P^c \) = Retail price of cigarettes (baht per pack)  
- \( P^0 \) = Factory price or imported price of cigarettes (baht per pack)  
- \( t_r \) = Import duties (per cent) applied to the import transaction CIF price  
- \( t_e \) = Statutory tax inclusive of excise tax (= 80\%)  
- \( h \) = Tax for Health Promotion Fund (= 2\%)  
- \( k \) = Television tax (= 1.5\%)  
- \( t_f \) = Provincial tax (up to 1 baht per pack of 20 cigarettes)  
- \( m \) = Profit margin (baht per pack)  
- \( t_v \) = Value added tax (= 7\%)
## Annex 2. List of institutions and key informants

<table>
<thead>
<tr>
<th>Institution / Department / Organization</th>
<th>Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Public Health, Bangkok</td>
<td>Permanent Secretary of Public Health, Dr Prat Boonyawongwirote&lt;br&gt;Dr Paichit Warachit, Deputy Permanent Secretary of Public Health, supervising the Department of Disease Control&lt;br&gt;Dr Seri Hongyok, Inspector General (Former Deputy Director General of the Department of Disease Control)&lt;br&gt;Dr ML. Somchai Jakkapan, Director General, Department of Disease Control&lt;br&gt;Dr Samarn Futrakul, Director, Office of the Alcohol and Beverage and Tobacco Control Committees&lt;br&gt;Dr Panuwat Panket, Director, Bureau of Non-Communicable Diseases, Department of Disease Control, MoPH&lt;br&gt;Dr Siriwat Tiptaradol, Deputy Permanent Secretary of Public Health</td>
</tr>
<tr>
<td>Medical Service Department, Bangkok Metropolitan Administration, Bangkok</td>
<td>Dr Kraijak Kaewnin, Director</td>
</tr>
<tr>
<td>Southeast Asian Tobacco Control Alliance (SEATCA), Bangkok</td>
<td>Ms Bang-On Ritthipakdee, Director</td>
</tr>
<tr>
<td>Thai Health Promotion Institute</td>
<td>Dr Hathai Chitanond, Chairman</td>
</tr>
<tr>
<td>Tobacco Control Research and Knowledge Management Centre (TRC), Bangkok</td>
<td>Dr Lakkhana Termsirikulchai, Director</td>
</tr>
<tr>
<td>Action on Smoking and Health Foundation Thailand (ASH Thailand), Bangkok</td>
<td>Prof Prakit Vathesathogkit, Executive Secretary</td>
</tr>
<tr>
<td>Ministry of Education, Bangkok</td>
<td>Dr Chaub Leechor, Inspector General&lt;br&gt;Dr Benjalug Numfa (Ph.D), (Director of Bureau Academic Affair 2nd education standards, Office of the Basic Education Committion</td>
</tr>
<tr>
<td>Office of the Basic Education Commission, Bangkok</td>
<td>Head</td>
</tr>
<tr>
<td>Department of Agriculture Promotion, Ministry of Agriculture</td>
<td>Mrs Somsri Boonroeng, Director, Industrial Corp Promotion Division, Bureau of Agricultural Product Promotion and Management</td>
</tr>
<tr>
<td>Social Security Office, Nonthaburi</td>
<td>Mrs Suchitra Boonchoo, Deputy Secretary</td>
</tr>
<tr>
<td>Greenleaf Foundation (Smoke-Free Hotels Project), Bangkok</td>
<td>Dr Chirapol Sintunawa, Vice Presdident Amphai Wejwithan Project manager</td>
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<tr>
<td>Denla Kindergarten, Bangkok</td>
<td>Mr Arn Pandepjpong, Principle</td>
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<tr>
<td>Rangsit University, Bangkok</td>
<td>Dean (Dr Pisit Narmjantra), Faculty of Medical Technology</td>
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<tr>
<td>Dentist Network for Smoke-free Society, Bangkok</td>
<td>Department of Health, Dr Siripen Arunprapan</td>
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<tr>
<td>Nursing Network for Tobacco Control, Bangkok</td>
<td>Dr Supranee Senadisai, Chairman</td>
</tr>
<tr>
<td>Health Professional Network for Smoke-free Society, Bangkok</td>
<td>Dr Somsri Paosawat, Chairman</td>
</tr>
<tr>
<td>Tawandang German Brewery (Ram Intra Branch), Bangkok</td>
<td>Managing Director, Mr Supote Teerawattanachai</td>
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<td>Institution / Department / Organization</td>
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<tr>
<td>Department of Trade Negotiations, Bangkok</td>
<td>Mr Somkiat Triratanapan, Deputy Director General</td>
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<tr>
<td>Lake Hill Restaurant, Bangkok</td>
<td>Mr Varun, Manager</td>
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<tr>
<td>The Customs Department Investigation and Suppression Division III, Bangkok</td>
<td>Mr Vorapat Jaovisidha, Director</td>
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<tr>
<td>Fiscal Policy Office, Income and Consumption Policy Division, Bangkok</td>
<td>Sumalee Satitchaichareon, Director</td>
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<tr>
<td>Excise Department, Bangkok</td>
<td>Mr Satit Rankasiri, Consultant in Tax Collection</td>
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<tr>
<td></td>
<td>Siriporn Liengsombat, Deputy Director General</td>
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<td></td>
<td>Poonsak Suvannarat, Director Prevention and Suppression Bureau</td>
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<td></td>
<td>Chawewean Pornleecharoen, Director of bureau of tax administration standard and development</td>
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<tr>
<td>The Royal Thai Police, Bangkok</td>
<td>Police Colonel Saroch Nimcharoen, Deputy Commandant, Traffic Development and Service Division</td>
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<tr>
<td>The Department for Special Investigation, Bangkok</td>
<td>Police Colonel Suchat Wonganantachat Director General</td>
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<tr>
<td>The Royal Thai Military, Bangkok</td>
<td>Project manager for Healthy Royal Thai Armed Forces, Lieutenant General</td>
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<td></td>
<td>Kamonporn Suansomjitr</td>
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<tr>
<td>Consumer Protection Office, Bangkok</td>
<td>Mr Niroth Chareonprakob, Secretary General</td>
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<tr>
<td>Thonglor Police Station, Bangkok</td>
<td>Police Colonel Jirapat Phumijitr, Head</td>
</tr>
<tr>
<td>Occupational Health and Work Safety Institute, Bangkok</td>
<td>Director, Mr Sakchai and three other colleagues</td>
</tr>
<tr>
<td>Office of Disease Prevention and Control, Region1, Bangkok, Alcohol and Tobacco Unit</td>
<td>Tobacco Control team</td>
</tr>
<tr>
<td>Office of the Council of State, Bangkok</td>
<td>Secretary General, Mr Sa-nga Akkarapridi, Public health law division</td>
</tr>
<tr>
<td>Dept. of Mental Health, Ministry of Public Health, Bangkok</td>
<td>Dr Yongyud Wongpiromsarn, Senior Expert, Head of Advisor Group</td>
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<tr>
<td>Smo̦king cessation clinic, Phramongkutklao Hospital, Bangkok</td>
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<tr>
<td>Thai Health Professional Alliance against Tobacco (THPAAT), Bangkok</td>
<td>Prof Dr Somsri Pausawasdi, President THPAAT</td>
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<td></td>
<td>Ass Prof Dr Naeng-Noi Charnond, Director THPAAT</td>
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<td></td>
<td>Ass Prof Dr Suthat Ranrugruanghiranya, Medical network</td>
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<td></td>
<td>Dr Dentistry Wikul Visalseth, Dentistry network</td>
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<td></td>
<td>Mr Katha Bunditanukul, Pharmacists network</td>
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<td></td>
<td>Assoc. Prof Dr Surinthorn Kalampakorn, Nursing network</td>
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<td>Asst. Prof Psit Namjuntra, Medical Technology</td>
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<td>Assoc. Prof Dr Prawit Janwanatanakul, Physical Therapy</td>
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<td></td>
<td>M Sanong Klumchim, Thai Public Health Association</td>
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<td></td>
<td>Mr Natapat Nichakietthana, Thai Traditional Medicine</td>
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<td></td>
<td>Dr Bhakasit Wannawibool, Chinese Traditional Medicine</td>
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<td>Smo̦king cessation clinic, Srinakharnwirot University Hospital (SWU), Bangkok</td>
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</tr>
<tr>
<td>Institution / Department / Organization</td>
<td>Informants</td>
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<tr>
<td>President's Office Chulalongkorn University, Bangkok</td>
<td>Assoc Prof Jiruth Sriratanaban, M.D., PhD. Assistant to President of Chulalongkorn University in Health Promotion Policy Assoc. Prof. Boonchai Stimannaithum, D.Eng. Assistant to President of Chulalongkorn University in Physical Environment Khun Yaowadi Administrative Officer Khun Nongnat Administrative Officer</td>
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<tr>
<td>Thanyarak Institute on Drug Abuse, Pathumthani, Bangkok</td>
<td>Dr Apinai Jinpipat, Medical Officer Ms Somporn Suwanmao, Pharmacist Ms Wassana Khongsombat, Nurse</td>
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<tr>
<td>The Thoracic Society of Thailand</td>
<td>Prof Dr Art Nana, President</td>
</tr>
<tr>
<td>The Anti-Tuberculosis Association of Thailand</td>
<td>Prof Dr Prapal Yong Jaiyut, President</td>
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<tr>
<td>Matichon Public (Newspaper), Bangkok</td>
<td>Norrinee Ruangnoo, Assistant Chief reporter</td>
</tr>
<tr>
<td>Association for the Development of Environmental Quality, Bangkok</td>
<td>Dr Sansanee Keeratiwiryaporn, Secretary general</td>
</tr>
<tr>
<td>Royal Thai Army Radio and Television, Bangkok</td>
<td>Ms Thawinan Nokkran, Senior Public Relations Manager</td>
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<tr>
<td>The Advertising Association of Thailand, Bangkok</td>
<td>Mr Witawat Jayapani, President</td>
</tr>
<tr>
<td>Chulalongkorn University, Faculty of Pharmaceutical Sciences, Health Consumer Protection Project, Bangkok</td>
<td>Vithaya Kulsoomboon, Associate Professor and Manager of the project</td>
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<tr>
<td>Ministry of Information and Communications Technology, IT Regulation Bureau, Bangkok</td>
<td>Mr Thongchai Sangsiri, System analyst &amp; Ms Rawiwan Pongpanich, Legal Officer</td>
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<tr>
<td>True Vision, Cable TV, Bangkok</td>
<td>Prapparnpong Maknun, Senior Manager, Corporate Affairs &amp; Communications</td>
</tr>
<tr>
<td>The Post Publishing Public Company, Bangkok Post (Newspaper), Bangkok</td>
<td>Ms Kultida Samabuddhi, Assistant News Editor – General news section</td>
</tr>
<tr>
<td>“Stop Smoking” project for the Royal Thai Navy, Bangkok</td>
<td>Rear Admiral Dendecha Pathumpetch and Captain Piyachart Charoenwattanapanich, Officers in charge</td>
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<tr>
<td>Office of Disease Prevention and Control, Region 10, Chiang Mai, Alcohol and Tobacco Control section</td>
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<td>Amari Rincome Hotel, Chiang Mai</td>
<td>Ms Warunee Khammeru, Executive Assistant Manager Ms Nantarut Suttana, Administration Manager</td>
</tr>
<tr>
<td>Chiang Mai Christian School</td>
<td>Ms Auranat Foeyard, Principal Ms Somsri Chaiyasate, Manager and Assistant Principal Ms. Rumphan Sakunpunsap</td>
</tr>
<tr>
<td>Tawandang Chiang Mai Bar and Restaurant</td>
<td>Mr Chaiwat Klannark, Manager</td>
</tr>
<tr>
<td>Golden Monkey Bar and Restaurant</td>
<td>Ms Arreerat Inthawong, Manager</td>
</tr>
<tr>
<td>Nakornping Hospital, Chiang Mai</td>
<td>Dr Chatchaval Siririnirundr, Director Mr Prakit Prakunkorn, Deputy Director Ms Darin Shinawatra, Nurse Mr Maitree Vongverapant, Clinical Psychologist Ms Roongaroong Ruechai, Nurse</td>
</tr>
<tr>
<td>Institution / Department / Organization</td>
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</tbody>
</table>
| Consumer Protection section, Provincial Public Health Office, Chiang Mai | Mr Jaroon Yanasarn, Head  
Mr Pison Sribundit, Pharmacist |
| Chiang Mai Pharmacy                                              | Mr Pison Sribundit, Pharmacist                                            |
| Vice Governor Chiang Mai                                         | Mr Chumporn Saengmanee                                                   |
| Excise Office of Chiang Mai                                      | Mr Dumri Aempradit, Government Excise Officer                             |
| Kids Ark Foundation                                              | Ms Rita Holm Gustafsson                                                  |
| Chiang Mai Police Department                                     | Police Colonel Wachira Kanjanawipada  
Police Lieutenant Ben Wongkrau |
| Yupparaj Wittayalai School, Chiang Mai                           | Mr Banchong Phonrit                                                      |
| Office of Disease Prevention and Control, Region 12 Song Khla     | Ms Saowaluck Musikarangsr, Head of Gen Admin  
Dr Suwit Thammapalo Director                                       |
| Relevant restaurants, pubs/bars, and hotels entrepreneurs, Song Khla (10) | Focus group                                                                 |
| Smoke-free markets and pubs/bars, Song Khla                      | Field visits in several markets, pubs and bars                            |
| Provincial Governor, Songkha                                     | Mr Matee Na Nakorn, Vice Governor of Songkha                              |
| Excise Department Songkha                                        | Mr Nipon Pannual, Director                                                |
| The Customs Department, Region 4, Song Khla                      | Mrs Nutthika Pongsrikul, Director of Customs Control Division             |
| Provincial Public Health Office Song Khla                        | Dr Sunpong Ritthiruksa, Deputy Provincial, Chief Medical                  |
| Hadyai Public Health Office, Song Khla                           | Mr Suthat Wanno, Head  
Mr Weerapong Jinadit                                                     |
| Hadyai Hospital, Song Khla                                       | Dr Pirote Warachit, Deputy Director, Medical Division                      |
| Rattaphum Hospital, Song Khla                                    | Dr Suwit Kongchoochuyay, Director                                         |
| Satingpha Hospital, Song Khla                                     | Miss Chusri Ratkaew, Pharmacist                                           |
| Hadyai Police Station, Song Khla                                 | Police Colonel. Supawat Tubkliw, Head                                    |
| Chansiao Foundation, Song Khla                                   | Mr Elphan Porfaema  
Mr Ismaill Doyi                                                             |
| Songkhla Business Administration School, Songkhla                | Miss Suwapat Suwan  
Mr Phun Singhadaecha, Assistant Director                                 |
Annex 3. List of assessment team members and observers

1. Ms Virginia Arnold, Project Officer for the Bloomberg Initiative, Tobacco Free Initiative, World Health Organization, Switzerland
2. Dr Ponlekea Banhansupawat, Office of Disease Control and Prevention, Region 1, Thailand
3. Assoc Prof Dr Naowarat Charoenca, Faculty of Public Health, Mahidol University, Thailand
4. Dr Pantip Chotibenjamaporn, Deputy Director, Office of Disease Control and Prevention, Region 1, Thailand
5. Dr Annette David, Health Partners, L.L.C. Tamuning, Guam, former Regional Adviser, Tobacco Free Initiative, WHO Regional Office for Western Pacific
6. Dr Karen Evison, National Programme Manager, Tobacco Policy & Implementation Team, Ministry of Health, New Zealand
7. Christopher Fitzpatrick, Economist, Tobacco Free Initiative, World Health Organization, Switzerland
8. Mr Hemant Goswami, Burning Brain Society, Chandigarh, India
9. Mr Wijesiri Gunasekara, Epidemiologist, Sri Lanka
10. Asst Prof Dr Kitti Gunpaisak, Faculty of Communication Arts, Chulalongkorn University, Thailand
11. Dr Prakash Gupta, Epidemiologist and Director of Healis, Sekhsaria Institute of Public Health, Navi Mumbai, India
12. Dr Supranee Jiwasakapimas, Researcher, Faculty of Medicine, Siriraj Hospital, Mahidol University, Thailand
13. Dr Chai Kritiyapichatkul, Office of WHO Representative to Thailand
14. Ms Stefanie Laniel, Communications Officer, Tobacco Free Initiative, World Health Organization, Switzerland
15. Dr Fabio Luelmo, independent consultant, former WHO expert, Switzerland
16. Dr Armando Peruga, Coordinator, National Capacity Unit, Tobacco Free Initiative, World Health Organization, Switzerland
17. Mr Patrick Petit, WHO/TFI/NAC, Tobacco Price and Tax Economist, National Capacity Unit, Tobacco Free Initiative, World Health Organization, Switzerland
18. Dr Sathirakorn Pongpanich, Associate Dean, the College of Public Health Sciences, Chulalongkorn University, Thailand
19. Dr Neena Prasad, Bloomberg Philanthropies, United States of America (observer)
20. Asst Prof Dr Sunida Preechawong, Faculty of Nursing, Chulalongkorn University, Thailand
21. Asst Prof Dr Chardsumon Prutipinyo, Faculty of Public Health, Mahidol University, Thailand
22. Dr Khalilur Rahman, Regional Adviser, Tobacco Free Initiative, South-East Asia Regional Office, World Health Organization, New Delhi
23. Dr Sawat Ramaboot, Consultant, Office of WHO Representative to Thailand
24. Asst Prof Dr Suthat Rungruanghiranya, Faculty of Medicine, Srinakharinwirot University, Thailand

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11 in alphabetical order
25. Dr Luminita Sanda, Medical Officer for Capacity Building, National Capacity Unit, Tobacco Free Initiative, World Health Organization, Switzerland
26. Assoc Prof Dr Isra Sarntisart, Faculty of Economics, Chulalongkorn University, Thailand
27. Dr Vera da Costa e Silva, independent international consultant, Brazil, former director of Tobacco Free Initiative, World Health Organization
28. Asst Prof Dr Nithat Sirichotirat, Faculty of Public Health, Mahidol University, Thailand
29. Dr Chaisri Supornsilaphachai, Senior specialist, Department of Disease Control, Ministry of Public Health, Thailand
30. Dr Francis Stillman, Institute for Global Tobacco Control, Johns Hopkins Bloomberg School of Public Health, United States of America (observer)
31. Dr Tatri Taifahpoon, Faculty of Journalism and Mass Communication, Thammasat University, Thailand
32. Dr Manopchai Thamkantho, Faculty of Medicine, Siriraj Hospital, Mahidol University, Thailand
33. Dr Chairat Techatraisak, Director, Office of Disease Control and Prevention, Region 8, Thailand
34. Asst Prof Dr Lakkhana Termsirikulchait, Director, Tobacco Control Research and Knowledge Management Center (TRC), Thailand
35. Assoc Prof Dr Suchada Tungthangthum, School of Economics, Sukhothaithammathiraj Open University, Thailand
36. Dr Gajalakshmi Vendhan, Director, Epidemiological Research Center, Tamilnadu, India
37. Dr Mostafa Zaman, National professional officer, Noncommunicable Diseases, Office of the WHO Representative to Bangladesh
38. Ms Barbara Zolty, Policy Officer, National Capacity Unit, Tobacco Free Initiative, World Health Organization, Switzerland

<table>
<thead>
<tr>
<th>Institution / Department / Organization</th>
<th>Coordinators</th>
</tr>
</thead>
</table>
| Bureau of Disease Control, Department of Disease Control, Ministry of Public Health, Bangkok | 1. Dr Panuwat Panket (Director)  
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Annex 4. List of all recommendations, chapter by chapter

COORDINATION AND IMPLEMENTATION OF TOBACCO CONTROL INTERVENTIONS

1. Strengthen the leadership role of government and civil society and enhance its synergies.
   The sustainability of the Thai tobacco control model depends very much on two factors
   a. The continued leadership of civil society with the incorporation of new leaders. Key NGOs, with
      the assistance of ThaiHealth, need to consider a long-term plan to groom and mentor new leaders
      in civil society.
   b. The strengthening of the government leadership role in tobacco control. Authorities at all levels of
      the MoPH should play a more active and leading role in tobacco control. While the present model
      of informal coordination of tobacco control stakeholders remains, the highest MoPH authority
      possible needs to participate actively and regularly. Although Thailand faces many and important
      health challenges, the control of the tobacco epidemic requires their intense attention and priority.
      In addition, the mission recommends that the policy visibility of the Tobacco Control Cluster be
      enhanced, including its placement at a higher hierarchical level than at present and directly
      reporting to the Director-General of the DDC.

2. Reinforce the capacity of government to direct policy changes, formulate tobacco control strategies
   and coordinate multisectoral tobacco control planning.
   a. The two main policy national coordinating committees, the NCCTU and NCII, should be activated.
      Informal coordination mechanisms, especially the so-called “core tobacco control advisory group”
      of ThaiHealth have played and will play an important role in coordinating the key tobacco control
      stakeholders. Nevertheless, the MoPH has a responsibility to set in motion the full potential of
      the existing formal coordination mechanisms. Improving coordination between different intra-
      governmental structures and between all relevant tobacco control partners is urgent. For the sake
      of sustainability and future advancement, this coordination needs to be regular and based on the
      existing formal structures.
   b. Priority should be given to the creation of a national plan of action for tobacco control. The Tobacco
      Control Cluster should take the lead, engaging the various stakeholders in a meaningful way
      to guarantee broad support. The plan should identify concrete strategies and activities and be
      structured around the specific obligations of the WHO FCTC, paying special attention to those
      related to MPOWER and including a system for monitoring the plan’s implementation and out-
      comes. It should identify which stakeholder[s] and which level of governmental structure should
      play the lead role in implementing each activity and with what funds. It is strongly recommended
      that the plan be approved at the highest level of the MoPH as a national plan and included in the
      National Health Development Plan; this ensure a regular budget allocation for tobacco control.
3. **Enhance the implementation capacity of NGOs and the Government.**
   a. NGOs working in tobacco control need to broaden their implementation capacity at the grassroots level by bringing new organizations to the field. NGOs should immediately contact and engage other NGOs not yet involved in tobacco control. NGOs already working in health, such as the Thoracic Society of Thailand, are natural partners, but those working with environmental, development, human rights and other non-health issues should also be contacted.
   
   b. The MoPH needs to substantially increase its capacity to implement tobacco control interventions and programmes, involving dedicated structures and personnel at regional, provincial and district levels. The Tobacco Control Cluster should include among its role and functions the implementation of interventions and programmes at provincial and other levels. One specific implementation function that needs to be prioritized immediately is the enforcement of existing tobacco control legislation. Following the Thai tradition of increasing social awareness about the law before implementing coercive measures, the Government needs to create a substantial group of officers that can oversee compliance with the law according to a focused and structured plan of visits. Their function would be to hand out warnings to offenders and to educate them “on the spot”. The current role for enforcement belongs to the officers from the Royal Thai Police. Additionally according to the law there are several institutions that are in charge with appointing “operational officers” who should monitor compliance within their area of work and collaborate closely with the police officers. Thus, new posts do not need to be created: the function of inspection can be delegated temporarily to specific government officers within and outside the health sector across all jurisdictional levels, paying particular attention to provincial and district levels.

4. **Increase staff numbers and capacity and the financial resources fully devoted to tobacco control.**
   The limited capacity of qualified staff to face the tobacco control challenges of the country is a severe problem across many organizations and sectors.
   
   a. In the governmental sector, the number of staff at central level is clearly insufficient to face the tobacco control challenges of the country. If the MoPH has to take a renewed role in leading, coordinating and implementing tobacco control measures, the number of staff of the Tobacco Control Cluster must increase. In addition, the qualifications of the staff must provide a multidisciplinary approach to tobacco control as a health and development issue, including the communicational, legal, social and economic aspects of tobacco control. At subnational level, government staff at regional, provincial at district levels need to be trained adequately to face the tobacco control enforcement challenges of the country.
   
   b. In the area of tobacco control research, there is a need to develop a long-term plan in coordination with key universities to create a base of researchers.
   
   c. The ThaiHealth model of financial support to tobacco control should continue but with certain provisos.
      
      i. The amount of money allocated by ThaiHealth for tobacco control in the immediate future needs to be revised and probably increased. The checks and balances in ThaiHealth and the focus on funding known and trusted individuals has been an excellent strategy as it ensures performance and transparency. There is, however, a need to open up this funding to new organizations that wish to get involved in tobacco control as a core function of their work. This will ensure even broader support in Thailand for tobacco control.
      
      ii. The regular budget from MoPH needs to be substantially increased to strengthen its role and functions in the areas outlined above.
      
      iii. Additional sources of funding should be explored in order to expand local funding mechanisms for tobacco control.
MONITORING AND EVALUATION

1. Create an integrated national surveillance and monitoring system under the coordination of one single body that includes:
   a. existing surveillance efforts, such as GYTS and the GATS, as well as current national surveillance efforts made by the MoPH, the National Statistical Office and Mahidol University; and
   b. new components in order to:
      i. monitor regularly the efforts of the tobacco industry to undermine public health and to integrate the scant and disparate NGO monitoring and research activities on this topic to avoid duplication of work;
      ii. monitor progress in enforcing tobacco control policies and interventions pertaining to key articles of the WHO FCTC according to existing guidelines of the Conference of the Parties; and
      iii. assess the economic impact of problems created by tobacco use and of the benefits of implementing tobacco control measures.

2. Increase the human capacity for conducting research on monitoring and surveillance activities by establishing a regular training programme for professionals already involved.

3. Ensure regular funding from ThaiHealth and the Government to conduct the activities of the integrated national surveillance and monitoring system in a sustainable fashion, including repeating full surveys every three-four years.

4. Develop a tobacco surveillance plan of action to define:
   a. essential surveillance and monitoring indicators;
   b. data collection, storage, analysis and dissemination procedures;
   c. links with policy-making processes and decisions; and
   d. institutional responsibilities and roles in performing the different functions of the system at all levels of jurisdiction.

PROTECT PEOPLE FROM TOBACCO SMOKE - SMOKE-FREE ENVIRONMENTS

1. Ensure universal and equal protection for all workers and the public from exposure to second-hand smoke by enacting, implementing and enforcing a national 100% smoke-free law in Thailand with no exceptions.

2. Increase efforts directed at self-enforcement.
   a. Where possible, empower the local and other authorities to conduct inspection and monitoring of compliance.
   b. Increase the scope, frequency and intensity of efforts to educate the public and target audiences, in order to mobilize community support for smoke-free environments and increase self-enforcement.

3. Increase pro-active enforcement.
   a. Although reliance on self-enforcement will remain the focus of compliance efforts in Thailand, this will not work completely without a credible threat of punitive action for potential violators.
   b. Enforcement procedures need to be simplified.

4. Establish a coordinated, multisectorally integrated and systematic system based on an overall enforcement plan, both for surveillance of outcomes, monitoring compliance and for prosecuting violators.
   a. While no further research and evaluation is needed to justify smoke-free policy implementation, an evaluation strategy will be very useful to monitor the success of implementation, public support for the law and the health and economic impacts. In this way, ongoing public and political support for the need for stronger enforcement of legislation can be sustained.
b. Measuring outcomes, such as exposure to second-hand smoke in workplaces and public places, should be part of the monitoring system.

c. Compliance can be monitored using one or more of the mechanisms already in place for inspecting business premises (food, alcohol inspectors, etc.) and workplaces (labour inspectors, safety officers, etc.) and integrating compliance inspections into business licensing inspections, health and sanitation inspections, inspections for workplace health and safety, fire safety inspections and similar programmes.

d. Establish a regular mechanism for communicating the impact of law enforcement to the public. This effort is particularly important because the tobacco industry sometimes encourages and publicizes violations as part of its effort to create the impression that the law is not being respected.

5. Reinforce, integrate and coordinate the work of the MoPH with the work of the Steering Committee of the Towards 100% Smoke-free Environments in Thailand project.

6. Establish a multisectoral strategy for effective training of police officers and inspectors.

a. Police officers and inspectors of the MoPH and of the eight different governmental structures that are mainly responsible for monitoring compliance and reporting violations, and any others with an inspection and monitoring role, should be trained to inspect businesses and workplaces, warn them as necessary and report to the monitoring mechanism.

b. Training should comprise a standard programme and guidelines. A national curriculum for training law enforcers and inspectors for monitoring compliance, as well as for the training of trainers, should be developed and made available to all the agencies involved in training.

7. Provide adequate funds for implementation. Complementary to the regular funds that are allocated through various projects and grants by ThaiHealth and are instrumental in increasing the implementation of the smoke-free policy, dedicated government funds for advocacy (that could include regular mass-media campaigns) and enforcement will be necessary. These should be planned and allocated in a regular and sustainable manner in order to build political support and increase enforcement activities. Procedures should be evaluated regularly to ensure that appropriate levels of enforcement and resources are maintained.

OFFER HELP TO QUIT TOBACCO USE

1. Advocate for a systems approach for managing tobacco dependence. Evidence on treatment delivered as a population health service (systems approach) needs to be gathered to convince policy-makers and funders to pay more attention and allocate greater resources to treatment.

2. Give priority to the development of brief treatment interventions integrated into the health care delivery network (especially within primary care). As a minimum, this should include the identification of tobacco users among all who come to any health service for any reason, the delivery of brief advice on quitting and active referral to treatment services or a quit line, with appropriate quality improvement processes. This would ideally be incorporated into the national tobacco control plan.

3. Fund tobacco dependence management. Managing tobacco dependence, including the entire package of tobacco treatment and management interventions, must be considered an important component covered by health insurance schemes, specifically the UC insurance and the Social Security Fund/Workmen’s Compensation Fund. First-line medications should be incorporated into the national essential drug list and covered by these insurance schemes.

4. Update and consolidate current practices into national guidelines on the treatment and management of tobacco dependence. All relevant stakeholders should be engaged in this task and designating the national tobacco control programme at the MoPH should be designated as the focal point. The guidelines should reflect a balance between individual clinical interventions and the population-based approach. They should also include a package of interventions.
5. Establish a national quit line. This should replace the existing multiple, uncoordinated quit lines.
6. Promote attempts to quit. A promotional strategy needs to be developed in order to increase the number of people attempting to quit and demand by smokers for cessation services. This strategy should be directed to smokers though the media and existing health care services by promoting the referral of smokers to the appropriate services. Consideration should also be given to means of reaching populations that may be hard to contact using conventional promotional methods.
7. Monitor services. A monitoring and evaluation strategy should be developed to assess the utilization, efficacy, cost-effectiveness and impact of treatment and management services. Results of monitoring and evaluation should be disseminated to all stakeholders.

**WARN PEOPLE ABOUT THE DANGERS OF TOBACCO**

1. Packaging and labelling
   1. Policies on health warnings should be progressively harmonized so that all tobacco products contain the strongest possible health message, including RYO tobacco. For example, this would ensure that warnings on RYO tobacco packaging are also in colour, as is currently required for cigarettes, as well as adding additional pictorial health messages (rather than just the two that are currently required). Also, the addictive nature of nicotine can be included in the warnings. The possibility of plain packaging could continue to be pursued.
   2. A specific mandate should be given to an institution to conduct research on health warning labels. The TRC appears to have some capacity to conduct research on health warnings on all tobacco products, and could therefore be given responsibility for conducting research on warnings in the general population and also in specific target groups such as adolescents, women and lower-income smokers.
   3. The excise authorities should insist that the stamp on cigarette packages should be placed away from the health warning labels. This regulation should be strongly enforced.
   4. The MoPH should increase its collaboration with enforcement agencies in order to improve awareness among enforcers.
   5. Until health warnings are uniformly implemented on all tobacco products, existing warnings on RYO tobacco packaging should be better enforced.

2. Public awareness and mass-media campaigns
   1. A nationally coordinated media strategy should be developed with sustained funding and with the goal of educating the public on tobacco control issues. This strategy would emphasize increased collaboration within the tobacco control community to avoid duplication of efforts and materials, and would be more cost-effective. The strategy could benefit from a variety of specific interventions, such as:
      a. developing a set of tested and proven, hard-hitting messages for an ongoing mass-media campaign (television and radio spots), including information on the upcoming national quit line number to be aired during prime time on the national and private networks;
      b. developing workshops for the media on tobacco control, including tobacco industry tactics, which should result in increased and diversified news coverage on the issue;
      c. including media institutions in the process of policy implementation and enforcement in relation to strategic communications plans; and
      d. monitoring and evaluating mass-media campaigns by the appropriate institution (i.e. TCR) to ensure maximum effectiveness and impact.
2. The educational activities implemented by the Ministry of Education should extend their present focus on the health risks to more strategic information on tobacco industry tactics and consider better outreach of educational campaigns, especially in rural areas. GYTS data should be used for the development of the educational campaigns, both in urban and rural areas. However, in planning these activities, the authorities should bear in mind that the evidence of the effectiveness of schools programs remains inconclusive.

ENFORCE BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP

1. The existing law, which is reasonably strong, should be made more comprehensive. This will provide additional protection for Thai population from the tactics of the tobacco industry and enhance the leading role of Thailand in global tobacco control.
   a. Tobacco advertising through live broadcasts, the Internet and printed material from abroad should be restricted, even if it is claimed that it does not aim to advertise specifically in Thailand.
   b. Until Thailand is able to completely ban cross-border advertising, there are interim measures that can be taken. For example, during the broadcasting of international sports events that include tobacco advertising, there should be strongly worded anti-tobacco messages scrolled on the screen.
   c. No tobacco company trade name and business identity should be allowed to be associated with any form of non-tobacco products, services, activities and events.
2. The use of corporate social responsibility programmes by the tobacco industry should be prohibited by law.
3. The IT Regulation Bureau under the Ministry of Information and Communications Technology should be mandated to include tobacco advertising and sales in its current work in monitoring Internet content.
4. The provincial and district levels should increase their capacity for enforcing the law. This should be achieved through better dissemination of information to the public aimed at eventually increasing the reporting of law violations. In addition, more training programmes for enforcement officers and the local media should be organized, focusing on indirect advertising, in order to improve monitoring of compliance with the law and its enforcement.
5. A coordinated mechanism for collaboration in law implementation and enforcement should be put in place between the MoPH and other government institutions.

RAISE TOBACCO TAXES AND PRICES

1. Move towards increasing the tax rate on RYO tobacco, beginning with an analysis of the RYO sector and a proposal to bring RYO taxes in line with cigarette taxes. Increasing taxes on RYO tobacco is the most pressing concern for tobacco taxation in Thailand. Higher taxes will most likely result in a reduction in smoking prevalence (especially in rural areas). It is far from clear, however, how one should proceed to increase taxes on RYO tobacco, and a major study on the sector and new ways to tax it should be started immediately by the Ministry of Finance in coordination with other agencies and organizations, including the Ministry of Agriculture. A few guidelines should be followed in carrying out this study.
   a. To make new or increased taxes administratively feasible, the sector will probably need to undergo a certain level of restructuring. This will entail redefining licences and changes in licence fees, pointing to a better separation of tobacco growing and processing.
b. The Ministry of Finance should collaborate with the Ministry of Agriculture, in the context of the pilot project described earlier in this report, to assist farmers that might be affected by a decrease in the demand for lower-grade tobacco to move away from tobacco production. To this end, the Ministry of Finance should work actively and constructively with the Ministry of Agriculture and the MoPH on their two-year pilot project in eight northern provinces to identify and test likely alternatives. The Ministry of Finance could contribute with projections and analyses of the revenue and tax revenue implications of these alternatives. To minimize any potential for conflict of interest, the contributing Ministry officials should not be within the department or on the board of TTM.

2. Make the base for excise tax more transparent by changing to an ad valorem system based on final retail value or by converting the ad valorem excise duty to an amount-specific excise tax.

Administration of the current ad valorem tax, based on the CIF or ex-factory price, is very difficult and doubts are likely to remain about alignment of the base price with market prices, both for imports and for local production. Consequently, the Government should either use retail prices as the tax base and print the pre- and post-VAT price on the packs, or completely change the system to an equivalent amount-specific system automatically indexed to consumer prices and growth in annual per capita income.

3. Licence fees for all tobacco-related activities should be increased. The licensing system is a valuable asset that the Government should make full use of. This means that licence fees should be increased to take into account the real value that they had when the system was inaugurated. The Government should also drastically increase the fee for the licence issued to TTM which, at 10 000 baht, is very low. The Government should also consider using licensing as a means of restructuring the RYO tobacco sector, although the exact nature of changes should be studied in detail in a dedicated study (see above). The new licence fee should also be adjusted periodically (e.g. every five years according to inflation).

4. A multisectoral and interministerial strategy on smuggling should be developed. This could include:
   a. a specific budget for joint activities in support of common objectives, especially at the regional/provincial level;
   b. designated focal points at all levels (national, regional/principal and district) and organizations;
   c. greater legal support from the centre to the provinces for court cases;
   d. higher fines in the case of conviction; and
   e. other relevant elements and provisions of the Protocol on Illicit Trade in Tobacco Products currently being negotiated by the Intergovernmental Negotiating Body established by the Conference of the Parties to the WHO FCTC.

In order to put this strategy into operation at provincial level, the coordinating structures of the Offices of the Governors should be employed for local coordination, and the Joint Committees of Border Provinces for international coordination, including information sharing across borders (e.g. with Indonesian and Malaysian counterparts). Joint training and training of trainers should be considered for promoting networking between these groups and establishing appropriate structures for sustained information exchange. A lead agency should be appointed for pursuing this coordination, and a budget allocated for joint activities.
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