THE TOBACCO ATLAS

Perspectives from the WHO South-East Asia Region

First Edition, 2020
Just like mommy

Children whose parents or siblings smoke are three times more likely to smoke than children living in non-smoking households.

Visit www.ash.org to learn more about smoking and health.
MESSAGE FROM THE REGIONAL DIRECTOR

The WHO South-East Asia Region is home to around 237 million adult smokers, or around one fifth of the world's smokers. It has by far the largest number of smokeless tobacco users (301 million), representing 82% of all users globally, and the world's highest prevalence of smokeless tobacco use among young people (7.3%). Besides being a major risk factor for non-communicable diseases, tobacco kills nearly 1.6 million people across the WHO South-East Asia Region every year.

As outlined in the second edition of the WHO Global Report on trends in prevalence of tobacco smoking (2000–2025), the prevalence of tobacco smoking in the Region is decreasing in almost all countries. Despite this positive trend, the Region may still not reach the target of a 30% relative reduction in tobacco use prevalence among adults by 2025. As per the report, a gap of 1.5% persists between the 2025 target prevalence and the 2025 projected prevalence of tobacco smoking among people aged ≥15 years in the Region. Thus, for the Region’s countries to attain the global targets, now is the time for them to bolster their efforts and fully implement all tobacco control measures.

To that end, this tobacco atlas will prove useful. Based on available evidence and data, the atlas tracks the tobacco prevalence and implementation of tobacco control measures in each of the Region’s Member States. The objective is to enable them to review progress and identify high-impact and achievable action points moving forward.

WHO will continue to support the Region’s Member States in their crusade against tobacco and in achieving related time-bound goals and targets. I am confident that this document will help do that, and that Member States will be able to leverage it strategically in their ongoing fight against the tobacco epidemic.

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Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia Region
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<td>BABT</td>
<td>British American Bangladesh Tobacco</td>
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<td>BAT</td>
<td>British American Tobacco</td>
</tr>
<tr>
<td>BMBM</td>
<td>Be Healthy Be Mobile</td>
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<tr>
<td>CDC</td>
<td>Center for Disease Control, Atlanta, USA</td>
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<tr>
<td>CSR</td>
<td>Corporate social responsibility</td>
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<tr>
<td>DPR Korea</td>
<td>Democratic People's Republic of Korea</td>
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<td>ENDS</td>
<td>Electronic nicotine delivery systems</td>
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<td>ENNDS</td>
<td>Electronic non-nicotine delivery systems</td>
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<td>FSFW</td>
<td>Foundation for a Smoke-Free World</td>
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<td>GATS</td>
<td>Global Adult Tobacco Survey</td>
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<td>Graphic health warnings</td>
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<td>Global School-based Student Health Survey</td>
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<td>Goods and Services Tax (India)</td>
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<td>Global Tobacco Control Report</td>
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<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<td>HTPs</td>
<td>Heated tobacco products</td>
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<td>ITC</td>
<td>Indian Tobacco Company (Limited)</td>
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<td>ITU</td>
<td>International Telecom Union</td>
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<td>JIT</td>
<td>Japan International Tobacco</td>
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<tr>
<td>MRP</td>
<td>Maximum retail price</td>
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<td>NCDS</td>
<td>Noncommunicable diseases</td>
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<td>NRT</td>
<td>Nicotine replacement therapy</td>
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<td>PMI</td>
<td>Philip Morris International</td>
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<td>POS</td>
<td>Point of sale</td>
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<td>PP</td>
<td>Plain packaging</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>South-East Asia</td>
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<td>Second-hand smoke</td>
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<td>ST</td>
<td>Smokeless tobacco</td>
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<td>STEPS</td>
<td>Stepwise approach to NCD risk factor surveillance</td>
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<td>TAPS</td>
<td>Tobacco advertising, promotion and sponsorship</td>
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<td>TFI</td>
<td>Tobacco Free Initiative</td>
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<td>TII</td>
<td>Tobacco industry interference</td>
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<td>UHC</td>
<td>Universal health coverage</td>
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<td>VAT</td>
<td>Value added tax</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHO FCTC</td>
<td>WHO Framework Convention on Tobacco Control</td>
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<td>WHO MPOWER</td>
<td>Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship and raise taxes on tobacco</td>
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<td>WHO SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
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<td>WHO TobReg</td>
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Executive summary

Tobacco use has been identified as a major threat to health and development of the nations. Tobacco use and second-hand smoke lead to nearly 9 million deaths globally (8 million attributed to tobacco use and 1 million because of exposure to second-hand smoke), and the majority of these deaths happen in low-and-middle-income countries. The WHO South-East Asia (SEA) Region with more than one-fourth of world’s population (26%) is among the top tobacco consuming and tobacco producing regions in the world. The region has nearly 20% of world’s smokers (237 million) and more than 80% of global smokeless tobacco users (301 million).

The countries in the Region are striving to achieve global tobacco control targets in their respective journeys towards achieving sustainable development goals (SDGs) while implementing WHO Framework Convention on Tobacco Control (FCTC), WHO MPOWER Package and NCD Best Buys. The first edition of “The Tobacco Atlas: Perspectives from the South-East Asia Region” attempts to project the present burden of tobacco use, progress made in implementation of policies and laws for prevention and control of tobacco, identifies challenges and suggests way forward to achieve the set goals and targets in the most effective possible way.

Chapter 1 highlights the burden of tobacco use (both smoking and smokeless tobacco), smoking trends, likelihood of reaching global NCD targets for smoking prevalence and age of initiation of tobacco use in the countries of South-East Asia Region. Smoking prevalence is high among men in Timor-Leste, Indonesia, DPR Korea, Myanmar, Thailand and Bangladesh. Smoking prevalence among women is comparatively low in the Region. India is the only country which is likely to achieve 30% relative reduction in smoking prevalence among adults aged 15 years and above by 2025. Indonesia is the only country in the Region with rising trends of tobacco smoking. Both men and women initiate smoking at a late age in Sri Lanka compared with other countries in the Region.

Chapter 2 chronicles use of smokeless tobacco and regulation policies in countries of the Region, particularly where prevalence is high. Smokeless tobacco use is highly prevalent among men and women in many countries including Bangladesh, Bhutan, India, Myanmar, Nepal, Sri Lanka and Timor-Leste. Regulation and control policies and mechanisms for smokeless tobacco include the WHO FCTC, WHO MPOWER package, and NCD Best Buys. Some countries make use of the ban to regulate smokeless tobacco in their respective jurisdictions at the national or subnational level.

Chapter 3 is about tobacco use (smoking and smokeless tobacco) among youth (students aged 13–15 years) and covers access and availability of tobacco to minors/youth with a focus on youth related
prevention and control policies in countries of the South-East Asia Region. All countries in the South-East Asia Region have laws and policies to restrict use of tobacco products to minors.

Chapter 4 discusses the challenge of new nicotine and tobacco products such as ENDS (electronic nicotine delivery system) and HTPs (heated tobacco products). The policies and steps taken by countries in the Region to regulate these products are discussed. Youth are especially vulnerable to the use of these new products. Six countries ban ENDS and one country regulates ENDS/HTPS in the Region. A case study from India is highlighted in this chapter.

Chapter 5 covers the tobacco industry in the South-East Asia Region including tobacco cultivation, production and manufacturing. India and Indonesia are among the top 10 producers of tobacco in the world. Tobacco production is on the rise in Bangladesh. Large transnational tobacco companies are increasing their share in many countries of the South-East Asia Region. Indonesia, Bangladesh and India are among the top 10 tobacco markets in the world.

Chapter 6 discusses initiatives taken by the governments in tobacco producing countries for providing alternative livelihoods for tobacco farmers and workers. Alternate crops and livelihood options available to tobacco farmers in some countries are described. Further, case studies from India, Bangladesh and Indonesia have been discussed.

Chapter 7 discusses tobacco industry interference at various levels across countries in the Region. Interference by the tobacco industry undermines efforts made for tobacco control by the countries. Bangladesh and Indonesia face largescale tobacco industry interference. A specific case study from Thailand finds mention here.

Chapter 8 discusses illicit trade in tobacco products across the Region, and the policy options to eliminate the same. Sri Lanka and India are only two countries in the Region to have ratified the protocol to eliminate illicit tobacco trade. Case studies from Bangladesh and Indonesia are presented here.

Chapter 9 discusses the burden of exposure to second-hand smoke among adults (at home and at the workplace) and among youth (at home) in countries of the South-East Asia Region. Adults in Timor-Leste and Indonesia have high exposure to SHS at home and at the workplace. Students aged 13-15 years (youth) in these countries also have high levels of exposure to SHS at home. The policies and laws related to the ban on smoking at various public places in the countries is also discussed.

Chapter 10 highlights anti-tobacco mass media campaigns that are underway in countries
of the Region. Mass-media campaigns are a cost-effective tool for tobacco control and one of the NCD “Best Buys”. Some countries have effectively used national-level mass media campaigns for advocacy and behaviour change. Countries including Bangladesh, India, Indonesia, Sri Lanka and Thailand implemented anti-tobacco mass media campaigns in recent years. Myanmar implemented a mass media campaign against the use of betel nut.

Chapter 11 discusses tobacco advertising, promotion and sponsorship (TAPS) and various parameters of policies related to TAPS ban in countries of the Region. Maldives and Nepal have banned all forms of direct and indirect advertising of tobacco. As a case study, India’s ban on depiction of smoking scenes in films and television has been discussed. Most countries lack comprehensive TAPS ban policies and face additional challenges in view of cross-border TAPS and rampant exploitation of modern technology and social media for TAPS by the tobacco industry.

Chapter 12 discusses health warning labels on tobacco products packages in countries of the Region. The progress made in implementing graphic health warnings (GHW) on tobacco packs in the South-East Asia Region is significant. All countries in the Region except DPR Korea are now implementing GHW on tobacco packs and some countries such as Timor-Leste, Nepal and Maldives have the largest GHWs in the world. Thailand is the first country in Asia to implement plain packaging.

Chapter 13 explains tax and prices of tobacco products across countries in the South-East Asia Region. Tobacco tax is one of the most cost-effective strategies (best buy) for tobacco control. However, because of low tax and prices, tobacco products still remain affordable in many countries. The tobacco tax structures for smoking forms (cigarettes, cigars, kreteks, bidi, etc.) and more so for multiple types of smokeless products are complex.

Chapter 14 discusses regulation of tobacco products including implementation of Articles 9 & 10 of the WHO FCTC in countries of the Region. There is limited capacity to test tobacco products in most countries. India has recently established three laboratories for testing tobacco products.

Chapter 15 is about tobacco cessation and support available to quit tobacco use in countries of South-East Asia. Information related to smokers who tried to quit smoking, were advised to stop smoking by health professionals, and other forms of support available including toll-free quitlines and nicotine replacement therapy is also provided. India’s M-cessation programme is highlighted.

Chapter 16 presents the way forward for effective tobacco control with guidance for the countries of the South-East Asia Region. The existing tools including WHO FCTC, WHO MPOWER package, and NCD Best Buys are presented as a case study in relation to the Regional Director’s vision to meet global, regional and national targets for tobacco control.

‘Informed policy-makers would be able to implement evidence-based policies in a more rational manner towards a tobacco-free South-East Asia Region’
Chapter One

The WHO South-East Asia (SEA) Region is home to nearly one-fifth of the world’s smokers (nearly 237 million), and more than 80% of the world’s smokeless tobacco users (301 million). Nearly 16 million die each year because of tobacco use in the Region. Tobacco control remains a challenge in view of countries having diverse populations with a large proportion of youth, tobacco cultivation in many countries, variety of tobacco products (both smoking and smokeless forms) being available and consumed, rampant tobacco industry interference, illicit trade happening across large (and porous) borders, and limited capacity for product regulation and tobacco cessation to name a few.

Nearly one and a half decades since most of the countries in the South-East Asia Region ratified the WHO Framework Convention on Tobacco Control, five countries (Bhutan, Maldives, Nepal, Sri Lanka and Thailand) have tobacco use prevalence lower than or around the current average global rate of 19.9% among adults aged over 15 years. Three countries have higher than average global prevalence rates but were able to reduce the same (Bangladesh, DPR Korea and India). The tobacco use prevalence rates in other countries (Indonesia, Myanmar and Timor-Leste) are still high.

Indonesia is the sole country in the SEA Region that has not ratified the WHO Framework Convention on Tobacco Control (WHO FCTC). Indonesia has high prevalence of tobacco use among adults (33.8%) and youth (12.7%). Indonesia is also the only country in the Region where smoking prevalence is expected to increase until 2025 (WHO Trends Report 2018).
Current tobacco use among adults

Bangladesh (GATS 2017, 15+ years)

Bhutan (STEPS 2014, 18–69 years)

DPR Korea (National Adult Tobacco Survey 2017, 15+ years)

India (GATS 2017, 15+ years)

Indonesia (Basic Health Research [RISKESDAS] 2018, 15+ years)

Maldives (STEPS 2011, 15–64 years - for males only)

Myanmar (STEPS 2014, 15–64 years)

Nepal (STEPS 2013, 15–69 years)

Sri Lanka (STEPS 2015, 18–69 years)

Thailand (The Smoking and Drinking Behaviour Survey 2017, 15+ years)

Timor-Leste (Demographic and Health Survey 2016, 15–59 years)

54.4%

Myanmar has the highest percentage of current tobacco use among men and women.
Current smoking prevalence among adults

Timor-Leste has the highest prevalence of current tobacco smoking among men - 69.5%

Nepal has the highest prevalence of current tobacco smoking among women - 10.3%
Current smokeless tobacco use among adults

Data Source

- Bangladesh (GATS 2017, 15+ years)
- Bhutan (STEPS 2014, 18–69 years)
- DPR Korea (National Adult Tobacco Survey 2017, 15+ years)
- India (GATS 2017, 15+ years)
- Indonesia (GATS 2011, 15+ years)
- Maldives (STEPS 2011, 15–64 years - for Male only)
- Myanmar (STEPS 2014, 15–64 years)
- Nepal (STEPS 2013, 15–69 years)
- Sri Lanka (STEPS 2015, 18–69 years)
- Thailand (The Smoking and Drinking Behaviour Survey 2017, 15+ years)
- Timor-Leste (STEPS 2014, 18–69 years)

62.2%
Myanmar has the highest prevalence of current smokeless tobacco use among men

26.8%
Timor-Leste has the highest prevalence of current smokeless tobacco use among women
Trends of current tobacco smoking among adults (≥15 years): 2000–2025
(not age-standardized)
**Age of smoking initiation (years)**

- **Overall**
- **Men**
- **Women**

**DATA SOURCE**
- Bangladesh, GATS 2017
- Bhutan, NCD STEPS 2014
- DPR Korea, National Adult Tobacco Survey 2017
- India, GATS 2017
- Indonesia, GATS 2011
- Maldives, STEPS 2011
- Myanmar, STEPS 2014
- Nepal, STEPS 2013
- Sri–Lanka, STEPS 2015
- Thailand, GATS 2011
- Timor-Leste, STEPS 2014

**Notes:**
- Men initiate smoking at a late age in Sri Lanka (20.5 years).
- Women initiate smoking at a late age in Myanmar (22.3 years).
two
SMOKELESS TOBACCO
A large variety of smokeless tobacco products are prevalent in different countries of the South-East Asia Region. Many products are prepared by mixing tobacco with areca nut and various locally available and popular flavours. Betel chewing with and without tobacco has traditionally been popular in Bangladesh, Bhutan, India, Myanmar, Nepal and Sri Lanka. *Paan masala* a very popular product available in India, consists of areca nut, catechu, cardamom and variety of natural and artificial perfuming and flavouring materials.

Countries where smokeless tobacco use is prevalent enforce various measures mandated under the WHO FCTC, WHO MPOWER package and NCD Best Buys for regulation and control. Tax, which is the most cost-effective measure for tobacco control, is very complex in case of smokeless tobacco in view of a large variety of products. Most smokeless tobacco products are taxed and priced very low, compared with tax on cigarettes, making these products largely accessible and affordable.

The ban is the extreme form of regulation adopted by countries to regulate use of smokeless tobacco products. India evokes food safety laws to ban smokeless tobacco and related products such as *Paan Masala* at the subnational level.

**Bhutan is the only country in the world that has banned the production, manufacturing and sale of all tobacco products**
Smokeless tobacco users outnumber the estimated number of smokers in the South-East Asia Region. The region houses more than 301 million smokeless tobacco users, accounting for more than 80% of the global smokeless tobacco users.

Source: WHO Trends Report 2018
Nepal is the only country which has banned use of any kind of tobacco products in public places, including smokeless tobacco products (2011).
# Tobacco Control Policies for Smokeless Tobacco in the South-East Asia Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Ban</th>
<th>Health warnings on ST pack</th>
<th>Prohibition on access to minors</th>
<th>Tax</th>
<th>Mass media</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>Ban on production, manufacturing and sale (except for import in specified quantity for personal use)</td>
<td></td>
<td>Yes</td>
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</tr>
<tr>
<td>DPR Korea</td>
<td>Ban on sale</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>India</td>
<td>Ban on manufacturing and sale (partial and subnational)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Conducted ST-specific campaigns e.g. ‘Mukesh’ and ‘Sunita’, a few years back (no campaign in 2016–2018)</td>
</tr>
<tr>
<td>Indonesia</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<td>Maldives</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Myanmar</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>National campaign on Betel nut in 2017</td>
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<tr>
<td>Nepal</td>
<td>Ban on use in public</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Sri Lanka</td>
<td>Ban on sale and import</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>Thailand</td>
<td>Ban on sale and import</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>Timor-Leste</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
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</table>

THE SOUTH-EAST ASIA REGION IS HOME TO MORE THAN 80% OF THE WORLD'S SMOKELESS TOBACCO USERS
INDIA: The taxation system for smokeless tobacco products is complex. For the purpose of tax, the smokeless tobacco products are categorized into 14 varieties. Three types of taxes, 28% GST (Goods and Services Tax), cess (varying from 7% to 204% for different varieties) and 10% NCCD (National Calamity Contingent Duty) are levied on smokeless tobacco products. In the budget for 2019–2020, central excise was re-introduced (0.5% ad-valorem on smokeless tobacco products).

Source: Central Board of Excise and Customs, Ministry of Finance, Government of India, 2017

BANGLADESH: In 2008, smokeless tobacco was placed under the category of manufacturing industry and 15% VAT was imposed on jarda and gul (popular smokeless tobacco products). A 10% supplementary duty on the ex-factory price of jarda and gul was imposed in 2009. For the year 2019–2020, the tariff value system for smokeless tobacco was abolished (i.e. tax base changed to retail price levying 50% supplementary duty) (excise tax) on MRP (maximum retail price of smokeless tobacco products along with additional 15% VAT and 1% Health Development Surcharge with the objective to increase the price of smokeless tobacco resulting in increased government revenue.

Source: National Board of Revenue, Bangladesh, 2019
three
Global evidence suggests that most of the current adult tobacco users initiate tobacco use during adolescence, which is continued into adulthood. As per global estimates, nearly 9 out of 10 smokers start smoking before 18 years of age and 98% start smoking by the age of 26 years. About 3 out of 4 adolescent smokers become adult smokers.

The higher sensitivity and vulnerability of children and adolescents to nicotine addiction implies that the earlier the smokers start smoking, the more likely they are to become addicted.
Prevalence of current tobacco use (%) among students aged 13-15 years (youth)

- Bangladesh GYTS 2013
- Bhutan GYTS 2019
- India GYTS 2009
- Indonesia GYTS 2014
- Maldives GYTS 2011
- Myanmar GYTS 2016
- Nepal GYTS 2011
- Sri Lanka GYTS 2015
- Thailand GYTS 2015
- Timor-Leste GYTS 2013

Timor-Leste has the highest prevalence of tobacco use among both boys and girls.
Prevalence of current tobacco smoking (%) among students aged 13–15 years (youth)

- Bangladesh GYTS 2013
- Bhutan GYTS 2019
- India GYTS 2009
- Indonesia GYTS 2014
- Maldives GYTS 2011
- Myanmar GYTS 2016
- Nepal GYTS 2011
- Sri Lanka GYTS 2015
- Thailand GYTS 2015
- Timor-Leste GYTS 2013

Timor-Leste has the highest prevalence of tobacco smoking among both boys and girls.
Prevalence of current smokeless tobacco use (%) among students aged 13–15 years (youth)

**Data Source**
- Bangladesh GYTS 2013
- Bhutan GYTS 2013
- India GYTS 2009
- Indonesia GYTS 2014
- Maldives GYTS 2011
- Myanmar GYTS 2016
- Nepal GYTS 2011
- Sri Lanka GYTS 2015
- Thailand GYTS 2015
- Timor-Leste GYTS 2013

Nepal has the highest prevalence of smokeless tobacco use among both boys and girls.
Large proportion of minors were not refused when buying cigarettes in Bangladesh, Indonesia and Myanmar.

More youth have access to cigarettes from common points of sale in Bangladesh, Indonesia, Myanmar, Thailand and Timor-Leste.

DATA SOURCE

Bangladesh GYTS 2013
Bhutan GYTS 2019
India GYTS 2009
Indonesia GYTS 2014
Maldives GYTS 2011
Myanmar GYTS 2016
Nepal GYTS 2011
Sri Lanka GYTS 2015
Thailand GYTS 2015
Timor-Leste GYTS 2013

Access and availability of cigarettes to students aged 13–15 years (youth)
A high percentage of youth in India, Nepal and Timor-Leste noticed tobacco advertisements or promotion at point of sale/billboards in the past 30 days.

A large percentage of youth in India, Myanmar, Sri Lanka and Timor-Leste noticed pro-cigarettes advertisements in print and entertainment media in the past 30 days.
Article 16 of the WHO FCTC aims at restricting access and supply of tobacco to adolescents and requires parties to adopt and implement measures to prohibit the sale of tobacco products to and by minors as well as other measures limiting the access of underage persons to tobacco products. All the countries in the South-East Asia Region have specified legal minimum age for tobacco sales. DPR Korea and Timor-Leste have the lowest minimum legal age at 16 and 17 years respectively, while Sri Lanka has the highest legal minimum age of 21 years. Thailand has recently increased the legal age to 20 years (from 18 years) in their new Tobacco Products Control Act (2017). The remaining countries have 18 years of age as the legal minimum age for sale of tobacco products.

Source: GTCR, 2019
Electronic nicotine delivery systems (ENDS) are devices that heat a liquid to create an aerosol that is inhaled by the user. The liquid contains nicotine (but not tobacco) and other chemicals that may be toxic to human health. "ENDS" is an all-encompassing term for multiple product categories. The most common ENDS are “electronic cigarettes”, also known as “e-cigarettes”, “vapes” or “vape-pens”. Other categories include “e-hookahs”, “e-pipes” and “e-cigars”. ENDS are available in various shapes, sizes, flavours and attractive colours that especially target the youth.

While some ENDS are shaped like traditional tobacco products, e.g. cigarettes, cigars, pipes, hookah etc., others are shaped like pens, USB memory sticks or basis cylinders. Different forms of nicotine are used in ENDS including nicotine salts aimed to deliver a high dose of nicotine.

The product range is diverse and keeps evolving over time in different geographical regions and/or markets. Juul from Juul Labs, Vype from British American Tobacco (BAT) and Blu from the Imperial brand are some of the commonly available ENDS. The other category of product ENNDS (electronic non-nicotine delivery system), are essentially the same as ENDS but the liquid used generally does not contain nicotine. However, many “zero-nicotine” solutions have been found to contain nicotine after testing.

WHO considers ENDS as harmful products.
<table>
<thead>
<tr>
<th>SEAR countries which completely ban the sale of e-cigarettes/ENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPR Korea</td>
</tr>
<tr>
<td>India</td>
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<tr>
<td>Nepal</td>
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<tr>
<td>Sri Lanka</td>
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<tr>
<td>Thailand</td>
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<tr>
<td>Timor-Leste</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SEAR countries which regulate e-cigarettes</th>
</tr>
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<tbody>
<tr>
<td>Maldives</td>
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<table>
<thead>
<tr>
<th>SEAR countries which neither ban nor regulate e-cigarettes/ENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
</tr>
<tr>
<td>Bhutan</td>
</tr>
<tr>
<td>Indonesia</td>
</tr>
<tr>
<td>Myanmar</td>
</tr>
</tbody>
</table>

43
Nicotine is addictive and ENDS use could lead to people, particularly young people, taking up more harmful forms of tobacco consumption. ENDS also has the potential for undermining tobacco control efforts implemented by the countries.

**Heated tobacco products**

Heated tobacco products (HTP), also known as heat-not-burn (HNB) tobacco products, are battery-operated devices that heat tobacco to a lower temperature (up to 350°C) than when a conventional cigarette is burned, a process which occurs around 600°C. This produces an aerosol containing nicotine and other chemicals, leaving the leaf material intact but depleted of volatile substances.

Currently, there is no evidence to demonstrate that HTPs are less harmful than conventional tobacco products. All forms of tobacco use are harmful, and HTPs should be subject to policy and regulatory measures like all other tobacco products (WHO 2018).

**INDONESIA** is one of the largest tobacco markets in the world. E-cigarettes are growing in popularity recently and are being sold online and through vape shops. E-cigarette sales reached US$ 144.5 million in 2018 and total sales are forecasted to reach US$ 419.6 million by 2022.

Currently, e-cigarettes remain unregulated in Indonesia, but were deemed legal products as of July 2018.
Endgame for ENDS

E-CIGS are banned in 6 and regulated by 1 Member State of the WHO South-East Asia Region
Tobacco production is primarily concentrated in regions with a mild and sunny climate, which is suitable for its cultivation. To produce various tobacco products for human consumption, the tobacco leaves are dried and cured after picking them at the plant and separating them from their stems. The processed dried leaves are used for manufacturing.

India is the second largest producer of tobacco in the world with an estimated annual production of around 800 million kgs. The Tobacco Board of India has resolved to gradually phase out tobacco cultivation to reduce production of Flue Cured Virginia (FCV) tobacco. The Board is not granting registration to new growers and not issuing any license for construction of new barns, creating any additional curing infrastructure and no expansion of FCV tobacco cultivation to new areas.

Source: Tobacco Board of India, Ministry of Commerce and Industries, July 2019
cigarettes, cigars, chewing tobacco, pipe tobacco and shisha tobacco. It is predominantly consumed for the stimulant alkaloid nicotine which is highly addictive in nature.

**Tobacco cultivation is not economically viable for most farmers in Indonesia.** This finding was mostly consistent across regions, type of tobacco grown, and whether the farmer was on contract to grow tobacco.

**Tobacco cultivation in Bangladesh** has increased recently. Bangladesh stands eleventh in the world in tobacco production. From 2007–2008, the land under tobacco cultivation has increased from 72,000 acres to 127,000 acres in 2014–2015, a 74% increase over a period of seven years.

A study on the economics of tobacco cultivation in Bangladesh is underway at present.

LARGE TRANSNATIONAL TOBACCO COMPANIES INCREASING SALES IN THE REGION

Tobacco industry market share in Indonesia

- HM Sampoerna TbK PT: 29%
- Gudang Garam TbK PT: 23%
- Djarum PT: 13%
- PT Bentoel: 7%
- PMI: 5%
- PT Nojorono: 5%
- Gelora Djaja: 1%
- Others: 17%

Source: A Snapshot of the Tobacco Industry in ASEAN Region, Southeast Asia Tobacco Control Alliance. April 2019, Bangkok, Thailand.
### Tobacco Industry Market Share in Thailand

- **Rothmans of Pall Mall Myanmar**: 40%
- **BAT**: 24%
- **Myanmar Japan Tobacco**: 18%
- **Others**: 18%

### Tobacco Industry Market Share in Myanmar

- **Thailand Tobacco Monopoly**: 71%
- **Phillip Morris International**: 28%
- **Others**: 1%

Source: A Snapshot of the Tobacco Industry in ASEAN Region, Southeast Asia Tobacco Control Alliance. April 2019, Bangkok, Thailand.
Largest tobacco companies worldwide in 2018, based on net sales (in billion US$)

- Indian Tobacco Company (Limited) 8.7
- Japan Tobacco 19.4
- Altria Group 19.6
- Imperial Tobacco 20.1
- Gudang Garam 6.3
- Korea Tobacco & Ginseng Corporation 4.1
- Philip Morris International 29.6
- British American Tobacco 26.1

Source: Statista 2019
Indonesia, Bangladesh and India are among the top 10 tobacco markets in the world.

Source: A Snapshot of the Tobacco Industry in ASEAN Region, Southeast Asia Tobacco Control Alliance. April 2019, Bangkok, Thailand.
Chapter Six

Article 17 of the WHO FCTC requires that Parties shall, in cooperation with each other and with competent international and regional intergovernmental organizations, promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers.

Tobacco growing countries in the South-East Asia Region have taken robust initiatives towards providing alternative livelihoods to tobacco growers and workers.

Indonesia: The law mandates welfare of tobacco farmers (Law No. 19/2013 concerning the Protection and Empowerment of Farmers). Both protection and empowerment is expected to defend the rights of tobacco farmers.

Tobacco is widely cultivated in three provinces—East Java, Central Java and West Nusa Tenggara. Tobacco is suitable for cultivation in both paddy fields and moorlands. Mostly, tobacco is cultivated as the second or third commodity and not as the primary crop. Rice-tobacco-corn is a common cropping pattern.

Various studies have proven that alternative crops such as red chilli, wetland rice, hybrid corn and soyabean are economically viable alternatives to tobacco crop.
Some farmers have switched over to alternate crops completely while some still grow tobacco along with other crops, e.g. coffee, cabbage, etc. (intercropping), in Magelang, Central Java, Indonesia.
The Ministry of Labour and Employment is implementing the ‘Skill Development Training’ programme in all states in India where bidi is being rolled. The programme entails providing an alternative source of livelihood to bidi rollers and their dependents through placement linked skill development training.

The initiative is being implemented in collaboration with the National Skill Development Corporation under the Ministry of Skill Development & Entrepreneurship with technical support from WHO. Till date over 6000 bidi rollers/dependents have been trained and over 2000 have been provided placement after training.

Source: WHO India 2019
Sri Lanka is committed to shift all tobacco farmers to alternate livelihoods by 2020

Source: WHO SEARO Inter-country Consultation on Alternative Livelihoods, March 2017, Colombo, Sri Lanka

The Department of Agriculture, Cooperation and Farmer’s Welfare (DAC&FW) had made budgetry allocations from 2015–2016 onwards under the crop diversification programme (CDP), an ongoing sub-scheme of the Rashtriya Krishi Vikas Yojana (RKVY), to encourage tobacco farmers to shift to alternative crops/cropping system (in tobacco growing states)

The tobacco farmers are also being provided information and technical support for diversification to alternative crops. Various states have reported tobacco crop area shifting of other crops such as maize, wheat, raagi, cotton, soyabean, mustard, ground-nut, castor, chickpea, chilli, potato, ginger, sugarcane, turmeric, moringa, oil palm, etc. as economically viable options to tobacco
Economically viable alternative crops to the highly remunerative flu cured virginia (FCV) tobacco in India is mixed cropping of hybrid cotton+chilli+groundnut and hybrid cotton+chilli+French bean

Source: Dinesh Kumar et al, 2010

Paddy and black gram were found to be more profitable than tobacco in Prakasan district, Andhra Pradesh. Many farmers have already given up growing tobacco due to high cost of production and decreasing international demand

Source: Krishna Rao & G. Nancharaiah, 2012
STOP TOBACCO INDUSTRY INTEREFERENCE
Article 5.3 of the WHO FCTC requires Parties to the Convention to take proactive measures to protect health policy from the vested interests of the tobacco industry. The Guidelines for implementation of Article 5.3 were adapted by the Conference of the Parties (COP) at its third session in 2008. Tobacco industry interference, including the state-owned tobacco industry, cuts across several tobacco control policy areas. Most countries in the South-East Asia Region face tobacco industry interference at various levels of tobacco control policy development and implementation.

WHO has described various forms of tobacco industry interference:

1. interfacing with political and legislative processes;
2. fabricating support through front groups;
3. influencing the scientific and policy agendas;
4. making unproven claims and discrediting proven science;
5. exaggerating the economic importance of the industry;
6. intimidating governments with litigation or the threat of litigation; and
7. manipulating public opinion to gain the appearance of respectability.

Some examples of Tobacco Industry Interference and response of countries in South-East Asia Region to these interferences are presented here.
Some examples of tobacco industry interference and the response of SEA Region Member States to such interference, are described in following boxes.

Thailand, which has been demonstrating good progress in halting TI interference over the years, was subject to strong interference in 2016. Thailand’s Excise Department received technical assistance from the International Tax and Investment Center (ITIC) on excise tax reform. The ITIC is a known TI lobby group which makes industry-friendly recommendations to governments. For example, the ITIC opposes substantial excise tax increases on tobacco claiming it encourages smuggling.

In 2015, the Thai government had accepted and acted on a proposal from the Thai Tobacco Monopoly (TTM) to investigate and reorganize the Thai Health Foundation. The investigation resulted in negative press for Thai Health.

The government has set up an ‘Article 5.3 Committee’ and is now developing a procedure to raise awareness within its departments on policies relating to FCTC Article 5.3 Guidelines.

Source: M.A. Kolandai, J.L. Reyes. South-East Asia Region Tobacco Industry Interference Index (2019), Southeast Asia Tobacco Control Alliance (SEATCA), Bangkok, Thailand.
Tobacco industry interference in Bangladesh

The Government of Bangladesh has not yet implemented guidelines on Article 5.3 of the WHO FCTC. The Government has around 10% share in British American Tobacco Bangladesh (BATB). The tobacco industry routinely lobbies with the National Board of Revenue (NBR) and the Ministry of Finance to reduce or increase tax on tobacco products. The tobacco industry also succeeded in pressurizing the Government to print graphic health warnings on the bottom half of tobacco packs in defiance of the tobacco control law.
eight
ILLICIT TOBACCO TRADE
Chapter Eight

Illicit tobacco trade refers to many practices associated with distribution, sale or purchase of tobacco products that are prohibited by law, including tax evasion (sale of tobacco products without payment of applicable taxes), counterfeiting, disguising the origin of products, and smuggling.

It can be undertaken either by illicit players who are not registered with relevant government agencies, as well as by legitimate entities whose business operations are contrary to applicable laws and regulations. Illicit trade in tobacco products impacts the affordability of these commodities; increases the choices of brands, which can increase overall demand; enhances access to tobacco products, particularly for youth; undermines health warnings; and reduces government tax revenue.

A 2019 report by the World Bank (2019) confirms that contrary to tobacco industry arguments, raising tobacco taxes is not the primary cause of illicit trade. Accumulated evidence indicates that the illicit cigarette market is relatively larger in countries with low taxes and prices, while relatively smaller in countries with higher cigarette taxes and prices. Non-price factors such as governance status, weak regulatory framework, and the availability of informal distribution networks appear to be far more important factors.

Illicit trade in tobacco products also undermines overall global tobacco prevention and
control interventions, particularly with respect to tobacco tax policy. Additionally, tobacco illicit trade often depends on and can contribute to weakened governance. Illicit tobacco products sell for considerably less than their tax-paid equivalents, thus inflicting greatest harm on the tobacco tax policies.

**Bangladesh: Tobacco illicit trade**

The country has a low estimated illicit cigarette trade incidence (2%), compared with the estimated global rates of 10%-12%. Annual revenue losses from illicit trade are about Taka 8 billion (US$ 100 million) or around 4% of total tobacco revenues. Cigarette taxation in Bangladesh is enforced through the cigarette stamp and banderole system since 2002, which together with control of smuggling and tightening of cigarette intelligence, has helped keep the illicit trade in check. Bangladesh was the first country to sign the WHO Framework Convention on Tobacco Control and consistent with its significant achievements in the area of tobacco control, Bangladesh should ratify the illicit trade protocol.

Source: NBG - Tobacco Illicit Trade - Bangladesh. pubdocs.worldbank.org/en/455291548434730684

The Protocol of 2012 was developed in response to the growing international illicit trade in tobacco products, which poses major health, economic and security concerns around the world. It is estimated that one in every 10 cigarettes and tobacco products consumed globally is illicit. If illicit trade were eliminated, governments worldwide could gain at least US$ 30 billion/year in tax revenue.

The Protocol contains a full range of measures to combat illicit trade distributed in three categories: preventing illicit trade, promoting law enforcement and providing the legal basis for international cooperation.

Moreover, the Protocol aims to secure the supply chain of tobacco products, through licensing, due diligence and record keeping, and requires the establishment of a global tracking and tracing regime that will allow Governments to effectively follow up tobacco products from the point of production to the first point of sale. For it to be effective, the Protocol provides for intensive international cooperation including on information sharing, technical and law enforcement, cooperation, mutual legal and administrative assistance, and extradition.

The Protocol counts 56 Parties as of now. Only India and Sri Lanka from the South-East Asia Region are Parties to the Protocol. The establishment of an effective track and trace system to follow the tobacco products through the supply chain from production or import to sale to consumers goes a long way in preventing and controlling illicit tobacco trade. Secure excise stamps are crucial but not enough to prevent tax evasion if there is no downstream verification that cigarettes have tax stamps and that these are authentic.

Overall cost of the implementation of the tracking and tracing system to combat illicit tobacco trade is relatively negligible in relation to the final retail price of the tobacco products. Many countries in the South-East Asia Region share large, porous borders which are prone to illicit trade of tobacco products.

All countries in the Region should ratify the Protocol and initiate measures to stop illicit trade in tobacco products at the earliest. The countries with common borders and having cross border illicit trade of tobacco should collaborate and prepare common action plans involving Customs, finance and trade authorities.
INDONESIA has been using tax stamps as fiscal markers for tobacco products and alcohol for decades. All tobacco products that are domestically produced or imported must bear an excise stamp on the packaging. To prevent forgery, the government has added a series of security features to the excise stamps that are difficult to falsify.

Since 2016, the Ministry of Finance’s Directorate-General of Customs and Excise (DGCE) has implemented the High-Risk Excise Control Programme, a flagship programme under the Customs and Excise Strengthening Reform Programme, to curb the sale of illegal cigarettes. Enforcement operations focusing on points of production and distribution of illegal cigarettes have been carried out by regional and central DGCE offices and have been supported by police and the army.

Due to such concerted tax administration and enforcement efforts, the market share of illegal cigarettes has decreased significantly in Indonesia. The estimated share fell more than two-thirds, from 12.1% in 2016 to 7% in 2018, reflecting success of the DGCE reforms. Moreover, during the same period, the government raised the tobacco excise tariff on an annual basis by more than the inflation rate. The experience of Indonesia provides further evidence that increasing tobacco excise tariff is not necessarily a significant factor in curbing tobacco illicit trade and comprehensive and concerted enforcement efforts are key to suppressing these activities.

Illicit trade estimates generated by the tobacco industry cannot be trusted as these are used to oppose tobacco control regulations such as raising taxes on tobacco by countries.

Governments need to seek for industry independent estimates for illicit trade in partnership with academia, researchers and civil society.

Surveys of tobacco packs and research on illicit tobacco trade led by the governments and trusted partners would provide high-quality estimates to support the implementation of evidence-based tobacco tax policies and other tobacco control measures.
Effective track and trace system with secure excise stamps is crucial to control illicit tobacco trade
PROTECTION FROM EXPOSURE TO SECOND-HAND SMOKE
Article 8 of the WHO Framework Convention on Tobacco Control deals with exposure to second-hand smoke (SHS). Exposure to second-hand smoke can lead to severe and fatal diseases including cardiovascular diseases, respiratory diseases and cancer. Children and infants are particularly susceptible to SHS and are at increased risk for respiratory disease, middle ear disease and sudden infant death syndrome (SIDS).

There is no safe level of exposure to second-hand smoke. Almost all non-smokers living with smokers are exposed to and are at greater risk of premature deaths and diseases. Fetuses and pregnant women exposed to SHS are more at risk of still birth, congenital malformations and low birth weight.

There is enough evidence to support that smoke-free laws save lives. Effective implementation of smoke-free policies leads to reduction in hospital admissions for acute coronary syndrome, and reduced mortality from smoking-related illnesses.

Smoke-free environments encourage smokers to reduce tobacco use, attempt to quit, and remain tobacco-free in the long-term. Article 8 of the treaty (protection from exposure to tobacco smoke) includes the broad statement that “scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability” (WHO FCTC 2004). Article 8 forms the basis for international action to reduce the burden of disease attributable to second-hand tobacco smoke and is especially important as it creates a legal obligation for the treaty’s Parties to take action.

Overall smoke-free laws are in place in all countries of the South-East Asia Region. Even Indonesia implements smoke-free policies at subnational level. Bangladesh has a subnational “Tobacco-Free Hospitals” initiative in place. India has released “Tobacco-Free Educational Institutes” Guidelines on World No Tobacco Day 2019. The recent anti-tobacco law enacted by Thailand (2017) has expanded to include many more public places under the ambit of smoke-free law. Myanmar launched the “smoke-free universities” campaign. Countries those have made considerable achievements in implementing smoke-free policies in the Region include Bhutan, India, Nepal and Thailand.
Second-hand smoke exposure among adults at home (%)

- Total
- Men
- Women

- Bangladesh, GATS 2017
- Bhutan, STEPS 2014
- DPR Korea, National Adult Tobacco Survey 2017
- India, GATS 2017
- Indonesia, GATS 2011
- Maldives, NCD STEPS 2011
- Myanmar, NCD STEPS 2014
- Nepal, NCD STEPS 2013
- Sri Lanka, NCD STEPS 2015
- Thailand, GATS 2011
- Timor-Leste, NCD STEPS 2014
Second-hand smoke exposure among adults at the workplace (%)
Second-hand smoke exposure among students aged 13–15 years (youth) at home (%)

- **Bangladesh GYTS 2013**: 31.1 (Total), 33 (Boys), 27.7 (Girls)
- **Bhutan GYTS 2019**: 17 (Total), 18.3 (Boys), 15.9 (Girls)
- **India GYTS 2009**: 21.9 (Total), 24.1 (Boys), 18.8 (Girls)
- **Indonesia GYTS 2014**: 61.7 (Total), 57.3 (Boys), 52.7 (Girls)
- **Maldives GYTS 2011**: 34.5 (Total), 35.1 (Boys), 33 (Girls)
- **Myanmar GYTS 2016**: 33.2 (Total), 33 (Boys), 29.5 (Girls)
- **Nepal GYTS 2011**: 40.4 (Total), 38.4 (Boys), 36.3 (Girls)
- **Sri Lanka GYTS 2015**: 33.8 (Total), 31.3 (Boys), 36.6 (Girls)
- **Thailand GYTS 2015**: 13.4 (Total), 13.9 (Boys), 13 (Girls)
- **Timor-Leste GYTS 2013**: 66 (Total), 69.6 (Boys), 62.1 (Girls)
Smoke-free public places

- Health-care facilities
- Educational facilities except universities
- Universities
- Public transport
- Government facilities
- Indoor offices and workplaces
- Restaurants
- Cafes, pubs and bars

Source: GTCR, 2019

Countries implementing smoke-free laws

- Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste
- Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste
- Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste
- Bhutan, DPR Korea, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste
- Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand
- Bangladesh, Bhutan, India, Nepal, Sri Lanka, Thailand
- Bhutan, India*, Myanmar, Nepal, Thailand, Timor-Leste
- India*, Nepal, Thailand, Timor-Leste

*with designated smoking rooms
Smoke-free signage at a garden in Thailand

Local smoke-free law enforcement through mobile courts in Medan City, Indonesia
TOBACCO KILLS!
Low- and middle-income countries have been in the forefront of developing anti-tobacco mass media campaigns, showing that countries can successfully implement this intervention regardless of income classification.

Detailed national-level data collected on a global basis for anti-tobacco mass media campaigns shows that the countries of the SEA Region are increasingly using the “best buy” of media campaigns as an effective tool for tobacco control. Research says that mass media campaigns are very effective in the cessation of tobacco use.

<table>
<thead>
<tr>
<th>Name of the country</th>
<th>Name of mass media campaign (between 1 July 2016 and 30 June 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Dhoan</td>
</tr>
<tr>
<td>India</td>
<td>What damage will this cigarette or bidi do?</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Cigarettes are eating you alive</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Avoid chewing betel so you don’t regret your life choices</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Song 'Dunwetiye'</td>
</tr>
<tr>
<td>Thailand</td>
<td>Stop smoking, 3 million smokers in 3 years</td>
</tr>
</tbody>
</table>
Anti-tobacco mass media campaign

- Running national campaigns
- Airing campaign on television and/or radio
- Worked with journalists to gain coverage in the news
- Done evaluation to assess the impact of campaign
- Campaign part of comprehensive Government tobacco control programme

COUNTRIES
- DPR Korea
- Indonesia
- Myanmar
- Thailand
- Bangladesh
- DPR Korea
- India
- Indonesia
- Sri Lanka
- Thailand
- Timor-Leste
- Bangladesh
- DPR Korea
- India
- Indonesia
- Myanmar
- Sri Lanka
- Thailand
- Timor-Leste
STOP TOBACCO BANGLADESH: SOCIAL MEDIA CAMPAIGN

The Ministry of Health and Family Welfare of Bangladesh completed its second entirely government-funded mass media campaign from 20 May to 22 June 2019 using the public service announcement (PSA) namely, “Invisible Killer” developed by the vital strategies. The PSA was aired on the state-owned Bangladesh Television for four weeks. More PSAs are being developed in the local language to support the upcoming campaigns.

Facebook: Stop Tobacco Bangladesh
Twitter: Stop Tobacco BD
Website: www.StopTobacco.org.bd

Amassed 427 000 followers on Facebook
Total reach increased to more than 139 million (page & posts) with over 6 million engaged and over 80 000 people were talking about the campaign on social media.
A national campaign of six weeks duration was launched by the Ministry of Health and Sports, Myanmar, in collaboration with People’s Health Foundation, a civil society organization, and other related ministries in September 2017. The health literacy promotion unit in the Department of Public Health in the Ministry of Health and Sports developed two video clips (30 seconds duration) which were telecast through national TV and private TV channels. Radio messages were also developed and aired through FM/AM radio channels along with an outdoor campaign with stickers and posters. The campaign was launched at a high-level event attended by the Union Minister of Information, who read the message from the State Counselor in the presence of the Union Minister of Health and Sports and was widely covered by the media.
Many youth experiment with tobacco as a result of exposure to tobacco advertising, promotion and sponsorship. Complete bans on tobacco advertising, promotion and sponsorship decrease tobacco use. Guidelines for Article 13 of the WHO FCTC are intended to assist Parties in meeting their WHO FCTC obligations by drawing on the best available evidence as well as Parties’ experiences. The Guidelines to Article 13 of the Convention provide directions on the best way to implement this Article in order to eliminate tobacco advertising, promotion and sponsorship effectively at both domestic and international levels. Countries with the highest levels of achievement in TAPS ban in the South-East Asia Region are Maldives and Nepal.

The tobacco industry spends billions of dollars each year for marketing its products. Tobacco advertising, promotion and sponsorship (TAPS) encourages and influences youth to experiment with tobacco products and initiate regular use. TAPS reassures current tobacco users, glamourizes tobacco use, and increases the social acceptability of tobacco use. It is well documented that TAPS increases tobacco consumption. Partial bans have little or no effect on tobacco consumption.

Article 13 of the WHO Framework Convention on Tobacco Control states that comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products. The guidelines of Article 13 confirm that adequate protection from TAPS means banning all direct and indirect forms of TAPS.

Bangladesh, Bhutan, India, Myanmar, Sri Lanka, Thailand and Timor-Leste have banned advertising on national television, radio and print media as well as on some but not all forms of direct and/or indirect advertising.

Maldives and Nepal have banned all forms of direct and indirect advertising.

Marlboro targets growth markets in Timor-Leste.
### Billboards and outdoor advertising
- **Banned**: Bangladesh, Myanmar, Timor-Leste, Bhutan, Nepal, Sri Lanka, Thailand, Maldives
- **Allowed**: DPR Korea, India, Indonesia

### Display at point of sale
- **Banned**: Bhutan, DPR Korea, Myanmar, Thailand, India, Sri Lanka, Indonesia, Timor-Leste, Bangladesh, Maldives

### Internet advertising
- **Banned**: Bangladesh, Myanmar, DPR Korea, Bhutan, Nepal, Indonesia, Sri Lanka, Timor-Leste, Maldives, Thailand
- **Allowed**: India

### Surrogate advertisements
- **Banned**: Bhutan, Nepal, Bangladesh, DPR Korea, India, Thailand, Indonesia
- **Allowed**: Sri Lanka, Maldives

### Sponsorship
- **Banned**: Bangladesh, Nepal, DPR Korea, Bhutan, Sri Lanka, Indonesia, Thailand, Myanmar, Timor-Leste
- **Allowed**: Maldives, India

### Product placement in TV and films
- **Banned**: India, Thailand, DPR Korea, Maldives, Timor-Leste, Indonesia, Nepal, Bangladesh, Myanmar, Sri Lanka, Bhutan

### Internet sales
- **Banned**: Bangladesh, Sri Lanka, India, Maldives, Nepal, DPR Korea, Sri Lanka, Thailand, India
- **Allowed**: Myanmar

### Advertising at point of sale
- **Banned**: Bangladesh, Sri Lanka, India, Maldives, Nepal, DPR Korea
- **Allowed**: Thailand, Indonesia
Only DPR Korea bans free distribution of tobacco products

All countries in the South-East Asia Region have banned tobacco advertising, promotion and sponsorship through vending machines.

Four countries in the South-East Asia Region are just one provision away from a complete advertising ban: Bhutan, Sri Lanka and Thailand need only to ban brand-stretching, and India needs only to ban advertising of tobacco products at point of sale.

Enforcement official convincing shopkeeper to remove and destroy advertisement of tobacco products in Bangladesh.
India: Ban on depiction of smoking scenes in films & television

In India, The Union Ministry of Health and Family Welfare enacted the Film Rules 2005 to regulate depiction of tobacco products and its use in films. The Film Rules, as amended, mandate that all films and TV programmes that have been produced on or after 2 October 2012 shall have:

- A strong editorial justification explaining the necessity of the display of tobacco products or their use in films to Central Board of Film Certification (CBFC).
- Anti-tobacco health spots of minimum 30 second duration at the beginning and middle of a film/TV programme.
- Anti-tobacco ‘health warning’ as a prominent static message during the period of display of tobacco products or their use.
- One audiovisual ‘disclaimer’ on the ill-effects of tobacco use of minimum 20 second duration, at the beginning and middle of the film/TV programme.

The said Rules prohibit the following:

- Display of brands of cigarettes or other tobacco products or any form of tobacco product placement.
- Close-ups of tobacco products and tobacco product packages.
- Depiction of any tobacco product or its usage in any form in promotional materials and posters of films and television programmes.

In case the brand names or logos of tobacco products form a part of the picture in any media, the same should be cropped or masked so that the brand name and logos are not visible.


Discounts on tobacco products (promotion) in Mumbai, India

Point-of-sale advertisement, Mumbai, India
twelve
Consumers have a right to be warned about the harmful health impact of the products they purchase and consume, and this includes sufficient and accurate information regarding the risks of tobacco use. Article 11 of the WHO FCTC relates to packaging and labelling of tobacco products, stating that parties shall adopt and implement effective measures to ensure that tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions.

Graphic health warnings (GHWs) providing accurate information about the risk associated with tobacco use can help stimulate tobacco users to reduce their consumption and quit. Effective health warnings communicate risks of consuming tobacco, as well as the risks of exposure to second-hand smoke.

GHWs on tobacco product packages constitute a cost-effective means of reliably reaching tobacco users each time they use the product.

**World's largest graphic health warnings are implemented by Timor-Leste**
THAILAND’S PLAIN PACKAGING LEGISLATION

As per Thailand’s new legislation, by September 2019 all tobacco products will have plain packaging. Thailand already has graphic health warnings covering 85% of tobacco product packaging. Plain packaging of tobacco products restricts the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style.

Introduction of the plain packaging regulation would make Thailand the first country in Asia and the eleventh in the world to adopt this kind of ‘negative’ packaging to discourage cigarette smoking. Australia was the first country to enforce plain packaging; the most recent country was Mauritius.

With Maldives announcing legislation to implement graphic health warnings on tobacco packs (90% on both sides of tobacco product packs) effective from 1 December 2019, all countries in the South-East Asia Region except DPR Korea are now implementing graphic health warnings on tobacco packs.

Five countries in the South-East Asia Region are implementing the largest pictoral health warnings in the world:
- Timor-Leste
- Maldives
- Nepal
- Thailand
- India
The WHO South-East Asia Region leads in implementing **BEST BUYS** for effective tobacco control: plain packaging/graphic health warnings on tobacco packs

Thailand is implementing plain packaging on tobacco product packs since September 2019. Introduction of plain packaging has made Thailand the first country in Asia to implement plain packaging on tobacco packs.

Timor-Leste, Nepal and Maldives implement the largest graphic health warnings.

10 SEA Region countries implement graphic health warnings on tobacco packs.
Plain packaging of cigarette packs came into implementation in September 2019 in Thailand

Large Graphic Health warning on cigarette pack in Nepal
Chapter Thirteen

Tobacco Taxes and Price

Article 6 of the WHO Framework Convention on Tobacco Control states that price and tax measures are effective and important means of reducing tobacco consumption. Parties to the WHO FCTC should adopt measures including tax and price policies on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption.

It is well established that raising taxes to increase the price of tobacco products is one of the most cost-effective tobacco control measure considered ‘WHO best-buy intervention’. On an average, a 10% price increase on tobacco products reduces consumption by 5% in low and middle income countries (some instances have reported up to 8% reduction) and by 4% in high income countries.

Nearly half of this reduction is due to tobacco users quitting tobacco use, and half due to existing users smoking less.

Increasing excise tax rates on tobacco to reduce its affordability and lower its consumption is a policy measure that can simultaneously save millions of lives, reduce poverty and increase countries’ domestic resources for financing development.

Higher tobacco taxes improve public health, increase revenue and reduce the economic burden associated with tobacco use (The World Bank 2017).

Earmarked taxes for tobacco: The Thai government imposes a 2% surcharge tax on tobacco and alcohol producers and importers, which is used to fund Thai Health Promotion Foundation (Thai Health) for tobacco control and health promotion activities. Thai Health has intervened to raise tobacco excise tax on a continuous basis and has demonstrated that dedicated funding is essential for success. The current annual Thai Health budget is approximately US$ 120 million.

Source: Suladda Pongatta 2019
Affordability of tobacco products is usually measured in terms of relative income price (RIP) which is defined as the percentage of per capita income needed to purchase a given number of packs of tobacco products. Cigarettes have become less affordable in Bangladesh, India, Maldives, Sri Lanka and Timor-Leste and more affordable in Myanmar since 2008.

Countries in the South-East Asia Region can levy higher and uniform taxes on all tobacco products to decrease overall affordability of all tobacco products. Rise in tax and price will make tobacco products less accessible for minors and less attractive for new users.

Bidis are taxed at a very low rate in countries of the South-East Asia Region.
REGULATION OF TOBACCO PRODUCTS
Chapter Fourteen

**REGULATION OF TOBACCO PRODUCTS**

Tobacco is one of the few openly available commercial products that is mostly unregulated in terms of its contents and emissions, more so in low- and middle-income countries. Regulation of tobacco products forms an important strategy to reduce the demand of tobacco products. Tobacco smoke contains more than 7000 harmful chemicals and toxins, 69 of these being carcinogenic.

Article 9 of the WHO FCTC relates to regulation of contents and emissions of tobacco products. Partial guidelines for implementation of Article 9 & 10 of WHO FCTC provide guidance to the Parties to the Convention on testing contents and emissions and their disclosure. The Parties are required to adopt and implement effective legislative, executive and administrative or other measures for such testing and measuring of contents and emissions of tobacco products.

No tobacco testing laboratory existed in the South-East Asia Region till recently, when India established three functional labs to test tobacco products in 2019.

WHO is providing constant support to its Member States for regulation of tobacco products through coordination with the tobacco testing laboratories to get the tobacco products tested and technical guidance by providing updated standards and validated methods for testing contents and emissions of these products. In response to the need for clear and practical guidance for testing tobacco products at the country level, WHO launched a new guidance on tobacco products regulation in 2018.

**Tobacco-testing laboratories in India**

India is the only country to establish tobacco testing laboratories in the South-East Asia region. Three laboratories are functioning to test tobacco products since 2018 at Noida (Uttar Pradesh), Guwahati (Assam) and Mumbai (Maharashtra).
WHO TobReg

The WHO Study Group on Tobacco Product Regulation (WHO TobReg) comprises of scientists and experts in the field of tobacco product regulation, laboratory analysis of the contents, emissions and design features of tobacco products, toxicology, and tobacco dependence.

The group meets every two years and reports to the WHO Executive Board (EB) through the Director-General to draw the attention of WHO Member States to the organization’s work in tobacco regulation, and aid countries in implementing the tobacco product regulation provisions of the WHO FCTC. The WHO TobReg is supporting WHO on understanding the science and evidence generation related to new tobacco and nicotine products such as HTPs and ENDS/ENNDS.

WHO TobLabNet

The WHO Tobacco Laboratory Network (TobLabNet) is a global network of government, academic and independent laboratories aiming to strengthen national and regional capacity for testing and research of the contents and emissions of tobacco products in accordance with Article 9 of the WHO Framework Convention on Tobacco Control.

Source: WHO Global Tobacco Control Report 2019
Nicotine content in tobacco is one of the most highly addictive substances available in the world.

Mobile phone-based tobacco cessation programmes, such as the Be He@lthy Be Mobile mTobaccoCessation programme, reach a wide population of users with personalized support through mobile text messaging. These programmes help tobacco users to quit and are efficient and cost-effective. In India, the m-TobaccoCessation programme achieved a self-reported 19% quit rate at 4–6 months of follow-up, compared with an estimated baseline population quit rate of 5%.

Source: Gopinathan et al 2018
NATIONAL TOBACCO QUITLINE

Ministry of Health and Family Welfare
Government of India

QUIT TOBACCO
FOR A HEALTHIER LIFE

TOLL FREE
1800-11-2356

8:00 am - 8:00 pm
Except on Monday

Vallabhbhai Patel Chest Institute
University of Delhi, Delhi-110007
Article 14 of the WHO FCTC requires Parties to adopt and implement effective measures to promote tobacco cessation and ensure adequate treatment for tobacco dependence. The Article 14 guidelines recommend a number of specific actions that Parties should take to successfully design and implement a comprehensive national cessation strategy.

Recommended actions include a combination of population-level and individual-level approaches to help tobacco users quit.

Population-level approaches include integration of tobacco use screening and brief intervention into health-care systems; establishment of cessation services such as tobacco quitlines, and web-and-mobile phone-based cessation interventions. Individual-level approaches include provision of direct cessation support to individual tobacco users including pharmacological and behavioural support.

Article 14 is one of the least implemented articles in the South-East Asia Region
mCessation programme in India
The Ministry of Health & Family Welfare in collaboration with the WHO-ITU (International Telecom Union) developed mCessation programme for India. It was launched by the Union Health Minister of India as part of the Prime Minister’s Digital India initiative in January 2016. The programme, which is fully funded by the Government of India, is based on an innovative approach where text messages are sent to mobile phones of tobacco users who are willing to quit and get registered for the programme. The text messages follow an algorithm for a period of six months and encourage the tobacco users to set a quit date and support to deal with the withdrawl symptoms. The programme has more than 2 million registered users. The content is now available through text messages as well as the Interactive Voice response (IVR) mechanism in 12 national languages. WHO supported the Ministry to get the mCessation programme evaluated in 2017. It revealed a 19% self-reported quit rate among a sample of tobacco users who were registered for the mCessation programme.

Source: WHO, India
Toll-free telephone quitline/helpline to support tobacco cessation is available in Bhutan, India, Indonesia, Sri Lanka, Thailand and Timor-Leste

Nicotine replacement therapy (NRT) is available to support quitting tobacco use in DPR Korea, India, Indonesia, Maldives and Thailand

Source: WHO Global Tobacco Control Report 2019
Smokeless tobacco users (%) who made a quit attempt in the past 12 months

- **Bangladesh (GATS 2017, 15+ years)**
  - Overall: 31.4%
  - Men: 27.4%
  - Women: 33.8%

- **India (GATS 2017, 15+ years)**
  - Overall: 33.2%
  - Men: 35.2%
  - Women: 28.4%

- **Thailand (GATS 2011, 15+ years)**
  - Overall: 16.4%
  - Men: 14.3%
  - Women: 26.3%
Smokeless tobacco users* (%) advised to quit by a health-care provider in the past 12 months (*among those who visited a health care provider in the past 12 months)

- **Bangladesh (GATS 2017, 15+ years)**
  - Overall: 57.2%
  - Men: 50.7%
  - Women: 59.2%

- **India (GATS 2017, 15+ years)**
  - Overall: 31.7%
  - Men: 33.3%
  - Women: 28.6%

- **Thailand (GATS 2011, 15+ years)**
  - Overall: 16.3%
  - Men: 13.2%
  - Women: 16.9%
WHO supported training of health professionals in tobacco cessation, Timor-Leste, 2019
All countries except one in the WHO South-East Asia Region are Parties to the WHO Framework Convention on Tobacco Control and all countries are implementing the WHO MPOWER package to reduce the demand for tobacco. The results of ongoing efforts to implement comprehensive tobacco control policies and enforce tobacco laws include declining trends exhibited for both smoking and smokeless tobacco prevalence. However, there remains much to do to keep up with the challenges posed by tobacco industry interference, illicit trade, and the introduction of new and emerging products.

An evaluation of the progress of the implementation of tobacco control policies and programmes in all South-East Asia Region Member States was conducted in 2018. Nearly a decade and a half of implementing the WHO FCTC has resulted in five Member States of the Region: Bhutan, Maldives, Nepal, Sri Lanka and Thailand - showing tobacco use prevalence lower than the current average global rate among adults. Three countries- Bangladesh, India and the Democratic People’s Republic of Korea - that had higher than average global prevalence rates of tobacco use among adults were able to show a decline. High prevalence rates of tobacco use in Indonesia, Myanmar and Timor-Leste remain a cause for concern.

The reduction in prevalence of smokeless tobacco use among adults in Bangladesh and India is a silver lining in a scenario where the Region is home to more than 80% of world’s smokeless tobacco users. Although tobacco smoking is on the decline, most countries will miss the voluntary target of 30% relative reduction in tobacco use among persons aged 15 years and above (WHO NCD Action Plan) by 2025. The WHO Thirteenth General Programme of Work 2019–2023 aims to achieve 25% relative reduction in prevalence of current tobacco use among persons aged 15 years and above by 2023 which is in line with the Sustainable Development Goal Target 3.a.

Effectively addressing noncommunicable diseases in Member States of the WHO South-East Asia Region is among the Flagship Priority Programmes of the Regional Director, Dr Poonam Khetrapal Singh. Tobacco is a major risk factor for the significant noncommunicable diseases. Dr Poonam Singh’s vision encompasses a single-minded resolve to transform health and well-being for each of the Region’s 1.8 billion people. With her clear guidance on moving forward in the next five years, she recommends a three-pronged strategy-to sustain our achievements, accelerate progress to complete the unfinished agenda and harness the full power of innovation.

Member States of WHO South-East Asia have ambitious targets to achieve effective tobacco control. WHO supports building on every country’s capacity and strength to ensure healthy lives and promote well-being for all at all ages. While working towards controlling the tobacco epidemic, there is an urgent need to prevent children and youth from initiating use of tobacco products, especially the new and emerging ones. A balance of implementation of policies to reduce demand as well as supply of tobacco is to be achieved to ensure a tobacco-free South-East Asia in the future.

The Flagship Priorities of the Regional Director prioritize WHO’s technical support to Member States; promote a strong focus on results and accountability; and inspire sustainable and result-oriented national efforts. So much so that 80% of the Regional Office’s resources - both technical and financial - are focused on them. To tackle the tsunami of noncommunicable diseases, all 11 Member States have set national targets for 2025. They have developed multisectoral action plans aimed at developing a whole-of-society approach to effectively address the problem of noncommunicable diseases.
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