



Accelerating WHO FCTC Implementation in the WHO South-East Asia Region

A PRACTICAL Approach



**World Health
Organization**

Regional Office for South-East Asia

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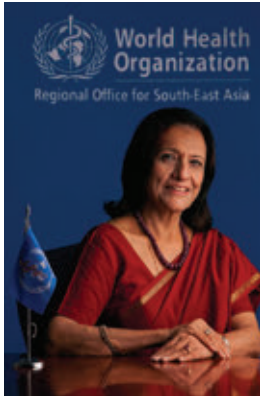
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Foreword



Tobacco kills more than 7.2 million people worldwide every year, with over 80% of them living in low- and middle-income countries (LMICs). The WHO South-East Asia (SEA) Region is home to one in every four smokers globally (nearly 246 million), and more than 80% of the world's smokeless tobacco users (290 million). More than 1.3 million persons in the Region die each year as a result of tobacco use. Tobacco control remains a challenge in the Region in view of countries having contrasting geographical patterns, diverse populations and ethnicity, wide range of political systems, different socio-cultural norms, rampant tobacco industry interference, and large variety of tobacco products consumed.

The World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) is an evidence-based treaty which consists of demand reduction and supply reduction measures. The treaty has also been recognized as one of the implementation target (target 3a) under the Sustainable Development Goals (SDG3) to be achieved by 2030.

To assist the country-level implementation of the WHO FCTC demand reduction measures, WHO introduced a package of six effective tobacco control policies in 2008, called the MPOWER package.

The SEA Region Member countries are working towards achieving the voluntary target of 30% relative reduction in prevalence of current tobacco use in persons aged 15 years and above by 2025 as enshrined in their respective National NCD Action Plans under the Global NCD Monitoring Framework. For more than a decade of WHO FCTC implementation in the SEA Region, Member States have achieved many milestones, but a lot still remains to be done. Countries have been constantly taking steps to enhance various tobacco control initiatives.

The WHO Regional Office for South-East Asia (SEARO) has guided and supported its Member States in the effective implementation of FCTC and the MPOWER package. This document has been developed to further accelerate the implementation of WHO FCTC in the SEA Region Member States. A PRACTICAL Approach for the prevention and control of tobacco in the Region comprising a mix of effective demand and supply reduction measures is recommended to support countries.

It is hoped that the countries will gain and benefit by curtailing the tobacco epidemic and reducing its impact on the health of citizens, the environment and national economies by adopting and implementing the "PRACTICAL Approach".

A handwritten signature in black ink, appearing to read 'Poonam Khetrpal Singh'.

Dr Poonam Khetrpal Singh
Regional Director

List of Abbreviations

AFTA	ASEAN Free Trade Area
ASEAN	Association of South-East Asian Nations
COP	Conference of the Parties to the WHO FCTC
ENDS	electronic nicotine delivery system
ENNDS	electronic non-nicotine delivery system
FCTC	Framework Convention on Tobacco Control
GATS	Global Adult Tobacco Survey
ITP	Illicit Trade Protocol
MDGs	Millennium Development Goals
MoHFW	Ministry of Health and Family Welfare, Government of India
NCD	noncommunicable diseases
NRT	nicotine replacement therapy
SDGs	Sustainable Development Goals
SEAR	South-East Asia Region
SHS	second-hand smoke
ST	smokeless tobacco
UN	United Nations
WHO	World Health Organization
WHO FCTC	World Health Organization Framework Convention on Tobacco Control
WTO	World Trade Organisation

Introduction

Tobacco kills more than 7.2 million people worldwide every year, with over 80% of them living in low- and middle-income countries (LMICs) (GBD, 2015). Tobacco use also imposes a heavy economic burden on the world. The cost of smoking alone is estimated to be US\$ 1.4 trillion, or 1.8% of global GDP (USNIC WHO, 2016). The WHO South-East Asia (SEA) Region has a high burden of tobacco use, with more than 1.3 million persons dying due to tobacco-related illnesses every year. The Region is home to nearly one fourth of tobacco smokers and more than 80 per cent of smokeless tobacco users in the world (WHO SEARO, 2015).

Tobacco use is a leading risk factor for major noncommunicable diseases (NCDs), mainly cardiovascular diseases, chronic respiratory diseases, diabetes and cancer. The Global Action Plan for Prevention and Control of NCDs 2013–2020, including a comprehensive monitoring framework with 25 indicators and 9 voluntary global targets, was endorsed by the Sixty-sixth World Health Assembly in May 2013 (WHO, 2013). The Action Plan for Prevention and Control of NCDs in South-East Asia, 2013–2020, provides a roadmap for regional and national actions for developing and implementing policies and programmes to reduce the burden of NCDs within the regional socioeconomic, cultural, political and health system contexts (WHO SEARO, 2013).

The agreed global target of 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years and above by 2025 is included in the regional and national NCD Action Plans of SEA Region countries. Achieving this target could prevent more than 200 million deaths worldwide during the remainder of the 21st century (WHO 2015). Moving towards set targets not only provides a context for development of policies and programmes of actions to attain the target, but also provides an opportunity for policy-makers to monitor progress towards the achievement of the target over time. The countries will get an opportunity to set a benchmark towards achievement of this goal during the UN High-Level Meeting on NCDs scheduled to be held in 2018.

The countries are now facing the unfinished agenda of the Millennium Development Goals (MDGs) and the challenge of achieving targets under Sustainable Development Goals (SDGs), also known as the 2030 Agenda for



WHO FCTC is key element to achieve sustainable development goals

Sustainable Development. SDGs constitute a set of 17 Global Goals with 169 targets between them covering a broad range of sustainable development issues. SDG 3 pertains to ensuring healthy lives and promoting the well-being for all at all ages (UN 2015).

The World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) has been recognized as one of the "means of implementation" (Target 3a) under SDG 3. SDGs are intertwined with one another and so the interrelations of tobacco production and consumption with development extend beyond the health goal. Thus the implementation of the WHO FCTC as reflected in SDG 3a is key element to achieve 2030 Agenda for Sustainable Development.

Given previous experience with the MDGs and the more ambitious SDG agenda to be achieved by 2030, it is important to 'start implementation now'. Mere inclusion of the FCTC as the "means of implementation" to achieve SDG 3 is not going to achieve the desirable results unless tobacco control is seen as a commitment to achieve the overall SDGs at the country level.

WHO Framework Convention on Tobacco Control

To address the global burden of tobacco, the World Health Assembly in 2003 unanimously adopted the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC). In force since 2005, the main objective of the WHO FCTC is to protect present and future generations from the devastating health, social, environmental and economic consequences of exposure to tobacco and its consumption. Ratified by 180 Parties (countries) as on March 2017, the WHO FCTC currently covers about 90% of the world's population. All the Member States of the WHO South-East Asia Region are Parties to the Convention except Indonesia which has not ratified the treaty yet.

The WHO FCTC is a legally binding treaty which commits Parties to the Convention to develop and implement a series of evidence-based tobacco control measures to reduce the demand and supply of tobacco.

The core demand reduction provisions are contained in Articles 6–14 of the WHO FCTC. They include:

- (1) Price and tax measures.
- (2) Non-price measures including protection from exposure to tobacco smoke; regulation of the contents of tobacco products; regulation of tobacco product disclosures; packaging and labelling of tobacco products; education, communication, training and public awareness; ban on tobacco advertising, promotion and sponsorship (TAPS); and measures concerning tobacco dependence treatment/cessation.

The core provisions to reduce the supply of tobacco are contained in Articles 15–17 of the WHO FCTC:

- (1) Illicit trade in tobacco products.
- (2) Sales of tobacco to and by minors.
- (3) Provision of support for economically viable alternative activities for tobacco growers/workers.

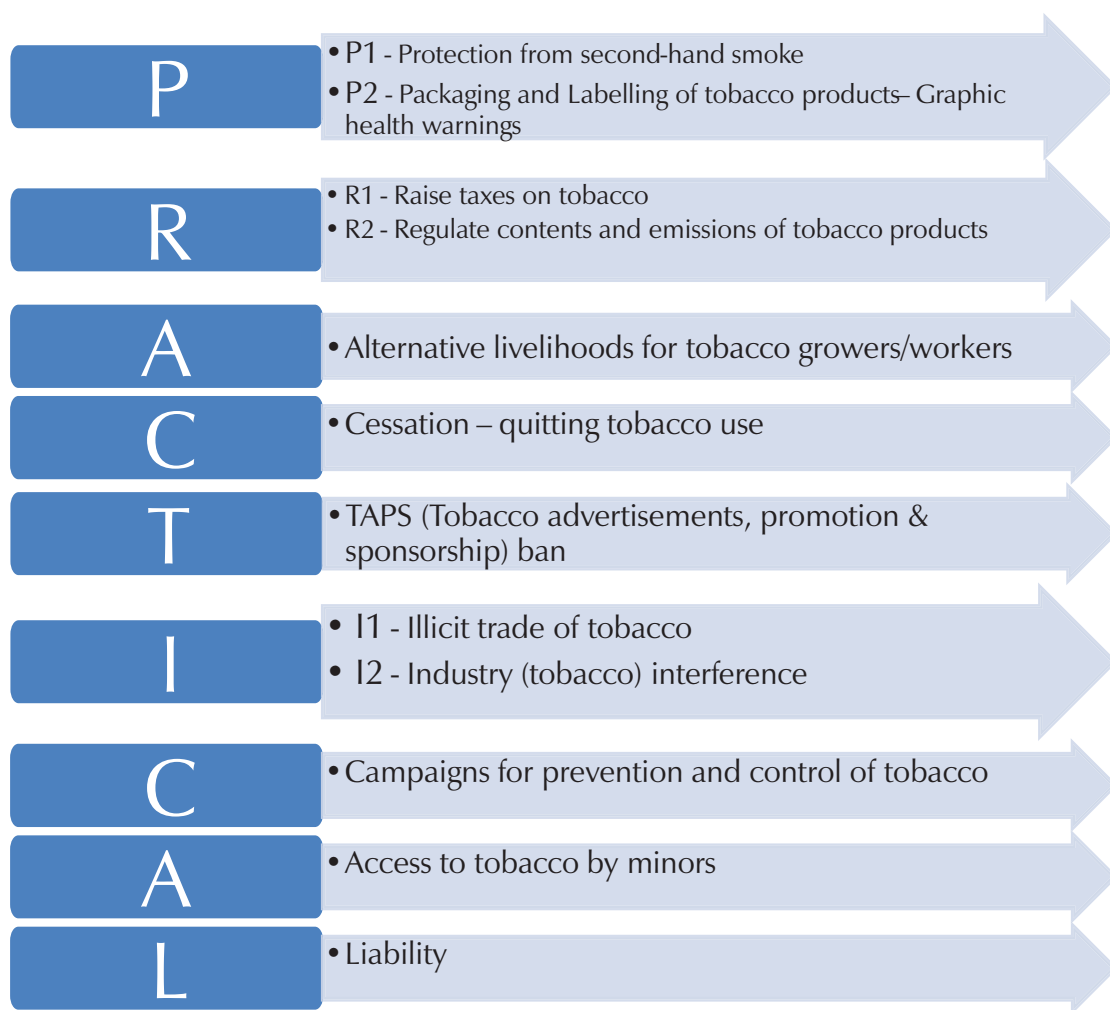
In 2008, WHO introduced a package of six evidence-based tobacco control demand reduction measures that are proven to reduce tobacco use to assist countries to fulfil their obligations under WHO FCTC. These measures, known as the MPOWER package, reflect one or more provisions of the WHO FCTC. MPOWER refers to M: Monitoring tobacco use and prevention policies; P: Protecting people from tobacco smoke; O: Offering help to quit tobacco use; W: Warning about the dangers of tobacco; E: Enforcing bans on tobacco advertising, promotion and sponsorship, and R: Raising taxes on tobacco.

WHO SEA Region Member States have achieved various levels of success in implementing WHO FCTC. Since 2008, the countries have implemented the WHO MPOWER package. Some countries like Thailand and Sri Lanka have done well in implementing tobacco control policies and measures. Thailand has achieved the highest levels of MPOWER scores. Sri Lanka is the only Member State which has ratified the Protocol to Eliminate Illicit Trade of tobacco (the Protocol). Although taxes and prices of tobacco products have increased, these are still quite affordable in many of the countries. There are many challenges to tobacco control such as use of multiple and diverse tobacco products, high usage of smokeless tobacco, interference by the tobacco industry, introduction of new tobacco products, and accessibility to youth, etc.

To achieve the voluntary targets under the NCD Action Plan, and for further fulfilment of SDG goals and targets with WHO FCTC being one of the implementation targets (SDG 3a), SEA Region countries are at a stage where they can look at the current gains and gaps and prepare for full implementation of the treaty to achieve the target of 30% relative reduction in tobacco use prevalence by 2025.

To accelerate the implementation of WHO FCTC in SEA Region Member States, a PRACTICAL Approach is proposed for the prevention and control of tobacco. The PRACTICAL Approach is a mix of demand and supply reduction measures of the WHO FCTC which can be implemented by the countries for effective tobacco control to meet the global/regional and national targets for tobacco control and to save lives.

PRACTICAL Approach



P1 – Protection from second hand-smoke

Article 8 of WHO FCTC – Protection from exposure to tobacco smoke

Article 8 of the WHO FCTC requires the Parties to adopt and implement effective measures to protect people from exposure to SHS in indoor workplaces, public transportation, indoor and other public places.

The WHO FCTC guidelines emphasize that only 100 per cent smoke-free environment legislation provides appropriate protection for the public, and that all indoor workplaces, all indoor public places and public transportation should be entirely smoke-free.

Smoke-free laws in many low-income countries still include exemptions or waivers and allow for designated smoking areas or include other loopholes resulting in weak laws. The restaurants, pubs and bars are particularly exempted from smoke-free legislation and only

one third of countries completely ban smoking in these establishments (WHO 2015). For some establishments such as hospitals and health-care settings, there is an urgent need to make them smoke-free, in order to protect patients and staff from second-hand smoke (SHS), thus giving a strong health message to the community. The bans on smoking should also include outdoor spaces of all health care facilities, schools and universities, thus modelling workplace smoke-free policies and behaviour.

Exposure to SHS is not limited to workplaces and public places; significant exposure – especially of infants and young children – occurs in homes also. Ban on smoking in these private indoor settings is an area for further research (US NCI WHO 2016).

Overall smoke-free laws are in place in all SEA Region countries. Indonesia implements smoke-free policies at subnational level. India has developed “Tobacco Free School” guidelines, while Bangladesh has subnational “Tobacco Free Hospitals” initiative in place. The Tobacco Products Control Act (2017) in Thailand has called for stricter enforcement of smoke-free environments.

Smoke-free policies should be extended beyond indoor public places to include some outdoor spaces. For example, the city of Vancouver (Canada) has banned smoking on public beaches and in public parks (Vancouver board of parks and recreation 2010). Similarly New York City (US) has passed legislation banning smoking in all public parks, beaches and



Exposure to SHS is harmful to children



An ENDS device

pedestrian plazas (New York City Council 2011). Developed countries such as Australia, Canada and the United States have introduced legislation banning smoking in cars when children are present. Bahrain, Cyprus, England, South Africa and Wales also ban smoking in cars when children are present, while Mauritius was the first country to implement a vehicle smoking ban in cars carrying any passengers (ASH 2015). In the SEA Region, Thailand bans smoking in all health facilities, educational establishments, sports venues, service and entertainment places, general public places and public vehicles. The Recent Tobacco Control Regime Decree law of Timor-Leste

(2016) also provides for ban on smoking in many public and service areas including public vehicles. India has witnessed examples of community-level initiatives to implement smoke-free laws and policies. Even before the national smoke-free law came into effect, there were examples of sub-national smoke-free jurisdictions, e.g. Chandigarh was the first city to be declared smoke-free in 2007. This is an excellent example of multi-stakeholder partnerships for implementing smoke-free laws (Kaur J., Jain D.C., 2011).

Tobacco companies have now come up with electronic nicotine delivery systems (ENDS), which are battery-operated devices designed to heat a liquid (which contains nicotine) into an aerosol for inhalation by the user (also known as e-cigarettes). WHO has noted that “the use of ENDS in places where smoking is not allowed, (i) increases the exposure to exhaled aerosol toxicants of potential harm to bystanders, (ii) reduces quitting incentives, and (iii) may conflict with the smoking de-normalizing effect” (WHO 2014). The typical use of unadulterated ENDS/ENNDS produces aerosol containing many toxicants that have known health effects resulting in a range of significant pathological changes. ENDS aerosol contains nicotine, the addictive component of tobacco products. In addition to dependence, nicotine can have adverse effects on the development of the foetus during pregnancy and may contribute to cardiovascular disease. Health risks from passive exposure to exhaled aerosol from ENDS/ENNDS users – or second-hand aerosol – are also well documented. (WHO 2016).

Some governments (e.g. France, Turkey) have taken action to prohibit ENDS use in places where smoking is prohibited; either by interpreting existing legislation as inclusive of ENDS or by explicitly passing new legislation to include ENDS (Institute for Global Tobacco Control 2016). Many countries have banned the use of ENDS in enclosed public spaces, including bars, restaurants and other workplaces and selected enclosed places (ibid). The WHO ENDS Report to COP 7 may be referred to for recommendations to regulate ENDS.

In SEA Region, law provides for ban on ENDS in Sri Lanka and Timor-Leste. Maldives and Nepal also regulate ENDS. India has some examples of ban on ENDS at subnational level.

To overcome the smoke-free laws enacted by the countries, the tobacco industry is introducing “heat not burn” tobacco products. Philip Morris lately introduced IQOS, a battery-powered device that heats tobacco leaves packed in cigarette shape. As per the

company report (March 2017), the product is becoming popular in many countries. WHO is monitoring the evolution of the “heat not burn” tobacco products that have been introduced in several countries by the tobacco industry.

Evidence also suggests that implementation of smoke-free legislation entails a transition period, and requires high levels of compliance after which the legislation becomes self-enforcing. The studies have found that public approval and compliance with smoke-free policies have increased over time after their implementation in countries including low- and middle-income countries (IARC 2009).



Smoke-free laws should be simple, clear and enforceable in order to be effective. Involvement of civil society as an active partner is very important in the process of developing, implementing and enforcing legislation, especially to act as a watchdog. The continuous monitoring and evaluation of the impact of smoke-free legislation is imperative. Comprehensive smoke-free policies are far more effective in reducing exposure to SHS as compared with partial restrictions on smoking as these help improving air quality; reduce non-smokers’ SHS exposure; encourage smokers to reduce their tobacco uptake by limiting the times and places where they can smoke; and motivate smokers to attempt to quit (Chaloupka 1999).

Smoke-free legislation helps change social norms and makes tobacco use less acceptable. Smoke-free legislation also limits smoking in schools and thus prevents youth from taking up this habit to some extent. Smoke-free policies provide motivation for smokers to initiate cessation. Once cessation has been attempted, these policies help prevent relapses by reducing opportunities to smoke and thus increase the chances of a successful cessation attempt (Hopkins et al 2010).

Suggested actions to accelerate implementation of smoke-free policies/laws:

- Countries should enforce strict implementation of their smoke-free laws and make them comprehensive and inclusive.
- There is an urgent need to keep a watch on introduction of new tobacco products such as ENDS, heat-not-burn tobacco, by the tobacco industry to overcome smoke-free laws. India is also grappling with a large waterpipe industry, that lures especially youth to smoking. Such products should be regulated with appropriate policies. Thailand has included e-cigarettes and waterpipes as tobacco products in the Tobacco Products Control Act (2017).

P2 – Packaging and labelling of tobacco products

Article 11 of WHO FCTC – Packaging and labelling of tobacco products

Article 11 of the WHO FCTC requires prominent health warning labels on all tobacco packaging. In 2008, the WHO FCTC Conference of Parties (COP) adopted evidence- and best practice- based guidelines for implementing Article 11, which recommended that parties

consider using health warnings that cover more than 50% of the principle display area of tobacco packs and aim to cover as much of the principal display area as possible. One of the most powerful tactics by which tobacco companies promote their product is via advertising through packaging of various tobacco products.

The evidence shows that people living in countries with health warning labels on tobacco packs are more knowledgeable about the harmful effects of tobacco and are thus more likely to quit and stay quit as compared with countries where health warning labels are not required (WHO 2011).

Article 11 of the WHO FCTC also requires the Parties to implement effective measures to ensure that tobacco packaging does not promote a tobacco product by false or deceptive means. The tobacco companies mislead the public by creating the false impression that a particular tobacco product is less harmful than others by labelling it as “light”, “low tar”, “mild”, etc. Most of the SEA Region countries have banned the use of such misleading and deceptive terminology on tobacco product packages including those of smokeless tobacco products. The use of plain packaging is also helpful to counteract such packaging and labelling tactics of the tobacco industry.



Graphic health warning for smoking and smokeless tobacco products in India

In order to counteract the use of tobacco packages as a means of advertisement and promotion, countries have implemented plain packaging of tobacco products after fighting a fierce battle with the industry. The theme of World No Tobacco Day (WNTD) in 2016 was “Get Ready for Plain Packaging”, to encourage and support countries to implement plain packaging of tobacco products. Plain packaging is the “standardized packaging” which means that logos, colours, brand images or promotional information is removed from tobacco packaging. Instead, tobacco packaging features black and white or other contrasting colour

combinations, and a brand name, a product name and/or a manufacturer's name. Astride the package's drab exterior are graphic health warnings documenting tobacco's adverse effects, including desiccated, cancerous lungs, gangrenous limbs, and asthmatic children. The net result is a product that is significantly less appealing.

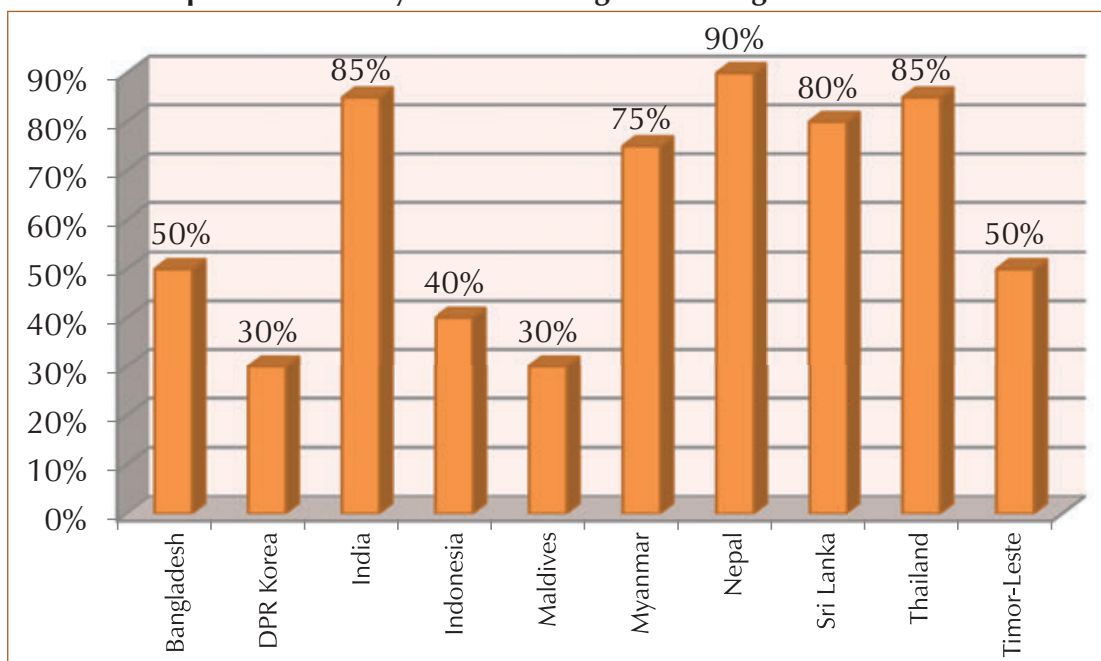
Australia was the first country to enforce plain packaging since December 2012. Research has shown that plain packaging makes the product less appealing, especially to youth, and thus prevents them from initiating or experimenting with this habit. Australia's daily smoking rates among 14-year-old youths has declined after the introduction of plain packaging; from 15.1 per cent in 2010 to 12.8 per cent in 2013. Three other countries – France, United Kingdom and Ireland – have also introduced plain packaging.



Plain Packaging of cigarette packs

Although plain packaging is now restricted to developed nations; developing economies of South-East Asia have also passed legislations related to packaging and labelling of tobacco products. The Tobacco Product Control Act, Thailand (2017) has a provision to regulate through plain packaging. Other countries such as Nepal have decided to have health warnings covering 90 per cent of the principal display area of tobacco packs which is very near to plain packaging itself. India recently increased the size of pictorial health warnings from 40 per cent on the front to 85 per cent on both sides of all tobacco products packs. Sri Lanka is contemplating implementation of plain packaging of tobacco products. These are significant steps taken by SEA Region countries for implementation of Article 11 of WHO FCTC. Graphic health warnings (GHWs) on tobacco product packs is a recommended best buy for tobacco control.

Figure 1: Percentage of the principal display areas on both sides of tobacco product packs covered by health warnings in SEA Region countries



(Note: DPR Korea and Maldives have provision for only text warnings and Bhutan has a ban on production, sale or trade of tobacco in the country)



Examples of graphic health warnings on tobacco product packs

Suggested actions to accelerate implementation of Article 11 of the WHO FCTC

- The countries should strictly implement provisions under Article 11 of the WHO FCTC to maximize compliance.
- The countries with text-only warnings on tobacco products should move forward to have graphic health warnings (GHWs) on all tobacco products as mandated by WHO FCTC.
- Efforts should be made to enact laws for plain packaging of tobacco products.

R1 – Raise tax on tobacco

Article 6 of WHO FCTC – Price and tax measures to reduce the demand for tobacco

“Sugar, rum and tobacco are commodities which are nowhere necessities of life, which have become objects of almost universal consumption, and which are, therefore, extremely proper subjects of taxation... By taxing these commodities the people might be relieved from some of the most burdensome taxes; from those which are imposed either upon the necessities of life, or upon the materials of manufacture” (Adam Smith, 1776)

Article 6 of the WHO FCTC requires the Parties to implement tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption.

Article 6 also requires Parties to prohibit or restrict, as appropriate, sales to and/or importation by international travellers of tax and duty-free tobacco products.

The 2015 Addis Ababa Action Agenda, the outcome document of the 3rd International Conference on Financing for Development, recognised “tobacco taxation” as an important

public health measure for reducing demand for tobacco, and at the same time a mechanism to generate resources for development. It has been estimated that tobacco control if put in place in low- and middle-income countries will cost just US\$ 0.11 per person per year and even this could be generated by tobacco taxation (FCA 2015).

Tobacco taxes and prices are key factors in controlling the demand for tobacco products and essential components of an integrated approach to tobacco control. Decades of research has proven that significantly increasing the excise tax and price of tobacco products is the single most consistently effective tool for reducing tobacco use (US NCI and WHO 2016).

A substantial body of research has shown that demand for tobacco products is price elastic i.e. increasing the excise tax and thus prices of tobacco products results in reduced demand for tobacco products. A 10 per cent increase in the prices of tobacco products is expected to reduce the demand for tobacco products by 4 per cent in high-income countries and by 5 per cent in low- and middle-income countries. Thus demand for tobacco products is often more responsive to prices in low- and middle-income countries as compared with high-income countries. There is evidence to show that a significant increase in tobacco taxes and prices reduce tobacco use by compelling some current users to quit, proscribing potential users from initiating tobacco use, and reducing the amount and frequency of consumption

among current users. Tobacco use by young people is generally more responsive to changes in taxes and prices of tobacco products than tobacco use by older people (US NCI and WHO 2016).

In addition, lower-income countries' revenue depends more on indirect taxes, including tobacco and other excise taxes, than on direct taxes, such as income taxes; thus the contribution of tobacco excise tax in revenue generation for low- and middle-income countries could be quite substantial. Higher taxes on tobacco products increase tax revenues and improve public health, but still remain an underutilized intervention.

Tax/price increase of tobacco products is helpful in promoting tobacco cessation. Tobacco taxation is especially effective for young people who have limited disposable income and thus get discouraged to spend a greater share of it on tobacco products. Tobacco use by young people is generally more responsive to changes in taxes and prices of tobacco products as compared with older people.

Research has shown that simpler tobacco taxation structures, particularly specific taxes, are associated with less variability in the prices tobacco users pay across brands, thus preventing them from switching to cheaper brands or types of tobacco products, and are more effective in reducing tobacco use as compared with tier-based complex tax structures (WHO 2015).

SEA Region countries have varied tax structure for tobacco products. Tobacco products are subject to differential tax treatment. Typically, higher taxes are levied on cigarettes as compared to other tobacco products. Excise tax on cigarettes was raised from 87% to 90% of retail price in Thailand (Feb. 2016). However, in many countries, such as Bangladesh, India, Indonesia, Myanmar and Nepal, the tax structure is not uniform across different tobacco products. The tax structure is often complex and multi-tiered with different excise rates being applied on different tobacco products. India levies tiered specific excise taxes on cigarettes based on the length of the cigarette and on whether or not there is a filter. Differential taxes lead to loopholes. Bhutan has ban on growing, production, manufacturing and sale of tobacco and 100% sales tax and 100% custom duty is applied on tobacco products for personal consumption only. Tobacco products are low-priced in DPR Korea. In Indonesia, taxes vary based on product type (kreteks vs standard or white cigarettes), type of production (hand- vs machine-made), production volume and government estimates of retail price. Maldives recently raised tax on cigarettes (2016). Sri Lanka is contemplating further increase in tobacco taxes. The newly enacted Tobacco Control Regime of Timor-Leste (2016) provides for tax & pricing policies to be applied to all tobacco products.

Tobacco taxes are earmarked by a number of countries. Early examples of earmarking include India's Bidi Workers' Welfare Cess (1976). In 2005-2006, the Indian government introduced a health cess on most smoked and smokeless tobacco products. This is an additional excise duty and the revenue generated is used to fund national health programmes. Thailand is a pioneer in innovative health financing. A dedicated taxation of 2% is levied on tobacco and alcohol over and above the existing taxation, popularly known as the Sin Tax. In Thailand, the Asian Development Bank estimates that 60% of the deaths averted by a

50% tobacco price increase would be concentrated in the poorest third of the population, which would pay only 6% of the increased taxes (WHO 2015).

The SEA Region has a high prevalence of smokeless tobacco (ST) in many countries, mainly Bangladesh, India, Myanmar and Nepal. ST is taxed at low rates compared with cigarettes. Non-cigarette smoking tobacco products such as *bidi* (or *beedi*) in India are taxed at very low rates. Non-uniform taxation of tobacco products provide opportunities of switching over to low-priced tobacco products when taxes are raised selectively, and mainly on cigarettes or other tobacco products. To reduce the already existing price gap, lessen the likelihood of switching over to less expensive tobacco products by consumers, and maximize the public health impact, tax increase may need to be greater for other tobacco products than cigarettes.

In some countries where incomes and purchasing powers are growing rapidly, tobacco has become increasingly affordable, which has occurred despite increase in tobacco taxes because the resulting price increases have not been large enough to offset growth in real incomes (WHO 2015).

The tobacco industry interferes with the national governments' efforts to raise taxes or price of tobacco products. Complex tax structures are favourable to tobacco industry. WHO helps the ministries of health to engage with ministries of finance and provides the evidence base on the benefits of raising taxes on tobacco products.

Under the Bloomberg Initiative, WHO is supporting Bangladesh, India and Indonesia with technical support by collaborating with partners and stakeholders to raise taxes on tobacco products. Missions comprising tax and economic experts visited these countries in 2016–2017 to work for tax reforms. WHO continuously provides technical support and encourages Member States to raise tobacco tax/price for reducing the demand of tobacco.

Despite the fact that raising tobacco taxes to more than 75% of the retail price is among the most effective and cost effective interventions, only a few countries have increased the tobacco taxes to best practice level (WHO 2015).

Suggested Actions to accelerate implementation of Article 6 of the WHO FCTC

- Countries should implement the simplest and most efficient tax regime that meets their public health and fiscal needs, taking into account their national situation and circumstances. A well-designed tax system is one that is simple and easy to administer in order to minimize tax avoidance and evasion, generate expected revenues, and result in tax increases being passed on to consumers as price increases. Simplicity in tax systems improves transparency and limits opportunities for tax avoidance and tax evasion. However, being well-designed is not enough to ensure that a tax system will have a positive impact on public health and revenues (US NCI WHO 2016).
- The taxation on all tobacco products should be uniform across various types of tobacco products so that there is effective rise in prices of all available tobacco products and these become less accessible and affordable, especially for the youth.

- Tax rates should be monitored continuously and increased or adjusted on a regular basis taking into account inflation and income growth developments in order to reduce tobacco consumption. To ensure high compliance levels, strong tax administration is needed to implement and administer tax policies efficiently. Compliance can be strengthened by adopting state-of-the-art monitoring and tracking and tracing systems combined with strong enforcement.

R2 – Regulation of contents of tobacco products

Article 9 of WHO FCTC – Regulation of contents of tobacco products.

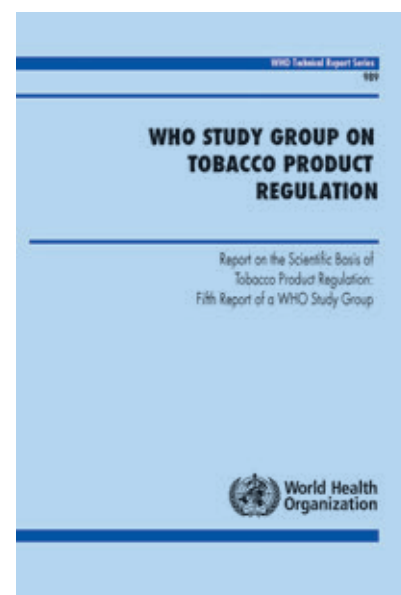
Article 10 of WHO FCTC – Regulation of tobacco product disclosures

Article 9 of the WHO FCTC mandates that all parties, in consultation with competent international bodies, shall propose guidelines for testing and measuring the contents and emissions of tobacco products, and for the regulation of these contents, adopt and implement effective legislative, executive and administrative or other measures.

Article 10 of the WHO FCTC requires countries to mandate the manufacturers and importers of tobacco products to disclose to government authorities information about the contents and emissions of tobacco products. The countries should further adopt effective measures for public disclosure of information about the toxic constituents of tobacco products and the emissions they produce.

Tobacco companies are constantly modifying their products to make them more attractive to tobacco users and at the same time mislead them by affecting their perception, knowledge and attitude towards tobacco use. For example, flavoured capsules have been placed in the filter of cigarettes, to provide highly concentrated flavour and to mask the harsh character of tobacco smoke. Such tactics encourage tobacco consumption and help sustain smoking and thus continued exposure to the toxic chemicals found in tobacco products. The Articles 9 and 10 of the WHO FCTC require the tobacco industry to test and disclose the contents and emissions of tobacco products to regulatory authorities. Also the regulatory authorities must prohibit or restrict product design features that increase their attractiveness. Governmental authorities, with access to information on tobacco contents, would be in a better position to understand the nature of their tobacco products market and thus regulate the same. To help collect such information, governmental authorities can mandate the use of analytical laboratory methods for the testing and measuring of contents of tobacco products.

The WHO Study Group on Tobacco Product Regulation (TobReg) has identified a non-exhaustive list of priority toxic contents and emissions of tobacco products for regulation under Articles 9 and 10 of the WHO FCTC. When requiring the testing and measuring of nicotine, the Tobacco Laboratory Network (WHO TobLabNet) standard and validated methods should be used by the laboratories performing the tests on tobacco products on behalf of the manufacturers and importers of tobacco products.



WHO Study Group on tobacco product regulation has developed a series of technical reports.

The WHO “TobLabNet” methods could also be adapted for a number of smokeless tobacco products (ST). Further product- specific analysis is needed to cover the entire range of ST, especially the products prevalent in the SEA Region that have currently not been selected by the “TobLabNet” due to lack of relevant laboratory expertise. ST also contains metals, humectants, aldehydes and other toxicants; and further work is needed to recommend standard quantitative analysis procedures. ST manufacturers may be directed to disclose nicotine, pH levels, TSNA (tobacco-specific nitrosamines) and toxicants, from approved laboratories. ST manufacturers could reduce levels of toxicants using technologies, but they generally failed to do so due to lack of comprehensive regulatory policies and testing facilities for ST.

Regarding Articles 9 and 10, COP 7 (seventh session of the Conference of the Parties) made the following recommendations:

- Engagement in discussion on the regulation of addictiveness reduction, to identify barriers to implementation and to increase knowledge and bridge the gap between science and policy development;
- Weighing the positive and negative consequences of implementing addictiveness reduction policies;
- Identification of strategies to build capacity for Parties wishing to monitor markets through registration, licensing or notification of tobacco products in order to inform policy-making; and
- Examination of market developments and usage related to “heat-not-burn” tobacco products and other novel tobacco products.

Recently, as part of the global efforts to address the problem of tobacco use, the Global Tobacco Regulators Forum (GTRF) was organized upon the initiative of various governments with the assistance of WHO. The GTRF is a network of tobacco regulatory agencies from various jurisdictions which will serve as a community of practice for tobacco product regulation. WHO shall act as Secretariat to the GTRF. The GTRF is envisioned as a platform for knowledge exchange and learning between tobacco regulatory agencies of different countries. The first meeting of GTRF was held in April, 2017.

Currently in the SEA Region, Thailand and DPR Korea have laws requiring manufacturers and importers of tobacco products to disclose to governmental authorities information on the contents and ingredients used in the manufacture of their tobacco products. DPR Korea has a surveillance system to check the contents of tobacco products, and it conducts quality control on all tobacco products locally produced and imported by strengthening technical capacity of the inspection rooms. The Tobacco Control Regime of Timor-Leste (2016) provides for the measurement and tests regarding the levels of tar, nicotine, carbon monoxide and other substances in tobacco products and submits the same to competent health services. Indian tobacco law has provision to test contents / emissions of tobacco products but could not be implemented in the absence of tobacco testing labs in the country.

Suggested actions to accelerate implementation of Articles 9 and 10 of the WHO FCTC:

- Countries are required to consider requiring manufacturers and importers of tobacco products to disclose to governmental authorities at specified intervals information about the contents of their tobacco products by product type and for each brand within a brand family. Manufacturers and importers may provide a copy of the laboratory report that shows the products tested and the results of the testing and measuring conducted on that product. The proof of accreditation of the laboratory that performed the testing and measuring may also be submitted.
- Countries should consider regulating the use of flavourings and additives to all tobacco products which increase their attraction and facilitate their consumption. Furthermore, regulating storage conditions of ST such as refrigeration (which affect addictiveness and toxicity), affixing the date of manufacture, regulating packaging material etc are also provisions for regulation.
- All new and emerging tobacco products such as vapourizers and other novel devices should also be regulated under the WHO FCTC.

A – Alternative livelihoods

Article 17 of WHO FCTC – Provision of support for economically viable alternative activities to tobacco growing

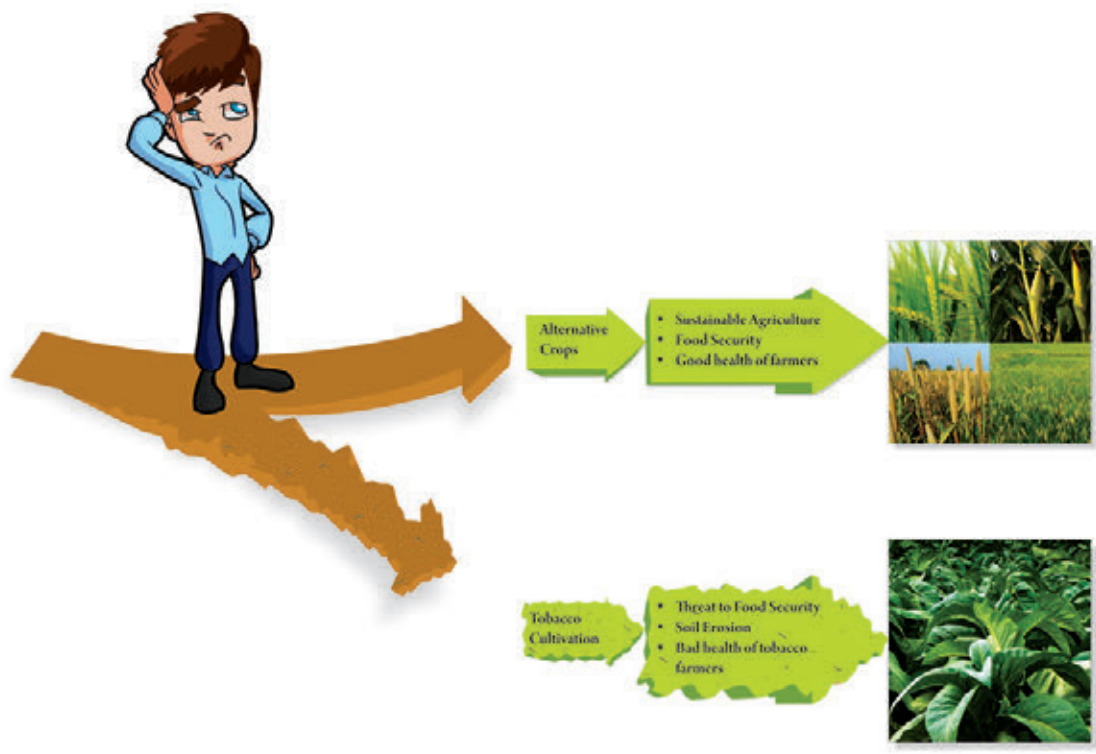
Article 17 of the WHO FCTC requires that Parties shall, in cooperation with each other and with competent international and regional intergovernmental organizations, promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers. Providing economically viable alternatives to tobacco growing is one of the main supply reduction strategies for tobacco control.

Article 17 is the least implemented articles of the Convention. This is an area where greater effort needs to be focused for the identification of best practices and the sharing of experiences, because the tobacco industry continues to argue that demand-reduction measures under the WHO FCTC will swiftly extinguish the economic benefits of tobacco growing to local and national economies, reduce employment and damage national economies. In reality, annual consumption of tobacco usually decreases by fractions of percentage points, thus allowing growers to gradually diversify into other activities as government adjustment programmes are implemented. Mechanization of tobacco growing and competition in international trade generally bear much more responsibility for decreasing employment. Therefore, the tobacco industry's claims are incorrect. Moreover, Parties are required to protect the implementation of Articles 17 of the WHO FCTC against the commercial and vested interests of the tobacco industry in accordance with Article 5.3 of the Convention and the guidelines for its implementation. Parties report that key challenges for the implementation of these Articles include the scarcity of information on specific programmes and relevant research, and the need for strengthened platforms for information sharing among interested parties (COP7).

Tobacco growing is a very labour intensive process. Research has shown that there are viable alternatives to tobacco farming, and these tend to be specific to individual countries and regions. WHO and UNCTAD jointly launched the “Status of Tobacco Production and Trade in Africa – Factsheets” in December 2015. In 2016, WHO and UNCTAD expanded the scope of this work by developing factsheets for all countries in the world. These data are available on the website of WHO and should support the implementation of Article 17 by providing information on tobacco production, consumption and trade. A video entitled *Alternative Livelihood for Tobacco Farmers in South-East Asia* was produced by the WHO Regional Office for South-East Asia and the World Lung Foundation. This was widely disseminated with support from the Convention Secretariat.

The Convention Secretariat is in the process of developing a comprehensive health-care protocol to monitor tobacco growers' health. This will be developed to guide action related to health-care management, as well as action to promote, protect and ensure surveillance of tobacco growers' health problems. A number of publications describing good

practices, instruments and measures to support the implementation of these policy options and recommendations can be accessed at the Implementation Database of the Convention Secretariat. The Convention Secretariat is developing, within the WHO FCTC information platform, a section on assistance to Parties with the objective to provide a coordination platform to bring together and strengthen collaboration between Parties, international, intergovernmental and nongovernmental organizations (IGOs and NGOs), and other organizations that provide or could provide resources and technical assistance (COP7).



Alternatives to tobacco growing are beneficial

The SEA Region is a big tobacco growing region. India and Indonesia are among the five largest tobacco growing countries in the world. Other countries which grow tobacco include Bangladesh, DPR Korea, Myanmar, Thailand and Sri Lanka. Tobacco growing provides livelihoods to millions of tobacco farmers and workers in the SEA Region. There is a consensus that helping small farmers switch from tobacco to alternative crops can be a useful part of sustainable local economic development programmes and can help overcome barriers to adopting and implementing strong tobacco control policies.

Implementing successful crop substitution and diversification programmes and supporting farmers' transition to alternate livelihoods require an understanding of the characteristics of tobacco-farming systems in producing countries and of the linkages between growers and tobacco companies (US NCI WHO 2016). The tobacco growers and workers may be involved in policy development and these policies should be protected from commercial and other vested interests of the tobacco industry. In addition, education and training programmes should be provided for farmers and workers, and every effort should be made to remove financial constraints for switching over to alternative livelihoods.



Alternative livelihoods to tobacco growing should be explored

One big challenge for alternative livelihoods is that tobacco farmers and vendors are globally being used as frontline groups by the tobacco industry to oppose the tobacco control policies and WHO FCTC. Tobacco farmers were used as a front group by the tobacco industry during the Seventh Session of the Conference of the Parties to WHO FCTC, held in November 2016 in India.

The need for diversification in the context of rural sustainable development and the implementation of rural extension projects, and training and research to create

new opportunities for income generation in tobacco-growing areas cannot be undermined. If tobacco growers and vendors are protected, they will not be used as front groups by the tobacco industry. Discussions on the health, environmental and developmental impacts of tobacco farming will help them understand and accept other economically viable alternatives. There are several examples of initiatives taken globally by various countries to promote alternatives to tobacco growing. Research conducted over the last five years or so further corroborates that a substantial shift by tobacco farmers to alternate crops is possible if evidence-based, structured initiatives in the desired direction are planned without any further delay (Kaur J. et al, 2014).

The WHO Regional Office for South-East Asia (SEARO) organized the Expert Group Consultation on Alternative Livelihoods for Tobacco farmers and Workers in New Delhi in July 2015. Global and regional success stories for implementing Article 17 in Bangladesh, Brazil, India, Indonesia, Kenya, Philippines, Thailand, and Uganda were brought into focus. SEARO also organized a Regional Intercountry Consultation on Alternative Livelihoods for Tobacco Farmers and Workers in Sri Lanka in March 2017. The consultation intended to move forward from evidence to action. Member States were represented by their ministries of agriculture and draft action plans to implement alternate livelihood options based on the existing evidence in their respective countries were prepared. Sri Lanka committed to completely shift all their tobacco farmers to alternative livelihoods by 2020.

The SEA Region has various examples of experimenting pilots for alternative livelihood options for tobacco farmers and workers. Case studies from Bangladesh and Indonesia are cited here.

Bangladesh's experience in shifting tobacco farmers to food production.

Bangladesh has policies to encourage the production of alternative crops. As part of its efforts to bring tobacco consumption to zero by 2040, the government has drafted a policy to inspire tobacco farmers to go for alternatives crops to tobacco. The goal of the policy is to protect public health, environment and food security through controlling the supply of tobacco by regulating tobacco cultivation; and to arrange alternate livelihoods for the tobacco farmers; and promote alternative crops.

A 10% duty is levied on export of raw tobacco to discourage cultivation.

The Bangladesh Bank has instructed all scheduled banks not to sanction loan for tobacco farming since 2010.

In 2015, the Agriculture Extension Department instructed its field officers not to promote tobacco cultivation any more. However, the enforcement of the instruction is sub-optimal. Sporadically field officers are supporting farmers to go for alternative crops to tobacco.

[WHO, Bangladesh]

Tobacco farmers shifting to alternative livelihoods in Indonesia

Indonesia is the fifth largest producer of tobacco in the world. Tobacco is produced largely in three provinces: East Java, Central Java and West Nusa Tenggara. Government policies, related to tobacco production and alternative crops, as stated in the Strategic Plan of the Ministry of Agriculture, as well as the Directorate-General of Plantation Strategic Plan for 2010–2014 and 2014–2019 are: (1) balancing between supply and demand, (2) introducing alternative crops, and (3) examining the diversification of tobacco products in addition to cigarettes, such as for pharmaceuticals or insecticides.

Farmers in the three tobacco growing provinces have been shifting from tobacco agriculture to alternative agriculture options. A research was conducted into the conditions of those who had made the shift and factors that influenced them to do so. This cross-sectional study was carried out in the three tobacco-growing provinces from June to July 2015, and enrolled 450 farmers by Muhammadiyah Tobacco Control Centre, Yogyakarta, Indonesia.

Some of the factors that influenced current tobacco farmers to keep growing tobacco were family traditions, tobacco industry pressure, profitability, and a belief that only tobacco could be grown on their land. Of these, 85% said that they also grew other crops such as vegetables and grains. The results suggested that tobacco farmers were looking for alternative means of livelihood. Among the ex-tobacco farmers, nearly 98% said they were very happy that they had shifted to other crops. Rice, vegetables and fruit were among the crops they were growing now. The most important factor that caused them to switch was the tobacco industry's monopoly in controlling market prices. A comparison of the monthly income between tobacco growers and ex-growers showed that tobacco farming is not profitable.

[WHO, Indonesia].

Suggested actions to accelerate implementation of Articles 17 and 18 of the WHO FCTC:

- The alternative livelihoods to tobacco growing could be mainstreamed into ongoing agriculture and related policies and programmes of the tobacco growing countries using the local policies, evidence and best practices. Multisectoral policies and actions are required to support alternative livelihoods. There is a need to create basic infrastructural facilities to support the tobacco farmers such as sustained supply of water for irrigation, markets, fertilizer availability, roads and transportation for shifting over to alternative crops.
- Agricultural universities could be engaged to provide technical support for the effective transfer of technologies related to alternative crops. The governments should provide farmers with soft loans, auction platforms and minimum support prices for alternative crops. Tobacco farmers who are willing to switch to alternative crops should be provided with technical assistance.
- Livelihood options other than agriculture such as animal husbandry, etc. may also be explored by the governments of tobacco growing countries.

C – Cessation

Article 14 of WHO FCTC – Demand reduction measures concerning tobacco dependence and cessation.

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.

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 interventions in 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.

Tobacco dependence is a chronic, relapsing disorder that often requires repeated interventions and multiple attempts to quit. Tobacco control policies, especially the demand reduction strategies such as increased taxation, anti-smoking media campaigns and comprehensive smoke-free policies, increase the demand for tobacco cessation services and thus the rates of subsequent cessation. Tobacco users make multiple attempts to quit over a lifetime, and governments can support these efforts by making cessation resources readily available to all tobacco users who need them.

A variety of behaviour therapies, ranging in complexity from simple advice offered by a physician or other health-care providers or much more extensive therapy offered by counsellors, have been shown to be efficacious for tobacco cessation. Research demonstrates the effectiveness and cost-effectiveness of interventions to promote and support cessation, including the use of pharmacological and behavioural treatments, promotion of cessation by health-care professionals, and integration of cessation treatments into health-care systems. The Five A's (Ask, Advise, Assess, Assist and Arrange) and Five R's (Relevance, Risk, Rewards, Repetitions, Roadblocks) are part of a counselling technique known as "Brief Advice", spanning a few minutes. This is a research-based counselling approach that has proven global success (WHO). Brief advice is a cost-effective tool for tobacco cessation and can be implemented in primary health-care settings for maximum outreach.



Nicotine patch is applied on the skin to help quit tobacco use

Medications available for tobacco cessation can broadly be divided into following two categories :

- (1) nicotine replacement therapy (NRT)
- (2) non-nicotine replacement therapy

Nicotine replacement therapy: Nicotine replacement therapy (NRT) is a method of substituting the nicotine in tobacco products by an approved nicotine delivery product so that the tobacco user does not have uncomfortable withdrawal symptoms upon stopping the tobacco product. The dose of NRT is monitored and gradually reduced to make the process of cessation comfortable for the tobacco user. As compared to blood levels of nicotine following tobacco smoke inhalation, NRT blood levels increase relatively slowly. Nicotine through tobacco smoke reaches the brain within a few seconds compared with medicinal nicotine which takes a few minutes to a few hours. Hence motivation and patience is essential for the user. All types of NRTs, such as nicotine patch, nicotine gum, nicotine inhaler, and nicotine nasal spray, have been shown to have more or less similar success rates. Better success rates are achieved when both counselling and NRTs are combined.



Nicotine gum is a popular form of NRT

Non-nicotine replacement therapy: In this type of therapy, medications; which act on the similar set of neurotransmitters that are affected by nicotine and provide effective and behavioural regulation, are used. This tackles the need, or impulse to use nicotine and to minimize withdrawal effects. First-line drugs include Bupropion and Varenicline. Some other anti-depressant drugs are also used to treat tobacco dependence.

Combination therapy: Combined behavioural and pharmacological therapies appear to be the best approach for treating tobacco dependence. Because these therapies operate by different mechanisms, complementary and potentially additive effects lead to increased quit rates. Nicotine replacement therapies (NRT) combined with supportive counselling are the most widely used and intensively reached treatment method. Although self-help strategies alone marginally affect quit rates, individual and combined pharmacotherapies and counselling either alone or in combination can significantly increase quitting among tobacco users.

Emerging low-cost technologies (mobile phones) and system-level interventions (using electronic health records to aid the identification of tobacco users, prompt clinicians to intervene and guide interventions via evidence-based treatment algorithms) can facilitate successful implementation of cessation treatment (US NCI WHO, 2016).

Article 14 is one of the least implemented articles in SEA Region countries. Recent progress includes Member States launching different initiatives to further tobacco cessation. India launched the mTobacco Cessation programme, using mobile technology for tobacco cessation with the support from the WHO-ITU Be Healthy Be Mobile Initiative. India and Indonesia launched national Quit Lines in 2016. Sri Lanka and Thailand also have Quit

Lines in place. Bhutan, India and Thailand have national tobacco dependence treatment guidelines to aid tobacco cessation. WHO supported Bangladesh to conduct training of trainers on use of brief advice for tobacco cessation in primary health-care settings and develop a network of trainers in 2016. DPR Korea undertook a KAP survey on smoking cessation in 2016. Thailand recently initiated a project to build capacity of oral health-care providers for tobacco cessation in collaboration with WHO. On the other hand, some of the SEA Region countries lack even the basic facilities for tobacco cessation.



Nicotine contained in tobacco is highly addictive substance

Suggested actions to accelerate implementation of Article 14 of the WHO FCTC :

- Countries should make efforts to build capacity for tobacco cessation using cost-effective strategies including integrating “Brief advice” in primary health care and using innovative technologies such as mCessation.
- Integrating tobacco cessation with other health programmes, for example NCD, maternal health, oral health and TB is another cost-effective option to gear up health-care systems for tobacco cessation.

T – TAPS (Tobacco Advertising Promotion and Sponsorship) ban

Article 13 of WHO FCTC – Tobacco advertising, promotion and sponsorship

Article 13 of the WHO FCTC requires Parties to undertake a comprehensive ban on all tobacco advertising, promotion and sponsorship; including a comprehensive ban on cross-border advertising, promotion and sponsorship originating from its territory.

The Parties are required to prohibit all forms of tobacco advertising, promotion and sponsorship that promote a product by any means, that are false, misleading or deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions. Also the Parties should restrict the use of direct or indirect incentives that encourage the purchase of tobacco products by the public.



Advertisement by tobacco industry

The tobacco industry employs a wide array of communication tools to market its products to the public, from mass media advertising, sponsorship, sales promotion and packaging to internet and new media strategies. Research shows that tobacco marketing and tobacco use are casually linked, and that comprehensive marketing bans are effective in reducing tobacco use (US NCI WHO, 2016).

The studies have shown that tobacco marketing and advertising influence the adolescent tobacco use behaviour in numerous ways. Along with direct advertising of tobacco products, there are numerous indirect ways of tobacco marketing including sponsorship, loyalty programmes, product sampling, promotional items or brand sharing, brand stretching, packaging, point of sale promotions and product placement in entertainment media. Research has shown that tobacco companies' sponsorship of sporting events, entertainment events, festivals, cultural venues and social causes, enhance brand awareness, reinforces brand image, and improves sales and/or market share (Dewhirst 2002, WHO 2013). The distribution of free samples of tobacco products is another form of sales promotion. Sampling tobacco teams often target venues and events such as bars, nightclubs, shopping malls, music concerts, festivals and their own sponsored events (Sepe et al 2002, WHO 2013).

Tobacco companies may create brand awareness and build brand imagery by using their brand name, logo, trademark or other distinctive feature (including colour combinations) on a promotional item such as branded lighters, T-shirts, baseball caps, key chains and badges. Such items may be distributed at the point of sale, at special events or through competitions. These indirect forms of marketing also promote tobacco use as shown by various research studies and recognized by the WHO FCTC, which defines tobacco advertising and promotions as “any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly” (WHO 2003).

The movies and other entertainment media portray the tobacco use habit as normal among youth and thus promote tobacco use among them. A systematic literature review conducted in 2015 identified exposure to tobacco use in films as a factor associated with increased risk of youth tobacco use (Wellman et al 2016). Guidelines for implementation of Article 13 of the WHO FCTC recognize that the depiction of tobacco use in movies is a form of promotion of tobacco use. The WHO publication “Smoke-Free Movies: From Evidence to Action” assists countries in understanding the basis for taking action to control and reduce the depiction of smoking in movies (WHO 2015).



Smoke-free movies: from evidence to action – 3rd edition (WHO, 2015)

Tobacco companies have now started internet marketing of tobacco products which has become an interactive, participatory and global venue for marketing and is accessible to potential consumers every day. This thus has a wide scope of reaching out to youth (Freeman 2012). Tobacco industry also uses internet marketing and promotion for ENDS/e-cigarettes.

Almost all SEA Region countries have enacted laws to ban tobacco advertising, sponsorship and promotion (TAPS). However, there are many loopholes in the existing



World No Tobacco Day theme 2013

laws. For example, India and Bangladesh tobacco control laws provide for point of sale advertisement of tobacco products. Thailand has very comprehensive TAPS ban in place. Enforcement of TAPS ban is a cause of concern in many SEA Region countries because of weak implementation of the laws.

WHO recommends comprehensive TAPS bans as a “best buy” measure to reduce tobacco use.

India – Regulating the depiction of tobacco usage in films and television

The Ministry of Health and Family Welfare of India has enacted rules to regulate depiction of tobacco products or their use in films and television programmes. The amended law mandates that all films and TV programmes produced on or after 2 October 2012, depicting tobacco products or their use, shall have:

- (1) A strong editorial justification explaining the necessity of the display of tobacco products or their use in films to the Central Board of Film Certification (CBFC)
- (2) Anti-tobacco health spots of minimum 30 seconds duration at the beginning and middle of a film/TV programme
- (3) Anti-tobacco ‘health warning’ as a prominent static message during the period of display of tobacco products or their use
- (4) Audio-visual ‘disclaimer’ on ill effects of tobacco use of minimum 20 seconds, at the beginning and middle of film/ TV programme.
- (5) The said Rules prohibit the following:
- (6) Display of brands of cigarettes or other tobacco products or any form of tobacco product placement.
- (7) Close ups of tobacco products and tobacco products packages.
- (8) Depiction of any tobacco products or their 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.

Implementation of the Tobacco Free Films policy has raised tremendous awareness among youth and the masses in India about the ill effects of tobacco use and second-hand smoke.

(WHO, India)

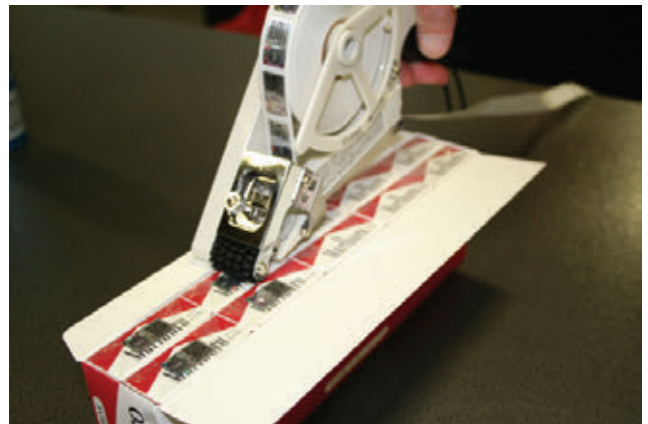
Suggested Actions to accelerate implementation of Article 13 of the WHO FCTC:

- Countries should enforce comprehensive TAPS ban as per the provisions under their existing laws.
- TAPS ban laws should comply with the requirement under Article 13 of the WHO FCTC.
- A watch should be kept on tobacco industry tactics to advertise, promote and sponsor their products in various ways including modern technology and social media in collaboration with partners and stakeholders including civil society.
- Keep an eye on indirect/surrogate advertisement of tobacco products by the industry.

11 – Illicit trade of tobacco

Article 15 of WHO FCTC – Illicit trade in tobacco products

Article 15 of the WHO FCTC obliges Parties to control illicit tobacco trade. During the second session of the Conference of Parties (COP) to the WHO FCTC in 2007, an intergovernmental negotiating body was established to draft and negotiate a protocol on illicit tobacco trade, which would use, build on, and complement Article 15. The protocol to eliminate the illicit trade in tobacco products was adopted at the fifth session of the COP in November 2012 and was opened for signature by the parties to the WHO FCTC on 10 January, 2013. Ratification, acceptance, approval, accession, or formal confirmation by 40 countries is required for the Protocol (Illicit Trade Protocol) to enter into force. As of March 2017, 26 countries have ratified the Protocol.



Hi-tech tax stamps help to curb illicit trade of tobacco

The Protocol obliges Parties to implement a tracking and tracing system for all tobacco products that are manufactured in or imported into a country. For example, Brazil and Turkey adopted high-tech tax stamps (with encrypted scannable codes) and related monitoring systems. Other countries such as Canada and Philippines also followed the same. In US also, several states have adopted high-tech tax stamps, licensing requirements and enforcement mechanisms that have yielded positive results. The Protocol also call for a licensing system and the exercise of due diligence by businesses as key measures for securing the supply chain in order to prevent counterfeiting and evasion of taxes on sales.

Circumventing taxes on tobacco products through illicit means (tax evasion) and through licit means (tax avoidance) undermines the effectiveness of tobacco control policies.

The large-scale smuggling of tobacco products is a particular threat as it has a greater impact on public health and national economies; and at the same time provides funds to support many illegal activities.

Internal tobacco industry documents reveal that the tobacco companies at the global level have facilitated smuggling of tobacco products. Illicit tobacco trade involves both genuine and counterfeit tobacco products. A legal tobacco company may not declare some of its products to tax authorities and divert them through illegal channels to domestic and international black markets. On the other hand, some illegitimate tobacco companies may produce counterfeit products and do not keep record of these products. Large tax



Tracking and tracing of tobacco products is a means for monitoring the illicit trade

differences between jurisdictions create incentives for tax avoidance (e.g. cross-border shopping) and tax evasion (e.g. bootlegging). These incentives diminish as the distance between jurisdictions increase.

Large scale illicit trade in tobacco products is easily conducted in countries with weak governance, high corruption, and lax administrative control. The illicit trade in tobacco products often co-exists with illicit trade in other products in environments where smuggling is easily tolerated by national governments and public at large.

Experience from countries have shown that illicit trade could be successfully addressed, despite increased tobacco taxes. Thus this does not compromise on tax revenues, rather increase them at the same time, along with increased public health concerns.

WHO has proposed that Parties could use posting bonds on cigarette shipments to hold tobacco exporters accountable for their exports. To secure the movement of tobacco products between excise regimes, an exporter would be required to put up a financial guarantee prior to export, and would forfeit the bond if the product fails to arrive at its declared destination with all its applicable taxes paid. If properly implemented, this measure would create an incentive for manufacturers to ensure legal distribution of their products; because they would assume a financial risk for products that end up as contraband. The existing guarantee system of European Community states, the community transit guarantee, may serve as a model for developing a global export bond regime (US NCI and WHO 2016). Lastly, global co-operation is required in all efforts to eliminate illicit trade in tobacco products.

Sri Lanka is the only SEA Region Member State which has ratified the Illicit Trade Protocol. Myanmar signed it but did not proceed for ratification.

Suggested actions to accelerate implementation of Article 15 of the WHO FCTC:

- All SEA Region countries should ratify the Protocol and initiate measures to stop illicit trade in tobacco products at the earliest.
- The SEA Region countries with common borders and having cross-border illicit trade of tobacco should collaborate and prepare common action plans to effectively deal with the matter.
- Countries should establish multi-stakeholder mechanisms to counter industry tactics promoting illicit trade of tobacco products.

12 – Industry interference

Article 5.3 of WHO FCTC – Protection from tobacco industry

Article 5.3 of the WHO FCTC requires that, “in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry. At its third session in November

Health over trade

“My fight for the health over trade issue dated back to the Forty second World Health Assembly and our group drew up a resolution advocating that trade sanctions should not be used to force a country to accept imported tobacco products.”

*[Dr Hatai Chitanondh, Thailand,
(President, Conference of the Parties
2007-08)]*

2008, the Conference of the Parties adopted guidelines for implementation of Article 5.3 of the WHO FCTC. The guidelines assist the Parties to meet their legal obligations to implement the provisions under Article 5.3. The purpose of the guidelines is to ensure that the efforts to protect tobacco control from commercial and vested interests of the tobacco industry are comprehensive and effective.

The tobacco industry interferes with tobacco control in several ways. The industry interferes with the national government efforts to implement tobacco control policies, programmes and laws. The industry has targeted new potentially trend-setting measures taken by the national governments such as Australia’s move to plain packaging. The first stage of tobacco industry lobbying occurred in the context of an Australian Preventative Health Task force report, which examined, among other things, Australia’s regulation of tobacco products. The taskforce, which was composed of expert public health practitioners, was lobbied by the tobacco industry, including on the lawfulness of plain packaging. The second phase of lobbying came when Plain Tobacco Packaging Bill 2009 was referred for a parliamentary inquiry and members of the public were permitted to make submissions. These submissions showed the way the tobacco industry rallies chambers of commerce and similar industry groups, libertarian-leaning think tanks, law firms, academics and associations of intellectual property lawyers in its defence. The submissions also illustrated how the industry uses legal arguments that are misleading and overwhelm public health policy-makers.

The industry exploits trade and investment agreements as a means of improving access to foreign markets for imported tobacco products. International investment agreements are generally used to gain improved access to markets in a way not possible from a company’s home country. The production of Philip Morris cigarettes in the Philippines by Philip Morris Philippines Manufacturing Inc (PMPMI) is an example of the way preferential trade agreements can be used to access foreign markets. The Philippines and Thailand are both members of ASEAN and participants in the ASEAN Free Trade Area (AFTA). Under the WTO agreement, Thailand is permitted to maintain tariffs on the importation of tobacco



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products, including cigarettes. Therefore, Thailand applies an ad valorem tariff of 60 per cent for cigarettes from the territory of WTO members. However, pursuant to some other agreements governing AFTA, Thailand charges no tariff on the importation of cigarettes from original AFTA members including Philippines and charges a 5 per cent ad valorem tariff on importation of cigarettes from new members. Thereby, cigarettes from Philippines are treated preferentially and thus also stimulate consumption in the country (US NCI and WHO 2016).

These agreements are also used for the purpose of creating staging points for international litigations. Tobacco companies use international trade and investment in attempts to resist domestic regulation. The industry argues that many tobacco control measures require the payment of compensation under international investment law.

Thus, governments face challenges in coordinating their public health policies with their trade and investment policies. Another challenge is policy coordination between the health community on one hand, and the trade and investment communities on the other. Health officials often have limited capacity to engage with trade and investment officials on questions of trade policy. Similarly trade or investment officials hardly have any training in public health which limits their capacity to foresee potential implications of their actions. These gaps were quite evident when some WTO members objected to tobacco control measures at the WTO, despite their support for the same measures in the WHO FCTC context. Thus policy coordination and legal capacity are increasingly important to meet these challenges.

An increasing number of Parties reported national workshops to inform government departments on their obligations under Article 5.3 of the Convention. In some cases, national consultations are followed by the elaboration of national guidelines on implementation of Article 5.3. The work mandated by the Conference of Parties (COP) analysing the impact of the WHO FCTC globally has also touched upon the impact of Article 5.3 implementation. Evidence shows that the Convention has facilitated global mobilization and exchanges among Parties and civil society, and highlighted the means by which the tobacco industry interferes

“Tactics aimed at undermining anti-tobacco campaigns, and subverting the WHO Framework Convention, are no longer covert or cloaked by an image of corporate social responsibility. They are out in the open and they are extremely aggressive.”

Dr Margaret Chan, keynote speech, 15th World Conference on Tobacco or Health, Singapore, 20 March 2012

with policy-making processes and how this harms tobacco control. Although the implementation of the Convention has not changed previously documented tactics to oppose tobacco control by the tobacco industry, it has, in fact, resulted in a change in the intensity of their use (for example, legal challenges to delay and weaken tobacco control measures), including additional new alliances and industry front groups in addition to those that already existed (WHO FCTC 2016).

The Union developed FCTC Article 5.3 toolkit to guide governments to safeguard laws and policies from the tobacco industry. The Convention Secretariat has initiated a project for the establishment of tobacco industry monitoring centres (observatories) in all BRICS countries. The Government of Brazil, in partnership with the Union launched the first observatory in Rio de Janeiro in March 2016. It will collect and analyse virtual documents on strategies and tactics of tobacco industry that undermine tobacco control policies and make the same available for use by the governments, legislators and decision-makers. Beyond the BRICS countries, Sri Lanka is in the process of establishing an observatory for Article 5.3.

Tobacco industry interference in tobacco control policies and programmes in SEA Region countries is rampant. The industry interference starts right from the stage of tobacco growing to production and sale of tobacco products. The industry consistently tries to undermine tobacco control efforts at the country level by preventing, weakening and delaying the treaty provisions. Many developed and developing countries have initiated measures to implement Article 5.3 of WHO FCTC. Nepal has imposed a complete media ban on any activities of the tobacco industry that are intended to promote tobacco use.

ASEAN publishes a report on the implementation of Article 5.3 on a regular basis to guide the countries against tobacco industry interference in tobacco control.

There is lack of awareness and access regarding the available guidelines, tools and resources to implement Article 5.3. This could be addressed by promoting these resources through knowledge hubs and additional electronic means of communication available with the countries.

Suggested actions to accelerate implementation of Article 5.3 of the WHO FCTC:

- Countries should be aware of the available tools and resources for implementation of Article 5.3 and enhance access to the same.
- The tools and resources should be widely shared and disseminated to all stakeholders.
- Intercountry collaborative mechanisms may be established to gain access to tobacco industry tactics and interference in the Region.

C – Campaigns

Article 12 of WHO FCTC – Education, communication, training and public awareness

Article 12 of WHO FCTC requires its Parties to promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Towards this end, each Party shall adopt and implement effective legislative, executive, administrative or other measures.

Anti-tobacco mass media campaigns involve the use of one or more forms of media (e.g. print, radio, billboards, television, social media) to inform the public about the health risks of tobacco, discourage tobacco use, promote anti-tobacco social norms and provide resources for cessation assistance. Campaigns also help in generating public support for various tobacco control policies such as smoke-free legislation and tobacco cessation. Evidence shows that anti-tobacco campaigns, when implemented as part of a comprehensive tobacco control programmes, discourage tobacco use in adults, prevent initiation among youth, and encourage adult cessation (NCI 2008). Mass media campaigns typically seek to prevent tobacco initiation or increase quit attempts by educating current and potential tobacco users and changing the attitudes and beliefs that contribute to tobacco use (Strasser et. al. 2009). The effect of anti-tobacco campaigns is greater when combined with school and/or community-based programmes. Messages targeted to disadvantaged persons and those meant for broader audiences have both demonstrated effects among disadvantaged populations and those with limited reach (Durkin et. al. 2012). It is very important to set the agenda for discussion in these campaigns and educate the audience about harmful effects of tobacco use.

Many SEA Region countries are implementing mass media anti-tobacco campaigns under national health programmes to raise awareness on harmful effects of tobacco on health, environment and economy. Such campaigns are largely supported by the national governments. However, some countries are not using this effective tobacco control strategy to reach out to masses. Evaluations of mass media anti-tobacco campaigns have found them to be very effective.



Bangladesh - Live long, don't smoke campaign

The Indian Ministry of Health and Family Welfare's (MoHFW) new outdoor campaign is set to reach a significant portion of the Indian population. With technical support from Vital Strategies (a partner of Bloomberg Initiative), MoHFW launched "Tobacco Tears You Apart," an anti-tobacco campaign that appears on the exterior

of trains on some of India's busiest major railway routes across eight states (Vital Strategies: <https://www.vitalstrategies.org/vital-stories/tobacco-kills-message-features-on-indias-trains>).

The campaign is one of the most geographically extensive health promotion campaigns to utilize the world's most heavily used railway network, which is used by over 10 million people every day. The campaign will also feature a Public Service Announcement (PSA) filmed in B. Barooah Cancer Institute in Guwahati, Assam and at the Tata Memorial Hospital in Mumbai, Maharashtra, which shows real victims suffering from horrific cancers and disfigurements as a result of their addiction to chewing tobacco. The railway ads could reach people who had not previously seen the campaigns on TV.



Campaign against smokeless tobacco use in India

For low- and middle-income countries, producing and implementing mass media campaigns could be expensive. Thus one successful strategy could be to adapt existing evidence-based anti-tobacco campaigns from other countries. For example, Australia's "Sponge" campaign has been adapted by 10 countries, including Bangladesh and India. The campaign graphically depicts the damage to the lungs by smoking, by showing tar squeezed from a lung like a sponge. Similarly, an Australian advertisement that depicts fatty deposits being squeezed out of an artery has been adapted by over 40 countries (US NCI and WHO 2016).

The smokeless-tobacco campaign in India used testimonials from a surgeon and patients at Tata Memorial Hospital in Mumbai. The communication message approach was designed to reflect the realities of disfiguring, disabling, and fatal cancers caused by smokeless tobacco. Evaluation of the campaign identified significant differences across a range of campaign behavioural predictors by audience segments aware of the campaign versus those who were "campaign unaware" (Turk et. al. 2012).

Indonesia has also launched anti-tobacco mass media campaigns from time to time. In 2015, a national anti-tobacco campaign graphically showing the real health harms of exposure to second-hand smoke from the point of view of a woman was launched by the Ministry of Health in Jakarta.

Suggested actions to accelerate implementation of Articles 12 of the WHO FCTC:

- Countries should implement mass media campaigns as part of national health programmes to reach out to masses.
- Evidence-based and tested campaign material should be used as relevant to the local situation.
- Earmarked tobacco taxes may be used by the national governments to fund such campaigns.

A – Access to tobacco by minors

Article 16 of WHO FCTC – Sales to and by minors

Article 16 of the WHO FCTC requires its Parties to adopt and implement effective legislative, executive, administrative or other measures at the appropriate government level to prohibit the sales of tobacco products to persons under the age set by domestic law / national law or 18 years of age. These measures may include:

- (1) Requiring that all sellers of tobacco products place a clear and prominent indicator inside their point of sale about the prohibition of tobacco sales to minors and, in case of doubt, request that each tobacco purchaser provide appropriate evidence of having reached full legal age;
- (2) Banning the sale of tobacco products in any manner by which they are directly accessible, such as store shelves;
- (3) Prohibiting the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products which appeal to minors; and
- (4) Ensuring the tobacco vending machines are not accessible to minors and do not promote the sale of tobacco products to minors. The countries may implement a total ban on tobacco vending machines.

Youth access policies are intended to limit the commercial supply of tobacco products to youth, with the goals of preventing or delaying initiation of tobacco use by youth and reducing underage consumption, changing social norms about tobacco use and decreasing overall prevalence of tobacco use. A variety of policy measures are available to regulate the sale and distribution of tobacco products to youth. Sufficient resources are needed to implement and enforce these policies well enough to limit youth access to commercial

sources of tobacco.

Tobacco use among youth is among the highest in several SEA Region countries. Almost all SEA Region countries have formulated laws/legislation to prohibit sale of tobacco to and by minors.

Bangladesh, DPR Korea, India, Indonesia, Maldives, Myanmar and Nepal prohibit



Board for display at point of sale in India

sale of tobacco to and by minors (up to 18 years of age). Sri Lanka has prohibition on the sale of any tobacco product to persons under 21 years of age. In the recently enacted Tobacco Products Control Act of Thailand (2017), the age of prohibition for sale to and by minors is raised to 20 years. Sales to and by minors (under 17 years) is prohibited in the selected places in Timor-Leste under the law.

Suggested actions to accelerate implementation of Article 16 of the WHO FCTC:

- Countries should strictly enforce laws to prohibit access of tobacco products by minors.
- Countries should take measures to implement “best buys” including smoke-free policies, TAPS ban, health warnings and raising taxes/price of tobacco products to create overall reduction in demand of tobacco.
- Countries should also endeavour to prohibit the sale of tobacco products in small packets or single units which makes them cheap and increases the affordability of such products to minors.
- Countries should implement school-based programmes to raise awareness about harmful effects of tobacco on health, environment and the economy.

L – Liability

Article 16 of WHO FCTC – Sales to and by minors

Article 19 of the WHO FCTC mandates the following:

- (1) For the purpose of tobacco control, the Parties shall consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate.

At Seventh Session of the Conference of the Parties (COP 7) in November 2016, Parties adopted the report from the expert group on liability, which included the development of a toolkit to help Parties implement Article 19, on civil liability. The design and approach of the toolkit envisaged by the expert group has two main parts. The first part of the toolkit consists of three scenarios through which Parties might wish to use their civil liability mechanisms to hold the industry to account, and that are presented here in the form of diagrams and key questions to be asked as well as litigation and reform options that might be chosen on that basis. The second part consists of an index of procedural reforms common to all scenarios identified in this report, which might strengthen civil liability mechanisms based on best practices from around the world. The toolkit is intended to guide Parties to the specific information that they may be seeking, which is contained in the expert group's report to COP6 and other resources. As a future development, the toolkit will contain electronic links to specific sources of assistance available to Parties including technical support, information gathered in accordance with Article 21, international cooperation in accordance with Article 22, and experiences collected over time by the Convention Secretariat (WHO FCTC 2016).

The following are the examples of legal regimes that have been used in respect of civil and criminal litigation against the tobacco industry by different parties:

- (1) Civil codes and civil liability regimes
- (2) Constitutions
- (3) Tobacco-control laws
- (4) Consumer protection law
- (5) Medical services and medical insurance legislation
- (6) Tobacco damages and health-care costs recovery legislation
- (7) Advertising and labelling laws and product advertising regulations
- (8) Customs and excise legislation
- (9) Racketeering and corruption legislation

- (10) Labour laws
- (11) Trade practices legislation.

Suggested actions to accelerate implementation of Article 19 of the WHO FCTC:

- Countries are encouraged to consider options, including developing their own legislation or liability procedures to recover health-care costs caused by treating victims of tobacco.
- Countries should get access to the toolkit for effective implementation of Article 19 of the WHO FCTC.
- Countries should build capacity for evidence generation and use against the tobacco industry.
- Countries should raise awareness regarding provisions and resources available to implement Article 19.

“Tobacco control cannot succeed solely through the efforts of individual governments, national nongovernmental organizations and media advocates. We need an international response to an international problem.”

Dr Gro Harlem Brundtland (Former WHO Director-General).

Conclusion

SEA Region Member States should accelerate implementation of WHO FCTC by adopting “PRACTICAL Approach” to control the tobacco epidemic in order to protect their citizens from the harms of tobacco use, and to reduce its economic and environmental impact on national economies. Countries have progressed in implementing MPOWER and have achieved various milestones. In the context of achieving voluntary targets under the NCD Action Plan and Monitoring Framework, the time is ripe to enhance and expand existing tobacco control policies and programmes by investing necessary resources. With the WHO FCTC being an implementation target as part of the UN 2030 Sustainable Development Agenda, it becomes imperative to achieve full implementation of the Treaty for effective tobacco control in the Member States of WHO South-East Asia Region.

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The WHO Framework Convention on Tobacco Control (WHO FCTC) is an evidence-based treaty that reaffirms the right of all people to the highest standard of health and was developed in response to the globalization of the tobacco epidemic.

Member States of the WHO South-East Asia Region have made attempts to implement the demand and supply reduction strategies for tobacco control as recommended by the treaty. Countries are at different levels of achievement of tobacco control policies and programmes.

While recognizing the need to accelerate implementation of the WHO FCTC in the Region, this document has been developed to support the Member States in implementing the treaty using a 'PRACTICAL' Approach which pertains to identified demand and supply reduction strategies under the treaty. Effective tobacco control is a priority to curb the epidemic of tobacco in the Region.

