

Regional Strategy for Tobacco Control

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CONTENTS

	<i>Page</i>
1. BACKGROUND	1
2. GOALS	4
3. GENERAL OBJECTIVES	4
4. SPECIFIC OBJECTIVES	4
5. FUNDAMENTAL PRINCIPLES.....	5
6. TARGETS.....	6
7. STRATEGIES	7
7.1 Establishment of a National Tobacco Control Committee, Formulation of a National Tobacco Control Policy and a Plan of Action and Enforcement of Legislation.....	7
7.2 Setting Appropriate Price and Tax Policies	8
7.3 Protection from Exposure to Second Hand Smoke.....	9
7.4 Prohibition of all forms of Advertisement, Promotion and Sponsorship	10
7.5 Education, Communication, Training and Public Awareness	11
7.6 Promotion of Cessation of Tobacco Use and Adequate Treatment for Tobacco Dependence	12
7.7 Ban on Sale of Tobacco Products to and by Minors	12
7.8 Support for Laboratory analysis of Tobacco Products for Tobacco Product Regulation and Disclosure	14
7.9 Packaging and Labeling of Tobacco Products	14
7.10 Research, Surveillance and Exchange of Information.....	15
7.11 Control of Illicit Trade in Tobacco Products	16
7.12 Partnership Building for Tobacco Control.....	17
7.13 Identification and Mobilization of Financial Resources.....	18

1. BACKGROUND

Tobacco is currently the second major cause of death in the world. Already tobacco kills one in ten persons globally, accounting for approximately 5 million deaths per year. This figure is expected to rise to 10 million annual deaths by 2030, with 70% of their deaths occurring in low-income countries. In the next century, deaths from other diseases are likely to continue to decrease; whereas due to the increase in smoking prevalence, there will be catastrophic effects of tobacco¹. Tobacco will account for more deaths than the total deaths from malaria, maternal conditions and injuries combined. Peto and Lopez estimated that about 100 million people were killed by tobacco in the 20th century and the cumulative number would be 1.3 billion if current smokers continue².

Home to one quarter of the world's population and undergoing significant demographic and socioeconomic changes, the WHO South-East Asia Region is a lucrative market for the tobacco industry. The Region has been made a fertile ground for the tobacco habit and a possible scene of tobacco-related morbidity and mortality explosion by the turn of the century.³ It has been estimated that there are approximately 1.1 million deaths in the Region attributable to tobacco in the year 2000⁴.

Tobacco consumption in the Region is increasing rapidly, especially among the youth and the poor. The current consumption rates range from 25.7% to 59.6% for men, and although female smoking prevalence was considered to be low (1.7% to 6.7%) except in Nepal (29%), Bangladesh (21%), Myanmar (21%) and Maldives (15%), recent prevalence reports from countries like India and Bangladesh show an increasing prevalence among females⁵.

Indonesia, Thailand and India were among the world's largest cigarette consumers in 1994 accounting for 5.7% of the world's total. Indonesia is ranked as having the fifth largest number of smokers in the world, while India and Thailand are estimated to have approximately 240 million and 11 million tobacco users. Although India ranked only 14th for consumption of manufactured cigarettes, if the estimated amount of *bidis* consumed is added, India ranks second globally in total cigarettes/*bidis* consumption³. In

Bangladesh, there are an estimated 20 million smokers, 5 million of them women⁷. Smokeless tobacco use also remains high in India, Bangladesh, Myanmar and Nepal although it is very low in Thailand and Sri Lanka except in certain regions⁸.

A considerable amount of tobacco was produced in the Region. Tobacco production in India, Indonesia, Bangladesh, Thailand and DPR Korea were among the world's 25 leading producers of tobacco and ranked 3rd, 7th, 18th and 21st respectively in 1994. India accounted for 65% of the Region's total tobacco leaf production in 1990-91 which increased to 71% in 1998-1999. Indonesia continues to be the largest producer of cigarettes in the Region, followed by India, Thailand and Bangladesh³.

The tobacco consumption scenario in the Region is very different from others in its complexity. There is great variation in the pattern and mode of tobacco use, both in smoking and smokeless forms, such as cheroots, kreteks, pan, panmasala, betel quid with tobacco, gutka etc.

Tobacco-related illnesses such as cancer and cardiovascular and respiratory diseases are already major problems in most countries in the Region. Tobacco-related cancers account for about half of all cancers among men and one fourth among women. Approximately half of all cancers in men in India are tobacco-related, while over 60% of those suffering from heart disease below the age of 40 are smokers. Due to a very high prevalence of smokeless tobacco use in various forms, India has one of the highest incidences of oral cancers in the world³. In Sri Lanka, it is estimated that over 43% reported cases of cancers are tobacco-related. Oral carcinoma is also the most prevalent form of cancer in Sri Lanka and cardiovascular diseases is the leading cause of death. Thailand reports 10 000 cases of tobacco-related lung cancer each year⁴.

In India, it has been estimated that about 30% of male deaths in middle age are attributable to smoking⁵. It was estimated that smoking causes about 700 000 deaths per year⁹. In Indonesia, in 2001, 21% of all deaths were attributable to tobacco, and is expected to rise dramatically within the next few decades. According to a report by the Ministry of Health, the estimated number of mortality cases attributable to tobacco use in 2001 was 412 964 - 211 271 males and 201 693 females¹⁰. In Bangladesh, tobacco is responsible for a significant proportion of all cancers. Smoking had also been identified as one of the most important factors contributing to a high prevalence of chronic bronchitis (33.9% among men and 28.3% among women) and chronic obstructive airway disease in Nepal⁴.

Tobacco poses a major challenge not only to health, but also to social and economic development and to environmental sustainability. Tobacco use is a major drain on the national financial resources.

Recognizing the enormous premature mortality caused by tobacco use and adverse effects of tobacco on social, economic and environmental aspects, Member States of the World Health Organization at the World Health Assembly in May 1996, decided to initiate the development of a binding international instrument on tobacco control (WHA49.17). In May 1999, the World Health Assembly, the governing body of the World Health Organization, adopted a resolution (WHA52.18) that paved the way for starting multilateral negotiations on the WHO Framework Convention on Tobacco Control (FCTC) and possible related protocols. The WHO FCTC was unanimously adopted by the Fifty-Sixth World Health Assembly in May 2003 following almost three years of negotiations. A total of 168 countries and the European Community had signed FCTC and 48 countries became Contracting Parties to the Convention (as of December, 2004), making it one of the most rapidly embraced UN treaties of all time. The FCTC entered into force and became part of international law on 27 of February 2005.

Member States of the South-East Asia Region have shown their strong commitment towards tobacco control. Ten out of eleven countries have signed the Framework Convention on Tobacco Control and nine countries have ratified it.

Based on the provisions of FCTC, this regional strategy aims to develop a framework for comprehensive tobacco control in the Region. Parties to the Convention are legally bound to implement the provisions of the treaty. On the other hand, non-party Member States would also require effective tobacco control programmes to protect their population from the tobacco epidemic. This strategy will be useful for such Member States too.

The regional strategy contains the vision and strategic plan for tobacco control in the WHO South-East Asia Region for the next five years (2006-2010). While the Convention provides guidelines to reduce the harm from tobacco, definitive actions to control tobacco have to take place at country level. The successful implementation of FCTC provisions depends almost entirely on the ability of the countries to implement and enforce its provisions. Although it is recognized that Member States, when applicable, will have to adopt different sets of measures based on their needs and resources,

international evidence shows that, in order to be effective, national tobacco control policies should be comprehensive enough to cover all major aspects of the demand for and supply of tobacco products.

2. GOALS

The goal of the strategy is to improve health and well-being, increase productivity, decrease poverty and stimulate social and economic development in the Region through sustained reduction in tobacco use and tobacco-related harm among the population.

3. GENERAL OBJECTIVES

The general objective is to provide a regional strategic framework for the WHO South-East Asia Region for implementing national tobacco control measures which are comprehensive, sustainable and accountable.

The provisions of the WHO Framework Convention on Tobacco Control should be appropriately reflected in the national policy and plans of actions and legislation in order to reduce tobacco uptake and consumption, promote cessation of tobacco use, protect non-smokers from environmental tobacco smoke and protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

4. SPECIFIC OBJECTIVES

The South-East Asia Regional Strategy on Tobacco Control aims at providing support to Member States in:

- (1) formulating, promoting and implementing a national policy and a plan of action for tobacco control;
- (2) developing, enacting, promulgating, implementing and enforcing comprehensive national tobacco control legislation, as appropriate, in all countries in line with WHO FCTC;
- (3) enhancing awareness on the dangers of tobacco use by enhancing education, training, communication and advocacy through wider media coverage including counter-marketing so as to prevent initiation and to promote cessation of tobacco use;

- (4) protecting non-smokers from exposure to second hand smoke by taking measures to designate smoke-free places including health and education facilities, work places, public places and public transport;
- (5) banning all forms of tobacco advertisement, promotion and sponsorship;
- (6) establishing appropriate tax and price measures aimed at minimizing tobacco consumption;
- (7) strengthening and updating on a regular basis the regional online database on tobacco control measures and interventions.
- (8) strengthening inter-agency collaboration and partnership at country and regional levels for tobacco control interventions.

5. FUNDAMENTAL PRINCIPLES

The Regional Strategy on Tobacco Control is based on the following principles:

- (1) Tobacco control strategies should be evidence-based and sufficiently flexible to allow incorporation of new evidence as and when available.
- (2) Tobacco control policies shall be protected from commercial and other vested interests of the tobacco industry.
- (3) Tobacco control activities should be anti-smoking and anti-tobacco use but neither anti-smoker nor anti-tobacco user.
- (4) Tobacco control activities should promote non-smoking and non-tobacco use as the social norm.
- (5) Citizens of all Member States have the right to receive adequate and correct information regarding health, social and economic hazards of tobacco and effective tobacco control measures.
- (6) Consumers have a fundamental right to consumption of safe products and the right to relevant information.
- (7) All smokers and tobacco users would receive support for tobacco cessation.
- (8) All non-smokers, especially children, have the right not to be exposed to second hand smoke.
- (9) Clear target groups (high-risk and hard to access) would be identified, such as adolescents, out-of-school youth, women, low-income and less educated groups. Tobacco control strategies should target these

populations as well as populations with the highest prevalence of smoking/tobacco use and diseases attributable to tobacco.

- (10) Community interventions for protecting the youth, enforcement of smoke-free places and strengthening health literacy should be enhanced.
- (11) Strong political commitment towards tobacco control should be evident in the nature of forming multisectoral committees for tobacco control, designation of national and regional tobacco control focal points and allocation of specific and adequate funds for tobacco control programmes.
- (12) Countries should set up their own mechanisms to mobilize funds for tobacco control activities.
- (13) WHO would support countries in identifying sources of funding and mobilize resources to sustain national tobacco control programmes.
- (14) Tobacco control programmes and interventions should be partnered with relevant health and non-health programmes.
- (15) Inter-agency collaboration and partnership at regional level would be promoted for tobacco control interventions.
- (16) Tobacco control interventions in low-income and less educated groups should be delivered as part of broader national poverty alleviation measures.

6. TARGETS

- (1) To have comprehensive, sustainable and accountable national and sub-national policies and strategies for tobacco control in all countries within a time-frame to be determined by WHO in consultation with Member States.
- (2) To have a comprehensive ban on all forms of tobacco advertisement, promotion and sponsorship within a time-frame to be determined by WHO in consultation with Member States.
- (3) To have limitation of access to tobacco products by minors in all countries within a time-frame to be determined by WHO in consultation with Member States.
- (4) To have all health and education facilities, workplaces, public places and public transport in the Region to be tobacco-free within a time-frame to be determined by WHO in consultation with Member States.

- (5) To establish on-line database for tobacco surveillance and to establish TFI web sites in all countries within a time-frame to be determined by WHO in consultation with Member States.
- (6) To have clear, visible and rotating health warning labels on all manufactured cigarettes and cigarette packages manufactured in and imported into the Region within a time-frame to be determined by WHO in consultation with Member States. Effects will also be made to bring other tobacco products under health warning.
- (7) To have national tobacco legislation in all countries of the Region within a time-frame to be determined by WHO in consultation with Member States.
- (8) To establish national laboratories in one or two countries of the Region for testing tobacco products and to measure the yields of toxic constituents from tobacco product emissions.
- (9) To show a decrease in per capita tobacco consumption of at least 1% by the end of 2010.

7. STRATEGIES

7.1 Establishment of a National Tobacco Control Committee, Formulation of a National Tobacco Control Policy and a Plan of Action and Enforcement of Legislation

- (1) Strong political commitment is crucial to combat the tobacco epidemic. A high-level national tobacco control committee should be established in all countries with the health sector taking the leading role. It should be multisectoral and include government departments and agencies such as foreign affairs, trade, finance, education, agriculture, information, home affairs, legal and justice, industry and enterprises responsible for licensing and data collection on tobacco production, development affairs etc. It should also include NGOs such as health professional societies, health charities, women and child health societies, academic institutions and religious groups. Representatives from media groups should also be its members. The role of this committee is to address tobacco control issues at national level as well as cross-border issues. Existing committees should be reviewed and strengthened to address FCTC issues. Sub-committees will be necessary in specific areas such as legislation, communication, education and information, research etc. Sub-national committees should also be formed at provincial/district levels.

- (2) All countries should have a clearly-stated, comprehensive, accountable and sustainable national tobacco control policy and a plan of action. Existing plans and policies should be reviewed and amended, as appropriate, to reflect the provisions of FCTC.
- (3) Countries should establish a "tobacco control cell" with a designated national focal point for tobacco control in the ministry of health as well as focal persons at various decentralized levels. There should be specific and adequate manpower, time and funds allocated for implementing tobacco control activities.
- (4) *SWOT* (Strengths, Weaknesses, Opportunities and Threats) analysis should be performed in all countries to find the current situation of tobacco control measures. Challenges and opportunities should be identified and measures explored to meet and overcome challenges. Mechanisms to monitor change should also be clearly stated in the national plan of action.
- (5) By the end of 2010, all countries should have comprehensive tobacco control legislation in line with FCTC. After enactment, legislation should be promulgated to achieve awareness among the authorities and the public for enforcement.
- (6) The national tobacco control committee should advocate for fiscal measures and significant allocation of government revenue, including those from tobacco taxes, to fund national tobacco control programmes.
- (7) Provisions of WHO FCTC should be translated into the local language and widely disseminated in order to educate and empower the public and to create awareness about their respective rights and obligations under the treaty.

7.2 Setting Appropriate Price and Tax Policies

- (1) *Tax increase* is the single most effective intervention to reduce the demand for tobacco. Numerous studies indicate that higher tobacco prices significantly and consistently reduce tobacco use as price increases encourage people to stop smoking, prevent others from starting in the first place and reduce the number of ex-smokers who resume the habit¹¹. Even relatively modest increases in taxes would generate significant health benefits^{5,11}. A price increase of 10% would reduce consumption by 4% in high-income countries and by about 8% in low and middle-income countries, as lower income tend to make

people more responsive to price changes. Children and adolescents are also more responsive to price rises than older adults, so this intervention would have a significant impact on them. Evidence indicates that young people, people with low income and those with less education are more responsive to price changes^{5,12}. It was estimated that a 25% price increase yields a 7-13% decrease with effects increasing over time¹².

- (2) Member States should implement appropriate tax policies and, where appropriate, price policies on tobacco products. A tobacco price policy should aim to bring about an increase in the real price of tobacco products that is greater than the effects of inflation. The World Bank recommended that policy-makers who seek to reduce smoking should use as a yardstick tax levels adopted as part of comprehensive tobacco control policies. Tax rates should be periodically reviewed and amended for increase.
- (3) It has been estimated that a modest increase in cigarette excise tax of 10% would increase tobacco tax revenues by about 7% overall with effects varying by country. A proportion of the tobacco revenue should be used for tobacco control programmes; tobacco tax increases that are earmarked for anti-tobacco media campaigns, prevention programmes, subsidization of tobacco cessation products and programmes and other activities to reduce tobacco use, generate even larger reduction in tobacco use and improvement in health than the tax increase alone¹¹.
- (4) Given the widespread use of oral tobacco and smoking tobacco products other than manufactured cigarettes in the Region, measures to bring all the tobacco products under tax and price measures should be sought, in order to avoid substitution of one tobacco product by another.

7.3 Protection From Exposure to Second Hand Smoke

- (1) The accumulation of scientific evidence which shows that involuntary exposure to second hand smoke causes death, disease and disability, emphasizes the need for stronger regulation to protect non-smokers, especially children from exposure to tobacco smoke. Prohibition of smoking at public places and workplaces not only protect non-smokers but also create an environment that encourages smokers to cut back or quit. Regulation also contributes to altering the social perception of smoking behaviour that was commonly accepted before, and

deglamourize smoking. Strong public support for regulation throughout the Region, not only from non-smokers, but also from a majority of smokers, can encourage countries to introduce or strengthen legislation or other relevant measures¹⁴. The ban on smoking in public places must be strict; this requires publicity and government enforcement. Efforts should be made to make it a social norm.

- (2) Strategic national actions on protecting from exposure to tobacco smoke should include:
 - (a) introducing or strengthening legislation to make all public places smoke-free, including public transport and workplaces;
 - (b) banning smoking in all health institutions and their premises;
 - (c) banning smoking indoors and outdoors in all educational institutions and their premises; libraries, nurseries, day care centres etc. and
 - (d) restricting smoking in restaurants and bars, shopping malls, escalators, elevators etc.

7.4 Prohibition of all Forms of Advertisement, Promotion and Sponsorship

- (1) Empirical evidence shows that a comprehensive ban on advertising of tobacco covering all media and all forms of direct and indirect advertising contributes to a reduction of tobacco consumption. It also reduces the social desirability of smoking, particularly among young people. According to the World Bank, such a comprehensive ban can reduce the consumption of tobacco products by around 7%¹⁴.
- (2) Strategic national actions for prohibition of tobacco advertisement, promotion and sponsorship should include:
 - (a) a ban on all forms of direct and indirect advertising of tobacco products from all electronic media, print media, folk media and other media, such as the internet. Research studies have shown that partial ban and voluntary agreement do not work.
 - (b) a ban on promotion, brand stretching and sponsorship of sports, education and social events including international events, activities and/or participation therein.
 - (c) a comprehensive ban/restriction on cross-border advertising, promotion and sponsorship originating from its territory, subject to the legal environment and the technical means available to the

country. Member States should cooperate in the development of technologies and other means necessary to facilitate the elimination of cross-border advertising.

- (d) restrictions on the use of direct or indirect incentives that encourage production and purchase of tobacco products.

7.5 Education, Communication, Training and Public Awareness

- (1) Evidence suggests that continuous and intensive information and education programmes on hazards of tobacco and on tobacco control measures proved to be effective instruments for increasing political acceptance of policy measures. All countries should promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate.
- (2) Successful development and implementation of tobacco control policies should be ensured through a comprehensive information and training strategy which should include:
 - (a) advocacy to policy-makers at various levels with emphasis on specific obligations of FCTC;
 - (b) provision of relevant and adequate health education and information to the community through wide media coverage, ensuring that the general public including children, young people and vulnerable groups are fully informed about health risks, addictiveness, social and economic costs of tobacco consumption and exposure to tobacco smoke, and about the benefits of cessation and tobacco-free styles;
 - (c) facilitating and strengthening education, training and public awareness campaigns, including counter-marketing with special attention paid to not involving the tobacco industry in information campaigns;
 - (d) developing and implementing effective and appropriate basic curricula and training programmes on tobacco control for policy-makers, health professionals, students, educators, media personnel and other relevant persons; integration of tobacco control approaches into health and education curricula; strengthening of existing health education communication mechanisms for dissemination of tobacco control information.

7.6 Promotion of Cessation of Tobacco Use and Adequate Treatment for Tobacco Dependence

- (1) Individual attempts to quit have very low success rates; evidence shows that advice and behavioural support are effective in motivating smokers to quit. Low-cost, community-based interventions where no clinics or pharmaceuticals are used, have shown promises in several countries. Pilot projects on community-based cessation programmes in the Region have proved to be effective to a certain extent and should be appropriately replicated on a wider scale in all countries since they could be implemented with little expense and could also induce changes and images in the community towards tobacco use.
- (2) Countries should develop and disseminate appropriate, comprehensive and integrated guidelines on cessation of tobacco use, based on scientific evidence and best practices. Effective programmes should be designed and implemented in educational and health institutions, health care facilities, workplaces and sporting environments.
- (3) Diagnosis and treatment of tobacco dependence and counselling services on cessation of tobacco should be included in national health and education programmes, plans and strategies.
- (4) The use of nicotine replacement therapies (NRT) has been proved to increase the rate of success of tobacco cessation. Nicotine replacement treatments and other pharmacological aids to quitting can roughly double the chance that an individual will successfully quit¹⁵. However, studies on NRT in the Region show very low levels of long-term success (or a high rate of relapse). The widespread use of nicotine replacement is presently limited by several factors, including high retail prices and complex regulatory issues¹⁶. Mechanisms should be sought among countries and through affiliation with Parties to the Convention to facilitate accessibility and affordability for treatment of tobacco dependence including pharmaceutical products.

7.7 Ban on Sale of Tobacco Products to and by Minors

- (1) Research studies show that nowadays an overwhelming majority of smokers start smoking before age 25, often in childhood or adolescence. In high-income countries, 8 out of 10 smokers begin in their teens; in middle and low-income countries most smokers start by the early twenties, but the trend is towards younger age. Individuals who start at a

young age are likely to become heavy smokers, and are also at increased risk of dying from smoking initiated in later life⁴.

- (2) Anti-tobacco campaigns should target youth, both in school and out of school. Child-to-child education programmes and peer group education programmes have proved effective.
- (3) All Member States shall adopt and implement effective legislative, executive, administrative and other measures to ban the sale of tobacco products to persons under the age set by national law or eighteen, whichever is lower. Youth access laws are most effective when administered in a comprehensive manner. These measures should include the following:
 - (a) Requiring all sellers of tobacco products to place a clear and prominent indicator inside their point of sale about prohibition of sales to minors;
 - (b) Requiring all sellers of tobacco products, in case of doubt, to request young buyers to provide appropriate evidence of having reached the age of majority as determined by domestic law;
 - (c) Ban the sale of tobacco products in any manner by which they are directly accessible, such as store shelves, vending machines, self-service displays, mail order and electronic sales;
 - (d) Ban the distribution of free sample of tobacco products to minors and the general public;
 - (e) Ban the sale of cigarettes and other smoking tobacco products individually or in small packets which increase the affordability of such products to minors and to low-income groups;
 - (f) Ban the manufacture and sale of sweets, snacks, toys, tooth paste, tooth powder or any other objects in the form of tobacco products which appeal to minors;
 - (g) Imposing penalties (such as graduated fines) against sellers and distributors, in order to ensure compliance with the regulations.
- (4) All countries shall adopt and implement effective measures to prohibit the sale of tobacco products by persons under the age set by national law or eighteen, whichever is lower.
- (5) Since the majority of parents including smokers do not want their children to smoke, campaigns to enforce legislation and educate retailers can reduce illegal sales to minors.

7.8 Support for Laboratory Analysis of Tobacco Products for Tobacco Product Regulation and Disclosure

- (1) Countries shall adopt and implement measures for testing and measuring contents of tobacco products and emissions from tobacco smoke; they should also implement measures to disclose to governmental authorities and the public information about the contents and emissions of tobacco products.
- (2) Laboratory facilities required for this are expensive. Sophisticated technical expertise is also required. WHO has undertaken a regional situational analysis of existing laboratory testing facilities for tobacco products in the Region and would provide technical support for the establishment of new facilities in one or two countries and upgrading of the existing ones so as to comply with the provisions of FCTC.

7.9 Packaging and Labeling of Tobacco Products

- (1) Mandated labels on tobacco products inform smokers of the hazards of smoking and encourage smokers to quit and discourage non-smokers from starting to smoke. Evidence shows that health warnings are effective only if they contain multiple, strong and direct messages that are prominently displayed. Large warnings increase public awareness on the health effects of smoking and make cigarette packs less attractive to the youth. FCTC provisions state that each unit packet and package of tobacco products and any outside packaging and labelling of such products should carry health warnings and messages which:
 - (a) shall be approved by the competent national authority;
 - (b) shall be rotating;
 - (c) shall be large, clear, visible and legible;
 - (d) should be 50% or more of the principal display areas but shall be no less than 30% of the principle display areas;
 - (e) may be in the form of or include pictures or pictograms.
- (2) All health warnings and product information displayed on each packet or package or any outside packaging should appear in the principal language or languages of Member States.
- (3) Member States should implement effective legislative, executive, administrative and other measures to ensure that tobacco product packaging and labelling do not promote a tobacco product by any

means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards of emissions, including any term, descriptor, trade mark, figurative or any other sign that directly or indirectly creates the false impression that a particular tobacco product is less harmful than other tobacco products.

7.10 Research, Surveillance and Exchange of Information

- (1) Tobacco surveillance should be included by countries as an activity in their WHO biennial workplan.
- (2) Sentinel prevalence surveys with nationally representative sample of population should be conducted regularly, preferably once every two years, using standardized methods. WHO should explore measures to provide technical and financial assistance, if possible, for selecting the sample, carrying out prevalence surveys and analysing the data.
- (3) Countries should establish a mechanism to effectively coordinate with other relevant ministries/agencies and private organizations and NGOs in order to collect comprehensive surveillance data and information.
- (4) Countries should develop web sites on tobacco control. WHO has prepared a list of indicators under six broad headings:
 - (a) Socio-demographic characteristics
 - (b) Tobacco production, trade and industry
 - (c) Tobacco consumption
 - (d) Prevalence of tobacco use
 - (e) Tobacco mortality and morbidity, and
 - (f) Tobacco control measures, organizations and institutions.
- (5) WHO should strengthen the existing online database system with regular updates from countries. It should also explore ways to support the development of country web sites on tobacco control.
- (6) WHO should facilitate and support the sharing of information and expertise as appropriate.
- (7) Consumers can learn about the health effects of tobacco in several ways. One is through published scientific and epidemiological research which may be summarized in the media. WHO should provide technical and financial support as appropriate to countries for carrying out research in priority areas. Research can range from basic biological research on

products and their harms, to intervention research aimed at ascertaining the most effective means of prevention and of changing the behaviour of users. All countries need to increase and improve studies in tobacco-attributable mortality to be able to estimate the disease burden of tobacco in the Region. Many areas of research such as illicit trade and cross-border advertising need to be explored and carried out. Countries should also be encouraged to conduct research that addresses the determinants and consequences of tobacco consumption and exposure to tobacco smoke, the economic impact of tobacco as well as research for identification of alternative crops.

7.11 Control of Illicit Trade in Tobacco Products

- (1) It has been estimated that globally, one third of manufactured cigarettes were being taken illegally into countries and sold. This makes cigarettes available at a low cost thereby increasing consumption. This also adversely affects excise tax collections and ensures enormous profits for the perpetrators. Although the tobacco industry always claims that smuggling is the result of high prices, studies have shown that the level of tax on tobacco products in a country does not relate to the level of smuggling¹⁴. The availability of cheap cigarettes and other tobacco products undermine efforts to promote cessation and further hook those people in need of help. The creation of a black market removes all control over the sales¹⁷. Apart from representing a threat to public health by encouraging consumption, smuggling deprives governments of tax revenues and reinforces criminal organizations and corruption. Unless smuggling is counteracted at both national and international levels, the impact of other tobacco control measures will be largely undermined¹⁴.
- (2) Action against illicit trade of tobacco products is a supply reduction measure which is key to an effective control strategy. Enforcement of legislation against smuggling and selling illegally imported tobacco products is urgently needed. Measures to control illicit trade of tobacco products should include:
 - (a) Control of smuggling which includes adopting appropriate measures to ensure that all packages of tobacco products sold or manufactured carry the necessary markings such as prominent tax stamps, local language warnings, country of origin and country of destination and product information which will allow the products to be effectively tracked and traced, as well as aggressive

enforcement and consistent application of tough penalties to deter smugglers. All persons engaged in the business of manufacturing, importing, exporting, wholesale, storage and transport of tobacco products should be licensed.

- (b) Control of illicit manufacturing and counterfeiting;
- (c) Monitoring and collection of data on cross-border trade in tobacco products, including illicit trade;
- (d) Exchange of information among related departments such as tax, customs, law enforcement agencies and local authorities and among countries of the Region;
- (e) Development and enforcement of collaborative interventions with neighbouring countries to regulate tobacco products and reduce cross-border illegal trade, promotion and advertising of tobacco products.

7.12 Partnership Building for Tobacco Control

- (1) WHO should assist countries through direct technical support and promotion of technical cooperation among countries to strengthen current capacity-building initiatives encompassing both government and nongovernmental sectors to enhance multisectoral involvement in tobacco control.
- (2) WHO should seek means of strengthening collaboration among health, finance, trade, other related departments and international relations sectors at global, international and country levels in order to improve technical capabilities relating to non-health aspects of FCTC (e.g. WTO rules).
- (3) The problem of tobacco should be brought into the broad purview of relevant noncommunicable disease control programmes, health promotion programme, tuberculosis control programme and other programmes for poverty reduction and environmental protection. As tobacco production and consumption exacerbate poverty and undermine sustainable development, tobacco control should also be a key component of national development assistance programmes.
- (4) Regional and country-level co-cooperation and coordination with UN and other international organizations under UN ad hoc task forces should be enhanced.

- (5) Cooperation and collaboration with regional bodies such as ASEAN and SAARC on tobacco control should be strengthened.
- (6) Partnership should be enhanced with (a) international and national NGOs to strengthen activities to the grassroot level; (b) WHO collaborating centres for research, training, public awareness and advocacy; US Center for Disease Control and Prevention (CDC), to support global surveillance for tobacco use and its consequences; with research institutions to expand evidence-based policies; with academic institutions to build capacity and with the private sector to channel resources and expertise.
- (7) International tobacco control campaigns (such as World No Tobacco Day and Quit and Win) in countries should be supported.

7.13 Identification and Mobilization of Financial Resources

- (1) Financial resources are crucial to achieve the objectives of the Regional Strategy for Tobacco Control. Each Member State should provide financial support in respect of its national activities and promote, as appropriate, utilization of bilateral, regional, sub-regional and other multilateral channels to provide funding for the development and strengthening of multisectoral comprehensive tobacco control programmes.
- (2) WHO should assist countries in identifying sources of funding and mobilizing financial resources to implement and sustain national tobacco control programmes; e.g. funds from European Union.
- (3) WHO is well positioned to play a role in providing institutional funding and channelling funding from public and private sources to tobacco control activities. WHO should mobilize extra-budgetary funds from Member States for supporting and furthering programmes related to tobacco control²². WHO should encourage Member States to cooperate with international and regional intergovernmental organizations and financial and development organizations of which they are members.
- (4) The World Bank provides financial and technical support for tobacco control programmes through its existing channels of support for development and poverty alleviation in Member States. National governments may request loans or credits from the World Bank for programmes that include tobacco control²².

- (5) NGOs, foundations and groups can be an important element of funding for tobacco control activities.
- (6) Private foundations and organizations have become more involved in tobacco control. The United Nations Foundation is one of the major donors to WHO's Tobacco Free Initiative. Projects sponsored by this Foundation include programmes to strengthen national capacity building in tobacco control; youth education projects; and media and advocacy campaigns involving NGOs at the grassroot level²².
- (7) Governmental support for tobacco control activities should be provided as part of the public health infrastructure by directly creating and promoting tobacco control programmes or by offering assistance to health delivery and research institutions. Earmarked tax from tobacco revenues should be used for tobacco control activities/ programmes.

References

- (1) Peto R, Smoking and death in the past 40 years and the next 40 years: *BMJ* 1994, 309: 937-939 (8 October).
- (2) Peto R, Lopez AD. The future worldwide health effects of current smoking patterns. In: Koop CE, Pearson CE, Shwarz MR, eds: *Global health in the 21st century*. New York, 2000.
- (3) World Health Organization, Regional Office for South-East Asia. *Health Situation in the South-East Asia Region 1999-2000*. World Health Organization, Regional Office for South-East Asia, New Delhi, 2001.)
- (4) Ezzati M, Lopez AD, Rodgers A, Hoorn SV, Murray CJ and the Comparative Risk Assessment Collaborating Group. Selecting major risk factors and global and regional burden of disease. *The Lancet*. Vol 360. November 2, 2002. Available at <http://www.thelancet.com>.
- (5) World Health Organization, Regional Office for South-East Asia. *Country Reports*.
- (6) Gajalakshmi C.K, Jha P, Ranson K and Nguen S. Global patterns of smoking and smoking-attributable mortality. In Jha Prabhat, Chaloupka F eds: *Tobacco control in developing countries*. Oxford University Press, 2000. 11-35.
- (7) Bangladesh Institute of Development Studies. *Craving for Nicotine: A study on Tobacco Prevalence in Bangladesh*. Dhaka, June 2001.
- (8) World Health Organization, Regional office for South-East Asia. *Country Profiles on Tobacco or Health*. New Delhi, 2002.
- (9) Government of India, Ministry of Health and Family Welfare. Gupta PC, Reddy KS eds: *Report on Tobacco Control in India*. New Delhi, November 2002. 89.

- (10) Ministry of Health, Republic of Indonesia. The Tobacco Source Book: Data to Support a National Tobacco Control Strategy. English Summary: December 3, 2003.
- (11) Jha P, Chaloupka FJ. Curbing the epidemic: governments and the economics of tobacco control. Washington DC: World Bank, 1999.
- (12) Chaloupka FJ, Hu TW, Warner KE, Jacobs R, Yureleki A. The taxation of tobacco products. In: Jha Prabhat, Chaloupka F eds: Tobacco control in developing countries. Oxford University Press, 2000: 237-272.
- (13) World Health Organization: Making a difference, World Health Report 1999. Geneva: WHO, 1999.
- (14) World Health Organization, Regional office for Europe. European Strategy for Tobacco Control. Copenhagen. 2002
- (15) Foulds J; Strategies for smoking cessation. BMJ, Volume 52(1), 157-173, 1996.
- (16) Rao M, Mcneil A, West R. Smoking cessation, evidenced-based recommendations for the health care system. BMJ, 1999, 318:182-185.
- (17) Levy D, Gitchell J, Chaloupka F. The effects of tobacco control policies on smoking rates: A tobacco control score card: PIRE working paper, Calverton, MD 2003.
- (18) Edwards R, Brown JS, Hodgson P, Kyle D, Reed D and Wallace B. An action plan for tobacco control at regional level. Public Health (1999)113, 165-170. (<http://www.stockton-pressco.uk/ph>)
- (19) World Health Organization, Regional Office for the Eastern Mediterranean. Plan of action for tobacco control in the Eastern Mediterranean Region. Personal communications.
- (20) World Health Organization, Western Pacific Region. Regional Action Plan Tobacco Free Initiative, 2005-2008. Personal communications.
- (21) World Health Organization. Framework Convention on Tobacco Control. WHO: Geneva, 2003. (available at <http://www.who.int>)
- (22) World Health Organization. Potential sources and mechanisms of support. Document distributed at Open-ended Intergovernmental Working Group on the WHO FCTC. A/FCTC/IGWG/1/INF.DOC./1. 27 May 2004.
- (23) World Health Organization. Guidelines for Controlling and Monitoring Tobacco Epidemic". WHO, Geneva, 1998.
- (24) World Health Organization, Regional Office for South-East Asia. WHO Framework Convention on Tobacco Control, Report of the First Sub-regional Awareness Raising Workshop Katmandu, Nepal, 18-19 March, 2004. New Delhi, August, 2004.
- (25) World Health Organization, Regional Office for South-East Asia. A Guide to Comprehensive Tobacco Control. New Delhi, July 2004.
- (26) World Health Organization, Regional Office for South-East Asia. Tobacco Surveillance and Information System. New Delhi, February 2004.

- (27) World Health Organization, Regional Office for South-East Asia. Intercountry Workshop of National Focal Points for Tobacco Control. Bangkok, Thailand, 27-30 July, 2004. New Delhi, December, 2004.
- (28) World Health Organization, Regional Office for South-East Asia. Multisectoral Mechanisms for Comprehensive Tobacco Control. Report of a regional Consultation, Bangkok, 9-11 July 2003. New Delhi, April 2004.
- (29) World Health Organization, Regional Office for South-East Asia. Effective Collaboration between Health and Financial Sectors for Tobacco Control. Report of the Jakarta Consultation, 3-4 December 2003. New Delhi, July 2004.
- (30) World Health Organization, Regional Office for South-East Asia. Global Tobacco Control Law: Towards a WHO Framework Convention on Tobacco Control. Report of an International Conference, 7-9 January 2000. New Delhi, August 2000.
- (31) World Health Organization, Regional Office for South-East Asia. A Policy Framework for Tobacco Control. New Delhi. 2000.
- (32) World Health Organization, Regional Office for South-East Asia. First Action Plan for Tobacco Control-Years 2000 to 2004. New Delhi, 2000.
- (33) World Health Organization. Tobacco Regulation Recommendation. Guiding Principles for the Development of Tobacco Product Research and Training Capacity and Proposed Protocols for the Initiation of Tobacco Product Testing. WHO, Geneva, 2003.