Evaluation of tobacco control policies and programmes including implementation of the WHO MPOWER technical package in SEAR Member States

Regional Office for South-East Asia (WHO-SEARO)
World Health Organization

Evaluation Report

ACT for Performance and MDF

July 10, 2018

ACT FOR PERFORMANCE BV

HNK Ede Horapark

Bennekomseweg 41

6717 LL, Ede, The Netherlands

+ 31 (0)615094443

+ 31 (0)8008098

ACT FOR PERFORMANCE SARL

16, Immeuble le Palmier

Avenue Lukusa, Commune de Gombe

Kinshasa, Democratic Republic of Congo

+ 243 819009055

+ 243 990065532

ACT FOR PERFORMANCE INC

1330 Lajoie, Montréal, Canada

H2V 1P5

+ 1 514 923-4992

www.mdf.nl

HNK Ede Horapark

Bennekomseweg 41

6717 LL, Ede, The Netherlands

MDF Office network: Bangladesh, Belgium, D.R. Congo, Ghana, Indonesia, Kenya, Myanmar, Sri Lanka, and Vietnam

Table of contents

List of Acronyms

ADB	Asian Development Bank
ASEAN	Association of Southeast Asian Nations
BI	Bloomberg Initiative
BNCA	Narcotic Control Agency
CCS	Country Cooperation Strategy
COP	Conference of the Parties
CSOs	Civil Society Organizations
CSR	Corporate social responsibility program
DAC OECD	Development Assistance Committee
DALY	Disability-Adjusted Life Year
DPRK	Democratic People's Republic of Korea
EF	Evaluation Framework
EU	European Union
WHO FCTC	WHO Framework Convention on Tobacco Control
GHW	Graphic Health Warning
GTCR	Global Tobacco Control Reports
GYTS	Global Youth Tobacco Survey
GATS	Global Adult Tobacco Survey
MoF	Ministry of Finance
MoH	Ministry of Health
MPOWER	Monitor tobacco use and impact of prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion, and sponsorships; Raise taxes on tobacco.
NCD	Noncommunicable Diseases
NGOs	Non-governmental Organisations
NTCC	National Tobacco Control Cell
PHF	People Health Foundation
SDG	Sustainable Development Goals
SEAR	South East Asia Region
SEARO	Regional Office for South-East Asia
SEATCA	Southeast Asia Tobacco Control Alliance
SLT	Smokeless tobacco
TAPS	Tobacco advertising, promotion and sponsorship
TFI	Tobacco Free Initiative
ToC	Theory of Change
ToRs	Terms of Reference
TQS	Tobacco Questions in Surveys
UN	United Nations
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WCO	World Health Organization Country Office
WHA	World Health Assembly
WHO	World Health Organization
WB	World Bank

Acknowledgments

EXECUTIVE SUMMARY

The purpose of this evaluation is to evaluate the progress of the implementation of tobacco control policies and programmes in South-East Asian Region (SEAR) Member States, including the WHO MPOWER technical package. The evaluation provides a learning opportunity for the WHO and its partner governments of the SEAR Member States, and reports on policy and program results, trends, and impacts with respect to internationally agreed targets, e.g. Noncommunicable Diseases (NCD) and Sustainable Development Goals (SDG).

Specific objectives are:

➢ Study and map the existing tobacco control policies and programmes in SEAR Member States;

➢ Identify enabling factors, opportunities, challenges and threats in implementing the tobacco control policies and programmes in SEAR Member States;

➢ Recommend concrete strategies adapted to the political situation of the respective country, to strengthen and accelerate the implementation of the WHO FCTC for each of the SEAR Member States;

➢ Review WHO's supporting role and make recommendations to strengthen tobacco control infrastructure at the country level.

This evaluation was executed in three phases. During the first phase, an Inception report was prepared, which defined the methods and scope of the evaluation, and the evaluation framework was developed, including the questionnaires. The second phase consisted of fieldwork. The eleven Member States countries in the South East Asia Region (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste) were visited by the Evaluation team, where interviews and focus groups were conducted with the WHO country offices, the Ministry of Health and other relevant ministries (Finance, Education, Agriculture, etc.), Civil Society Organizations (CSOs) and other stakeholders (UN agencies, experts etc.), and complemented by direct observation in selected sites. Analysis and reporting was done in the third phase. This report was prepared based on country data reference notes, presented in 11 distinct documents.

Key conclusions

More than a decade after the launch of the WHO FCTC, five out of the 11 South East Region Member States (Bhutan, Sri Lanka, Nepal, Maldives and Thailand) show tobacco use prevalence is lower than, or around the current average global rate, among adults aged over 15 years (19.9%). Three other countries have higher than average global prevalence rates but were able to reduce them (Bangladesh, India and DPR Korea). The prevalence rates of the other countries (Indonesia, Myanmar and Timor-Leste) have worsened over the last decade (see Tables 5 and 6, section on Impact).

Smokeless tobacco is a major problem in most of the SEAR countries (Bangladesh, Bhutan, India, Myanmar, Nepal, Sri Lanka and Timor-Leste). Bhutan and Sri Lanka have prohibited the manufacturing, importation, or selling of any smokeless tobacco. According to the latest survey, Bangladesh and India have reduced their rates of prevalence of adult smokeless tobacco use.

In 2016, the SEAR ranks 3rd lowest among the six WHO regions with a tobacco use prevalence of 16.9 % for adults (31.6% for men and 2.2% for women), as shown in the table below.

According to the WHO[1], the prevalence of tobacco smoking appears to be decreasing in all regions of the world (except for the African and East Mediterranean regions), but only the Americas region is on track to reach the 2025 target of a 30% reduction among both males and females.

Age-standardized current tobacco prevalence* among persons aged 15 years and older
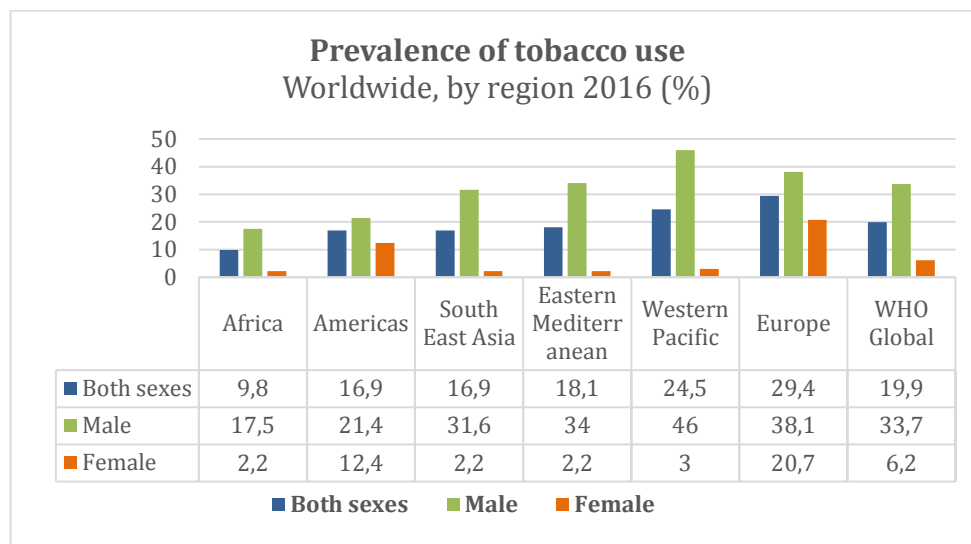
Prevalence of tobacco use
Worldwide, by region 2016 (%)

	Africa	Americas	South East Asia	Eastern Mediterranean	Western Pacific	Europe	WHO Global
■ Both sexes	9,8	16,9	16,9	18,1	24,5	29,4	19,9
■ Male	17,5	21,4	31,6	34	46	38,1	33,7
■ Female	2,2	12,4	2,2	2,2	3	20,7	6,2

■ **Both sexes**   ■ **Male**   ■ **Female**

* The percentage of the population aged 15 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis.

Source: WHO Global Health Observatory (GHO) data retrieved in the WEB: http://www.who.int/gho/tobacco/use/en/

Bhutan, Sri Lanka, Nepal, Maldives and Thailand show the lowest prevalence rates of tobacco use, e.g. 7.4%, 15%, 18.5%, 18.8% and 20.7% respectively[2]. Bhutan has completely prohibited production and sale of all tobacco products since 2010. Nepal was able to build a comprehensive tobacco control infrastructure in a relatively short time, and succeeded to reduce prevalence of tobacco use among adult men and women, respectively from 35% in 2006 to 27% and from 26.4 to 10.3 in 2016[3]. This country reports the strongest progress in terms of implementation of MPOWER measures, i.e. passing from an average score of 1.9 in 2007 to 4.3 in 2017 (See Table 5, section 4.3.1 on Effectiveness).

India, Bangladesh and DPR Korea reduced the rate of prevalence of tobacco use from 34.6% in 2009 to 28.6 % in 2017; 43.3% in 2009 to 35.3% in 2017 and 27% in 2011 to 22% in 2015 respectively[4]. Myanmar, Indonesia and Timor-Leste show a rising trend of tobacco use in the past decade: respectively at 26.1%; 36.3% and 48.6%[5].

Being among the world's top-20 tobacco-producing countries, Bangladesh and India managed to reduce smoking prevalence rates over the years, and Thailand has maintained a rate around the global average. Only Indonesia, (a top 5 world-producer like India), shows an increase in the prevalence of tobacco use over the years, despite implementing MPOWER measures. Indonesia is the sole SEAR country that did not endorse the WHO Framework Convention on Tobacco Control (WHO FCTC). According to the 2018 *WHO Global Report on Trends in Prevalence of Tobacco Smoking 2000–2025* (2nd version), Indonesia is also the only SEAR countries where smoking prevalence is expected to increase until 2025.

---

1 WHO global report on trends in prevalence of tobacco smoking 2000–2025, Second edition, Geneva: World Health Organization, 2018

2 STEPS Bhutan (2014), STEPS Sri Lanka (2015), Demographic Health Survey Nepal (2016), STEPS Maldives (2011), Smoking and Drinking Behaviour Survey Thailand (2014).

3 Demographic Health Survey Nepal (2016)

4 GATS India (2016-2017), GATS Bangladesh (2017), GATS DPR Korea (2017)

5 STEPS Myanmar (2014), National Basic Health Research Indonesia (2013), National Survey for Noncommunicable Disease Risk Factors and Injuries Timor-Leste (2014).

Among the 11 SEAR countries, India and Maldives succeeded to reduce both prevalence of tobacco use and premature mortality from target NCDs. Heart disease and stroke, cancers, diabetes, and chronic respiratory diseases and other noncommunicable diseases (NCDs) cause tens of millions of deaths per year, according to the WHO, and approximately 9.6 million deaths in the South-East Asian region, and the SEAR Member States have set an overall goal to achieve 25% reduction in mortality associated with NCDs by 2025. Timor-Leste and DPR Korea slightly reduced the risk for mortality from NCDs, despite the prevalence rates among male, among the worst of the SEAR countries. The risk for mortality from NCDs in the other seven SEAR Member States remained stable (Myanmar, Sri Lanka and Thailand) or increased (Bangladesh, Bhutan, Indonesia and Nepal).

Bangladesh, India and Thailand have a long-term history of commitment to tobacco control and show best practices having implemented the most advanced tobacco control infrastructure in the region, including, although to various degrees, Article 5.3 of the WHO FCTC. All three countries benefit from a strong CSO coalition on tobacco control and, in the case of India and Thailand, from sustainable financial support.

These data demonstrate that the WHO FCTC has proven to be an effective framework since 2005 that fostered and guided the member state governments in the region in terms of development and implementation of their tobacco policies and legislation. All countries studied have put in place tobacco control laws and regulations in one form or the other, some as early as 2004 (India, Thailand).

For others, this has been more recent, like Timor-Leste in 2016, a country which also shows the worst prevalence of tobacco use of the region.

The countries have operationalized the provisions of MPOWER since 2008 and implemented tobacco control policies, at varying levels. Even Indonesia has implemented various measures of the MPOWER package, the set of six evidence based demand reduction measures.

More specifically, all countries made good progress in implementing article 8 (Protecting from exposure to tobacco smoke); article 11 (Packaging and labelling of tobacco products); and article 12 (Media campaigns).

However, the implementation of article 13 (Enforce bans on advertising, promotion and sponsorship) falls short. The bans exist, but are generally not enforced, and the tobacco industry tends to violate these provisions/rules. Efforts were made to improve Monitoring (article 20), however, this has been done insufficiently across the board. The interval between the surveys is irregular and long (many years) although some countries (India, Bangladesh and DPR Korea) have conducted GATS surveys recently (2016-2017). All countries levy an excise duty of tobacco products (article 6) at varying levels, but not high enough as the tobacco products remain affordable, even in Bangladesh, Sri Lanka and Thailand, where the excise on tobacco represents 75% or more of the retail price (77%, 75% and 87% respectively).

While there is generally a high level of willingness to quit smoking in the SEAR countries (> 55%), insufficient attention was given to "Offer to quit measures" (article 14), with some best practice exceptions (like in Thailand where Village Health Volunteers encourage people to quit and encourage them to seek cessation services). In India, promising national quit lines and mobile cessation services were put in place in 2016 and dental clinics are used for cessation counselling. All countries with the exception of Timor-Leste have small-scale cessation initiatives running, but not sufficiently scaled, staffed and financed. Overall, cessation facilities are insufficient to meet the demand for quitting tobacco in most SEAR countries.

Compliance with legislation is a general problem, mainly caused by weak law enforcement due to lack of resources, unfamiliarity with the legislation, absence of clear implementation guidelines, lack of political will, and rampant industry interference influencing the relevant authorities.

For instance, all countries have Smoke-free laws in Health-care facilities and Smoke-free zones are being put in place, yet these are not effective in all cases. All countries have laws to prohibit Sales to minors, but the implementation and enforcement of this regulation is an issue. If content and emission of tobacco products (articles 9 &10) are to be regulated under the law, the rules are not put in place to implement the same, as per the WHO FCTC guidelines.

SEAR Member States have developed comprehensive tobacco control strategies in line with the WHO FCTC, but encountered serious challenges in implementing some specific articles of the WHO FCTC, especially article 5.3 (Tobacco industry interference), article 15 (Illicit trade), article 17 (Economically viable alternative activities) and article 16 (laws to prohibit sales to and by minors), which have been implemented with varying levels of compliance among the countries.

Interference by the tobacco industry, particularly in the development and implementation of legislation and taxation, is a serious challenge in the region. Some countries do not have a policy protecting public health from tobacco industry interference (Indonesia, DPR Korea, Maldives, Myanmar and Thailand) and the other countries that have adopted such a policy have encountered the tobacco industry continues to have an influence in various forms. Almost 15 years after having ratified WHO FCTC, Thailand is still discussing a draft on a code of conduct for government staff on how to deal with the tobacco industry. As discussed, Thailand succeeded to maintain a rate of prevalence of tobacco use around the world average, but has not been able to reduce this in over a decade.

The tobacco industry targets adolescents with aggressive marketing methods, even in non-producing countries e.g. Bhutan, Timor-Leste (where there are no local tobacco industries). In Bhutan, 9.7% of high school students report that they were offered free tobacco products, and 14% of these students wore something with a tobacco brand logo on it (GYTS 2013). In Timor-Leste, where 90% of tobacco is imported from Indonesia, advertising, sponsorship and promotion by the powerful tobacco industry is clearly still evident despite the law in some public places – near schools, university and hospitals. In spite of a ban on sponsoring in Indonesia, about 50 music concerts were sponsored by cigarette companies in Jakarta alone during the last two months, as reported by the Jakarta Post newspaper, November 2017. In 2018, Members of the House of Representatives of Indonesia plan to resubmit a tobacco bill that defends the tobacco industry's interests, which was rejected by the President in 2017.

Only recently, small-scale initiatives are emerging to incite tobacco farmers to shift to alternative crops/livelihoods (Bangladesh, India, Sri Lanka, Myanmar, Nepal). Alternate livelihood programs are non-existent in Indonesia, Thailand and DPR Korea. According to the available data, tobacco production has increased in Bangladesh, Indonesia, Myanmar and Sri Lanka, remained steady in Thailand, and has been reduced in India and Nepal.

Illicit trade is a problem for all countries. Illegal cigarettes and beedis are being sold at cheap rates in the informal market, which makes cigarettes accessible and affordable. In 2016, Sri Lanka was the first country to sign the United Nations' Protocol to Eliminate Illicit Trade in Tobacco Products. The implementation of the Protocol has yet to come into effect (40 million of illegal cigarette sticks were reported the first half of 2017, compared to a total of four million sticks detected in 2016). India has ratified the Protocol in May 2018, the second SEAR country to do so. Myanmar has signed, but not yet ratified, the Protocol.

The WHO's support to the Member States provided a relevant response to the countries' needs for tobacco control. WHO has enabled an environment conducive to tobacco control policies and prevention. In all SEAR countries, WHO supports demand reduction measures (MPOWER) and also supply control measures, through technical assistance, evidence generation/research, training and advocacy. Despite WHO's support, limited financial and human resources are available for the

implementation of tobacco control policies in most of the Member States, in particular the small countries.

Bangladesh, India and Indonesia receive additional external funding, in particular from the Bloomberg Initiative (BI). In addition, India has put a considerable amount of their own resources in their tobacco control programme, and Thailand has established a sustainable mechanism of a healthy lifestyle fund (a percentage of the excise duty on tobacco and alcohol). Tobacco control can only be sustained when it is organized as part of a broader health lifestyle/ health system approach, and when the countries recognize that tobacco control has economic and environmental dimensions, and is linked more broadly than to only the health SDGs.

India, Indonesia, Nepal and Thailand have elaborated specific tobacco control programs, while the other countries have recently integrated tobacco control in their NCD strategy. For instance, Bangladesh closed its National Strategic Plan of Action for Tobacco Control and is now preparing a new multi-sectoral strategy to implement the NCD action plan (2017-2022), which includes tobacco control as one of the issues. The NCD action plan will probably sustain the tobacco control infrastructure, but on the other hand may also lead to a dilution of dedicated staff time.

The MPOWER implementation should be strengthened, with particular focus on the best buys and cost effective measures to reduce the demand of tobacco. High prevalence of the use of smokeless tobacco illicit trade, new and emerging products (such as the electronic cigarettes), high prevalence of smoking among adolescents and aggressive targeting by the industry remain many of the challenges which still need to be addressed with appropriate and effective policies and programmes. As pointed out by the 2018 WHO Trends Report (2nd version), most people start smoking when they are young. Data shows an increased use of tobacco among youth in many SEAR countries, in particular in Bhutan (30% prevalence), notwithstanding their strict policy on tobacco control and the low prevalence rate for adults (7%). As reported by the evaluation team, smoking is traditionally considered bad for one's karma, but religion has apparently less of a grip on adolescents in this country.

Good policies and legislation are without teeth when implementation and enforcement fall short, which is generally the case in the region. Political will is needed, amongst both politicians and citizens, as are more investments in the tobacco control infrastructure and strategies. Advocacy at all levels, synergy and coordination, championing, critical research and campaigning have proven to be important strategies to shift the political economy from tobacco interests to public health interests.

The Member States should particularly acknowledge the results of studies done in the region (India, Indonesia, Sri Lanka) that show that the economic costs of tobacco use are much higher than the revenues generated (See section 4.2 on Efficiency). Smart policy and innovative health financing would thus reinvest much more than the current meagre 0.1% of tobacco revenues (regional average) into tobacco control. A recent study also showed that misleading advertising by tobacco companies may be responsible for the increase in the SLT prevalence, which is as harmful as smoking. Countries should thus strengthen policies to restrict SLT usage and prevent further increase in prevalence (See section 4.4.1 on Impact).

The evaluation has also substantiated that effective tobacco control policies are multi-sectoral and regional, foster multiple approaches, create synergy between stakeholders, build on alliances between government and CSOs, and use innovative approaches for surveillance and monitoring (e.g. use of youth reporters with mobile phones).

Recommendations for WHO

This section summarizes the recommendations concerning WHO's role to strengthen the tobacco control infrastructure:

R1 Review and broaden the MPOWER package to include supply control measures and address new challenges such as the increased use by adolescents.

R2 Promote the multi-sectoral approach by including other sector ministries (e.g. Agriculture, Commerce, Trade, Customs, Women & Child, Education) and by strengthening the collaboration with other UN agencies (e.g. UNICEF, UNDP, FAO).

R3 Adopt a Result-Based Management approach in the support programs, by linking part of the financing to results obtained.

R4 Lead and strengthen the coordination, both with donors and other international partners, and internally, among WHO HQ, RO, and the WCOs. In order to increase efficiency, approach WHO's support to tobacco control in the region as a program, with a clear management and accountability structure. Motivate and incite the WCO focal points on tobacco.

R5 Strengthen WHO's upstream work (studies/research, catalytic activities, guidance, capacity development, advocacy, awareness building, surveillance) in the field of tobacco control, and in particular WHO's advocacy role, at all relevant levels of partner governments.

R6 Bring together the two global biennial surveys into a single survey to decrease the transaction costs for the countries. Integrate indicators for a multi-sectoral approach.

R7 Intensify resource mobilisation and work with the Member States on innovative and sustainable financing mechanisms (e.g. healthy lifestyle fund financed by a percentage of the excise duty on tobacco).

R8 Support strategic studies and critical research, especially evidence-generating research on the economic benefits of tobacco control and impact studies.

R9 Reposition WHO's support to tobacco control as a specific program within Health System Strengthening (HSS) programs.

Recommendations for the Member States countries

The following recommendations are meant for the SEA member countries to strengthen and accelerate the implementation of the WHO FCTC.

R10 Respect the general obligations and guiding principles of the WHO FCTC, and strengthen its implementation. Introduce the mulisectoral approach and increase the financial resources available.

R11 Shift the paradigm and change the culture of tobacco use. Select a "Champion of non-smoking" to speak out about the benefits of quitting tobacco use. Champions (politicians, actors, athletes, scientists) can mobilize people, change public opinions and should be the face of anti-tobacco campaigns.

R12 Change the message and start reporting on the economic and other benefits of tobacco control (environment) for the country. The economic costs of tobacco use exceed 5 – 8 times the tobacco tax revenues. Governments and citizens pay dearly for the cost of smoking. Let people and politicians know about the larger costs of tobacco, including the cost to the overall economy of the country and environment.

R13 Prioritize and focus on adolescents/youth. Research shows that risk factors for noncommunicable diseases (NCDs) are associated with behaviours that begin at a young age and get reinforced during adolescence. Yet, tobacco control strategies have not addressed adolescents

adequately; in the region, a disconnect exists between NCDs, adolescent health, and national policies.

R14 Seek Efficiency. Countries should strengthen the collaboration with national and local CSO partners and create alliances for the implementation of tobacco control activities. Countries should also intensify regional collaboration to control illicit trade of tobacco products. Countries should take initiatives to foster effective coordination between donors and other international partner organizations operating in their country. Country governments should take leadership on the tobacco control programs executed in their country, set the priorities, coordinate and monitor the actions, and define the roles of the stakeholders involved. Countries should develop a database on tobacco control and integrate a few WHO FCTC-related indicators in their routine surveys, like STEPS, SMART, and DHS etc.

R15 Consider tobacco control as sustainable development and link it to the Sustainable Development Goals (SDGs). Evidence has been generated on the contribution of tobacco control to SDGs beyond health. Tobacco control not only leads to healthier lifestyles, but also to decreased economic and environmental costs.

R16 Adopt WHO's Global Action plan for NCDs 2013-2020 and implement the ''best-buys'' - the core policies and measures of the MPOWER package. Countries should enforce their laws and assure compliance with the rules, especially compliance by the tobacco industry. Countries should considerably increase the excise duty on tobacco products. Evidence-based research shows that price is a key factor underlying the purchase of tobacco products, which are still affordable in the region; hence, the tax/price level is too low. Taxation is a highly cost-effective control measure, but not yet well applied. Countries should also sign and ratify the Protocol to eliminate illicit trade in tobacco products and take measures to implement the same. Last but not the least, countries should stop supporting tobacco farmers and offer them instead economically viable alternatives and incentives to shift to alternative crops/livelihoods.

1 EVALUATION MANDATE, SCOPE AND OBJECTIVES

1.1 Introduction

Tobacco control support by the WHO has made a significant contribution to the effective implementation of tobacco control policies in SEAR Member States. The WHO South-East Asian Regional Office (SEARO) is assisting eleven (11) Member States in the region to implement the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC). With the notable exception of Indonesia, ten countries in the region have endorsed the convention[6]: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste.

Tobacco use is considered as one of the biggest public health threats in the South East Asia Region, with nearly one-fourth of world's smokers and more than 80% of smokeless tobacco users globally. In response to the global and epidemic threat of tobacco use, the WHO developed the WHO FCTC, which was adopted in 2003 and came into force in 2005. The WHO FCTC is the first global health treaty negotiated under the auspices of WHO. It establishes tobacco control as a priority on the public health agenda and provides an evidence-based tool for the adoption of sound tobacco control measures.

The MPOWER technical package was introduced in 2008 to achieve the objectives of the WHO FCTC and includes six proven measures to reduce demand for tobacco products:

➢ **M**onitor tobacco use and impact of prevention policies;
➢ **P**rotect people from tobacco smoke;
➢ **O**ffer help to quit tobacco use;
➢ **W**arn about the dangers of tobacco;
➢ **E**nforce bans on tobacco advertising, promotion, and sponsorships;
➢ **R**aise taxes on tobacco.

Implementation and compliance of MPOWER have been regularly monitored through Global Tobacco Control Reports (GTCR) and the WHO FCTC Conference of Parties (COP) reports and their accompanying documentation.

The present evaluation goes beyond these reviews and provides an assessment of i) the impact of WHO FCTC implementation in the SEAR Member States after more than a decade of implementation of the treaty, and ii) the role of support provided by WHO to assist the countries in their tobacco control efforts to achieve the national targets.

All eleven Member States participated in the evaluation; in India, we only evaluated WHO's role, not the results of Government policy implementation.

This evaluation took place between September 2017 and July 2018. The report describes the objectives of the evaluation, the methodology, and provides the major findings, conclusions and recommendations.

The Annexes present the evaluation framework and specific findings by country.

Country data reference notes, that present the country data gathered in each country by the evaluation team, are presented in distinct documents.

---

[6] http://medind.nic.in/ici/t12/i4/icit12i4p319.htm

1.2 Evaluation objectives and scope

The purpose of this study is to evaluate tobacco control policies and programmes in SEAR Member States including implementation of the WHO MPOWER technical package. This evaluation provides a learning opportunity for the WHO and the Governments of the SEAR Member States, and reports on policy and program results, trends, and impacts with respect to internationally agreed targets, e.g. NCDs and SDGs.

Specific objectives of the project are to:

- Study and map the existing tobacco control policies and programmes in SEAR Member States.
- Identify enabling factors, opportunities, challenges and threat in implementing the tobacco control policies and programmes in SEAR Member States.
- Recommend concrete strategies targeted to the political situation of the respective country, to strengthen and accelerate the implementation of the WHO FCTC for each of the SEAR Member States.
- Review and make recommendations (on WHO's role) to strengthen tobacco control infrastructure at the country level.

The scope of the evaluation included the eleven Member State Countries in South East Asia Region and covers the WHO MPOWER package and nine (9) tobacco control policies and programmes:

1. Article 5.3 of the WHO FCTC (tobacco industry interference);
2. Regulation of content/emissions of tobacco products;
3. Reducing access of tobacco products to minors (including tobacco free education institutions);
4. Tobacco free health facilities;
5. Protocol to eliminate illicit trade of tobacco;
6. Alternative livelihood programme;
7. Tobacco control programme at national and subnational levels to facilitate WHO FCTC implementation (availability of resources);
8. Noncommunicable Diseases (NCD) action plan;
9. Involvement of non-health sectors in tobacco control.

In 10 of the 11 Member States (not in India), the evaluation team looked into four (4) dimensions of the implementation of these policies and programmes:

- Political will/enabling environment;
- Implementation tools;
- Partner agencies;
- Compliance and level of implementation.

The baseline year for the evaluation was the year a particular country ratified the WHO FCTC. As Indonesia has not ratified the WHO FCTC, we took 2008 as the baseline for the MPOWER package implementation in this country. We took September 30, 2017 as the cut-off date for the evaluation.

In the report, recommendations are given with respect to reaching the following global targets on NCDs and, more recently, the Sustainable Development Goals (SDGs):

- WHO Global and Regional NCD Action Plans call for 30% relative reduction in the prevalence of tobacco use in persons aged 15 years and above by 2025.
- SDG target 3.4 calls for a one third reduction in premature mortality from NCDs by 2030.
- SDG target 3a pertains to implementation of the WHO FCTC.

2 POLICY AND PROGRAM SOLUTIONS OFFERED BY WHO AND THE MEMBER STATES

2.1 Role of the WHO in the implementation of tobacco control policies

The principle role of WHO in the implementation of tobacco control policies is to provide technical assistance and advisory services to the member countries. Specific policy and program activities in which WHO plays a key role in SEAR Member States are described below.

i. Implementation of the WHO FCTC Mandate and WHO MPOWER package

The Framework Convention on Tobacco Control is an evidence-based treaty that advocates for the rights of citizens to the highest standard of health and strengthens national and international coordination to tackle the tobacco epidemic. WHO-SEARO has played a catalytic role in helping Member States to put the WHO FCTC articles into practice by building capacity of the Member States to implement provisions under WHO FCTC, including the provision of guidance documents and technical and advocacy material (for instance on regulatory frameworks and taxes). In 2008, WHO introduced the MPOWER package, a mix of six proven demand reduction strategies to accelerate WHO FCTC implementation. The successful implementation of MPOWER measures in the region aim to reduce the burden of chronic diseases and premature deaths associated with tobacco consumption[7,8].

ii. Surveys and data collection to guide evidence-based policies

The WHO Regional Office provides technical support to the countries for conducting surveys, including: Global Youth Tobacco Survey (GYTS), Global Adult Tobacco Survey (GATS), Global School Based Student Health Survey (GSHS), and WHO STEPwise approach to Surveillance (STEPS). These surveys are used to determine the prevalence rates, socio-economic and cultural determinants and health impacts of tobacco use in the member countries[9]. Since WHO FCTC is focused on scientific evidence that tobacco use has adverse effects on health, the data collected assists countries in the formulation, tracking and implementation of WHO FCTC articles[10,11].

iii. The South-East Asia Regional Strategy on Tobacco Control

There are many region-specific issues and challenges in relation to tobacco use and control which need to be addressed. For instance, there is a significant variation in the pattern and mode of tobacco use, both in smoking and smokeless forms, between the South-East Asian region and other parts of the world. A Regional Strategy was therefore developed by the WHO Regional office and adopted by the Member States in 2005. A regional plan of action for the utilization of Global Youth Tobacco Survey Data and a South-East Asian regional plan of action for Tobacco Control 2006-2010 were also developed. Fostered by the regional strategy, the member countries have incorporated standard Tobacco Questions in Surveys (TQS) in their respective national surveys for instance[12].

More recently, the "Dili Declaration on Tobacco Control 2015" was signed by the health ministers of the Member States. As per this declaration, the Member States have committed to further reduction of tobacco use in the region. These measures include commitment towards achievement of NCD

---

[7] http://www.researchgate.net/publication/51804268 Tobacco epidemic in South-East Asia region ; Challenges and progress in its control
[8] http://apps.searo.who.int/PDS_DOCS/B4474.pdf
[9] http://apps.searo.who.int/PDS_DOCS/B5003.pdf
[10] http://www.who.int/tobacco/surveillance/gyts/en/
[11] http://apps.searo.who.int/PDS_DOCS/B5003.pdf
[12] http://medind.nic.in/ici/t12/i4/icit12i4p319.htm

prevention targets, strengthened implementation of WHO FCTC and MPOWER packages, building health systems capacity for cessation support and tobacco related NCD screening, regular collection of data to promote implementation of evidence-based tobacco control programs, and implementation of policies to reduce smokeless tobacco and electronic nicotine delivery systems use[13].

2.2 Existing tobacco control achievements

The Member States have made significant progress in implementing the articles of the WHO FCTC to reduce the demand as well as the supply of tobacco. All the member countries have national tobacco control laws which include provisions on health warnings, taxation on tobacco products, prohibition of tobacco sales to minors, bans on tobacco advertising and smoke-free places. Since 2008, all Member States in the region have adopted MPOWER measures to implement tobacco control strategies more effectively.

All countries studied have progressively strengthened their tobacco control legislation and have established national committees and programmes for tobacco control. The intensifying efforts made by the member countries suggest that existing tobacco control achievements and impacts, including institutional changes, will be sustainable over time. Moreover, the member countries have committed to the post-2015 agenda to reduce tobacco use by 30% in 2025, including a significant reduction of NCDs associated with tobacco use. To achieve this, the member countries must not only sustain the current efforts but rather intensify the implementation of provisions of the WHO FCTC.

Although a lot of progress has been made, countries can do more with regard to the provisions in WHO FCTC to introduce the comprehensive **ban** on tobacco advertisements, implant comprehensive **smoke-free policies**, enforce **pictorial warnings** on tobacco packs, and implement comprehensive **tobacco cessation** services. Governments also should increase **taxes on all kinds of tobacco products** (including smokeless tobacco) to reduce affordability and decrease tobacco consumption to ensure that tobacco control efforts are sustainable. Most of the Member States impose lower taxes on tobacco products consumed by the poor such as bidis, hand-rolled, cigarettes and smokeless tobacco. In addition to national measures, **regional cooperation** is needed to prevent illicit trade, counteract tobacco industry tactics, and create a momentum to make the tobacco control efforts sustainable in the region.

These interventions are a cornerstone to execute Global Action Plan 2013-2020 to reduce NCDs, of which tobacco is a significant contributor[14].

2.3 Progress of the Member States on achieving the NCD Action Plan targets

NCDs such as cardiovascular diseases, cancer, diabetes and chronic pulmonary disease account for approximately 9.6 million deaths in the WHO South-East Asia Region. Tobacco use is one of the largest risk factors for the main group of NCDs, and every year nearly 1.6 million deaths in the region are attributed to tobacco use. Since the 66th World Health Assembly in 2013, the Member States have adopted the Global Action plan and global voluntary targets on NCDs and set an overall goal to achieve 25% reduction in mortality associated with NCDs by 2025. To reduce the health threats of tobacco, the Member States have voluntarily agreed to achieve a 30% relative reduction in prevalence of current tobacco use in people aged over 15 years and over by 2025 (with 2010 as the baseline).

Measures to ensure reduction of tobacco use originally include the adoption of the four following evidence-based tobacco-control, known as WHO's **"best-buy"** interventions:

- Increase tobacco **excise duties** to reduce the affordability of tobacco products;

---

[13] http://apps.who.int/iris/bitstream/10665/190975/1/Dili%20Declaration.pdf
[14] http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

- Create **legislation** to introduce smoke-free environments in all indoor workplaces, public places and public transport;
- Use **mass media campaigns** and **health warnings** to warn people of the dangers of tobacco and, tobacco smoke; and
- Prohibit all forms of **tobacco advertising**, promotion and sponsorship.

In 2017, 'best buys' were reviewed and now consist of[15]:

Effective interventions with a cost effectiveness analysis of ≤ I$ 100 per DALY averted in low- and lower middle-income countries (expressed as International dollars (I$) per disability adjusted life year):

- Increase excise **taxes** and prices on tobacco products;
- Implement plain/standardized packaging and/or large **graphic health warnings** on all tobacco packages;
- Enact and enforce comprehensive **bans on tobacco advertising, promotion and sponsorship**[16];
- Eliminate exposure to **second hand tobacco smoke** in all indoor workplaces, public places, and public transport; and
- Implement effective **mass media campaigns** that educate the public about the harms of smoking/tobacco use and second hand smoke.

Effective interventions with a cost effectiveness analysis of ≥ I$ 100 per DALY averted in low- and lower middle-income countries: Provide cost-covered, effective and population-wide support (including brief advice and national toll-free quit line services) for **tobacco cessation** to all those who want to quit[17].

Other interventions recommended by WHO:

- Implement measures to minimize **illicit trade** in tobacco products;
- **Ban cross-border advertising**, including using modern means of communication; and
- Provide **mobile phone-based tobacco cessation services** for all those who want to quit.

To achieve this reduction, WHO has invoked the Member States to develop or strengthen national multi-sectoral policies in accordance with the WHO's Global Action plan for NCDs 2013-2020.

In 2014, the Member States agreed to four time-bound commitments:

1. Set national NCD targets for 2025 by 2015;
2. By 2015, develop national multi-sectoral policies and plans to achieve the national targets by 2025;
3. In accordance with the WHO Global Action Plan, reduce risk factors for NCDs by 2016; and
4. By 2016, strengthen health systems to address NCDs through a primary health care focus, based on guidelines set in the WHO Global NCD Action Plan.

The June 2016 regional consultation on strengthening health systems to address NCDs in South-East Asia Region resulted in a Ministerial Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level. In the declaration, the Member States committed to financing NCD control through a further increase in **taxes on tobacco products**[18]. In 2017, the WHO Global Conference on NCDs in Montevideo, Uruguay, emphasised the need to significantly increase the sustainable financing of national NCD responses through taxation. India, Nepal and Thailand have already established mechanisms to use tobacco taxes for health promotion. Although much work still needs to be done, the Member States are progressively intensifying tobacco control measures to achieve the NCD Action Plan target concerning the reduction in prevalence of tobacco use[19].

---

[15] WHO, NCD Action Plan 2017, Appendix 3, tobacco interventions, 2017.
[16] Requires capacity for implementing and enforcing regulation and legislation.
[17] Requires sufficient trained providers and a better functioning health system.
[18] http://www.WHO FCTC.org/images/stories/FCAStatementSEARO090916.pdf.
[19] http://www.searo.who.int/tobacco/documents/2012-pub1.pdf?ua=1

3 EVALUATION APPROACH

3.1 Evaluation questions

The criteria set out in the Terms of Reference for this evaluation were those recommended by the UN Evaluation Group and the OECD Development Assistance Committee for program evaluations, i.e. Relevance, Efficiency, Effectiveness and Impact and Sustainability. The evaluation questions are presented below for each criterion and in more detail in Annex B, the evaluation framework. In addition to the questions proposed by the terms of reference, two questions were added by the evaluation team to complete the assessment on Relevance: Are these mechanisms and measures to help reduce the demand and tobacco product still relevant? Does WHO adequately support Member States?

As requested by the Terms of Reference, the results of MPOWER and other policy implementation were assessed according the dimensions of: Enabling environment; Compliance; Implementation tools; Partner agencies and Impact. Indicators were developed by the Evaluation Team to measure the progress in the implementation of MPOWER and the 9 other policies and programmes. An integrated questionnaire was developed to help inform these indicators.

The evaluation was guided by the UNEG guidelines and the WHO Evaluation Handbook.

3.1.2 Evaluation Criteria

a. Relevance

- Are there mechanisms in place to evaluate tobacco control policies/programmes in SEAR countries? Are these mechanisms and measures to help reduce the demand and tobacco product still relevant?
- Does the WHO adequately support Member States? Does the Global Tobacco Control Report provide a comprehensive overview of the implementation of overall tobacco control policies and programmes in SEAR countries?

b. Efficiency

- Have the objectives of WHO FCTC and MPOWER package been achieved in a cost effective manner? Is there any possibility of improved results at the same cost?
- To what extent is the utilization of the funds for tobacco control supported?
- To what extent has the institutional organization, structure, and efficiency improved?
- To what extent has the investment in tobacco control policies contributed to annual savings in reduced health care costs? (desk review only)

c. Effectiveness

- Has implementation of tobacco control policies produced the expected results? Could better results be obtained by changing or modifying the policy instruments?
- To what extent were activities, resources and results appropriately coordinated, monitored and reported?
- To what extent is the country on track to achieve the objectives of WHO FCTC and targets of the WHO NCD Action Plan?
- What were the factors influencing WHO's contribution to the implementation of tobacco control policies in the Member States? (Context)
- To what extent has WHO been appropriately engaged in the implementation of tobacco control policies in the Member States? (Effectiveness of the WHO support)

d. Impact

- Overall impact of tobacco control policies in reducing the prevalence of tobacco use in SEAR Member States
- Role/contribution of WHO in reducing the prevalence of tobacco use

e. Sustainability

- Are the existing tobacco control policies and programmes sustainable?
- What are the resources required for sustainability?
- What are the expectations from WHO for sustainable measures to support tobacco control policies?

3.2 Evaluation Approach

The evaluation followed a theory-based, realist evaluation approach. Using a mixed methods approach, the team focused on generating evidence-based findings and practical recommendations for the client. Given the non-comparable nature of country contexts, the evaluation employed contextualised analysis and learning. What works in one context may not be appropriate in other contexts. The evaluation triangulated evidence from different sources to clarify and understand the conditions that influence change, as well as success and failure in different contexts.

The evaluation team developed a Theory of Change, as presented in Annex C, to inform the evaluation framework. It is based on the objectives of the WHO support to SEAR Member States in implementing tobacco control policies and programmes including the MPOWER packages, and on the expected results. It also provides a hypothesis to address the evaluation objectives in a coherent manner. The theory of change incorporates the inter-relationship between the WHO support and country performance in implementing the tobacco control policies, as shown in Table 1 below:

Table 1: WHO Support to the SEAR Member States for tobacco control

WHO Support to the SEAR Member States for tobacco control	Assumptions	
- Demand reduction measures (MPOWER)	i.	Relevance. The tobacco control policies and mechanisms exist and are relevant to assist in reducing the demand for tobacco products and to provide an overview of the progress
- Supply reduction measures	ii.	Sustainability. Progress through the implementation of MPOWER and policies and measures are sustainable
- Research, monitoring, evaluation, implementation and compliance measures	iii.	Efficiency. WHO support to the Member States is administered efficiently and effectively
- Assistance in securing funding for tobacco control/regional and international cooperation	iv.	Effectiveness. The implementation of the tobacco control policies produced the expected results in terms of progress towards the indicators of the WHO FCTC and the WHO NCD Action plan
	v.	Impact. Country-level objective: to accelerate the progress toward achieving Sustainable Development Goals (SDGs) 3.4, 3a

The Evaluation Framework (EF) was the main tool used during the evaluation, structured according to the five OECD DAC evaluation criteria, and comprises the questions presented in the Terms of Reference, and the specific dimensions of the implementation of tobacco control policies and programmes to be assessed (presented in Annex B). The evaluation framework sets out the data sources and methods of data collection to address the evaluation questions. The evaluation framework was composed of three parts:

- EF #1 to assess the progress of the implementation of MPOWER measures regarding the five dimensions: Enabling environment; Compliance; Implementation tools; Partner agencies and Impact (the last one added by the Evaluation Team);
- EF #2 to assess the other 9 tobacco control policies according to the same dimensions;

- EF #3 presents the key questions of the evaluation regarding the WHO ToRs and the OECD evaluation criteria.

Data collection and analysis methods and tools were designed to generate the evidence on the evaluation criteria and questions as set out in the EF. The lines of evidence to assess the WHO Support to the Member States were developed in sequence in order to gradually build up the knowledge-base of the evaluation team and facilitate the analytic discussion and especially the validation of the findings with the partners. The lines of evidence align with each step of the collection data methods, for example:

- Document review at the inception phase was completed to study and map the existing control tobacco control policies and programmes in the SEAR Member States (please see the Inception Report and the Mapping the existing control tobacco control);
- Document review at the data collection phase was done to complete the information gap and produce a preliminary assessment of the progress of the implementation of the MPOWER and other policies according to the Evaluation Framework (EF #1 and EF #2);
- Country interviews and site visits at central and regional levels in the capital and in one or two regions (two regions in Bangladesh, India, Indonesia, Myanmar and Thailand) were conducted to assess MPOWER and the other 9 policies (i.e. to complete the information asked in EF #1 and EF #2 with new lines of evidence);
- Interviews including working sessions or focus groups with the WHO, the technical staff from MOH and other ministries involved and different stakeholders by Skype and/or face-to-face (F2F) were conducted;
- Field missions with country interviews and field visits with key informants and other partners were done to i) validate the preliminary findings (Country Briefs written by the National Consultants from the assessment of the implementation of MPOWER and the 9 other policies - information collected in the EF#1 and EF#2); ii) conduct analytic discussions regarding the main criteria of the evaluation (EF#3); iii) develop the conclusions and complete the data collection;
- Interviews were conducted, including meetings with high key informants: WHO, MoH and other key partners.

The 11 case studies were done through document review and field missions in all countries including four deep dive visits in Bangladesh, Indonesia, Myanmar and Timor (see Annex D for more details). Whilst all case studies are structured along the same lines of enquiry, the deep dives aimed to generate a wider body of evidence than the other six case studies through extensive consultations with a broader array of in-country stakeholders. In all 11 countries, the evaluation team collaborated with the relevant WHO-SEARO and Focal Points (WHO COs). The stakeholders interviewed were:

- Headquarters/regional office (WHO-SEARO);
- Country Staff and experts involved in tobacco control measures (the focal points WHO/Ministry);
- Policy makers;
- Relevant sectors outside health e.g. Customs, agriculture, Finance (taxation); Education etc.
- Non State Actors such as donors, citizen organizations (CSOs), and other partner organizations (Bloomberg Initiative; Southeast Asia Tobacco Control Alliance (SEATCA); Rockefeller Foundation, and Bill and Melinda Gates Foundation.

The analysis was based on the information from all country case studies organized in country data reference notes and sourced by relevant documents, interview notes, and group discussions transcripts. The Country Data Reference Notes include a summary of the progress of the implementation of tobacco control policies and programmes and the questionnaire used to collect data related to each dimension. The deep dive visits include a summary of the preliminary findings for each evaluation criteria.

The summary was based on a «score-card» tool through which the evaluation team followed the evaluation criteria (questions). This scorecard served to arrive at a conclusions on the progress of the implementation according to the five dimensions.

3.3 Constraints and limitations

The constraints and limitations of the evaluation are summarized below:

- The information was collected through desk review, field visits and by telephone. The field visits in the eleven SEAR countries were challenged by time constraints mainly caused by the long questionnaire;
- In some countries, no itinerary was prepared and the meetings were organized by the core team during the visit; some WHO focal points had very limited availability;
- The Government of India restricted the scope of the evaluation and did not want the team to look at the implementation of policies and measures but rather to focus on the effectiveness of WHO's support. This lead to a delay of the India field mission and subsequently of the overall evaluation process;
- Delayed evaluation in North Korea for procedural reasons and laborious communication with the national consultant, which ultimately led to a delay of the data analysis phase;
- Due to lack of data, the team was not able to do an efficiency assessment of the workplans of the WHO COs, nor to analyse financial data.

4 EVALUATION FINDINGS

4.1 Relevance

4.1.1 Relevance of the mechanisms and policies for tobacco control in SEAR countries

Finding #1: The tobacco control measures, policies and mechanisms studied are relevant to help reducing the demand for tobacco products based on the progress many countries have made to reduce tobacco use and smokeless tobacco in the South East Asian Region.

However, given the various challenges that remain (tobacco use among young males, smokeless tobacco use etc.), there is a need to strengthen the implementation of the MPOWER package, including measures to influence supply of tobacco products and cutting edge measures to better fight new products, marketing strategies and political influence of the tobacco industry.

In our view, tobacco industry interference is the major challenge. The companies exploit laws and target young people though advertising, sponsorship and promotion. In most of the countries, legislation needs to be enhanced by including regulatory measures against tobacco cultivation (Bhutan has adopted such measures).

In several countries, responsible ownership is an issue. While the central government usually leads the coordination in the sector, involving all relevant stakeholders, putting tobacco control policies into practice could be done with more force. Strengthening the policy instruments will not bring any change if governments do not shift into "action mode". A strong involvement of CSOs is necessary to hold government accountable.

The WHO FCTC's overall objectives, including the MPOWER package, are becoming increasingly relevant and valid as epidemiology data regarding noncommunicable diseases (NCDs) show persistent high rates in most of the South East Asian countries. The most recent trends of NCDs show that tobacco consumption is embedded in the culture of South-East Asia and is the leading cause of preventable deaths in the region. In some SEAR countries, the rates of prevalence of smoking and consumption of smokeless tobacco remain high after a decade of implementation of tobacco control policies, especially among male adults and youth (see chapter on Impact).

The activities and outputs of the implementation of tobacco control policies in the SEAR Member States are consistent with the overall goals of the WHO FCTC and are in line with its articles. This set of principles and general obligations is the sole and recognized guide to all parties to achieve the objective of this convention and its protocols, and to implement its provisions. The WHO FCTC has proven to be an adequate framework used by governments to introduce their tobacco legislation, which is now available in all SEAR countries. Although Indonesia has not adhered to the WHO FCTC, the country's policies and control measures are very much in line with the best practice laid out in the convention.

The WHO FCTC is the preeminent global tobacco control instrument, consisting of legally binding obligations for its parties, setting the foundation for reducing both demand for and supply of tobacco products and providing a comprehensive direction for tobacco control policy at all levels. All SEAR countries are implementing the various elements of MPOWER, the set of six major "best buys" and "good buys" in tobacco control, each with specific indicators to be measured[20].

---

[20] As explained earlier: (i) **M**onitor tobacco use and prevention policies; (ii) **P**rotect people from tobacco smoke;(iii) **O**ffer help to quit tobacco use; (iv) **W**arn about the dangers of tobacco; (v) **E**nforce bans on tobacco advertising, promotion and sponsorship and (vi) **R**aise taxes on tobacco.

However, the country governments could more forcefully pursue the implementation and enforcement of tobacco control policies. For instance, the legislation (law and decrees) regarding tobacco control needs to be seriously enforced and compliance should be systematically monitored. Governments and relevant ministries could be more proactive and responsible owners of the legislation in terms of enforcement and financial support.

Monitoring of compliance with the law is essential. For instance, law enforcement authorities often do not have the means to monitor compliance with a ban on the promotion of tobacco products, due to the absence of accountable leadership and lack of commitment to foster and lead concerted action involving various stakeholders. National NCD documents lack clear guidance for actionable measures to address tobacco use to prevent NCDs, specifically among adolescents.

More than a decade after the launch of the WHO FCTC, new issues have emerged, such as high prevalence of smoking among the young, and new products have been developed by the industry, such as the electronic cigarettes and newer forms of smokeless tobacco products. The need for inter-ministerial policy and program coordination to reinforce complementarity and the strengthening of anti-tobacco alliances is as strong as a decade ago.

SEAR Member States encounter the challenges described hereafter in the implementation of tobacco control policies and programmes.

Tobacco Industry Interference. The SEAR countries struggle to combat a tobacco industry seeking to pursue new markets, blatantly fighting tobacco control legislation, and interfering with the development of public health policies.

The tobacco industry has thus a strong political influence in all countries, in particular in tobacco producing countries. In Bangladesh, for instance, tobacco companies are continuing their advertisement and promotional activities, and ignoring the law. In Myanmar, the tobacco industry was able to delay the implementation of the Graphic Health Warning law and instead of having eight pictorial warnings on cigarette packs simultaneously, the industry is allowed to use only one pictorial warning per year. In Indonesia, the industry is opposed to any regulation regarding tobacco control (banning of advertisements, health warnings, smoke-free places, raising taxes, banning of sponsorship of sports and musical events). The Jakarta Post newspaper reported in November 2017 about 50 music concerts in the capital city sponsored by cigarette companies in the last two months only.

In non-producer countries, like Timor-Leste and Maldives, tobacco companies exploit inadequate laws and target young people through advertising, sponsorship and promotion.

In several countries, the industry is state-owned (Thailand, Myanmar) and ministers are on the company boards (Bangladesh, India, Sri Lanka). Some NGOs are supported by the tobacco Industry, such as ASH Bangladesh (Action on Smoking and Health) and few others.

A Cigarette Box Given By Companies to Retail Shops in Nepal: the box is to store loose cigarette sticks for retail sales less than a pack

Economic considerations. In the majority of countries, the economic costs of tobacco use are unknown or not acknowledged by decision makers, while the economic benefits of the tobacco industry are well-known, which leads to the perception that tobacco use is economically beneficial for the country. The few cost-benefit studies done on tobacco use

(Bangladesh, India, Indonesia, Sri Lanka) show in fact that the costs are much higher than the benefits in the form of revenue generated. In Bangladesh, the amount of land allocated for tobacco cultivation is increasing.

Institutional issues. Tobacco control is perceived as the sole responsibility of the Ministry of Health. Other relevant ministries such as finance, trade/commerce, Industry, education and agriculture are particularly difficult to sensitize on tobacco control. As a result, promising multi-sectoral strategies are poorly implemented due to lack of accountability and coordination. Tobacco control focal points from different ministries in task forces and other committees regularly change (civil servants are often transferred) which does not help the coordination. Cooperation and coordination between the various governmental and non-governmental stakeholders is generally limited.

Funding. Government funding of the implementation of tobacco control policies and programs falls short in some countries. In most SEAR countries, the programs largely depend on a few international donors, which is not sustainable in the long run. Mainstreaming of tobacco control in health and other relevant sector policies (industry, agriculture) is inadequate.

Advocacy. According to the stakeholders, high level advocacy is needed to address political bottlenecks and obtain improved results (e.g. diplomatic engagement, peer pressure at various national and international fora, and engagement of other sectors in a multi-sectoral approach with different ministries and other UN agencies). Advocacy in this field can only be successful with a long-term commitment. NGOs mention an «effective» raise of taxes on tobacco products as an example where advocacy has failed so far.

The MPOWER package that was put forward by the WHO in 2008 needs to be strengthened in order to address new challenges, such as control of supply, new products entering the market, and refined tobacco industry strategies to target the youth.

Not all South East Asian countries have yet adopted the WHO FCTC guiding principle to develop a comprehensive multi-sectoral approach. The Southeast Asia Tobacco Control Alliance (SEATCA) confirmed the need for a "whole-of-government" approach to prevent the tobacco industry from participation in policy development and to strengthen government accountability.

In all SEAR countries, the evaluation team observed that CSOs are relevant active partners to address the major challenges in tobacco control and play an important role as watchdogs. In countries with a weak "whole-of-government" commitment to tobacco control, CSOs could implement tobacco control measures as a substitute for government. According to CSOs, governments do not always fully cooperate in "putting policy into practice", and there is never sufficient budget for full implementation by the government in most of the SEAR countries.

4.1.2 Relevance of the WHO support to Member states

Finding #2: The WHO support to the South-East Asian Member States is highly relevant. However, after a decade of WHO FCTC implementation, an additional focus on upstream work is needed, such as high-level advocacy and stronger support for a multi-sectoral approach, including seeking synergies with other UN and other donors' programs.

Global mechanisms are in place to evaluate tobacco control policies and programmes in the eleven SEAR countries studied, but country-owned mechanisms for tobacco control monitoring are deficient across the board, in spite of the countries' awareness that annual data updates are highly useful to reinforce tobacco control. Monitoring is expensive and apparently not a priority in resource constrained environments.

The two complementary global reports produced by WHO on tobacco control are comprehensive, but one report would be sufficient given the scarcity of resources and

especially considering the need for specific country-level multi-sectoral data in the SEAR countries.

The WHO support to Member States is triggered by the (i) WHO FCTC; (ii) the Political Declaration of the UN High-Level Meeting on the Prevention and Control of NCDs (2011), which identified tobacco use as one of the four major risk factors for NCDs such as heart diseases, cancer, respiratory diseases, diabetes; and iii) the WHO Global action plan for the prevention and control of NCDs 2013–2020, which highlights some effective tobacco control interventions as "best buys" to tackle the NCD epidemic and attain the SDGs.

For more than a decade, the WHO has provided advocacy to strengthen and promote implementation of FCTC and MPOWER measures including (i) training on tobacco cessation, (ii) support in developing training manuals and modules, (iii) training on survey and research methodologies, (iv) training in tobacco control leadership, and (v) organization of regional meetings where regional and national strategies on tobacco control were elaborated.

WHO's support also included (vi) the organization of expert group meetings on important topics such as tobacco taxation and trade; (vii) capacity building for health and other sectors; (viii) intra-regional and international coordination and cooperation; (ix) the organization of World No Tobacco Day (WNTD); (x) the facilitation of participation of countries to the WHO FCTC Conference of the Parties' COP meetings (xi) alternative livelihoods, and (xii) smokeless tobacco. As a result, the governments in the region adopted WHO FCTC mandates such as bringing in laws and new regulations to reduce the prevalence of tobacco use and exposure to tobacco smoke[21].

According to the stakeholders interviewed in the SEAR countries, the WHO's support to Member States has been very instrumental to the implementation of tobacco control in the eleven South-East Asian Member States. In particular, WHO's upstream work and networking role was considered as highly useful.

Advocacy. The stakeholders appreciate the role of WHO in advocacy for tobacco control and do see a need for advocacy at a higher level in order to address political bottlenecks and tobacco industry interference. In particular government stakeholders expect WHO to take on a high-level advocacy role since multi-layer lobbying efforts are needed, in addition to the traditional technical assistance. High-level lobbying is necessary to encourage the countries to adopt stronger policies and to mobilize increased tobacco control budgets.

Moreover the WHO is well positioned to advocate for a multi-sectoral approach to tobacco control in the Member States. There is room for the WHO to build and strengthen relationships with ministries other than the Health Ministry and promote the multi-sectoral approach. This may entail training workshops with these ministries on tobacco production and control issues, and sharing of "best practices" through national fora.

Cost-benefit studies. SEAR Member States' expenditures on tobacco control per capita are negligible (an average of US$0,036). Recent studies show that governments need to spend only a few dollars per capita in low-income countries to implement effective tobacco control programs, which means that the cost of saving a life is very low when money is spent on tobacco control.

It is crucial for both decision makers and citizens to be aware of the high costs of tobacco use, which are much higher than the tax revenues from tobacco: tax revenues amount to only one fifth (1/5) of the economic costs of tobacco in Indonesia and one out of eight (1/8) in India, according to studies done (see chapter on efficiency). The other countries should do the same type of studies.

---

[21] http://www.searo.who.int/tobacco/documents/sea_tobacco_45.pdf?ua=1

Tobacco control in low-income and middle-income countries is likely to be affordable, even in countries where per capita public expenditure on health is extremely low. Tobacco control interventions are a cornerstone in achieving the targets set for noncommunicable diseases, to which tobacco use is a significant contributor. Investing in tobacco control is thus a cost-effective means of saving lives and improving health, particularly in the South-East Asia Region where resources are limited.

Multi-sectoral approach. As discussed earlier, the multi-sectoral approach has been adopted by countries, but not implemented. It is very difficult to coordinate and fund multi-sectoral programmes in general, and therefore also multi-sectoral tobacco control programs. The WHO is working closely with ministries of Health and Finance to raise taxes on tobacco and unify the taxation system. However, other key sector ministries such as Agriculture, Education, Finance, Customs, Trade, Industry etc. are not involved in tobacco control. According to the government officers and stakeholders (particularly in Indonesia and Thailand), WHO has a significant role to play in networking with non-health sectors and involving them in tobacco control discussion and policy formulation/programme implementation.

Coordination with other donors/UN agencies. Not much synergy exists between donors of tobacco control. The WHO could seize on opportunities to create more synergy with other UN organizations, in particular: with UNICEF and UNESCO who work with youth and are involved in Nutrition or Education; with FAO who deal with agricultural production; and with UNDP, which is concerned with overall development. According to our information, the countries do not have any other specific interventions on tobacco control other than the programme on education. Apart from some school level programmes for tobacco control (e.g. Tobacco free schools guidelines in India), the evaluation team did not come across other programs specifically focused on youth or on farmers.

Research and awareness building. Critical research on the effects of tobacco use can have a high positive impact, but this is non-existent in most of the countries. In Sri Lanka, research on tobacco related diseases led to a significant change in tobacco policy. The study calculated the costs of 36 diseases related to tobacco use, estimated at US$662 million annually, which triggered a substantial raise of taxes on cigarettes. Surveillance studies are not being done at regular intervals and the countries lack funding or capacity to conduct critical research. The research done is generally funded and supported by WHO or other donors such as Bloomberg (e.g. Indonesia, Sri Lanka, Myanmar). A country like Timor-Leste must build up its database on the impact of tobacco use on NCDs from scratch. Bangladesh, India and Sri Lanka also did studies on economic burden of tobacco.

The team was not able to collect the costs of studies and awareness campaigns.

Monitoring. There are two key, complementary global reports produced biennially by WHO (in alternate years) on the tobacco epidemic, and both reports are considered appropriate and comprehensive by the Member States studied. The Convention Secretariat and WHO work together when developing these reports to ensure that their work is complementary and coordinated. This includes exchanging data and mutual analyses and drafting of report sections to ensure clarity, accuracy and objectivity.

Table 2: Similarities and differences between two key WHO tobacco control reports

	Global progress report on the implementation of the WHO FCTC	Global report on the tobacco epidemic
Source of data	Parties to the WHO FCTC (180)	Member States to WHO (194)
Independently verified information	No (countries self-report data)	Yes
Tracks progress in tobacco control	Biennially (even-numbered years)	Biennially (odd-numbered years)
Demand side measures	All measures addressed	Some measures addressed
Supply side measures	All measures addressed	Not addressed
Comparison between countries possible	Qualitative and some quantitative comparisons	Qualitative and quantitative comparisons
Comparison between time periods possible	Yes	Yes

The Global progress report on the implementation of the WHO FCTC reflects actual implementation of the convention at the country level and is produced by the WHO FCTC Convention Secretariat. This report uses Member States' self-reported data to monitor their implementation of the WHO FCTC and its specific provisions. However, according to stakeholders, there are issues of reliability of data and data sources, and of accuracy of indicators used. For instance, some indicator target values are too ambitious, not realistic and need to be reviewed. Some data are missing or are incomplete and indicators are not sex-disaggregated. Some indicators are not well defined and irrelevant to measure the achievement of the WHO FCTC objectives.

The biennial WHO report on the global tobacco epidemic tracks the status of MPOWER measures over time and includes an assessment of achievement levels based on pre-set benchmarks. WHO collects national-level legislation from all Member States and creates a comparable assessment matrix, offering a like-for-like comparison of progress between different policy areas covered by the MPOWER measures.

The two reports contain some duplications and the report on the global tobacco epidemic does not address all FCTC measures, as shown above in Table 2. The sources of information form the substantial difference between the reports, which leads to discussions on data reliability and accuracy. From a perspective of cost-efficiency, the WHO should consider the production of only one report with different sources of information (permitting triangulation).

4.2 Efficiency

4.2.1 Efficiency of the implementation of tobacco control policies and the MPOWER package

Finding #3: Financial and human resources for the implementation of tobacco control policies and the MPOWER package in all SEAR Member States are limited. Results have been achieved in a cost effective manner, but more resources are needed to step up the achievements and to create a greater impact in the region. Considering the huge public health costs of tobacco consumption, scaling up is necessary.

Efficiency wins are possible because hardly any coordination exists between donors and other stakeholders in most of the SEAR countries to use the available resources in the most efficient way, neither at country nor at regional level.

Table 3: Government's annual expenditures on tobacco control (US$) and tax revenues from tobacco products in SEAR countries

	Country	Government's expenditures on tobacco control (US$)*	Gov Tax revenues from tobacco products (US$)	% of expenditures on tobacco tax revenues	Population	Expenditures per capita ($)
1	Thailand	9 500 000	2 450 000 000	0.4%	68 146 609	0,139
2	India	6 225 000	2 900 000 000	0.2%	1 326 801 576	0,005
3	Indonesia	4 000 000	10 250 000 000	0,04%	260 581 100	0,015
4	Sri Lanka	400 000	645 500 000	0.06%	20 810 816	0,019
5	Bangladesh	90 000	1 900 000 000	0.005%	162 910 864	0,001
6	Nepal	90 000	157 000 000	0.06%	28 850 717	0,003
7	Timor-Leste	25 000	15 500 000	0.16%	1 211 245	0,021
8	Bhutan*	23 000	–		784 103	0,029
9	Myanmar	7 500	108 000 000	0.01%	54 363 426	0,0001
10	Maldives	6 000	32 500 000	0.02%	369 812	0,016
11	DPK**	-	1 215 000 000		25 281 327	0,0000
	Total	20 366 500	19 673 500 000	0.1%	1 950 111 595	0,025

* Bhutan does not produce tobacco products and prohibits importations for sale. All tobacco products brought into the country are in principle for personal consumption.

**DPK: Democratic People's Republic of Korea

Source: Data from the WHO report on the global tobacco epidemic 2017, latest available years: 2008 in Bangladesh; 2014 in Bhutan; 2015 in India; 2015 in Maldives; 2016 in Myanmar 2016 in Sri Lanka. Expenditure data for Indonesia, Nepal, Thailand and Timor are from 2017 and have been collected by the Evaluation Team.

In the SEAR region, public investments in tobacco control have been minimal in terms of expenditure per capita and when compared with tobacco tax revenues (see table 3 above). The 11 SEAR Member States annually spend about US$ 20 million all together on tobacco control, which represents only 0.1% of the total annual tax revenues from tobacco products for the region, i.e. US$19.7 billion.

Thailand and India invest a larger amount of money in tobacco control than the other countries, respectively US$ 9.5 million dollars and US$ 6.2 million dollars annually, expenditures that represent 0.4%, and 0.2% of the annual tobacco tax revenues respectively.

Maldives is spending the lowest amount per year (US$ 6,000) and the country also collects the smallest amount of tobacco tax revenues (US$ 32.5 million). In comparison, Bangladesh collects US$ 1.9 billion in tobacco tax revenues, and reinvests US$ 90,000, a meagre 0.005%.

Considering the persistent high prevalence rates of tobacco use, the financial resources invested are insufficient compared to the huge health economic costs of tobacco consumption. Much higher resources are needed to fight the tobacco prevalence rate especially among youth. Studies show that the revenues from tobacco use do not meet its economic costs.

As discussed in the previous section on relevance, the WHO financed a few studies on the economic costs of tobacco consumption (Bangladesh, India, Indonesia, Sri Lanka). According to the Ministry of Health of the Government of Indonesia, revenues from the tobacco excise tax have been steadily increasing to $US 10 billion in 2015, which is 8% of the national budget. However, this amount only represents one fifth (1/5) of the estimated economic costs of tobacco use (US$ 46 billion), including

(i) the purchasing of tobacco (US$ 16 billion), (ii) Disability-Adjusted Life Years (DALY) (US$ 29 billion) and (iii) the medical costs due to diseases related to tobacco use (US$ 1 billion)[22].

In India, the tax revenues from tobacco products (US$ 3 billion) represent 1/8 of the total costs of tobacco consumption ($US 22.4 billion annually). In Sri Lanka, a research study estimated the costs of tobacco consumption at $US 661 million annually. This information was vital in Sri Lanka's decision to raise tobacco taxes. In Myanmar, a macro-economic study is currently being proposed with the support of the WHO FCTC 2030 to estimate the contribution of tobacco-control investments to annual savings in reduced health care costs.

Governments and citizens thus pay for the net costs of tobacco use, and these numbers should be widely communicated to decision makers and voters to increase awareness of this situation.

Eradicating tobacco use is smart politics, from a health and an economic perspective. However, the governments in the region do not allocate an appropriate specific budget for tobacco control. In most cases, tobacco control is streamlined in the regular budget of the Health Ministry or allocated to specific tobacco control units, cells or agencies. With the exception of Bhutan, the countries' studies do not apply an effective multi-sectoral approach, involving multiple ministries.

For instance, in Myanmar, Bhutan and Maldives, it appeared to be rather difficult to mobilize funds for tobacco control from the national budget. As a result, the MoH and other tobacco control units within the government depend on external donors such as WHO, Bloomberg Foundation, People's Health Foundation (PHF), and the Union (see also chapter on sustainability).

Not only are budgets for tobacco control very limited, but the government entities dealing with tobacco control are poorly staffed in the region, as illustrated by Table 4 on the next page.

Table 4: Government's expenditures and number of staff for tobacco control in the SEAR Member States

Budget	Human resources
The Governments of Maldives and Myanmar do not have specific budgets for Tobacco control. In the region they spent the lowest amounts (US$6,000 and $7,500 respectively). No budget is allocated for involvement of non-health sectors in tobacco control. In Bhutan, the Narcotic Control Agency (BNCA) receives a small budget for tobacco control (US$23,000 in 2017), which is insufficient according to the stakeholders met. Non-health sector agencies are mandated to look after tobacco control as part of their regular job, but there is no specific budget allocated for tobacco control in non-health sectors. Bangladesh annually invests only US$ 90,000 despite the high prevalence rate of smoking in the country (55% among male adults). However, the cabinet has recently approved a policy to utilize funds generated from a 1% health tax on tobacco products for tobacco control and health promotion. It is expected that the National Tobacco Control Cell (NTCC) will receive funding from that source in the near future. Non-health sector representatives are involved in tobacco	In the WHO report on the global tobacco epidemic, Myanmar reported three (3) civil servants working full-time on tobacco control. In our country study, we only found one (1) civil servant. The Maldives also reported three (3) agents working on tobacco control in the MOH, but not exclusively (as part of their NCD work). In Bhutan, fourteen (14) full time staff work for the national tobacco control programme. Bangladesh finances from its own budget two high-level (2) civil servants working on tobacco control. Other staff in the MoH dedicated to tobacco control are funded by the Bloomberg Initiative. The National Tobacco Control cell (NTCC) has seven (7) staff members to monitor tobacco use and prevention, supported by The Union. Nepal also employs seven (7) agents in the Tobacco Control Focal Unit in the Ministry of Health and Population dedicated to NCD and Tobacco Control. Sri Lanka houses in the Ministry of Health an entity responsible for monitoring Tobacco use and

---

[22] Soewarta Kosen, et al., Health and Economic Costs of Tobacco in Indonesia, Review of Evidence Series, Lembaga Penerbit Badan Penelitian dan Pengembangan Kesehatan (LPB), September 2017

Budget	Human resources
control taskforce committees at different levels, but no specific budget is allocated for involvement of these sectors in tobacco control. Some (limited) efforts were taken to coach them with respect to their responsibilities.	prevention, the National Authority on Tobacco and Alcohol (NATA), with ten (10) employees.
Nepal has an annual budget of US$ 90,000 for tobacco control that is part of the NCD Program budget of US$ 300,000, at the Ministry of Health in 2017 an amount that represent a negligible 0.028% of the total health budget. The Ministry of Home Affairs has reserved some budget for the Assistant Chief District Officer who is the Inspector for Tobacco Control. Apart from this, there are no clear provisions for involvement of non-health sectors in terms of resources.	In Timor-Leste, a technical unit of the MoH/NCD department dedicated to tobacco control is operational but with only one (1) agent out of the twelve (12) of the NCD department focusing on tobacco use and prevention, and with limited financial resources.
Sri Lanka has a dedicated budget for NCD within the Health budget, from which a part is allocated to the National Authority on Tobacco and Alcohol (NATA). The government reported expenditures of up to US$400 000 in 2016.	Thailand has a developed an institutional structure with a Bureau of Tobacco Control in the Department of Health that counts thirty (30) staff who are working on tobacco control including prevention and monitoring. In addition, the country has established the Thai Health Promotion Fund which deploys 1.5 FTEs dedicated to NCD and tobacco control. The National Statistics Office, in consultation with MOH and external experts, does a biennial survey on tobacco use and prevention.
In Timor-Leste, the MoH prepares a dedicated biennial budget for NCDs and tobacco control (US$300,000), including around $50,000 for tobacco control. However these allocations are still subject of budget negotiations. There is no budget allocation for involvement of non-health sectors in tobacco control.	In India, the National Tobacco Control Cell (NTCC) at the Ministry of Health and Family Welfare (MoHFW) is responsible for overall policy formulation, planning, implementation, monitoring and evaluation of the different activities envisaged under the National Tobacco Control Programme (NTCP). The National Cell functions under the direct guidance and supervision of the senior executive management of the Ministry. Technical assistance is provided on a demand basis by officers in the Directorate General of Health Services i.e. Deputy Director General (DDG)/ Chief Medical Officer (CMO). The NTCC is also supported by consultants in specific areas of tobacco control like Policy, National Coordination, Legislation, IEC etc. India has an elaborated tobacco control infrastructure and reports 400 staff working on tobacco control at all levels of government including the districts.
Of the 11 countries studied, Thailand dedicates the relatively largest budget to tobacco control, funded by the Thai Health Promotion Fund, a government body that is financed by a 2% surcharge levied on the alcohol and tobacco excise tax.	
India spends the second largest budget on tobacco control of the SEAR region through the National tobacco control programme and subnational tobacco control cells.	
Indonesia spends the third most important budget of the region (US$ 4 million), through the NCD Control Directorate. In this country, resources are allocated for the involvement of non-health sectors in tobacco control such as the Directorate of Customs and Tax of the Ministry of Finance, the regional governments (who develop their own smoke-free regulations), or the Ministry of Education, which has released a ministerial regulation to enforce all primary and secondary schools to be smoke-free.	In Indonesia, the government appointed one (1) focal point person in charge on tobacco control in the NCD department of the MoH, where twelve (12) full-time staff work for the NCD program (including the national tobacco control programmes).

4.2.2 Efficiency of the WHO's support on Tobacco control in SEAR Member States

Finding #4: The WHO has been instrumental in supporting the implementation of WHO FCTC and MPOWER despite its limited budget to support Member States' efforts to control and reduce tobacco use. There is scope for improvement in coordination among various levels of WHO for providing technical support at the country level.

Finding #5: MPOWER is perceived as a set of measures to be implemented by Governments, and supported on-demand by WHO units and country offices, rather than a coherent WHO program of support to countries with a program governance structure, a results framework, and defined mutual accountabilities.

WHO support to countries is very much activity- and input-driven rather than results-driven. Monitoring of measures (regular reporting) is an important activity supported by WHO. However, hardly any data are available to measure the impact of MPOWER in terms of reduced health care costs or lives saved for instance.

The long-term effort against tobacco consumption has led to a certain fatigue at the country office level, particularly in countries where no external donors, such as Bloomberg, are present. The continuation of the same staff at the country office level for a long time has led to demotivation and reduced capacity. The internal incentives to put in effort and develop capacity in tobacco control are relatively low. The focus on tobacco control has been diluted due to the integration of tobacco control in NCDs. Fostering a new esprit and energy is essential for WHO's efficiency in tobacco control.

The WHO country offices in the South-East Asian Region operate with limited budget to contribute to the Member States' efforts to tobacco control. The most important WHO support budget amounts up to US$ 200,000 annually in India and Indonesia, partly co-financed by donors such as Bloomberg, US$ 150,000 in Nepal and in Timor-Leste and approximately US$ 100,000 in Bangladesh. These budgets vary every year. For instance, in 2017 Bangladesh budgeted US$400,000 in tobacco control, which included the Global Adults Tobacco Survey with the CDC Foundation. In Bhutan, WHO provides to the MoH an amount of $25,000 annually to build capacities on tobacco cessation, monitoring and sensitization campaigns. In Thailand, the main WHO financial support came in 2015 for the GYTS survey. The expenses in tobacco control made by the WHO country offices in Maldives and Myanmar are negligible and are mainly used to finance the World Tobacco Day events.

The SEAR WHO country offices also work with limited human resource capacity, which impacts the efficiency of the support given to the Member States in the implementation of WHO FCTC and the MPOWER packages.

The overall WHO support to WHO FCTC implementation is organized according to the following categories of work: (i) demand reduction measures (MPOWER); (ii) supply reduction measures; (iii) research, monitoring, evaluation, implementation and compliance measures; and (iv) assistance in securing funding for tobacco control/regional and international cooperation. WHO mainly supports the activities under the category of Demand reduction measures (MPOWER) through technical assistance (with consultants, including studies), training, and advocacy.

To support the SEAR countries on tobacco control, the WHO Country Offices supported by the Bloomberg Foundation are in a much better position than the other WCOs in the SEAR region. In response to the persistently high prevalence rates in Indonesia, the WHO country office works here with two fully dedicated staff on tobacco control: one international staff specialised in public health and one national expert with legal expertise. In India, two staff are dedicated to tobacco control are also funded by Bloomberg International (one fully and one partly). It is important to note that until 2014, the WHO also supported the salary of 18 National and subnational level consultants to support the establishment of tobacco control cells in India.

In Bangladesh, two staff members are dedicated to the WHO NCD cluster, and tobacco control is just one of their activities. One staff is supported by Bloomberg. A national adviser has been appointed for research and publications.

The other SEAR WHO country offices support the Member States with only one staff, who is not necessarily a tobacco expert and generally not fully dedicated to tobacco control, but to the overall NCD portfolio. Moreover, most of these focal points have been there for many years, and as a result of this long-term effort, absence of incentives, and low budget, their motivation seems to be affected, especially those who have been there for more than a decade.

The 11 countries rely on the WHO for tobacco control support, but the organization cannot always respond adequately to the government's demands, especially with respect to technical expertise, as a result of the situation described above. For instance, the WHO country office in Myanmar finances the World Tobacco Day, but does not have programmatic funds for technical assistance and limits its technical support to foreign observation trips and workshops for government officials. Yet, the tobacco taxation legislation in Myanmar is very weak, and the WHO CO does not have the capacity to adequately respond to this challenge. According to stakeholders we met, specialized requests for technical support are forwarded to WHO-SEARO. In this case, the strength of the tobacco control policy in the country is a direct function of the strength of the WHO country office.

The WCO in Thailand is apparently less active in tobacco control compared to five years ago when a dedicated person was appointed to take care of tobacco control, according to our informants. Two staff dedicate 1/10th of their time to tobacco control and prevention. The CO supports monitoring, advocates for the recently adopted tobacco law or for tobacco control in relation to NCDs, and promotes a multi-sectorial approach to tobacco control by inviting the Excise Department of the Finance Ministry to the discussion with the health sector. But stakeholders reported that the WHO's priorities are increasingly geared more towards NCDs and other areas. In this respect, it is relevant to notice that the rates of prevalence in Thailand and Myanmar are still over 40% among male adults overall and 20% among young males.

For a country like India, the second largest consumer of tobacco in the world, there has been one staff member at WCO for almost 15 years and a consultant has been added recently with Bloomberg's support.

Resource mobilization on tobacco control is a difficult task, and tobacco control has not attracted more international and national funding. According to WHO, NCDs in general, and tobacco control in particular, are not popular subjects among local donors or international donors presently in-country. For instance, all government support and funding in Timor-Leste on tobacco control rely on WHO. In Indonesia, half of WHO's support on tobacco control depends on one sole external donor, which is a serious risk for sustainability of funding. Bloomberg is the sole external donor of WHO's tobacco control activities in the region, apart from core funding for NCDs coming from HQ (which includes tobacco control). The Bloomberg funds on tobacco control that are allocated for Bangladesh, India and Indonesia have been available since 2008 and are supposedly secured until 2022.

Some country governments are the major financiers of tobacco control activities, as is the case in Thailand where the Government has secured funding for a decade with a dedicated two percent surcharge levied on alcohol and tobacco excise tax (however, this is relatively low). In general, there is no clear path and sustainability strategy to replace external funds by national funds and to use available external funds more strategically (leveraging of national funds; upstreaming work). WHO should actively pledge with central and local partner governments to secure national funding, not only with public health arguments but also, and perhaps more importantly, with macro-economic arguments. Fundraising among the countries' rich could be another option (see sustainability).

WHO's country planning needs focus and priorities because of the limited resources available. The WHO Country Cooperation Strategy (CCS) is a medium-term vision for WHO's technical

cooperation with a given member state and supports the country's national health policy, strategy or plan. The CCS is aligned with the country's needs and policies, and prioritizes actions according to the available budget. The annual work plan is closely elaborated with the MoH. The WHO country representative is accountable for the results on the Country Cooperation Strategy (CCS). The Country Office is also accountable vis-à-vis the HQ for the global outcomes of tobacco control.

WHO's global planning follows a biennial cycle (12th programme of work), whereas the country office follows an annual cycle and produces annual work plans, responding to country needs. Therefore, the country office prepares its annual plan quite independently from the regional office and HQ. Given the lack of coordination at different levels within WHO and scarcity of the resources, it is efficient to focus on a few key elements where the WHO-CO has core expertise and appropriate human resource capacity, such as in Indonesia.

Notwithstanding the limited resources, overlapping activities is an issue (e.g. Myanmar, Nepal), because there is hardly any coordination between funding partners, very little at country level and none at regional and international levels.

The systematic coordination is not only absent between the donors but also within the WHO itself. WHO COs for instance produce information for the three bi-annual monitoring reports (NCD, WHO FCTC, and MPOWER), and for the annual Regional Director's report. However, they do not report on a regular basis to WHO-SEARO, and hence the tobacco control officer, who is best placed to coordinate, is only informally aware of what is happening in the countries. Moreover, monitoring is principally output monitoring, not necessarily outcome and impact monitoring.

The Tobacco Free Initiative Unit (TFI) in Geneva directly responds to countries' needs, which is a good principle. However, the TFI does not systematically coordinate with WHO-SEARO, who in turn has no coordinating authority with these colleague departments. MPOWER is not set up as a program with internal coordination, accountability, financing, and reporting mechanisms.

Reporting on tobacco involves high transactions costs. A lot of relatively expensive monitoring is done for various international fora without much apparent effort to harmonize the databases that feed these monitoring reports. The development of one database and one set of monitoring criteria would ease the task of Governments and WHO COs and bring more efficiency.

Following the Paris Declaration on Aid Effectiveness[23], it would be useful to move towards joint or at the least coordinated funding and evaluations. For instance, our evaluation team could not get access to the report of the evaluation that Bloomberg commanded two years ago of their tobacco control support.

Different global reports are produced, but at the more operational level of WHO-SEARO, an internal systematic reporting mechanism on tobacco control is lacking. The WHO reports monthly to Bloomberg, and reports annually within the NCD unit to the WHO Representative. There are informal meetings with WHO-SEARO such as phone calls or meetings during regional or global conferences. Once a year, the WHO's focal points in tobacco control in the SEAR region are meeting thanks to the Bloomberg funds. There is no regular format or formal reporting for the tobacco control team in the 11 SEAR countries.

For Bloomberg Initiative (BI) supported countries, WHO also participates in the monthly CSO partners call coordinated by The Union, an international voluntary organisation and a partner organisation with BI, providing a platform to fight TB, HIV, asthma, tobacco and lung disease.

---

[23] http://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm

4.3 Effectiveness

4.3.1 Effectiveness of the implementation of the MPOWER package

Finding #6: All SEAR Member States have adopted moderate to good MPOWER tobacco control strategies between 2007 and 2017. The most progress was made in Health Warnings (W), Smoke free policies (P) and Media campaigns (W). Results in the fields of Monitoring (M), Compliance (E) and Taxation on tobacco products (R) fall short. According to the stakeholders met, Offer-to-quit (O) measures could be effective but this field received insufficient attention in most of the countries (with the exception of India and Thailand).

The Member States have made varying level of progress in the implementation of the MPOWER Package and the 'Best buy practices' and interventions, specifically:

Monitor tobacco use and prevention policies. Monitoring scores are moderate because it is not systematically done in most of the countries, with the exception of some countries like Thailand, where the National Statistical Institute regularly monitors (Thailand, Indonesia, Myanmar and Nepal got in 2017 the maximum score, 4, on monitoring ''R''. See Table 5 next page). According to the *WHO report on the Global Tobacco Epidemic*, these four countries succeeded to collect recent, representative and periodic data on tobacco use at least every 5 years for both adults and youth.

All other countries collected data for either adults or youth. The quality of monitoring in India, Bangladesh and Sri Lanka even decreased over the last few years according to the WHO report.

In general, the tobacco control monitoring and surveillance mechanism lacks funding, which leads (among other things) to partial data-collection and to long and irregular intervals between the surveys. The data from the surveys are used by the Member States to support the development of tobacco control policies, but have not been used yet for impact evaluations of the existing policies related to tobacco control.

Member States in the region have completed between one to four rounds of the NCD risk factor survey[24].

Protect people from tobacco smoke. Smoke-free zones are being put in place by all 11 countries, yet are not in all cases effective. Compliance with this legislation is a major challenge in all countries. Most of the countries have good (Bangladesh, Bhutan, India, Sri Lanka, Timor-Leste) to very good (Nepal and Thailand) "P" legislation implemented, as shown in Table 5 below. In several countries, fines are levied on smokers, not to the facilities; in other countries fines are levied on both the smoker and the establishment (Bhutan, India, Maldives, Myanmar, Sri Lanka).

Bhutan, Nepal and Thailand report to have 100% tobacco smoke-free public places and Sri Lanka reports to have >90% of its population covered by smoke-free laws. However, smoking is permitted in designated smoking areas indoors (Bhutan), designated smoking rooms (DSR) for restaurants and pubs/bars (India) or in airports, hotels having 30 rooms or more, and restaurants having a seating capacity of a minimum of 30 persons (India, Thailand, Sri Lanka). Thailand has recently strengthened its smoke-free legislation, bringing more places within the purview of the smoking ban including beaches.

---

[24] http://www.who.int/ncds/surveillance/steps/reports/en/

Table 5: Progress on MPOWER measures implemented by the SEAR Member States

Country	M (Monitoring			P (Smoke-Free Policy)			O (Cessation Programmes)			W (Health Warnings)			W (Mass Media)			E (Advertising Bans)			R (Taxation			Average Score MPOWER	Average Score MPOWER	Progress Score MPOWER
	2007	2017	Δ	2007	2017	Δ	2007	2017	Δ	2007	2017	Δ	2007	2017	Δ	2007	2017	Δ	2007	2017	Δ	2007	2017	2007-17
Bangladesh	3	2	-1	2	4	2	3	3	0	3	**5**	2	0	**5**		4	4	0	4	**5**	1	2.7	4	1.3
Bhutan	2	**4**	2	4	4	0	2	4	2	2	2	0	0	2		2	4	2	* -	*	*	2	3.3	1.3
DPR Korea	1	2	1	2	3	1	4	4	0	2	2	0	0	**5**		2	2	0	1	2	1	1.7	2.9	1.1
India	2	1	-1	3	4	1	3	**5**	2	2	**5**	3	0	4		4	4	0	3	3	0	2.4	3.7	1.3
Indonesia	3	**4**	1	3	3	0	3	3	0	2	4	2	0	**5**		2	2	0	4	4	0	2.4	3.6	1.1
Maldives	2	2	0	2	3	1	3	4	1	3	3	0	0	2		4	**5**	1	3	4	1	2.4	3.3	0.9
Myanmar	3	**4**	1	3	3	0	3	4	1	2	4	2	0	2		4	4	0	2	3	1	2.4	3.4	1
Nepal	3	3	0	2	**5**	3	2	4	2	2	**5**	3	0	**5**		2	**5**	3	2	3	1	1.9	4.3	**2.4**
Sri Lanka	4	3	-1	4	4	0	3	4	1	2	**5**	3	0	2		4	4	0	4	4	0	3	3.7	0.7
Thailand	3	**4**	1	2	**5**	3	4	4	0	5	**5**	0	0	**5**		4	4	0	4	4	0	3.1	4.4	1.3
Timor-Leste	2	3	1	2	4	2	2	2	0	2	4	2	0	4		2	4	2	1	3	2	1.6	3.4	1.9
Average	2.5	2.9	0.4	2.6	**3.8**	**1.2**	2.9	3.7	**0.8**	2.5	**4.0**	**1.5**	0	**3.7**		3.1	**3.8**	**0.7**	2.5	3.2	**0.6**	2.3	3.6	1.3

DPR Korea: Democratic People's Republic of Korea

Δ: Variance between 2017-2007

* Bhutan has completely prohibited production and sale of all tobacco products since 2010, so there is no taxation.

Score MPOWER_Group : 1 : highly insufficient; 2 insufficient; 3 moderate; 4 good; 5 very good. In the Monitoring column, 4 is the highest score - very good. See Annex E for the complete explanation of the score.

Source: WHO Data base on progress monitor 2007-2017 (TABLES WHO HQ RGTE17_CoreDataSet.xls)

In Nepal, smoke-free areas have been listed and outlined as a ban. But the smoke-free laws are partially implemented and monitoring of the practice is not very frequent, according to the stakeholders. Measurement of air quality is not done. Compliance was not reported in the GTCR for 2017. Violations at hotels, prisons, and airports are not reported either. The smoke-free areas law of Indonesia, a national law, can only be implemented when the provinces pass their own legislation at the subnational level.

Offer help to quit tobacco use. The evaluation team observed generally a remarkable high level of willingness to quit tobacco across the board (> 60%). India shows a very good implementation of the O measure: it implemented a national quit-line and a Mobile cessation service, and the costs of both Nicotine replacement therapy (NRT) and some cessation services are covered by the Government.

According to Table 5 above, most of the countries have moderate to good cessation measures implemented, except for Timor-Leste where no program is available. In most of the countries, little real attention was given until recently to offer-to-quit programs, which were not very effective as a result. However, it seems that these programs have recently received renewed attention.

Indonesia for instance introduced and allocated some resources for smoking cessation programs, which include smoking cessation counselling in local healthcare centers and developed in 2016 a national quit line program. Yet, only 500 healthcare facilities out of over 10,000 healthcare facilities in the country are included in this program and the quit line service is open from 8 am until 4 pm and functions with two supervisors and eight counsellors. Resources are thus lacking for a 24 hour a day service and to reach out to more health facilities, but international donors are not interested in this area, according to the MoH of Indonesia. We see the same pattern in Sri Lanka, where a program and infrastructure are in place for tobacco cessation with a quit line (subnational) that operates from 9am to 4pm, and with cessation programs with limited professional capacity at district health centers and a rehabilitation service at the state hospital for serious tobacco smokers.

> **Box 1: Mobile cessation for tobacco**
>
> The idea of mobile cessation for tobacco was floated in India since 2015-2016. The high digital penetration in India through mobile telephony was a major impetus for introducing M Cessation for tobacco. Challenges were the various languages, variable literacy, introducing the idea of self-help for care and the lack of available, easily accessible and affordable tobacco cessation interventions in the country.
>
> As part of the initiative, a digital library for M cessation was adapted to the Indian setting and translated into Hindi. The Government co-ordinated this activity along with other experts with the support of the Ministry of Health and Family Welfare. The M Cessation module, unlike in other countries, was developed for all forms of tobacco, both smoking and smokeless. Along with this, web-based messaging on the reasons for quitting, how to handle cravings, how to sleep better, and how to quit were also developed. The programme was launched country-wide through the National Health Portal in 2016-17.
>
> *Source: India's Country data reference notes, 2018*

The approach used is principally medical, through cessation clinics and the use of alternative drugs (nortriptiiline). A behavioral change approach is applied in some places, e.g. the quit lines, lifestyle centres (Sri Lanka), patient counselling by clinics (i.e. India, Thailand, Nepal) and a professional alliance (Thailand). Some countries (Thailand, Timor-Leste, India) do have specific tobacco control programs focused on poor people, as part of the village health worker package. A Cessation tool-kit is available for citizens in Maldives. Tobacco dependence treatment guidelines are available in Bhutan, India and Thailand.

Warn about the danger of tobacco. All countries have health warnings on packs of tobacco products, but GHW are not implemented in all countries (e.g. Maldives and DRP Korea have text warnings only). Some countries do not organise media campaigns (e.g. Maldives, Myanmar and Sri Lanka), as these are expensive and it is difficult to measure their impact on paradigm shifts.

Some countries such as Bangladesh, India, Nepal, Sri Lanka and Thailand are international best practices. These countries have adopted large health warnings (≥50% of the package) with seven appropriate characteristics and conducted a campaign including airing on television and/or radio. Pictorial warnings covering a significant area on tobacco product packages have been implemented in Bangladesh (50% on both sides of the package of all tobacco products), India (85%), Sri Lanka (80%), Thailand (85%), Nepal (90%), and Timor-Leste (80% on front and 100% on the back). The Sri Lanka Cabinet has approved plain packaging of tobacco packs).

In Maldives, the textual warning covers 30% of the packet (based on the Ministry of Health (MOH) circular in 2011), but the warning itself is ineffective as it has been the same for too long. MOH, The Tobacco Control Board and WHO have worked on graphical health warnings on the tobacco packages. The regulations have been prepared to introduce these warnings, but these have been stalled by the President's office and are not yet implemented This

Graphic health warnings in Myanmar: as showed, not all packs are compliant with the law

country does not organize mass media campaigns on the dangers of tobacco use. Working with the media is left to some NGOs who execute advocacy programs.

In DPR Korea, packaging and labelling is controlled by the law and nationwide anti-tobacco mass media campaigns are conducted on a regular basis. Description of health warnings on tobacco package is mandatory, but it is a relatively small textual warning not accompanied by a pictorial warning. In this country, the share of the population reached by public awareness programmes and mass media campaigns is relatively limited.

In Bhutan, as part of Tobacco Control Program, media campaigns are organized, funded by WHO and using printed press and radio. The campaign advertisements of 4 – 5 minutes are aired 20 – 30 times in a year, which is not much, and do not target specifically the youth among whom prevalence rates are increasing (cigarettes). Nevertheless, 74% of youth noticed anti-tobacco messages in the media[25] and 70 - 80% of the population was reached by anti-tobacco campaigns.

Enforce bans on advertising, promotion and sponsorship. The majority of the countries have banned tobacco advertising in mainstream media and prohibited promotions and sponsorship events, but not all countries enforce the bans well nor monitor compliance. With some exceptions, most of the countries have not developed corporate social responsibility (CSR) regulations (Nepal and Thailand recently passed the regulation, in 2017).

Maldives reports ban of all forms of direct and indirect tobacco advertising, but CSR regulations are pending. However, due to insufficient mechanisms and tools for monitoring and enforcement, violations of the bans on promotion and sponsorships occur. Tobacco promotion can be observed nationwide in Maldives, and some of these events have even been given social media and print media coverage. Nepal has clear provisions in the laws, but monitoring seems weak as surrogate

---

[25] GYTS 2013

advertisements exist in the form of internet sales, CSR activities and logo displays. No enforcement guidelines are available.

Tobacco companies in Bangladesh and India ignore the law while continuing tobacco advertisement and promotional activities, notwithstanding the existing comprehensive bans on tobacco advertising, promotion and sponsorship (TAPS), but, according to the stakeholders, tobacco companies in these countries organize increasingly aggressive sale events.

In Myanmar, tobacco companies use hostesses with a coloured uniform of the tobacco brand at point of sales for promotion, discount and marketing. In this country, the tobacco industry supports community development through their CSR-program, which is in fact a promotional activity. In 2017, the American Chamber of Commerce in Myanmar gave the award for the best performing CSR program to an international tobacco industry, which owns a large cigarette production site in the country[26].

Indonesia's regulation on tobacco advertising is highly insufficient as it is not a prohibition but merely a restriction. As a matter of fact, tobacco advertisements can be seen in Indonesia between 9:30 pm up to 5:00 am. Billboards are allowed as long as they do not exceed 72 square meters in size.

Raise taxes on tobacco. Since the introduction of the WHO FCTC more than a decade ago, the SEAR countries steadily improved their taxation standards for tobacco products. All countries tax the tobacco products at varying levels, but by and large not high enough to make products unaffordable for a large part of the population. Moreover, a large informal market exists in the countries where compliance is not effective.

In Indonesia, which is not a party to the convention, the excise duty on tobacco products increased annually by an average 10%. The last reform in 2017 succeeded to simplify the regime (less variability for different products) but did not sufficiently affect the affordability of the products for the consumers. Since 2012, government revenue from tobacco excise duty has been increasing, which indicates that the regulation does not influence smokers to quit or prevent young people from starting to smoke. A young person can still buy an individual cigarette for a dime.

Bangladesh, Sri Lanka and Thailand report an excise duty on tobacco that represents more than 75% of the retail price (77%, 75% and 87% respectively), in line with WHO's recommendations. Indonesia, Maldives, Sri Lanka, have established duties between 51 – 75% of retail price. In India (despite a significant increase in 2014), DPR Korea, Myanmar, Nepal and Timor-Leste, the duty is less than 50% of the retail price, according to the WHO report on the global tobacco epidemic (2017).

Despite the 77% tobacco excise duty in Bangladesh, cigarette prices are among the lowest in the world, and local hand-rolled 'bidis' are even cheaper (mostly sold on the informal market), as is the case in India. According to the stakeholders, the tobacco industry keeps the base price very low so that the prices do not go up significantly even after taxation. The industry created different categories of prices, and the tax burden on their cheaper products is therefore relatively limited compared to their expensive brands. As a result, people switch between different brands instead of quitting.

Sri Lanka has also gradually increased the excise duty on tobacco products, but the increase is not at par with raising incomes (indicated by GDP), so smokers, including smokers living in poverty, do not have much difficulty purchasing cigarettes. Moreover the excise duty on tobacco products in Sri Lanka is complicated and non-transparent as it is for other commodities.

As best practices, we can mention Thailand which has established a Fund (Thai Health Promotion Foundation) that draws upon a dedicated funding of 2 percent of the alcohol and tobacco excise duty

---

[26] 2017, SEATCA, Review of Tobacco related CSR activities in ASEAN region

revenues; Bangladesh intends to establish such a fund as well. Thailand also earmarks 1.5% of their alcohol and tobacco excise duty revenues for broadcasting of anti-tobacco messages.

4.3.2 Effectiveness of the implementation of tobacco control policies

Finding #7: SEAR Member States have put in place tobacco control laws and regulations in one form or the other, operationalizing the provisions of WHO FCTC, but at the same time face serious challenges in implementing some articles such as 5.3 (Tobacco industry interference), 15 (Illicit trade) or 17 (Economically viable alternative activities). All countries have developed Smoke-free laws for Health-care facilities and other public spaces, as well as laws to prohibit sales to minors, yet with various levels of compliance.

Of the 11 SEAR Member States, Bhutan has the strictest policy on tobacco control in place with the Tobacco Control Act 2010, entirely prohibiting tobacco cultivation, manufacturing, selling and distribution. The law allows importation for personal consumption. Other countries like Thailand and India are recognized for their leading initiatives in establishing evidence-based and best-practice MPOWER and other tobacco control measures. *In general, the countries focus on MPOWER and as a consequence show weak implementation of the 9 other tobacco control policies.*

The interference by the tobacco industry is a key issue, particularly in the countries where the industry has production sites. Indonesia is among the world's top 5 tobacco producers along with India. Bangladesh, Nepal, Myanmar, Sri Lanka and Thailand also produce tobacco to a lesser extent. In these countries, law enforcement and compliance monitoring are relatively weak, and the tobacco industry is successful in influencing tobacco control regulations (e.g. health warnings, excise duties, prohibition of advertisements/sponsorship/promotion). Several countries (e.g. Indonesia, DPR Korea, Maldives, Myanmar, Thailand) do not have a policy yet to prioritize public health over industrial production or to protect public health against tobacco industry interference (Article 5.3 of WHO FCTC).

As already mentioned, Indonesia did not sign the WHO FCTC, but the MoH, with the support of SEATCA, adopted a code of conduct for tobacco control as part of the civil service reform initiated by the government to manage conflicts of interest, a key achievement that will help the MoH to somewhat curtail tobacco industry interference.

In Maldives, the 2010 Public Health and Tobacco Control Act prohibits any government engagement with the tobacco industry, but the legislation with respect to article 5.3 of the FCTC has not yet been enacted and there is no policy nor regulation to protect public health against vested tobacco industry influence. Nevertheless, a practice has evolved where the MoH, and in particular the Health Protection Agency (HPA), does not engage in any dialogue with the tobacco industry. However, this does not stop other government entities from doing so, according to the stakeholders. Lobbyists from the industry are observed at decision-making levels in parliament and in government.

Recently, in 2017, Thailand passed a law that forces the administration to control interference from the industry. The country intends to launch a code of conduct for government staff on how to deal with tobacco industry (the policy is currently in the draft stage). Thailand ratified the WHO FCTC in 2004 but, just like Myanmar, has a government-owned tobacco company, creating a conflict of interest within the government among various ministries.

In other countries (e.g. Bangladesh, India, Sri Lanka), government officials are members of the boards of tobacco companies.

Some SEAR countries have adopted policies to protect public health against the vested tobacco industry (Bangladesh, India, Nepal, Sri Lanka and Timor-Leste), but they all encounter tobacco industry influence anyway.

- In Bangladesh, the Smoking and Tobacco Products Usage (Control) Act was adopted in 2005 and the rules for implementing the law have been enacted in 2015. However, the country has not yet implemented article 5.3 of the WHO FCTC. No communication strategies are in place, and no Code of Conduct for government officials is available for dealing with tobacco industries. Tobacco companies in Bangladesh hamper the implementation of the existing tobacco control legislation, just do not comply with the law, or undermine law enforcement.

- India adopted the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act in 2003 (COTPA) and the law came into force in 2004. The WHO FCTC was ratified in 2005. The GOI has committed to implement the article 5.3. Recent articles in newspapers expose the lobbying efforts by the tobacco industry and state that "the industry spares no attempt to deter, dilute, or delay effective measures for tobacco control." The Tobacco Board under the Commerce Ministry supports tobacco growing and the Central Tobacco Research Institute promotes research on tobacco crops.

- In Nepal, the 2010 Act and Directives 2011 & 2014 allow protection of Public Health against the vested interests of the tobacco industry. The law prohibits all advertisement, promotion and sponsorship activities by the tobacco Industry. Although the country does not have a specific policy on tobacco industry interference, clear provisions exist in the existing legislation to ensure no unnecessary interference by the industry through media or any other means. According to the interviews, no actions are seen to discourage tobacco production and manufacturing, in spite of the recent adoption of corporate social responsibility regulations.

- Sri Lanka has adopted the National Authority on Tobacco and Alcohol Act No. 27 of 2006, but there are no clear rules for government officials and employees working in tobacco control regarding engagement with the tobacco industry. For example, officers do not have to sign a declaration indicating potential conflict of interest. A few members of the Board of Directors of Ceylon Tobacco Company PLC (CTC) are civil servants or staff of semi-government organizations.

- In Timor-Leste, the decree No.14/2016 concerning tobacco imports (no tobacco product manufacturers are present in the country) has been enacted, but the country needs WHO support to advocate for the implementation of this decree through policies and a code of conduct. Tobacco is grown in two municipalities and the production is negligible and only for the local market.

In Bangladesh, Nepal, and Sri Lanka, legislation does not include any provisions regarding tobacco regulation through testing of tobacco products content and emissions. Some regulations do exist in India, Indonesia, DPR Korea, Maldives, Myanmar and Thailand and Timor-Leste, but these are not up to WHO norms and standards for tobacco products content and emissions.

In India, the law requires disclosure of information about ingredients of tobacco products, but there is no mechanism in place to regulate thorough testing of the content and emissions given the absence of laboratory capacity to do so. The government is now establishing three labs to test tobacco products, which are likely to become operational in the near future.

In Thailand, regulations prohibit the use of misleading terms and advertisements that would cause a consumer to believe a tobacco product is relatively harmless or that encourages consumers to consume a tobacco product. However, the regulations do not specifically prohibit the use of figurative illustrations.

In Indonesia, the restrictions on additives that are put in place are not scientifically proven safeguards and do not apply for cigarettes with local content, e.g. clove, incense, rheum officinal.

In Timor-Leste, the government has established a disclosure policy, ordering the tobacco importers to disclose all ingredients of tobacco importations, but no guidelines have been developed, and monitoring is not regularly conducted due to inadequate financial resources.

The law in DPR Korea provides for display of nicotine and tar level on all cigarettes packages, which gets strictly monitored through established mechanisms.

All countries have adopted laws to prohibit sales to minors (< 18; some countries < 20), but the implementation, enforcement, and surveillance of this regulation appears to be challenging. Thailand and India have developed best practices in this area. Thailand actively promotes smoke-free schools and universities, and the recently reviewed legislation increased the legal age of smoking from 18 to 20. India has developed guidelines for tobacco free schools.

Legislation for smoke-free health-care facilities exist in all countries, but is implemented to varying degrees, and there are generally no guidelines for enforcement of these rules to make health facilities free of tobacco. Better monitoring mechanisms need to be established.

Illicit trade is a problem in all countries, even for countries that have banned production like Bhutan where illegal cigarettes are sold on local markets and no taxes are paid. The member countries have general legislation to counter illicit trade, but according to our information, they do not have specific legislation to counter the illegal production, manufacturing, and importation of tobacco products.

Only Sri Lanka had signed and ratified (in 2016) the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products. Myanmar has signed, but not yet ratified, the treaty. In Sri Lanka, however, enforcement is a challenge because, like in Bhutan, illegal cigarettes and beedis are being sold on the market at cheaper rates than legal products (half the price), which reinforces affordability. India has acceded to the Protocol in May 2018.

With the exception of Bhutan, where tobacco production is prohibited, we have not come across a policy in practice to regulate tobacco cultivation. Tobacco production has increased in Bangladesh, Indonesia, Myanmar and Sri Lanka, remained steady in Thailand, and was reduced in India and Nepal. Data was not available for Timor-Leste and DPR Korea. No tobacco is grown in Maldives.

Some countries have put in place alternate livelihood programs: In India, the Crop Diversification Program under the National Agricultural development program Rashtriya Krishi Vicas Yojanapays provides attention to alternate livelihoods for tobacco producers. India is also implementing alternate livelihood programs for bidi rollers, especially women, under existing programmes of the Government.

In Nepal, the law discourages tobacco farming and recommends alternate livelihoods for workers in the tobacco industry, however, at present there are no mechanisms in place to put this into practice.

Workshop for Tobacco Farmers on Alternative Crops 2012-13, State Tobacco Control Program sponsored by the WHO, Andhra Pradesh, India.

In Sri Lanka, the government decided to promote alternative crops for tobacco farmers in 2017, and a program was field tested in one area with 50 farmers with the objective to provide all tobacco farmers an alternative livelihood by 2020. However, the Ceylon Tobacco Company (subsidiary of British American Tobacco) provides considerable facilities and incentives for tobacco growing farmers and their families to keep them in th business.

In Myanmar, the government made a decision in 2016 to encourage farmers to grow alternative crops instead of tobacco, but failed so far to put this intention into practice; no projects are in implementation currently. Bangladesh has recently taken the initiative to draft a policy to encourage farmers to look for alternative crops. In Thailand, the government owns the largest tobacco manufacturer in the country (Thailand Tobacco Monopoly), which operates under the supervision of the Ministry of Finance and generates significant revenues. No alternate livelihood programs are being implemented.

Most countries have centralized tobacco control in an inter-ministerial structure with dedicated staff (e.g. Bhutan, Indonesia, India) under the supervision of the Ministry of Health. Over time, tobacco control has been integrated in national NCD strategies. India, Indonesia, Nepal and Thailand still have national strategies for tobacco control. The other countries are developing and implementing multi-sectoral NCD action plans. In Timor-Leste, for instance, there is no specific tobacco control strategic plan in place, but the NCD strategy contains key indicators for Tobacco control. The MoH has empowered municipalities to implement subnational level tobacco control programmes, carried out with the financial support and guidance of the MoH.

A multi-sectoral tobacco control approach has been developed in India, Indonesia, and Thailand, and was applied in Nepal until 2016 and in Bangladesh from 2007-2010. For all other countries, it is a new approach. As discussed in the section on relevance, these plans are generally not accompanied by specific budget allocations, nor by a clear definition of roles and responsibilities.

Annex A provides more details for the 11 countries studied.

4.3.2 Effectiveness of the WHO support

Finding #8: The WHO is actively engaged in support for the implementation of all MPOWER measures and most of the other tobacco control policies in all SEAR member countries. WHO provides technical assistance, capacity building, and financial support and mobilizes resources for country needs (see also the findings in the relevance and efficiency sections).

The WHO support is highly appreciated and makes a difference particularly in the low-income Member States of the SEAR, but also in the middle-income country of Indonesia, where the WHO presence is vital for effective tobacco control. The involvement of WHO is based on country's needs felt and assessed, and fully aligned with country policies. In almost all countries, WHO supported surveillance and monitoring activities in addition to technical support on (MPOWER) policy and regulation development and compliance practices. In some countries, WHO also supported media campaigns.

However, SEAR Member States must realize that they cannot rely on WHO forever and need to invest their own resources in effective tobacco control policies and to achieve the WHO FCTC targets and for sustainability. We occasionally observed a misconception and lack of understanding among stakeholders (multi, bilateral, CSO, NGOs and private sector) about WHO's role in tobacco control. WHO is not in the driver seat, the governments are, and WHO's role is to support the Member States in the development and implementation of tobacco control policies and programs. The misunderstanding of WHO's role leads to too high expectations of what WHO can do.

Leadership should come from national and subnational governments and corresponding line ministries. However, in most of the countries (with the notable exception of Bhutan, India, and Thailand), government action in this field is weakened by conflicting interests between ministries, a lack of political commitment and ownership, low levels of accountability, and limited resources. This is the reason that in most countries the WCO and its non-governmental partners play a champion role.

4.4 Impact

4.4.1 Impact of tobacco control policies on tobacco use prevalence rates

Finding #9: Of all SEAR countries, Bhutan, Sri Lanka, Nepal and Maldives show the lowest rates of prevalence of tobacco use. Thailand shows a persistent prevalence rate of about 20%.

Bangladesh, India and DPR Korea made progress in reducing the prevalence of tobacco use, but are still high, while the prevalence in Myanmar, Indonesia and Timor-Leste have worsened over the last decade, as shown in Table 6.

The prevalence rate of smokeless tobacco (SLT) has been reduced in some countries according to a recent survey (e.g. GATS in Bangladesh and India), but is still a real problem across the board, particularly among women, as shown in Table 7 below.

The WHO reported that, on average, 35% of the adults in the SEAR region use tobacco in one form or another, with the highest rate of 62% in Myanmar (STEPS 2014). According to a recent study[27], misleading advertising by tobacco companies may be responsible for the increase in the SLT prevalence, which is as harmful as smoking. Countries should thus strengthen policies to restrict SLT usage and prevent further increase in prevalence.

Table 6: **Prevalence of tobacco use* in the SEAR Member States**

Country	Year of Latest Survey (Adult)	Male (%)	Female (%)	Year of Latest Survey (Adult)	Adult (%)	Male (%)	Female * (%)	Year of Latest Survey (Youth)	Youth (%)	Male (%)	Female (%)
Bangladesh	2004	47	3.8	2017 (GATS)	**35.3**	46	25.2	2014	9.2	13.2	2.1
Bhutan	N/A	N/A	N/A	2014 (STEPS)	**7.4**	10.8	3.1	2013	30.3	39	23.2
DPR Korea	2002	58.6	N/A	2017 (GATS)	**22**	46.1	-	N/A	N/A	N/A	N/A
India	2009	34.6	3.8	2016-17 (GATS)	**28.6**	42.4	14.2	2009	14.6	19	8.3
Indonesia	2004	65.9	4.5	2013 (National)	**36.3**	64.9	2.9	2014	20	36	4
Maldives	2001	44.5	11.6	2011 (STEPS)	**18.8**	34.7	3.4	2014	11.2	15.8	6.8
Myanmar	2003	46.5	13.6	2014 (STEPS)	**26.1**	43.8	8.4	2016	13.6	26.3	3.7
Nepal	2006	34.8	26.4	2016 (National)	**18.5**	27	10.3	2016	7.2	9.5	4.8
Sri Lanka	2006	29.8	2.6	2015 (STEPS)	**15**	29.4	0.1	2015	3.7	6.7	0.7
Thailand	2004	39.8	3.4	2014 (National)	**20.7**	40.5	2.2	2015	15	21.8	8.1
Timor-Leste	2005	N/A	N/A	2014 (National)	**48.6**	69.5	9.6	2015	23.4	31.8	14.1

* Smoking any tobacco product [%]. Data from the 2008 (Appendix III: Internationally comparable prevalence estimates) and *2017 WHO Reports on the Global Tobacco Epidemic* and from other surveys, as indicated. GATS Bangladesh (2017); STEPS Bhutan (2014); Global Adults Tobacco Survey in DPR Korea (2017); GATS India (2016-2017); National Basic Health Research Indonesia (2013), STEPS Maldives (2011); STEPS Myanmar (2014); Demographic Health Survey Nepal (2016); STEPS Sri Lanka (2015); The Smoking and Drinking Behaviour Survey Thailand (2014); National Survey for Noncommunicable Disease Risk Factors and Injuries Timor-Leste (2014).

---

[27] Suliankatchi RA1, Sinha DN2, Rath R3, Aryal KK4, Zaman MM5, Gupta PC6, Karki KB7, Venugopal D8, Smokeless tobacco use is 'replacing' the smoking epidemic in the South East Asia Region, 2017 retrieved in the WEB: https://www.ncbi.nlm.nih.gov/pubmed/29281083

Table 7: Prevalence of Smokeless Tobacco Use (SLT) in the SEAR Member States

Country	Year of Latest Survey (Adult)	Adult (%)	Male (%)	Female (%)
Bangladesh	2017	20.6	16.2	24.8
Bhutan	2014	19.7	26.5	11
DPR Korea	2017	N/A	N/A	N/A
India	2016-17	21.4	29.6	12.8
Indonesia	2013	N/A	3.9	4.8
Maldives	2009	N/A	8.5	4.2
Myanmar	2014	43.2	62.2	24.1
Nepal	2012	17.8	31.1	4.8
Sri Lanka	2014	15.8	26	5.3
Thailand	2014	3.3	2.5	3.9
Timor-Leste	2014	19.8	16.1	26.8

* Data from *2008 and 2017 WHO Reports on the Global Tobacco Epidemic*

Bhutan, who has the strictest policy on tobacco with the enactment of the Tobacco Control Act 2010, presents the lowest prevalence rate in the SEAR of tobacco use, at 7.4% (STEPS 2014). However, efforts must be taken to ensure that this result be maintained, because the prevalence of tobacco use among youth increased from 18.8% in 2009 to 30% in 2014, a 63% increase (GYTS 2013). The prevalence of smokeless tobacco is also high at 19.7% (26.5 % for males and 11% for females), as presented in Table 7 above.

Culture may explain these trends. In Bhutan, a Buddhist country, smoking is considered bad for one's karma and tobacco control is supported by religious authorities. As the younger generation is probably less influenced by religion, they are more attracted to tobacco use than their parents. The 2013 GYTS survey showed that 9.7% of students were offered free tobacco products by tobacco company representatives and 14% of students wore garments with a tobacco brand logo.

Production, manufacture and sale of any type of tobacco product is prohibited in Bhutan, and importation of tobacco products is only allowed for personal use. However, illicit trade and selling of cigarettes and smokeless tobacco products on the black market are a problem[28]. According to the Bhutan Narcotic Control Agency, most of the violations of the smoke-free laws were related to illegal possession of tobacco. The borders with India are rather porous, and both cigarettes and smokeless tobacco are amply available at markets close to the border with Bhutan. Bhutanese smokers cross the border to smoke and then come back with products (see Annex A for more details on each SEAR countries).

Sri Lanka also presents one of the lowest smoking prevalence rates among adult smokers in the region, at 15% (STEPS 2015) which has remained stable over the decade. The country has well implemented MPOWER and other policies on tobacco control, except for "O" and "E" measures. Comprehensive smoking cessation measures, including pharmacologic treatment and intensive counselling, are only available in some institutions in the country. Stakeholders interviewed reported that the country should improve enforcement of the ban on the sale of single cigarettes and adopt a ban on the sale of cigarettes within a radius of 500 metres from school and religious places (as of

---

[28] In 2014-2015, 139,952 sticks/pcs cigarettes, 162,440 sticks/pcs bidi, 1095.448 kilograms of smokeless tobacco (Baba) were seized according to the 2016 Bhutan report on WHO FCTC

September 1, 2016, manufacturing, importation, or selling of any smokeless tobacco product is prohibited). Easy accessibility and affordability of illicit cigarettes is a problem; these are being sold at US $0.16, half the price of a legal cigarette, which sells at US$ 0.32.

In Sri Lanka, there is strong political commitment for tobacco control as the President is very committed to tobacco control, but on the other hand, the Ceylon Tobacco Company has a monopoly and is very powerful and influential ─ production of tobacco increased since 2014 from 3000 to 4972 tons ─ and uses mechanisms to violate regulations with respect to advertisement, sponsorship and promotions.

Other major challenges are the use of non-smoking tobacco (13.5% of tobacco chewers[29]), illicit tobacco coming into the country (as it is difficult to control smuggling at sea borders), and finding the right incentives for farmers to stop growing tobacco. Sri Lanka was the first country in SEAR to ratify the Protocol to eliminate illicit trade in tobacco.

In Nepal, the prevalence rate of tobacco use is 18.5% among adults (with smokeless tobacco at 17.8% ─ men at 31.3% and women at 4.8%). According to the Nepal Demographic Health Survey of 2016, 27% of the male population used tobacco, a considerable reduction compared to the 34.8% in 2006. Our informants attributed this reduction to the Tobacco Control and Regulatory Act of 2011.

Indeed, Nepal made the most significant progress with the implementation of the MPOWER measures, according to the GTCR, i.e. a total progress of 2.4 points from a MPOWER score of 1.9 in 2007 to 4.3 in 2017. Nepal did especially well with the implementation of graphical health warnings covering 90% of the packaging (W); there are also clear provisions for enforcing the law against TAPS (E). The excise duty on tobacco was increased most recently in 2016, but is still low compared to other countries and compared to WHO recommendations. The country will soon launch the WHO FCTC 2030 project.

In the past two years, the production of tobacco has decreased from 2227 tons to 618 tons and the land used for tobacco cultivation from 1724 to 639 hectares. In the previous decade, the production had typically been constant or growing.

In Maldives a STEPS survey conducted in 2011 sets the average tobacco use prevalence rate at 18.8% and at 34% for adult users which is remarkable reduction compared to the 53.5% in 2009. The country has no surveillance mechanism for tobacco use and prevention, so the most recent data are provided by the STEP survey (2011) and a Youth GSHS from 2014. We may expect limited progress towards the targets of the WHO FCTC and the WHO NCD Action Plan as specific policies are absent or have not been properly put in place. The Tobacco Control Act was ratified in 2010, but the required specific regulations for proper implementation of the Act have not been elaborated, leading for instance to steadily increasing tobacco imports from 2006 to date.

In Maldives, the MoH and the Tobacco Control Board, supported by the WHO, developed legislation for graphical health warnings on the packets, which has not yet been implemented. Apart from a few NGOs warning against the harmful health impacts of tobacco use, we were not informed about any mass media campaign on the dangers of tobacco use. There is no quit-line, and a ban on advertisement and promotion exists, but without strong enforcement, leading to many violations. Direct advertising at points of sale (POS) is rampant, and indirect promotion is increasing, for instance in movies. Sheesha and Hookah smoking seems common among women, youth and substance user groups, but there are no prevalence data.

Thailand seems to have the most advanced tobacco control infrastructure in the region, but present nevertheless a relatively high average prevalence of tobacco use (a little over 20% since 2004).

---

[29] Government of Sri Lanka, Ministry of health and nutrition, Annual health bulletin, 2015.

Smoking prevalence among adult men has remained consistent at about 40% (39.8% in 2004 and 40.5% in 2014 (The Smoking and Drinking Behaviour Survey, 2014). Smoking prevalence among youth has not declined, and in fact reached 21.8% (GYTS 2015) among the young male population, the third worst rate in the South East Asian Region.

Thailand has the longest commitment in tobacco control, and the country has implemented over the years the most comprehensive tobacco control policies in the region. They have established best practices such as: the Health Promotion Foundation; focal points for tobacco control in each province with a budget for funds of US$ 25,000; and village workers trained to promote and help implementing MPOWER measures.

In 2017, a new Tobacco Control Act was enforced, which underscores Thailand's commitment to control tobacco products and enhance public health protection under the WHO FCTC framework. The new law fosters several measures that are expected to reduce tobacco use further, such as CSR activities related to bans on tobacco. Thailand has also closed the loopholes that were barriers to achieving a comprehensive ban on tobacco advertising, promotions and sponsorship.

On the other hand, the state-owned Thailand Tobacco Monopoly (TTM) is the largest tobacco company, and systematically opposes tobacco control policies, via sponsored newspaper articles for example. Tobacco production has remained steady over the years, and government income from the TTM has grown continuously since the 1990s.

Thailand's sin tax policy is a global best practice. This Excise Tax has been applied since 1992, and recently increased from 85% to 87%. In spite of this relatively high tax level, tobacco consumption remains stable, which suggests that the level is not high enough to discourage buyers. According to interviews with the MoH and MoF, there have been lots of cheap tobacco products from Cambodia and China that are cheaper than the local tobacco products. Also, there has been no reduction in tobacco sales, and TTM revenue have been increasing over the last decades. Therefore, affordability may not have been reduced.

Government income from the TTM has grown continuously since the 1990s, the result of increased production of more expensive, higher-profit margin, mid and premium-range cigarettes, as well as regular tax rate increases. In 2013, TTM total revenue of over US$2 billion (61,748 million Baht) derived from US$109.5 million (3331 million Baht) of profits and US$1.9 billion (58,417 million Baht) of taxes ranked the monopoly second in terms of assets among state enterprises, and third among revenue providers.

According to the data available, the Democratic People's Republic of Korea shows a declining trend in tobacco use at 22% in 2017 down from 27% in 2011. Among male adults, tobacco smoking prevalence reduced from 54.8% in 2006 to 46.1% in 2017 (Global Adults Tobacco Survey 2017). Daily prevalence among males aged above 17 years was 37.7% in 2016. According to the interviewees, smokeless and non-cigarette products are not available in the country and no tobacco use is reported among women. No more data are available.

The national tobacco law is in line with WHO FCTC guidance, but implementation of the legislation falls short and implementation guidelines need to be developed or updated. Currently, effective enforcement of the tobacco control law is being discussed within the government, in particular a strict ban on smoking in smoke-free places, including schools and public places. Smoking in restaurants and hotels and other closed public settings is still very common. Compliance with the law and punishment of violators are other issues to be reinforced. The legislation only provides for text warnings, not for graphic warnings, and should thus be revised in line with the WHO FCTC. A surveillance system is yet to be established in the country and a tobacco excise duty does not exist. The country produces tobacco (no production data available), but the government has developed a

policy and program for alternate livelihoods for tobacco farmers. We have not seen data on the results of this program.

A recent WHO-SEARO mission to Pyongyang observed that lung cancer is the sixth principal cause of death among females even when less than 1% of females use tobacco. Constant exposure of females to adult male smokers is one of the plausible causes. Or the data is not correct about female smoking given cultural norms.

India has completed two rounds of the Global Adult Tobacco Survey (GATS), in 2009 and in 2016-17, and the reports show a reduction in the prevalence rate of tobacco use from 34.6% in 2009 to 28.6% in 2017 (among male adults, this has decreased from 47.9% in 2010 to 42.4% in 2017). The use of smokeless tobacco among adults has also decreased since 2009, from 25.9% to 21.4%, as shown in Table 7 above — 32.9% to 29.6% among male and 18.4 to 12.8% among female.

Among the top 5 tobacco-producing countries in the world, India has also reduced its production of tobacco in the past three years since 2014, from 315 000 tons to 202 000 tons.

India is a country that has been implementing WHO FCTC policies since 2004 and WHO MPOWER since 2008 — one of the longest commitments to tobacco control in the region. India has put in place some of the best practices with the support from the Bloomberg Foundation and the WHO (as an example, the tobacco free movie rules). The tobacco control law COTPA 2003 is compliant with FCTC strategies. Further, to effectively implement COTPA 2003 and WHO FCTC provisions, the Government put in place a national tobacco control programme in 2007-08, with funding provided on a sustained basis.

Positive trends are observed, but challenges remain, in particular with regard to smokeless tobacco use, interference by the tobacco industry and a non-effective excise duty, making tobacco products affordable. India ratified the Protocol to eliminate illicit trade on tobacco in May 2018.

In Bangladesh, the average prevalence rate of tobacco use among adults significantly reduced from 43.3% in 2009 to 35.3% in 2017 according to the GATS survey, 2017 (among male adults from 58% to 46% and among female adults from 28.7% to 25.2%). Smokeless tobacco prevalence for adults also decreased (to 20.6%, 16.2% of men, and 24.8% of women currently use smokeless tobacco). Unlike in India, production of tobacco has been increasing in the last three years, and tobacco farming has doubled in Bangladesh.

Bangladesh gradually forced an increase of the tobacco price through taxation, but not enough because the sales price remains affordable. The country performed well in implementing smoke-free policies ("P"), via large health graphics warning, and in operating regular media campaigns including television and/or radio ads ("W"). On the other hand, Bangladesh did not implement an effective tobacco cessation program ("O").

> **Box 2: Ban of smokeless Tobaccoin India**
>
> Based on GATS 2008-2009 reports, and in line with WHO recommendations, India used food regulations to ban Gutkha, a form of smokeless tobacco (SLT).
>
> Under the Food Safety and Standards Act or State Health Acts, several State Governments and Union Territories issued orders to ban forms of smokeless tobacco such as zarda, khaini and other flavoured and processed chewing tobacco products. However, according to a WHO study, the bans were not implemented properly. The industry circumvented the regulations by selling twin packs – pan masala & tobacco. The finding of this study were submitted by MOH to the Supreme Court and disseminated through workshops at state level.
>
> *Source: India's Country data reference notes, 2018*

As is the case in India, Indonesia and Thailand, Bangladesh houses an active and strong coalition of CSOs fighting against tobacco use, which fostered a gradual reinforcement of the bans on tobacco advertising, promotion and sponsorship over the last decade ("E"). Bangladesh, along with India, are

also the countries among the four top producers in the region that have already included, although imperfectly, Article 5.3 of the WHO FCTC (rules for implementing the law have been enacted in 2015).

We may presume that Bangladesh's policies and practice produced positive effects as the prevalence rate is improving according to the data available, notwithstanding aggressive sales strategies by the tobacco companies (according to informants), which also try to hamper law enforcement and do not necessarily comply with the law.

Three out of the eleven countries, Myanmar, Indonesia and Timor-Leste, show a negative trend with increasing tobacco use prevalence rates compared to 10 years ago.

Myanmar presented a smoking prevalence rate of 26.1% (STEPS, 2014), up from 22% in 2009. Moreover, the prevalence of smokeless tobacco use also showed a growing trend, at 43.2% in 2014 up from 29.7% in 2009 (males=62.2%; females=24.1%).

In the region, Myanmar also has one of the highest prevalence rates of tobacco use among youth, at 13.6% in 2016 (boys, 26%; girls, 4%) down from 18.6% (boys, 30%; girls, 6.8%) in 2011 (Global Youth Tobacco Survey). In Myanmar, betel chewing is very common and traditional among tobacco users, for both men and women, with a prevalence rate of 42.8% (according to the tobacco control atlas in the ASEAN region), the highest among ASEAN countries.

Myanmar adopted a national tobacco control law in 2006, but there is no specific policy to protect public health against vested tobacco industry influence. The legislation for packaging and labelling was updated in September 2016. The tobacco legislation needs to be updated because it deals with smoke-free places and TAPS, but not with cessation, taxation, tobacco industry regulations, and illicit trade. There is a need to enhance the smoke-free and TAPS ban policies, which do not seem to be well respected. With respect to other important measures to control tobacco supply, such as alternative livelihoods for tobacco farmers, and control of illicit trade, not much has been done yet. Interference by the tobacco industry which challenges policy development and implementation is an important underlying factor in the country. The best-selling cigarette, Red Ruby, is produced by the company owned by the military of Myanmar.

A pro-tobacco bill in Parliament is currently on the agenda for debate, a bill that aims to protect tobacco farmers rather than public health. If passed, this bill has the potential to roll-back the few achievements in tobacco control (such as the 75% pictorial health warnings size that is currently applied on cigarette packs front and back). Myanmar is open to accepting assistance from the tobacco industry in implementing tobacco control policies, a clear violation of Article 5.3 of WHO FCTC.

In Indonesia, tobacco control policies have not performed well over the last decade. Tobacco use prevalence rose from 34.7% in 2010 to 36.3% in 2013 (National Basic Health Research Indonesia 2013). The current rate for smoking prevalence among adult men is about the same than Timor-Leste, the highest in the region (64%). A recent survey among youth, conducted by the Ministry of Health, estimates that the prevalence among children has worsened, from 7.2% in 2013 to 8.8% in 2016, while the expected target was 5.4% under the national development plan 2014-19.

The country did implement tobacco control policies, but without apparent results. Indonesia is the only SEAR country that has not yet ratified WHO FCTC. The champions of tobacco control lose out against the strong influence and aggressive marketing by the tobacco industry in a country with a long history of tobacco use among male adults. In the country, an intense political debate is actually taking place to apply a comprehensive ban on all tobacco advertising, promotion and sponsorship (TAPS), one of the hardest challenges because the legislation involves various ministries and different laws, i.e. broadcast law, press law, and film law. At the moment, Indonesia has banned tobacco promotion events and sponsorship, but not direct tobacco advertising.

In 2015, Members of Parliament proposed a tobacco bill that defends tobacco industry's interests. The bill was rejected by the President in 2017, but the House members reinstated it as one of their priority bills in 2018. High level advocacy is thus needed to foster political will and obtain more results, e.g. diplomatic engagement and efforts at multiple national and international fora for peer pressure and engagement of other sectors in a multi-sectoral approach, which is new in Indonesia.

Tobacco production increased since 2015 from 193 790 tons to 198 296 tons.

<u>Timor-Leste</u> shows the worst trend with respect to the average tobacco use prevalence rate, going up from 23.4% in 2005 to 48.6 % in 2014 (69.5% among adult men) according to the National Survey for Noncommunicable Disease Risk Factors and Injuries Timor-Leste, 2014. This might improve as the country introduced comprehensive tobacco control legislation in 2016, a commitment under the Framework Convention of Tobacco Control (WHO FCTC). On the other hand, MPOWER measures and WHO FCTC policies need to be truly implemented to effectively manage tobacco importation and use, which does not seem to be the case in Timor-Leste. Most measures are just on paper, such as raising excise duties, banning smoking in public places, cessation support etc. A violation framework with fines has not been developed, surveillance is quasi absent, and activities and resources are not appropriately coordinated between MoH, other relevant ministries and NGOs. CSOs however show strong commitment to support the government through advocacy and observations of violations of the legislation. Slowly, the provisions under the law are coming into force. The country recently implemented large GHWs on cigarette packs (85% in front and 100% on the back).

Tobacco Industry interference is a major challenge even for a country like Timor-Leste that only imports its cigarettes. Tobacco companies exploit the inadequate legislation and target young people through advertising, sponsorship and promotion.

Finding #10: High prevalence rates of tobacco use are caused by: (i) poor implementation and enforcement of tobacco control legislation; (ii) the limited resources Member States reserve for tobacco control despite the huge economic costs of tobacco consumption; (iii) weak tobacco control policies and programs that allow for poor compliance, and; (iv) weak counter-measures in place against tobacco industry interference, allowing the industry to delay or undermine effective implementation of FCTC and MPOWER measures.

Having a good policy is not enough, and should be complemented and supplemented by effective implementation and enforcement of the policies and legislation to obtain the intended effects. In addition to the key factor of lack of political will, insufficient implementation and enforcement of the law is a result of: (i) absence of guidelines for implementation and enforcement; ii) government staff not knowing the procedures for how to apply the rules; (iii) lack of proper dissemination and consequently knowledge of the policies and rules; and (iv) absence of penalties or fines making it a legislation without teeth.

The fields of graphic health warnings (GHW) and bans provide good examples of underperforming legislation. GHW legislation in Myanmar requires graphic health warnings on 75% of both front and back panels of tobacco packs, and mandates 10 GHW templates. With no clear guidelines on the use of these pictures, tobacco companies currently place only one (1) GHW template per year, which has less impact than when other mandatory templates are used as prescribed.

In Bangladesh, another example, the tobacco industry continues to organize promotion events and publish ads, despite a ban on advertisements and promotions, due to the lack of guidelines on implementation (who is accountable?), enforcement (what is the punishment?), and monitoring (who should supervise and monitor?)

Another example is that warnings are not seen by smokers who buy cigarettes as single sticks, which are generally smokers living in poverty and youth.

In Indonesia, the legislation on smoke-free areas is not well respected; people smoke anywhere, due to absence of rules and wide violation of rules, lack of enforcement and fines, and high social acceptance. As long as smokers and owners of public spaces know they are not monitored for violation of the law, they do not have care about or respect the law.

The long-term health and economic burdens of tobacco use are huge, and countries should therefore heavily invest in tobacco control to save lives and costs to the society.

Out of the eleven SEAR Member States, only two (2) countries, Thailand and India, provide smoking cessation services on a large scale. The tobacco cessation programs of the nine other SEAR member countries leave much room for improvement.

4.4.2 Impact of tobacco control policies in reducing risk of premature mortality from target NCDs

Finding #11: Most of the SEAR countries (8) are not making significant progress in reducing risk of premature mortality from target NCDs, according to the WHO NCD Progress Monitor reports, with the exception of three (3) countries: India, Maldives and Timor-Leste.

➢ India and Maldives are the only member states that has been able to reduce both prevalence of tobacco use and risk of premature mortality from target NCDs (respectively from 26% in 2015 to 23% in 2017 and from 16% in 2014 to 12% in 2017).

➢ Timor-Leste has also achieved gains in terms of reducing risk for mortality from NCDs (from 24% in 2015 to 21% in 2017), despite a context of a high prevalence rate of tobacco smoking.

➢ In the other eight SEAR Member States, the risk for premature mortality from target NCDs reduced slightly (DPR Korea), remained stable (Myanmar, Sri Lanka and Thailand) or increased (Bangladesh, Bhutan, Indonesia and Nepal).

➢ The total economic cost of tobacco-related cancers in 2015 in Sri Lanka have been estimated at US$ 121.2 million[30].

DPR Korea shows a slight reduction (from 27% in 2014 to 26% in 2017), Myanmar (at 24%), Sri Lanka (at 18%), and Thailand (at 16%) show relatively stable patterns, while in Bhutan we observe a slight increase (21% in 2015 to 23% in 2017) as in Nepal (at 22% in 2015 to 23% in 2017) according to the WHO Progress Monitor on NCD.

Bangladesh's risk for premature mortality increased from 18% in 2015 to 22% in 2017, and Indonesia's risk for premature mortality from target NCDs rose from 23% in 2015 to 27% in 2017 according to the WHO NCD Progress Monitor, and we may not see a reduction any time soon, as long as the country does not improve its tobacco use prevalence rates.

However, according to the 2018 WHO Trends Report (2nd version), smoking is on the rise in low- and middle-income countries: ''additional evidence that while numbers of smokers have fallen in high- and upper middle-income countries, numbers of smokers in low- and lower-middle income countries have steadily risen since 2000''[31]. The report pointed out that it is unlikely that a 30% relative reduction in global tobacco use could be achieved without significant strengthening of tobacco control in low- and middle-income countries.

4.4.3 Role/contribution of WHO in reducing prevalence of tobacco use

Finding #12: WHO support is vital in achieving the progress needed in establishing the various MPOWER and other tobacco control strategies (see also the findings in the relevance section 4.1.2).

---

[30] http://tobaccocontrol.bmj.com/content/early/2017/10/27/tobaccocontrol-2017-053791
[31] 2018, WHO, WHO global report on trends in prevalence of tobacco smoking 2000–2025 Second edition, p.27.

The WHO reports on tobacco use (the *Global Progress Report on the Implementation of the WHO FCTC,* and the *WHO Report on the Global Tobacco Epidemic*) are considered important by the Member States, and, in fact, are their main sources of data. The countries themselves do not prioritize monitoring and surveillance, given it is expensive, and have not established country-owned databases. Nevertheless, data on tobacco are needed, in particular multi-sectoral data.

The multi-sectoral approach to tobacco control is starting to be implemented in most of the Member States; however, it is weak and not very effective. WHO supports the countries in applying this approach and should widen these efforts, working on the supply side (for instance, a ban on illicit trade and promotion of alternative livelihood programs). The multi-sectoral approach will have more impact when the WHO seeks collaboration with other UN organizations such as UNICEF, UNDP, UNESCO, and FAO.

Advocacy has always been a key role of WHO in tobacco control, and is still very much needed, in particular high-level advocacy to encourage politician and decision-makers to adopt stronger policies and to mobilise funding. The WHO could focus more on upstream work, for instance by supporting critical research (e.g. cost-benefit studies), building alliances, using champions, and encouraging government funding. Partnerships between WHO and NGOs have proven to be effective in the long run, and could be strengthened further.

WHO can foster more impact when it intensifies coordination beyond the biennial surveys, for instance by facilitating workshops to bring together tobacco focal points from SEAR Member States, exchange lessons learnt, and give expert guidance to Member States on what could be done. This could be done in collaboration with relevant stakeholders, other UN agencies, Asian Development Bank (ADB), World Bank etc.

Ineffective implementation and enforcement of policies and legislation is a key factor underlying disappointing results with respect to reduction in tobacco use. WHO's support has been focused for a long time on the policies and legislation themselves, and less on implementation. Developing operational implementation guidelines for MPOWER is an area where WHO could step up to reinforce impacts.

4.5 Sustainability

4.5.1 Sustainability of the existing tobacco control policies and programmes

Finding #14: Sustainability of the existing tobacco control policies and programs in the Member States of the South East Region is a concern since the governments pay uneven attention and allocate few resources to tobacco control. As a result, tobacco control largely depends on external funding to implement measures, and achievements are not sustainable. Sustainability considerations are important because of the persistent threat from the tobacco industry to reverse the achievements in tobacco control.

An additional concern is the lack of coordination between relevant donors, ministries and UN agencies, which may lead to overlapping activities and thus inefficient spending of the already scarce resources.

Some countries, such as India and Thailand, have institutionalized tobacco control programs. India has established a very strong National Tobacco Control Cell (NTCC) at the Ministry of Health and Family Welfare (MoHFW) to implement National Tobacco Control Programme at the national and subnational level. In Thailand, a Foundation that finances MPOWER measures is funded by receiving 2% of the excise duty on tobacco and alcohol products. In Bangladesh, a similar approach is in preparation to make sustainable funds available for tobacco control. In Indonesia, starting in 2018,

the Ministry of Finance will secure a budget line for the MoH to conduct annual anti-tobacco media campaigns.

The WHO FCTC recommends that countries should have a budget allocated for its operations to ensure sustainability of tobacco control programs and should establish a tobacco control unit with dedicated staff. Some of the SEAR countries (such as Maldives and Myanmar) do not have a specific budget component for tobacco control in their operational budget, or the situation is not known (as is the case in Sri Lanka). The other countries have a tobacco control budget that is part of the budget allocated to the NCD program. Other governmental financial contributions for tobacco control (for instance, to fight illicit trade) are difficult to trace.

In any case, the countries largely depend on external funding from a handful of donors, such as Bloomberg International and WHO, which are the principle ones.

Some countries (e.g. Myanmar, Sri Lanka and Nepal), which are covered under the special projects, such as the "WHO FCTC 2030" project, will receive additional funds for tobacco control. For instance, Sri Lanka will receive assistance to undertake a government-wide programme of work to strengthen tobacco control. The project will run for five years and will bring international support to Sri Lanka from the WHO FCTC Secretariat, United Nations Development Programme (UNDP) and WHO. This will include expert advice, technical assistance and peer support to strengthen tobacco control action. This support is expected to reduce tobacco usage in the long run and aid Sri Lanka in meeting the NCD targets.

Generally, no budget is allocated to non-health sectors for their involvement in tobacco control, except for Ministries of Finance who work on excise duties. In Thailand, the Ministry of Education and Transportation was supported for their involvement in policy making and media campaigns.

The WHO budgets allocated to tobacco actions/activities are relatively limited, but readily available and traceable. On the other hand, they are part of the basket for NCD cluster support, which includes other important subjects sometimes seen as higher profile such as cardiovascular diseases, cancer, and diabetes etc.

The institutional sustainability of the tobacco control architecture is relatively fragile in most countries. In some countries, National Tobacco Control Cells (NTCC) or Units have been established but often with limited resources (staff and budgets). In the other countries, however, one tobacco focal person is located in the NCD department of the MoH. We have not come across any written strategy to institutionalize and sustain the capacity of the tobacco control architecture.

Indonesia's National Medium Term Development Plan (RPJMN) seeks a diversification of industries, and focuses in particular on the tobacco industry, which is "in a steady decline" according to the President's Office. No alternative livelihood program for tobacco farmers exists in the country, although WHO had commissioned a study on agroeconomics, which is nearly completed.

Achievements can be fragile as illustrated by the House of Representatives in Indonesia, which prioritizes a new tobacco bill that promotes tobacco industry interests, in spite of an earlier rejection by the President to discuss the bill during his Presidential term (2014 – 2019).

In Myanmar, the Parliament currently is debating a pro-tobacco bill which protects the rights of tobacco farmers over public health safeguards. This bill has the potential to roll-back the few achievements in tobacco control in the country, such as the pictorial health warnings size currently applied to cigarette packs.

4.5.2 The WHO's role to support sustainable tobacco control measures and policies

Finding #15: The expectations from WHO regarding sustainable measures to support tobacco control policies are principally to: strengthen existing support and sensitize partner

governments to commit more resources for tobacco control; clear, transparent and sustainable funding by the government; and to provide more funds.

UN's 2030 Agenda for Sustainable Development is a key factor leading to sustainable tobacco control and is welcomed by all SEAR countries studied. The convention includes SDG 3, to "ensure healthy lives and promote well-being for all at all ages", with the target 3A to "strengthen the implementation of the WHO FCTC in all countries, as appropriate".

The support of WHO and other implementing partners such as The Union, Vital Strategies and Campaign for Tobacco Free Kids – the primary partners of Bloomberg Initiative – to the SEAR Member States may cause a dependence of that external support, especially in small countries that do not allocate much of their own resources to the cause.

According to our interlocutors, WHO should also play a strategic role to strengthen collaboration between ministries, especially between the MoH and MoF, and help find innovative ways to raise funds for tobacco control.

The integration of the fight against tobacco use in the broader NCD strategy has led to more sustained funding on the one hand but also the dilution of attention on the other hand. Embedding tobacco control in a broader health system strengthening approach, with strong country ownership, and including coordination with large donors such as the World Bank, ADB, European Union, and other UN organizations seems promising. WHO could take a catalytic role to move the key actors in that direction. In addition, there is unused potential in collaboration with other UN organizations such as UNICEF and FAO to promote the multi-sectoral approach. UNICEF, for instance, receives considerable funding for adolescent programs. Its nutrition programs include education, communication and public awareness activities in schools, and could include the integration of modules on tobacco awareness.

In-country capacity of health professionals and community workers on tobacco control is an important factor that leads to active involvement and fosters sustainability. Since the launch of WHO FCTC, WHO executed many capacity building activities, such as awareness generation, trainings, refreshing courses, and "on the job" coaching for both governmental staff (not only MoH) and CSO staff. These activities have laid a solid base for a broad awareness of the dangers of tobacco use and exposure to second hand smoke. On the other hand, in the countries studied,

> **Box 3: Enhance sustainability by tax reforms**
>
> The World Bank Group's Global Tobacco Control Program, which assists countries in designing tobacco tax reforms as a win-win policy measure to (i) achieve public health goals by increasing prices, reducing smoking, and preventing initiation among youth, and (ii) raise domestic resources for investments that benefit the entire population.
>
> More specifically, the program assists government agencies in developing capacity to assess the health and social costs of tobacco use, and design, enact, administer and monitor tobacco taxation policies. Enhanced capacity will enable countries to increase prices and reduce tobacco use, taking into account the macro-economic and fiscal situation of each country, tax laws, and existing tax administration structure and processes.
>
> *Source: The World Bank*

civil servants are often transferred and tobacco expertise becomes therefore diluted. WHO's support should also focus on these institutional and managerial factors. Tobacco use has social and cultural reasons, and capacity building should thus include knowledge on behavioral change strategies.

Knowledge of the long-term economic costs of tobacco use has proven to influence decision makers and may thus help sustain attention for the issue. Economic studies have been done in Sri Lanka, Indonesia, and India. In Myanmar, the WHO FCTC 2030 project will fund an economic study on the costs of tobacco use.

WHO's (and its donors') long-term and unwavering support to tobacco control is aligned with its mandate, and has led in all countries to a tobacco control infrastructure. Tobacco focal points are present in all WHO country offices as well as at the MoH NCD departments or at special units or cells.

The WHO FCTC implementation interacts with other SDG targets as well.

Long considered a priority primarily for the health sector, tobacco control can also accelerate sustainable development across its social, economic and environmental dimensions. Suggestions have been developed to streamline tobacco control into a broader SDG implementation framework at national and local levels and to strengthen policy coherence with respect to tobacco control. Country medium term development plans (2016-2020) are crucial strategies in which tobacco control can be mainstreamed, and also the 13th general programme of work, just approved by the World Health Assembly.

5   CONCLUSIONS

5.1   Conclusion #1 Relevance

The WHO FCTC framework and the WHO's support to the Member States provided a relevant response to the SEAR country's needs relative to tobacco control, considering the high rate of tobacco use prevalence in most of the SEAR countries and the health threats of tobacco use for the group of NCDs. The WHO has been relevant in enabling an environment conducive to the development of tobacco control policies and to measures to prevent tobacco use. In all SEAR countries, the WHO supports the national efforts of countries, principally demand reduction measures ─ MPOWER and other provisions of the WHO FCTC ─ through technical assistance, studies, training and advocacy.

Stakeholders highlighted specific WHO support, in particular upstream work and alliance building that was particularly useful and should be strengthened. The efforts: to promote the multi-sectoral approach; to support critical economic research and evidence-based studies; to build awareness using champions; to improve the coordination between stakeholders; and to support monitoring and surveillance were all mentioned as important activities.

However, the WHO MPOWER package, including the "best-buy" interventions, needs to be enlarged to include supply and cross-cutting measures (i.e. MPOWER+ applied in India) to deal with the following constraints and challenges:

➢ Tobacco industry interference is a major challenge: influence on the legal framework; aggressive marketing targeting young people; supporting tobacco cultivation; delay of legislation through court cases;

➢ Weak government accountability and limited country coordination (which justifies a stronger involvement of the CSOs);

➢ Lack of synergy and coordination with other UN and donor programs; multi-sectoral approach not yet effective in most countries;

➢ Integration of tobacco control in NCD has led to sustained attention for the issue within a health system strengthening approach, but on the other hand has also caused a dilution of the attention of the WHO focal points;

➢ High transaction costs of monitoring: two costly biennial surveys that could be integrated.

5.2   Conclusion #2 Efficiency:

In spite of huge long-term economic costs of tobacco use, limited financial and human resources are available at WHO and the SEAR Member States for the implementation of tobacco control policies and the MPOWER package. Many more resources are needed to scale up results.

Member States invest a meagre 0.1% of the total annual excise revenues levied on tobacco products region wide (US$19.7 billion), which is insufficient to fight tobacco use and lower the prevalence rate among youth. According to economic studies done in Indonesia and India, tobacco consumption costs between five to eight times the excise revenues levied on tobacco products. Indeed, tobacco revenues do not meet the economic costs of tobacco consumption, and decision makers in the SEAR Member States should be made aware of this.

The limited financial resources available for tobacco control are not used in the most efficient way for the following reasons:

- Hardly any operational coordination exists between donors and other international organizations involved in the fight against tobacco use (e.g. joint planning and programming; shared evaluations);
- The integration of tobacco control into NCDs and the limited results over the years have shifted WCO attention and motivation away from tobacco control;
- WHO (and other international) support to countries is activity- and input-driven rather than results-driven. No data are available to measure the value-for-money of MPOWER in terms of reduced health care costs.

5.3 Conclusion #3 Effectiveness

Since the launch of WHO FCTC a decade ago, all the SEAR member countries have put in place tobacco control laws and regulations, some as early as 2004 and 2005 (Bangladesh, India, Thailand), while others, like Timor-Leste, were put into place only recently (in 2016). All countries made progress in developing policies and legislation, in institutionalizing tobacco control activities, and in implementing MPOWER measures. Even Indonesia, who did not sign the WHO FCTC, is implementing the various elements of MPOWER (the "best buys") with specific indicators to be measured.

However, most of the countries lack effective implementation and enforcement of the policies because of the lack of political will. In addition, as a result of the absence of guidelines for implementation and enforcement, there is a lack of knowledge about the procedures, and the policies and rules or absence of penalties or fines make it a legislation without teeth.

Overall, the countries perform relatively well in implementing Smoke-free policies (P), Health Graphics Warnings and Media campaigns (W). Bans on advertising, promotion and sponsorship measures (E) exist but are generally not complete and enforcement and compliance is weak. Tobacco companies tend to violate these laws and are not fined. Monitoring falls short (M), and Taxation on tobacco is ineffective (R). According to the stakeholders, Offer to quit measures are getting increased attention compared to the past (O).

As highlighted in the 2017 WHO report on the global tobacco epidemic, regular monitoring of the results of tobacco control is done by all SEAR countries, but often with long and irregular intervals. Monitoring had even been even reduced over the years in some countries (e.g. in Bangladesh, India, and Sri Lanka) according to the WHO summary data on MPOWER measures. However, India, Bangladesh and DPR Korea have conducted GATS surveys recently (2016-2017). Yet many gaps still exist in undertaking youth-related surveys.

Compliance with tobacco legislation for smoke-free zones, for health warnings, and for bans on advertisements, promotion, and sponsorship is a general problem in all countries, due to shortcomings in implementation regulations, lack of political will, law enforcement being unfamiliar with the legislation, and limited resources.

There is a high level of willingness to quit smoking across the board (> 60%), but the countries have given little real attention until recently to offer-to-quit programs and the programs are generally not very effective. India shows good practice in implementing a national quit line and a mobile cessation service in 2016, and free of charge nicotine replacement therapy and cessation counselling are also available in health care delivery system. Timor-Leste, the country with the highest prevalence rate, has no cessation program available.

All countries require health warnings on packages of tobacco products, but the Maldives and DRP Korea only require text warnings. Media campaigns are generally expensive, which is the reason why some countries do not organise media campaigns, i.e. Maldives, Myanmar and Sri Lanka. Some

studies exist, but it is generally difficult to measure whether these campaigns lead to behavioural changes and a paradigm shift with decision makers.

Some countries such as Bangladesh, India, Nepal, Sri Lanka and Thailand present international best practices in implementing pictorial warnings. Bangladesh requires a picture on a significant surface of tobacco product packages (50% on both sides of all tobacco products), India requires 85% of each panel (60% shall cover pictorial health warning and 25% shall cover textual health warning), Sri Lanka requires 80%, Thailand requires 85%, Timor-Leste 85% of the front side and 100% of the back side since 2016, and Nepal requires 90%; in Sri Lanka, Cabinet has approved implementation of the plain packaging.

The majority of the countries have banned tobacco advertising on mainstream media and have prohibited promotions and sponsorships, but not all countries apply effective monitoring and enforcement measures. Only two countries, Maldives and Nepal, have banned completely all forms of direct and indirect advertising. However, the countries do not do much about the numerous violations of these bans by tobacco companies, who apparently have a large influence on politicians and senior civil servants, and not only in the countries where the state or the military owns the industry (e.g. Myanmar).

The countries improved the excise regulations for tobacco products. All countries tax tobacco products at varying levels, but generally not high enough, keeping the tobacco products within the affordable range. Compliance is generally not effective and the excise does not affect the informal market. Bangladesh, Sri Lanka and Thailand apply an excise duty on tobacco of more than 75% of retail price (77%, 75% and 87% respectively), in line with WHO recommendations, while Indonesia and Maldives have set the excise between 51–75% of the retail price. In India, DPR Korea, Myanmar, Nepal and Timor-Leste, the tax represents less than 50% of the retail price of the most commonly sold cigarette brand.

The SEAR Member States also encountered serious challenges in implementing some specific articles of the WHO FCTC. All countries have laws to prohibit sales to minors, but the implementation and enforcement of these regulations prove to be difficult, and surveillance is a challenge (article 16 of the WHO FCTC). Countries that regulated emission and testing (articles 9 and 10) have not done so as per WHO TobLabNet norms and partial guidelines of the Articles 9 and 10 of WHO FCTC.

Some countries have not developed yet a policy protecting public health from tobacco industry interference, the crucial article 5.3 of the WHO FCTC (e.g. Bangladesh, DPR Korea, Maldives, Myanmar and Thailand). The other countries adopted such a policy but encountered tobacco industry influence anyway. For example, more than 15 years after having ratified the convention, Thailand is still discussing a draft on a policy on how government staff should deal with the tobacco industry. Bangladesh, India and Nepal are struggling to put in place mechanisms for implementation of Article 5.3.Thailand is making efforts to develop or strengthen policies in protecting public health from tobacco industry interference.

The continuing fight against tobacco use will not stop the tobacco industry from doing what it needs to do to survive. We did not come across bold disincentives for the industry, especially not in the countries where politicians and senior civil servants are on the boards of tobacco companies, or in the countries where the state or the military owns one of the tobacco companies. Interference by the industry in policy making and development of legislation, their aggressive marketing methods and non-compliance with promotion bans, is probably the main factor that explains underperforming legislation. The presence of the industry is very much felt in all Member States of the region. Many countries, like India and Sri Lanka, are brought to court by the industry because of their GHW policy, or their excise duty measures (Thailand), hence delaying implementation.

Tobacco cultivation is not regulated, but some recent initiatives are emerging to incentivize tobacco farmers to move from tobacco to economically viable alternative crops and livelihoods (e.g. in Bangladesh, India, Myanmar, Nepal and Sri Lanka). In Indonesia, the regulations only mention the need for the country to diversify its economy and encourage the tobacco industry to move into other products such as pesticides, pharmacy and cosmetics, but does not provide any details on how to do that. In Thailand, the state owned tobacco company has the largest share of the tobacco market in the country, which is not an incentive for the government to discourage tobacco farming. Hence, no alternate livelihood program is in preparation or in execution here. The production of tobacco in Thailand has remained steady over the years; it has increased in some countries (Bangladesh, Indonesia, Myanmar and Sri Lanka) while being reduced in others (India and Nepal), according to the available data.

In summary:

➢ Legal, regulatory, and institutional frameworks are in place in all countries, but enforcement and compliance leaves much to be desired;

➢ Member States reserve limited resources for tobacco control despite the huge economic costs of tobacco consumption;

➢ Weak counter-measures are in place against tobacco industry interference, allowing the industry to delay or undermine effective implementation of WHO MPOWER measures;

➢ Most problematic areas are illicit trade, too low excise tax duties, absent or ineffective cessation programs, inadequate bans on advertisement and sponsoring, continuous government support for tobacco production, and tobacco industry interference in policy making and legislation development;

➢ Taxes on tobacco products are not high enough to discourage tobacco use and are undercut by illicit trade;

➢ The WHO MPOWER package mainly intervenes at the level of restrictions (legal and institutional environment), and less at the level of the individual and social behaviour (except for the "O" and the "R");

➢ Tobacco control programs managed at district and municipal level are very effective;

➢ Macro-economic studies on costs of tobacco use can change paradigms of politicians and lawmakers (e.g. India and Sri Lanka);

➢ Campaigns with champions (e.g. social, political leaders, musicians, actors and athletes) and testimonials of tobacco victims are effective;

➢ WHO-SEARO could do more to foster a regional "Community of Practice" or alliance, and systematically share best practices among the Member States and other stakeholders ("best practice briefs");

➢ Conflicting interests within government: accountability to public health or to tobacco farmers, or to short-term revenues. Government officials are on the boards of tobacco companies (India, Bangladesh);

➢ In most of the SEAR countries, with the exception of Bhutan, DPR Korea and Myanmar, anti-tobacco CSOs are present, yet underutilized by the governments.

5.4 Conclusion #4 Impact

All countries have implemented the WHO MPOWER package and developed tobacco control policies, but with varying outcomes and impact.

Four out of the 11 SEA countries (Bhutan, Sri Lanka, Nepal, and Maldives) show a prevalence rate of tobacco use below the average global rate of current tobacco use[32] among adults aged over 15 years (7.4%, 15%, 18.5%, 18.8% respectively[33]), i.e. below 19.9%, and below the men's average overall rates, i.e. 33.7%[34].

Nepal and Maldives reduced their rates (respectively from 35% in 2006 to 27% in 2016 and from 44.5% to 34.7% among adult males), while Sri Lanka shows the same prevalence rates over the past decade (15%), and Thailand's rate remained stable (20.7%) despite its best practice in policy and MPOWER implementation. Nepal is the country that made the largest progress in implementing the MPOWER measures, passing from a WHO average score of MPOWER measures implementation of 1.9 in 2007 to 4.3 in 2017, i.e. a gain of 2.4 points, according to the WHO report on the global tobacco epidemic (See Table 5, Chapter 4.3.1).

India and Bangladesh made good progress in reducing the rate of prevalence of tobacco use (respectively from 34.6% in 2009 to 28.6 % in 2017; 43.3% in 2009 to 35.3% in 2017), along with DPR Korea (from 27% in 2011 to 22% in 2017), but these three countries still show adult prevalence rates above the global average[35].

Myanmar, Indonesia and Timor-Leste show prevalence rates of tobacco use worse than a decade ago, respectively 26.1%, 36.3% and 48.6%[36] (See Table 6, Chapter 4.4.1).

Smokeless tobacco is a major problem in SEAR countries, mainly due to misleading advertising by tobacco companies (e.g. Bangladesh, Bhutan, India, Myanmar, Nepal, Sri Lanka and Timor-Leste). Bhutan and Sri Lanka have prohibited the manufacture, import, or sale of any smokeless tobacco. According to the latest survey, Bangladesh and India were able to reduce the rates of prevalence of adult smokeless tobacco use (See Table 7, Chapter 4.4.1)

There is no clear link between the data on tobacco use and the data on the risk of premature mortality from target NCDs. India and Maldives are the only member states that has been able to reduce both prevalence of tobacco use and risk of premature mortality from target NCDs (respectively from 26% to 23% and from 16 to 12% in 2017). Timor-Leste reduced it slightly (from 24% to 21% in 2017). The other eight (8) SEA countries are not making progress on this indicator, fluctuating around 16% (Thailand) to 27% (Indonesia) in 2017 (See Chapter 4.4.2).

The prevalence of tobacco use among the young is of particular concern in the SEAR region. This is particularly the case in terms of the alarming rate among young boys (over 25% among young boys in Bhutan, Indonesia, Myanmar, Timor-Leste), and even more so in Bhutan (39%), where all production and publicity is banned. Bhutan implemented the strictest tobacco control policy in the region since the enactment of the Tobacco Control Act in 2010, and shows the lowest prevalence of adults in the region (7.4%). Religious leaders in Bhutan discourage smoking, which may explain the low level of adult smokers and the difference with youth, who are probably less influenced by religion. Cultural issues (youth interested in forbidden products), but also illicit trade (porous borders with India)

---

[32] The percentage of the population aged 15 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis.

[33] STEPS Bhutan (2014), STEPS Sri Lanka (2015), Demographic Health Survey Nepal (2016), STEPS Maldives (2011), Smoking and Drinking Behaviour Survey Thailand (2014).

[34] WHO Global Health Observatory (GHO) data retrieved in the WEB: http://www.who.int/gho/tobacco/use/en/

[35] GATS India (2016-2017), GATS Bangladesh (2017), GATS DPR Korea (2017)

[36] STEPS Myanmar (2014), National Basic Health Research Indonesia (2013), National Survey for Noncommunicable Disease Risk Factors and Injuries Timor-Leste (2014).

and tobacco industry interference (companies targeting the youth), may explain the trend among the youth.

Illicit trade is a rampant problem everywhere, and tobacco industry interference is aggressive in all SEAR countries, especially in Indonesia and Myanmar where pro-tobacco bills are sent to Parliament for debate. These bills serve the tobacco industry and tobacco farmers rather than public health. If passed, the bills have the potential to roll-back the few achievements made in tobacco control. Indonesia and Myanmar showed the worst prevalence rates of adult tobacco use in the region (e.g. 65% among males in Indonesia; 62% of smokeless tobacco among adult males in Myanmar) with Timor-Leste (69.5% in 2014 among male adults) being the last of the SEAR countries to introduce, in 2016, a comprehensive tobacco related legislation to reduce tobacco use.

Countries with a longer history of tobacco control and stronger tobacco control infrastructure (Bangladesh, India, Thailand), with sustainable financial means for tobacco control (India and Thailand), or strong external support from Bloomberg and WHO (Bangladesh and India) perform relatively better than the other countries in reducing the prevalence rates (7 and 6 percentage points respectively in Bangladesh and India) or in maintaining a prevalence rate around the average global rate (Thailand). These countries have developed some of the best practices in tobacco control and they all benefit from a strong CSO coalition for tobacco control. These countries steadily reinforced the MPOWER measures, including bans on tobacco advertising, promotion and sponsorship, and in a few cases supply-side measures (India). In addition — and most importantly — Bangladesh and India tried to control tobacco industry interference by including in the legislation, however imperfectly, Article 5.3 of the WHO FCTC.

Bangladesh, India, Indonesia and Thailand are also among the world's top-20 tobacco producing countries. As mentioned above, Bangladesh, India and Thailand were among the first countries to have signed and ratified the WHO FCTC and started implementing the policies before the others. However, it took until 2017 before Thailand renewed its commitment by amending the Tobacco Control Act in 2017, and decided to prepare a policy to protect public health against vested tobacco industry influence. Thailand is a country, along with India, that is a best practice model in the region, having for instance established the Health Promotion Foundation, trained village workers on MPOWER measures, and actively promoted smoke-free schools and universities. In spite of an advanced tobacco control infrastructure, the country's prevalence rate remains a little over 20% since 2004, probably due to tobacco industry interference, which is very strong in Thailand due to the presence of the state-owned Thailand Tobacco Monopoly (TTM).

5.5 Conclusion #5 Sustainability

Sustainability of the tobacco control programs in most SEAR countries (except India and Thailand) is a concern, as these are principally based on external funding. India allocates considerable funds to tobacco control and Thailand has established a health promotion foundation with earmarked funding sourced by the excise duty. Bangladesh intends to create a similar mechanism. No financing data are available for DPR Korea. In all other countries, governments allocate few resources to their tobacco control structures, while the wealthy tobacco industry use their resources to stall legislation and publicly promote their interests (e.g. in Indonesia, where the new Tobacco bill is stalled and Myanmar where Parliament currently debates a pro-tobacco bill).

Stakeholders have positive perceptions about WHO's role in tobacco control but are otherwise of the opinion that the organization can do more to: mobilize and coordinate international funding, lobby with politicians and decision makers in-country for paradigm changes, partner with CSOs, and develop innovative financing mechanisms (for instance, a small tax on international tobacco trade). Integration of tobacco control in broader health system strengthening programs also helps to sustain the fight.

6 RECOMMENDATIONS

6.1 Recommendations for WHO

In this section, we present our recommendations with regard to WHO's role in strengthening tobacco control policies, institutions, implementation, and monitoring.

6.1.1 Approach

R1 Review and strengthen the MPOWER package and add supply control measures to it. After a decade of MPOWER implementation, WHO should strengthen the MPOWER package (put in place in 2007 and revisited in 2017) to address new challenges, such as aggressive marketing strategies of the tobacco industry targeting adolescents and tobacco industry violations of promotion bans. A renewed package should also include measures that focus on control of tobacco cultivation, informal markets, and illicit trade. More specifically the WHO should:

➢ integrate the WHO FCTC resolutions that focus on supply control in the MPOWER package ("best buys");

➢ focus more on the implementation of the "best buys", as implementation of the policies and legislation is more of a problem than policy and legislation development. Implementation guidance is needed;

➢ scale up efforts, particularly with respect to (i) enforcement of and compliance with bans on sponsoring and advertisements; (ii) alternate livelihoods; (iii) control of illicit trade; and (iv) youth campaigns (in collaboration with UNICEF);

➢ promote best practices in cessation counselling, such as cessation manuals and the use of dental clinics in India;

➢ develop and promote policies and programmes for tobacco growers in adapting economically viable alternative livelihood options (Article 17 of WHO FCTC) (in collaboration with FAO);

➢ prioritize high-level advocacy and well-crafted media campaigns with national and international champions and testimonials with tobacco victims.

R2 Promote a multi-sectoral approach. WHO should (i) foster synergies between stakeholders, for example between MoH and other relevant ministries of the government; and (ii) collaborate with other UN-agencies, in particular FAO, UNDP, and UNICEF.

At the country level, WHO should strengthen and broaden their strategic partnerships with CSOs and the private sector (e.g. sensitizing banks to refuse credit to the tobacco industry), and facilitate and support anti-tobacco alliances.

R3 Work for results. The WHO should apply a Result-Based Management approach (for instance, linking financial support to partners to the results in the form of a variable tranche that will only be released after reaching pre-established and agreed benchmarks). More specifically WHO should:

➢ think globally and act locally, promoting that cessation counselling and behavioural change approaches be integrated in the work plan of health workers, community workers, and health facilities (e.g. Thailand, Nepal, Indonesia);

➢ Sensitize and train compliance officers to ensure strengthening of implementation of legal provisions and the WHO FCTC and MPOWER package.

6.1.2 Institutional strengthening

R4 Coordination. The WHO should coordinate international funding for NCD and tobacco control in the region. WHO should also approach its tobacco control activities in the region as a comprehensive

program and establish internal program collaboration and accountability mechanisms between the various departments and offices involved, with a leading role for WHO-SEARO.

More specifically WHO should:

> organise workshops for the WHO focal points and their counterparts in the MoHs to motivate them, exchange lessons learned, and strengthen their expertise in providing guidance to Member States.

R5 Advocacy. WHO should strengthen its upstream work, in particular advocacy at all levels of government, and use for instance the results of critical studies, such as the economic cost-benefit studies done.

Advocacy is a role that the stakeholders expect from WHO, not only from the COs, but also from the ROs and the secretariat in Geneva. This is because multiple layers of lobbying are needed to foster political will and encourage countries to adopt stronger policies and clear implementation rules, to enforce compliance, and to secure funding.

More specifically WHO should:

> use its influence and standing to denounce the participation of high-ranking Government officials on the boards of tobacco industry. A code of conduct could be developed and adopted by WHO FCTC;

> relentlessly invite the member countries to strictly regulate and supervise the tobacco industry, be it state-owned or privately owned.

R6 Monitoring. WHO should integrate the two biennial surveys on the tobacco epidemic into a single one to save resources. The survey should also include data on the multi-sectoral approach. WHO should also support the development of an in-country database with national statistic institutions to not only feed into the survey, but also ensure a more regular monitoring by the country itself.

R7 Resource mobilisation. Looking for financing or financing mechanisms is widely seen as one of WHO's core functions, because the fight against tobacco is hampered by limited resources, especially in the smaller countries in the region (and are certainly limited compared to financial leeway of the tobacco industry). Except for Bloomberg International, tobacco control is not popular among donors, compared to other NCD programs. WHO should thus leverage funding with donors and with the Member States themselves, make sure that within NCD work, there is room for tobacco control, and develop alternative financing strategies.

More specifically, WHO should:

> promote specific health funds financed by an earmarked percentage of the tobacco tax revenues (at least 10%), and by private donations, such as the "Thailand Healthy Lifestyle Promotion Foundation";

> pledge for budget lines in the countries' budgets dedicated to tobacco control;

> leverage funding for tobacco control with international funds such as the Global Fund and GFF, and pledge for an international tax on tobacco trade.

R8 Support strategic studies and critical research. WHO should extend its support for critical studies, in particular those studying the medium- and long-term economic benefits of tobacco control and prevention. Politicians may change their paradigm if they know that the economic costs of smoking are much higher than the tobacco tax revenues.

Not many tobacco related studies are executed in the SEAR countries and there is a need for evidence generating research on: the effects of tobacco policies, the political economy of tobacco control, and the cost-effectiveness of cessation counselling.

6.1.3 Management and governance

R9 Reposition WHO's support for tobacco control as a specific plan of action within Health System Strengthening (HHS) programs. This may help to (i) shift political commitment for tobacco industry to commitment for healthy lifestyles; (ii) broaden the message from health costs to social and economic costs; and (iii) embed cessation services in health systems.

The SDGs are guiding for policies and it makes sense to link tobacco control to more than only the Health SDGs (see for instance the ITCS tool of the Union) because of the fiscal dimensions, and the multi-sectoral nature of tobacco control. From this perspective, tobacco control should be promoted as a self-standing program within health system strengthening and not as a part of the NCD cluster.

More specifically WHO should:

➢ invest in the WCO focal points: more dedicated and qualified staff with requisite skill sets; training and coaching of existing staff; and mobilize/rotate the staff to avoid stagnation for long periods (which leads to lack of motivation);

➢ organize regional best practice meetings where WCO and government focal points exchange and share information on best practices such as the: smoke-free schools and universities in Thailand; tobacco free school guidelines in Indonesia; and cessation strategy in India (manuals; use of dental clinics).

6.2   Recommendations for the SEAR countries

The following recommendations are meant to strengthen and accelerate the implementation of tobacco control policies and measures in the SEAR Member States.

R10 Respect the general obligations and guiding principles of the WHO FCTC. To achieve the objectives of the Convention and its protocols and to implement its provisions, the Parties shall be guided, inter alia, by seven principles and six general obligations of the treaty.

The countries should reinforce their political commitment to the agenda and show political will to implement comprehensive multi-sectoral measures and responses with the aim to reduce production, trade, and consumption of all tobacco products at the national and local levels. Countries should "walk the talk" and implement and enforce the legislation that has been developed. The countries should deal with the conflict of interests between revenue and health objectives. Governments should integrate tobacco control in their National Development Strategies and five year Mid-Term Development Plans.

The countries should also raise their budget allocations for tobacco control and mobilize external funding with the Global Fund and the Global Financing Facility for health system strengthening programs that include tobacco control. The countries should also establish innovative and sustainable financing mechanisms such as healthy lifestyle foundations, funded through the excise duty on tobacco products (e.g. Thailand).

R11 Shift the paradigm and change the culture of smoking. Select a "Tobacco Control Champion" to speak out about the benefits of quitting tobacco.

Every country should select one or more champions who are highly popular among citizens and in particular the youth, to be the face of media campaigns and publicly speak out against tobacco use. Champions can be politicians, actors, athletes, and/or well-known academics. They should be authentic and committed to the fight against tobacco, bring their own networks, and be opinion leaders.

R12 Change the message and start reporting on the economic benefits of tobacco control for the country

The economic costs of tobacco use largely exceed the tobacco tax revenues (e.g. US$46 billion in Indonesia, an amount 5 times more than the tobacco duties/revenue received by the government). Governments and citizens pay dearly for the cost of smoking/tobacco use. Let people and politicians know about this cost.

R13 Prioritize and focus on adolescents

Research shows that risk factors for noncommunicable diseases (NCDs) are associated with behaviours that begin at a young age and are reinforced during adolescence. Yet, tobacco control strategies have not addressed adolescents adequately; in the region, a disconnection exists between NCDs, adolescent health, and national policies.

Countries should implement school awareness programs (e.g. India where tobacco free schools guidelines have been developed). Key elements of a strategy for the age group of 10-19 years are focusing on multi-sectoral actions; mapping risks, bottlenecks, and existing responses; promoting a life course approach; integrating tobacco control in ongoing adolescent health programs; integrating adolescents in national NCD programs; and integrating cessation counselling and tobacco substitutes into the primary health care system as a step towards universal health coverage.

R14 Seek Efficiency.

Countries should strengthen the collaboration with national and local CSO partners and create alliances for the implementation of tobacco control activities. In most of the SEAR countries, with the exception of Bhutan, DPR Korea and Myanmar, CSOs fighting against tobacco use are present and underutilized by the governments. The CSOs could specifically help with behavioural change actions, alternative livelihoods, cessation counselling and monitoring. In particular, youth groups could be valuable partners for the government.

Countries should intensify regional collaboration to control illicit trade of tobacco products.

Countries should take initiatives to foster effective coordination between donors and other international partner organizations operating in their country. Country governments should take leadership on the tobacco control programs executed in their country, set the priorities, coordinate and monitor the actions, and define the roles of the stakeholders involved.

Countries should develop a database on tobacco control and integrate a few WHO FCTC related indicators in their routine surveys like STEPS, SMART, and DHS etc. The data gathered should be used for developing new policies and to update existing policies.

Countries should explore innovative approaches. Work with youth groups to develop campaigns, use them as "reporters" (SMS-based; RapidPro), and use social media. Partner with CSOs for grass-root level advocacy (programming for scale), and use digital technology to promote tobacco control including cessation.

R15 Consider tobacco control as sustainable development and link it to the Sustainable Development Goals (SDGs)[37].

---

[37] The Sustainable Development Goals comprise a specific target to "Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate" in order to save more lives. There are proven, lifesaving strategies to combat this global challenge, and the MPOWER tobacco control measures are at the top of the list. The UN's 2030 Agenda for Sustainable Development was launched in 2016, and includes Sustainable Development Goal (SDG) 3, to "ensure healthy lives and promote well-being for all at all ages". Target 3A of the goal is to "strengthen the implementation of the WHO FCTC in all countries, as appropriate" as means of reaching SDG 3 by 2030.

Evidence has been generated on the contribution of tobacco control to SDGs other than Health.[38] Tobacco control not only leads to healthier lifestyles but also to decreasing economic and environmental costs.

Countries can refer to the Union's "Index of Tobacco Control Sustainability (ITCS)[39], which consists of 31 indicators that identify which structures, policies and resources a country has in place for sustainable tobacco control. The indicators refer to a range of key institutions such as national laws, financing mechanisms, available human resources, skills, and measures to protect public health policy against tobacco industry interference. This can support resource mapping and identification of constraints for effective implementation of Article 5.3 of WHO FCTC.

R16 Adopt WHO's Global Action plan for NCDs 2013-2020 and implement the ''best-buys'', the core policies and measures of the MPOWER package.

Countries should enforce their laws and assure compliance with the rules, especially violations by the tobacco industry. Advertisements, promotional events, and sponsoring by tobacco industry are fully or partially banned in all countries, but the resources to monitor compliance are lacking and in some cases the influence of the tobacco industry forestall forceful law enforcement. Working with youth reporters using SMS can be effective here. Countries should also develop guidance and training for law enforcement officers.

Countries should considerably increase the excise duty on tobacco products. Evidence based research shows that price is a key factor underlying the purchase of tobacco products, which are still affordable in most of the countries in the region; hence, the tax level/price is too low. Taxation is a highly cost-effective tobacco control measure being one of the "best buys", but not yet well applied[40]. This measure is undermined by illegal production and trade of tobacco products, sold on the informal market. Measures against illicit trade are therefore highly effective.

In this respect *Countries should sign and ratify the Protocol to eliminate illicit trade in tobacco products and take measures to minimize illicit trade in tobacco products*. Adopted at the WHO FCTC COP5 in 2012, the Protocol has been signed and ratified by Sri Lanka and recently by India only, out of the SEAR countries; Myanmar signed but did not ratify yet. Illicit tobacco trade is exacerbating the global tobacco epidemic and its related health and socioeconomic consequences[41].

Countries should stop helping tobacco farmers and offer them instead economically viable alternatives and incentives to adopt these alternative crops. In Bangladesh for instance, tobacco cultivation has dramatically increased over the last decade, due to a lack of regulation by the Ministry of Agriculture. Only very few alternative livelihood initiatives have been adopted in the SEAR region, e.g. in Bangladesh, India, Sri Lanka, Myanmar and Nepal. Controlling the supply is one of the most effective ways to fight against use of tobacco products, but is highly underutilized.

---

[38] Under the five-year WHO FCTC 2030 project funded by the United Kingdom, UNDP is partnering with the WHO FCTC Secretariat to help strengthen WHO FCTC implementation in low- and middle-income countries.

[39] An innovative new tool to assess the sustainability of national tobacco control programmes launched by The Union, the tool assists countries to make national tobacco control programmes sustainable. It is the first tool of its kind.

[40] The Action Agenda also stresses that the tobacco tax agenda is fully consistent with obligations acquired by 180 countries that are parties to the WHO Framework Convention on Tobacco Control (WHO FCTC) (an additional seven countries have signed the WHO FCTC but have not ratified it, and only nine countries are neither signatories or parties to the WHO FCTC). Raising taxes on tobacco products is one of the most cost-effective measures to reduce consumption of products that increase mortality, while also generating substantial domestic revenue for health and other essential programs— investments that benefit the entire population. Given this, the World Bank Group Tobacco Control Program gives priority attention to tobacco taxation. Country evidence documented by WBG assessments indicates that higher tobacco tax rates could save millions of lives each decade, reduce poverty, and boost public resources for development investment.

[41] 40 Parties are needed for the Protocol under the WHO FCTC, to come into force. Currently, only a few more Parties are needed for this important step to occur according to the 2017 WHO on the global tobacco epidemic.

ANNEX A   SPECIFIC COUNTRY FINDINGS

The section below presents specific findings from the detailed country data reference notes (presented in 11 distinct documents) and other raw country data gathered in each country by the evaluation team.

Bangladesh

One of the four world top-20 tobacco producers, Bangladesh succeeded to reduce the tobacco use prevalence rate over the years. Tobacco use prevalence significantly decreased among adults from 43.3% in 2009 to 35.3% in 2017 (from 58% to 46% among males; from 28.7% to 25.2% among females). Smokeless tobacco prevalence for adults was also reduced to 20.6% (16.2% of men, and 24.8% of women currently use smokeless tobacco). In 2009, around 26% of men used smokeless tobacco and 28% of women.

Bangladesh enacted its first tobacco control act in 2005 (Smoking and Usage of Tobacco Products Control Act), and it has been amended twice (in 2013 and 2015) to be in full compliance with the WHO FCTC. Note that the original Act did not cover smokeless tobacco. Many policy and programmatic initiatives were implemented since 2009, such as: a comprehensive ban on all forms of tobacco advertising, sponsorship and promotion in all media (except on the internet); smoke-free zones in all public transportation and public places including restaurants and cafes, indoor work office spaces, health care facilities, and all educational institutions (however, smoking in designated areas of workplaces is still allowed); and prohibition on the sale of all tobacco products (smoking and smokeless) to or by people younger than 18 years of age.

Challenges are: tobacco industry interference, absent government coordination, and lack of political commitment. Activities, resources and results are not adequately coordinated between MoH and other sector ministries and CSO/NGOs, and regular monitoring is weak.

According to the Department of Agriculture Extension (DAE), in the 2014 tobacco growing season, tobacco has been grown on 108,000 hectares of lands in 2014, up from the 70,000 hectares in the 2013 season.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — A multi-sectoral plan for the NCD Control and Prevention 2017 – 2022 has recently been prepared with technical support from WHO. This plan suggests involvement of multiple stakeholders but without clear definition of roles and responsibilities. Between 2007 and 2010, the country worked with a National Strategic Plan of Action for Tobacco Control. The National Tobacco Control Cell (NTCC) is the leading authority on tobacco control in Bangladesh and is working under the Ministry of Health and Family Welfare. However, the implementing entities are different and are supervised for a large part by the Home Ministry.

Partners — CSOs are playing a vital role as implementing organizations and partners of the government. In Bangladesh, several international organization are active: The Union, CTFK, and Vital strategies (as part of Bloomberg Initiative) support the programme. In NCD control, including tobacco, NGO and CSO partners are more active than other sector ministries. Interlocutors mentioned effective, and efficient engagement of the government is a main sustainability issue.

Financial sustainability — The financial sustainability of tobacco control is not secured by the government, and the WHO and its partners are mainly funded by a sole donor (Bloomberg). WCO also receives core funding for NCD, including tobacco. The Cabinet has recently approved the policy to utilize the funds being generated from a 1% health development surcharge on the excise duty

levied on tobacco products, for tobacco control and health promotion. It is expected that NTCC will receive funding from that source in the near future.

Actual debate related to tobacco control — There are a lot of debates going on such as the 1% health development surcharge; the ongoing GATS and STEPS surveys; the National Strategic plan for tobacco control; the Non-compliance with GHW legislation by tobacco companies; the needs to strengthen the NTCC with resources turning it into a fully functional directorate; the speech from the Honorable PM at the South Asian Speaker's Summit of 2015 when he clearly stated that the country should be tobacco free by 2040.

WHO support — The role and contribution of WHO in reducing the prevalence of tobacco use has been instrumental in Bangladesh and the WCO provided adequate support to the National Tobacco Control Cell of the MoH. WHO provides technical support in: policy preparation, capacity building of law enforcers, and evidence generation through research. WHO also provides logistic support to NTCC for tobacco control activities and financial support to NTCC to carry out specific activities like training etc. The WHO budgets allocated to tobacco actions/activities are small and included in the large basket of the NCD cluster, so it may be easily lost among others several topics more appealing for donors to support (e.g. cardiovascular diseases, cancer, diabetes etc.), especially since the two WCO Officers are not fully dedicated to tobacco control.

MPOWER — Bangladesh receives an insufficient score for Monitoring (M) which deteriorated between 2008 and 2016, and for O and R. Specific observations are:

+ People are more protected from second hand tobacco smoke, thanks to the smoke-free legislation (P) and more aware of the health risks related to tobacco use (W). The bans on tobacco advertising, promotion and sponsorship improved steadily over the last decade.

   In March 2016, Bangladesh introduced pictorial health warnings on all tobacco packages (including cigarettes, bidis, smokeless tobacco products and other tobacco products) that should cover at least 50% of the package surface. The country implemented anti-tobacco campaigns in various types of media (television, radio, and print media) and improved cessation services through awareness building and various training programs. An annual increase in tobacco excise reaching a level of 76% of the price of most sold cigarettes; in 2017, however tobacco products remained affordable.

— In general, data to implement and evaluate effective tobacco control policies (M) are partly available. Since 2007, GATS, GYTS, NCD risk factor surveys (STEP) for adults, GHSH, Global School Personnel Survey, International Tobacco Control Surveys, SMART by UNICEF and WFP were conducted, but the intervals between the studies are longer than expected (e.g. GYTS and STEPS).

— Practical and effective offers to quit tobacco use (O) and increase the price of tobacco through higher taxes (R) are underperforming.

POLICIES — Insufficient score, except for Protocol to eliminate illicit trade (3,6) and NCD (3,2) which presents progress.

There is no policy framework on prevention of illicit trade present, nor ratification of the protocol on illicit trade, but the Customs Intelligence and Investigation Directorate monitors illicit trade, which is massive. Illicit trade of cigarettes/smokeless tobacco and non-cigarette smoking tobacco products occured in the last three years, but is gradually reducing (lower number of products seized);

The country has an operational plan for the control and prevention of noncommunicable diseases (NCDs), for the period of 2017- 2022. For the first time, tobacco received some attention in this plan and the government has defined some (4) major activities and allocated the budget accordingly. The Noncommunicable Disease Control (NCDC) Department is preparing a multi-sectoral action plan for

NCD control with technical support from WHO. A specific budget is allocated in the operational plan for executing the NCD action plan.

Research — No data or no information could be collected on the amount of money going into research and media. Existing research in tobacco is inadequate. The surveillance studies are not being done at regular intervals. Government lacks funding and capacity as well to conduct research.

Cultural aspect — Cigarette prices in Bangladesh are among the lowest in the world, and local hand-rolled 'bidis' are even cheaper. Industry keeps the base price of tobacco products very low so that the prices do not go up significantly even after taxation. Chewing smokeless tobacco is socially and culturally acceptable, especially among women in rural areas.

Willingness to quit smoking — Overall, 59.9% of current smokers wanted to stop smoking immediately (GATS 2017).

Potential "Champion of Tobacco" in the country — Few potential champions (such as singers, directors, physicians) are interested in anti-tobacco activities, but they have been raising their voice in their respective field and participate at times in anti-tobacco activities. However, they are not systematically recognized by the mass population of the country.

Tobacco production — In Bangladesh, production of tobacco has been increasing in the last three years and tobacco farming has almost doubled. Following the Department of Agriculture Extension (DAE), in the 2014 season, tobacco has been grown to 108, 000 hectares of lands, from 70,000 hectares in the 2013 season.

Challenges and opportunities — Interference by the tobacco industry is the biggest challenge, and increasing tobacco cultivation is a good second. Other challenges include: failed advocacy efforts of NGOs and CSOs on tobacco taxation; the perceived economic benefits of tobacco; poor multi-sectoral coordination; the fact that tobacco control is still perceived as MOH responsibility only; and the short duration of donor funding. Small NGOs cannot carry out sustainable tobacco control programmes. Opportunities are the existing 'Smoking and Using of Tobacco Products (Control) Act; the Drafted Tobacco Control Policy and Program; the GO-NGO collaboration and coordination; the NCD operational plan 2017-2022 that included tobacco control activities and budget; and the ongoing drafting of the multi-sectoral NCD action plan.

Bhutan

Bhutan ratified the WHO FCTC in 2004. The country has been implementing a comprehensive ban on the sale of tobacco products (both smoked and smokeless forms) since 2004. Smoking is prohibited in public places; however, the smoke-free policy allows indoor designated smoking areas.

Despite the ban and enactment of the Tobacco Control Act, the Global Youth Tobacco Survey (GYTS) of Bhutan (2013) reported an increase in the prevalence of tobacco use, from 18.8 % in 2006 to 30.3 % in 2013.

The National Health Survey 2012 reported that 4% of the population aged 15 to 75 years used a smoked form of tobacco, and about 48% used smokeless tobacco. However, according to STEPS (2014; 18-69 yrs), the prevalence of current tobacco smoking is 7.4% (10.8% in male and 3.8% in female) and the prevalence of smokeless tobacco is 19.7% (26.5 % in male and 11% in female). These recent nationwide surveys clearly indicated the substantial burden of tobacco use in Bhutan.

There is no tobacco industry in Bhutan, and no activity by the industry to advertise, promote or sponsor tobacco products was noticed in the last year. However, tobacco companies might have tried to create some indirect influence, since a survey showed, 9.7% students were offered a free tobacco product from a tobacco company representative and 14% students had something with a tobacco brand logo on it.

The increasing trend of tobacco use among youth and higher prevalence of NCDs in recent years reflects that tobacco control and NCD prevention across all government and sectors needs more intensive efforts to be effective.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — A multi-sectoral action plan was approved in July 2015 by the Royal Government of Bhutan to tackle NCDs, thus synchronizing national efforts with the WHO's strategy for the region. It set Tobacco control as a priority action area and targets for reducing prevalence of tobacco use in persons aged over 15 years - 15% by 2020 and 30% by 2030. There is currently no national tobacco control strategic plan in place. Tobacco control activities have been integrated into the primary health care system since the launch of tobacco control activities in the 1980s.

Partners — Although there are a few CSOs that advocate and sensitize people on the negative effects of tobacco, Bhutan lacks CSOs working specifically on tobacco control.

Financial sustainability — A small budget on tobacco control is allocated from the government to the autonomous body serving as the Secretariat to the Tobacco Control Board for tobacco related activities, the Bhutan Narcotic Control Agency (BNCA), but no budget is provided to the MoH. Other funding comes mainly from WHO to the MoH. For instance, US$50,000 is given for two years to the MoH who shares 20% with the BNCA. The rest is spent by the MoH to do advocacy mainly on World No Tobacco Day and media campaigns on TV and radio on negative effects of tobacco consumption.

Actual debate related to tobacco control — (i) Includes the needs to strengthen tobacco cessation activities. The BNCA and MoH think WHO support is critical for cessation; (ii) the Global Adult Tobacco Survey is to be conducted in 2018 for the first time in Bhutan; (iii) draft findings of two recent surveys revealed unexpectedly high smoking rates among adolescents and youths. National Drug Use Survey of BNCA conducted in 2016 found 32% adolescents and youth were current smokers. On the other hand, the Global School-based Student Health Survey found 28% were current smokers. However, both reports are yet to be published.

WHO support — The BNCA, the lead implementing authority, acknowledges the role of WHO for the formulation of the current Tobacco Control Act. WHO provided important technical support for generating evidence and best practices to influence the policy makers (advocacy). WHO also provides small amounts of financial support to the MoH for tobacco control activities, especially on World No Tobacco Day.

MPOWER — Good to Moderate score, except for O and W (insufficient).

Since 2004, Bhutan has implemented a comprehensive ban (E) on the sale of tobacco products, both smoked and smokeless forms, and put in place comprehensive smoke-free provisions (P) since 2005. These tobacco control initiatives were further strengthened through the enactment of the Tobacco Control Act 2010, which provides for a comprehensive legal framework for the implementation of tobacco control policies and prohibits cultivation, manufacture, distribution, and the sale of tobacco products within Bhutan. However, Bhutan is the only country in the world having such a comprehensive ban. It was also among the first few countries to have signed and ratified the WHO FCTC in 2004.

The law does not ban consumption of tobacco products, though the use is banned in public places. A limited quantity of tobacco products may be imported by individuals after paying tax for personal consumption.

Apart from brief advice, the MoH has no activities focused on cessation. National tobacco dependence treatment guidelines have been prepared, and the MoH and WHO provided training to some health professionals. A toll-free number (112) is available in Bhutan for general health inquiry and emergency medical services, which is promoted by the MoH as the 'tobacco toll free' number throughout the

country. Thus In 2018, a tobacco quit-line is likely to be accessible 24/7.

POLICIES — Very Good/Good score, except for tobacco control program at sub- and national levels (rated insufficient)

The tobacco control act was developed in line with the WHO FCTC, and was enacted on the 6th of June 2010. This act prohibits cultivation, harvesting, manufacture, supply, distribution and sale of tobacco products. Though the sale of tobacco products is banned, consumption is not prohibited except in areas identified as smoke-free zones by the government. Cigarettes, piped tobacco and other tobacco products can be imported for personal consumption under a specific import quantity.

Currently there is no national tobacco control strategic plan. Bhutan also does not have a strategic communication plan at the moment. The National Communication Strategy for control of tobacco and doma (betal quid) is going to be started; the workplan and activity have been approved.

Research — Surveillance studies are conducted at regular intervals except for GATS. Factors associated with high tobacco use were not systematically studied[42]. The Government needs funding and technical capacity too to conduct research.

Cultural aspect — In Bhutan, being a Buddhist country, smoking is considered bad for one's karma; the cultural and religious values have been contributing greatly in the maintenance of the smoking ban.

The bilateral relations between Bhutan and India have been traditionally close and both countries share a good relationship. India is not only Bhutan's development partner, but it is also the largest trading partner. The borders are porous and both cigarettes and smokeless tobacco are very much available adjacent to the border in Bhutan. Bhutanese smoke there and come back (findings from site visits).

A recent nationally representative survey[43] found that one-fourth of adults in Bhutan use tobacco, with the majority of those using smokeless forms of tobacco. One of the possible reasons for more Bhutanese using smokeless tobacco could be because of the smoking ban in public places. It is convenient for the people to use smokeless tobacco, as they do not have to visit the "designated smoking room." Moreover, other people usually do not mind smokeless tobacco use, as it does not produce second hand exposure. Affordability could be another reason for more people, particularly from the poorer section of society, using smokeless tobacco in Bhutan. Socio-cultural factors (including acceptance of betel nut use) are important factors.

Willingness to quit smoking — According to STEPs 2014, among the 18–69 years age group, 69% of adult current smokers tried to stop smoking in past 12 months.

Potential "Champion of Tobacco" in the country — N/A

Challenges and opportunities — To strengthen the technical capacity to carry out implementation of WHO FCTC, the porous border and the fact that both cigarettes and smokeless tobacco are very much available adjacent to the border in Bhutan need to be taken into account. Bhutanese smoke on the other side of the border inside India and come back. The opportunities include (i) strengthening implementation of the Bhutan Tobacco Control Act 2010 involving relevant agencies; (ii) developing a multi-sectoral action plan to tackle NCDs, thus synchronizing national efforts with the WHO's strategy for the region; (iii) including tobacco control as a priority action area with a target of reducing prevalence of tobacco use in persons aged over 15 years (by 15% by 2020 and 30% by 2030) in the multi-sectoral national action plan; (iv) introduction in 2014 by the government of the country-wide roll

---

[42] Current tobacco use and its associated factors among adults in a country with comprehensive ban on tobacco: findings from the nationally representative STEPS survey, Bhutan, 2014; https://pophealthmetrics.biomedcentral.com/track/pdf/10.1186/s12963-016-0098-9?site=pophealthmetrics.biomedcentral.com

[43] https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-016-0098-9

out of WHO Package of Essential Noncommunicable Disease Interventions (PEN), which provides health-care workers the tools to detect and manage NCDs in their communities. It is a great opportunity to include community level health workers in sensitization and cessation activities.

Democratic People's Republic of Korea

According to the most recent country data, DPR Korea has shown a declining pattern in tobacco use: current smoking prevalence of 22% in 2017 down from 27% in 2011. Tobacco smoking prevalence has decreased among male adults, 59.9% in 2002, 54.8% in 2006, to 46.1% in 2017 (Global Adults Tobacco Survey 2017). Daily prevalence among males aged above 17 years was 37.7% in 2016.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — The country has a comprehensive and multi-sectoral strategy for tobacco control, but provisions for implementation are not yet developed. The MoPH plays a leadership role in multi-sectoral activities for tobacco control and coordinates with education, agriculture, commerce, civil society organizations and mass media, supervised by the Health Bureau (HB) within the Cabinet. The HB arranges regular meetings/consultations of multi-stakeholders to improve tobacco control, monitors the enforcement of the law and regularly makes a comprehensive evaluation of tobacco control activities. The Health Bureaus of provincial and county people's committee (subnational governments), health facilities including provincial and county hospitals and anti-epidemic stations are also involved. The National tobacco control strategic plan is incorporated into the National Strategic Plan for NCDs.

Partners — Many partners are involved in tobacco control including mass media, the education sector and civil society organizations, etc. Civil society organizations including Youth League, Women's League and Worker's League are playing an important role in raising awareness on the harms and dangers of smoking among people, and in monitoring/controlling smoking at smoke-free places in workplaces and neighbours.

Financial sustainability — There's no specific budget allocated to execute the NCD action plan nor to monitor tobacco use and prevention. However, financial support for tobacco control has increased since the introduction of the MPOWER package.

Actual debate — Effective enforcement of the tobacco control law is the ongoing discussion at the government level, particularly the implementation of a strict ban on smoking in smoke-free places, including schools and public places. Tobacco prices are too low, making these extremely affordable.

WHO support — WHO has provided technical and financial support to the successful implementation of a national strategic plan for NCDs, which includes ensuring tobacco control activities are in line with national tobacco control law, WHO FCTC, and the WHO global and regional strategic plan. WHO also supports surveillance and tobacco cessation activities.

MPOWER — Good score (but moderate for Offer to quit measure). Compliance and enforcement of tobacco control law should be strengthened including fines to violators of the law. Only text health warnings (no pictorial warnings); hence, need to reinforce in line with WHO FCTC guidance on warnings; National surveillance system in DPR Korea is yet to be established and tobacco price control measures need to be strengthened in DPR Korea.

POLICIES — Moderate

+ The national tobacco law is in line with WHO FCTC and recommendations, but the mechanisms and guidelines for implementation of the law need to be further developed and updated.

− Tobacco is grown in Korea (unknown production), and government policy/program for alternative livelihood for tobacco farmers and workers are not in place.

Research — The research on development, production and dissemination of NRT including nicotine replacement pills, nicotine patch and nicotine gums in Tobacco Cessation Research Centres and

Research institutions of central hospitals. Those research institutions also study effective methods of quality advice and consultation for smoking cessation. The Population Centre and National Institute of Public Health Administration play a key role on research of the tobacco survey, contributable factors to change of smoking prevalence, strategies and activities for reduction of the smoking rate, monitoring and evaluation of enforcement of the national tobacco control law, etc.

Cultural aspect ─ NA

Willingness to quit smoking ─ 42.2% of current smokers tried quitting smoking in the last 12 months (National Adult Tobacco Survey 2017).

Potential "Champion of Tobacco" in the country ─ NA

Tobacco production ─ NA

Challenges and opportunities ─ The tobacco control law explicitly depicts smoke-free places including indoor workplaces, restaurants, public places, etc. Compliance and monitoring of the implementation of tobacco control law should be further strengthened. The enforcement units with staff of tobacco control law are not specifically designated, which inhibits the enforcement and punishment (including penalties) to violators. The quality of smoking cessation advice in primary health care facilities is not satisfactory. Brief advice on cessation and NRT should be made available to all smokers and research on NRT to be strengthened. Health warnings on tobacco packages are still text type which needs to be upgraded to GHWs, and its coverage needs to be enlarged in line with WHO FCTC. The smoking surveillance system has not yet been established, which inhibits regular monitoring and evaluation of smoking.

India

India had a law to regulate cigarettes since 1975 when the Cigarettes (Regulation Of Production, Supply And Distribution) Act, was enacted, including provision for a statuary warning on cigarette packs – cigarette smoking is injurious to health. WHO has supported the implementation of tobacco control in India since 2001 and has been instrumental to the achievements in terms of prevalence of tobacco use. WHO supported the development of advocacy campaigns material and setting up of Tobacco Cessation Clinics in India to support tobacco control initiatives of the MoH. India shows a current tobacco use prevalence rate of 28.6% in 2017, a relative decline of 17% from 34.6% in 2009-2010. About 21.4% (199.4 million) of all adults currently use smokeless tobacco, including 12.8% of women.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan ─ India has been implementing WHO FCTC since 2004 and MPOWER since 2008. A National Action Plan for NCD has been initiated through several consultations in the period 2013-14, and various ministries are involved in tobacco control, e.g. MoF on the subject of taxation. National tobacco control strategic plan is in place for both national and subnational levels – National Tobacco Control Programme (NTCP), funded by the Government, has been implemented since 2007.

Partners ─ Since 2004, several NGO coalitions and international organizations are involved in advocacy and support the MOHFW in implementing tobacco control policies in India. Like Bangladesh and Indonesia, India is supported under the Bloomberg Initiative and is a priority country.

Actual debate ─ Recent trends show continued tobacco industry tactics and strategies to influence tobacco control polices, and the anti-tobacco lobby has not been effective. The number of NGOs working in tobacco control area has reduced over time.

WHO support ─ WHO has a long-term commitment with the government of India in supporting the building of the infrastructure on tobacco control and the implementation of the MPOWER measures and policies. The WHO has been instrumental in the results achieved in India, one of the two countries which showed a reduction of tobacco use prevalence as well as a reduction in the risk of premature

mortality from target NCDs. The WHO provides its support in all the MPOWER measures and other policies of the WHO FCTC (MPOWER+). The WHO initiated technical assistance in terms of providing national and subnational level consultants to support initiating tobacco control cells in the country (during 2006-2014). WHO has also initiated several capacity building workshops for the national and subnational focal points as part of the national tobacco control program.

Further, during our subnational visits, the subnational level focal points expressed their wish to continue WHOs' technical assistance support in terms of consultants and continuous capacity building support in the country, what was somehow discontinued after 2014. Also, some NGOs suggested that WHO should initiate online capacity building courses for the subnational and district level tobacco control focal points and continue strengthening tobacco control initiatives in the country.

Willingness to quit smoking — According to The Global Adult Tobacco Survey (GATS) 2016-2017, about 55% smokers wanted to stop/quit smoking; 50% of smokeless tobacco users are planning to quit. There is a huge demand for cessation services according to the stakeholders.

Research — WHO in India has initiated research on the costs of tobacco consumption. Illustrating that the tax revenues from tobacco products (US$3 billion) represent 1/8 of the total costs of tobacco consumption ($US 22.4 billion annually). These costs include the costs to buy tobacco, disability-adjusted life year (DALY), and the medical costs due to diseases related to tobacco. More research is needed to gather evidence on various subjects (including the impact of pictorial warnings, media campaigns, NTCP implementation etc.), especially to fight against tobacco interference, which is intense in India.

Potential "Champion of Tobacco" in the country — There are two types of potential future champions in the country: (i) tobacco victims who are suffering as a result of tobacco consumption and (ii) athletes who are ambassadors in anti-tobacco campaigns.

Tobacco production — In India, production of tobacco has reduced in the past three years from 315,000 tons in 2014 to 202,000 tons in 2017 (the major component in the Indian tobacco production in India is the Flue-Cured Virginia (FCV)). As per the tobacco board in India, there are 96,865 registered tobacco farmers in India, and directly or indirectly affect the livelihood of 45.7 million persons in India.

Challenges and opportunities — There are many gaps to be addressed: (i) The law allows selling of single cigarettes or smokeless tobacco; (ii) The law does not ban selling by non-licensed sellers; (iii) Point of sale advertisement is allowed; (iv) Designated smoking rooms (DSRs) are allowed in selected places; (v) Tobacco products are not regulated as provided under COTPA 2003 in view of no tobacco testing labs being available to do so; (vi) The Tobacco Board under the Ministry of Commerce supports tobacco growing; (vii) Not much progress has been made to provide alternative livelihood options to tobacco farmers and bidi rollers; (viii) There is no regulation of extensive surrogate, indirect media campaigns which promote use of paan masala, leading to violation of Article 13 of WHO FCTC and Section 5 of COTPA Act as it pertains to "brand stretching" and "brand sharing".

Indonesia

Indonesia is the only SEAR country that has not yet ratified WHO FCTC. It has a high prevalence of tobacco use, especially use of "kreteks", locally produced clove cigarettes. Implementation of tobacco control policies over the last decade has shown progress in the country, but led nevertheless to insufficient results. The adopted policies and their implementation still seem to fail to produce significant impact to reduce smoking and fight the tobacco industry's new products, marketing strategies and political influence. The prevalence of tobacco use increased over the last 10 years, and the country is showing the worst rate for prevalence among adult males in the SEAR (75.2%).

According to the *2018 WHO Global Report on Trends in Prevalence of Tobacco Smoking 2000–2025*, Indonesia is only country in SEAR where it is predicted that smoking prevalence will increase.

High-level advocacy is needed to address political bottlenecks and obtain better results, such as (i) diplomatic engagement and efforts at multiple national and international fora for peer pressure, (ii) engagement of other sectors in a multi-sectoral approach with different ministries and other UN agencies.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — Multi-sectorality is a new approach for tobacco control in Indonesia. In 2015, the MoH-RI issued a ministerial regulation that outlines the multi-sectoral action plan for NCD control including multiple factors. Six ministries are instructed to work together: the MoH-RI, the Ministry of Finance, the Ministry of Agriculture, the Ministry of Law, the Ministry of Trade, and the Ministry of Social Welfare. There is a national tobacco control strategic plan in place for both national and subnational levels (for instance the smoke-free regulations have been adopted by about 250 regional governments, out of 532 regional governments in total).

Partners — International, national, and regional NGOs play a large role in advocacy efforts and in implementation of all MPOWER elements; however, policy makers, in this case members of the House of Representatives, also play a great role in "defending" the tobacco industry's interests.

Financial sustainability — This is a concern since the partners' work is mainly funded by a sole donor (Bloomberg Initiative; Indonesia being a priority country). The WCO receives a small amount of core funding on tobacco control in the NCD cluster. Among the achievements, a line of budget given by the MoF to the MoH will be secured next year to conduct annual media campaigns.

Debate — There is a large national political debate going on to apply a comprehensive ban on all tobacco advertising, promotion and sponsorship (TAPS), one of the hardest challenges since the legislation involves different ministries and broadcast law, press law, and film law. There are no bans on direct tobacco advertising, only on tobacco promotion and sponsorship.

In 2015, the House of Representatives' members proposed a tobacco bill that defends tobacco industry's interests. The bill has been rejected by the President in 2017, but the House members reinstated it as one of their priority bills in 2018.

WHO support — Indonesia made some progress though implementing the MPOWER measures, and WHO has been Instrumental in these results. As the sole organisation continuously supporting the MoH since 2003, and more recently, other ministries to get involved in tobacco control, the WHO is playing a strategic role in tobacco control in Indonesia with the MoH and other ministries, particularly the Ministry of Finance, in terms of coordination, information, data, technical assistance and advocacy for tobacco control. More funds, technical assistance and advocacy are needed from the WHO to work on more issues, such as E (TAPS ban). Advocacy is a role that the government especially expects from the WCO, the Regional and HQ offices, since multiple layers and efforts of lobbying are needed, in addition to technical assistance, to encourage the country adopt stronger policies.

MPOWER — Moderate score

Some measures are embraced as a priority and implemented by the government, such as P (smoke-free policy), O (offer help to quit tobacco use) and W (warn about the danger of tobacco), while other measures face more harsh resistance within the government itself and from the tobacco industry, such as E (bans on advertising, promotion and sponsorship) and R (raise taxes).

+ Currently, the strongest MPOWER policies are for the "W" about the dangers of tobacco and the "R" (raise taxes on tobacco). The monitoring and evaluation plan of these policies can provide scientific evidence for further improvement. In late 2014, the MoH launched the first nation-wide anti-smoking campaign in collaboration with Vital Strategies with funding from the Bloomberg

Initiative. Since then, the MoH succeeded in securing government funds to conduct two to three national-wide anti-smoking mass media campaigns per year using TV spots, cinema and earned media.

— Policies and/or funding are insufficient for monitoring tobacco use, offering help, and enforcing bans on TAPS. Mechanisms for tobacco monitoring are deficient, but the country is aware of the need to get annual update data specifically for tobacco control. On the other hand, it is expensive and not a priority.

The WHO reports, including the Global Tobacco Control Report, provide a comprehensive overview of implementation of overall tobacco control policies and programmes, but there is a need for more detailed and updated data and multi-sectoral data from various sources including labour and agriculture[44].

POLICIES — Insufficient score, especially for Article 5.3 of WHO FCTC Protocol to eliminate illicit trade and alternate livelihood programs.

+ Policy is in place for tobacco free health facilities.

— There is no specific policy to protect public health from tobacco industry influence, just a Code of Conduct in the MoH; no help for tobacco farmers with alternative livelihood programs; Other policies are in place but insufficient or not strongly enforced for content/emissions of tobacco, restricting access to minors, illicit trade, tobacco control programs, and NCD action plan.

Research — the existing research in tobacco in the country is insufficient. More strategic, well-designed research is needed to provide scientific evidence for stronger tobacco control policies.

The WHO financed a study on the economic costs of tobacco consumption in Indonesia, estimated at US$46 billion dollars in 2015. These costs include the costs to buy tobacco (US$16 billion), Disability-Adjusted Life Year (DALY) (US$29 billion) and the medical costs due to diseases related to tobacco (US$1 billion)[45]. According to the MoH, revenue from tobacco excise tax has been steadily increasing to 10 billion $US in 2015, i.e. 8% of the national budget, an amount that still only represents one fifth of the estimated economic costs of tobacco in Indonesia.

Cultural aspect — Smoking is more the norm for males than females in Indonesia. Clove cigarettes are considered to be part of the national heritage for many smokers.

Willingness to quit smoking — The proportion of youth smokers (aged 13-15) reporting a willingness to quit is 88% (GYTS, 2014); among smokers age 15 and over, it is 48.8% (GATS, 2011).

Tobacco production — In Indonesia, tobacco production data from the MoH show an increase from 193, 790 tons in 2015 to 196, 154 tons in 2016 to 198, 296 tons in 2017.

Potential "Champion of Tobacco" in the country — Since the defeat in Indonesia of the 2010 Tobacco Control bill and the introduction by the tobacco industry of the ''Tobacco Bill'', no ''champions'' for tobacco control seem to clearly stand out in Indonesia, according to the stakeholders. Somebody, in particular a political figure or leader, should urgently be identified by the stakeholders to embrace that fight for tobacco control. Regional governments can be champions if they develop strong and comprehensive smoke-free regulation with an adequate evaluation plan that can show the benefits of such a health promoting policy.

Challenges and opportunities — The industry led tobacco bill is the biggest challenge (see section "debate" above)**.** The BI partners strongly suggest the government have a special unit specifically

---

[44] i.e. the Tobacco Source Book Data to support a National Tobacco Control Strategy which was first published in 2004 (See Indonesia Country brief for more details).
[45] Soewarta Kosen, et al., Health and Economic Costs of Tobacco in Indonesia, Review of Evidence Series, Lembaga Penerbit Badan Penelitian dan Pengembangan Kesehatan (LPB), September 2017

addressing tobacco control in Indonesia. Currently, the "persons in charge" for tobacco control in the government are also in charge for other health issues and often get rotated to other divisions. Strengthening tobacco control policies and practices takes a long time, while job rotations in the MoH-RI happen quite often. When new persons fill in for the tobacco control duties, their adjustment process often slows down the pace. This issue also exists at the regions.

Channelling the advocacy efforts to government agencies other than the Ministry of Health is also crucial. Tobacco control should be a multi-ministry agenda. This might be something that the WHO and the BI partners can do in the future. For example, the Central Statistics Agency (BPS) can be a partner for monitoring activities. The Ministry of Home Affairs can push regional governments to develop and implement smoke-free regulations. The Ministry of Communication and Informatics can take the lead to revise laws that still allow tobacco advertisement. The Ministry of Finance should be pushed to put higher taxes on tobacco. The Ministry of Agriculture should be assisted to develop alternative livelihood programs for tobacco farmers and workers. The Executive Office of the President can coordinate the tobacco control agenda among the ministries.

Maldives

In Maldives, the rate of smoking prevalence was 18.5% in 2011, representing a reduction since 2009 (53.5% among adult male in 2009 to 34.7% in 2011). Since specific policies have not been put in place, so far the expected results in terms of progress towards the indicators of the WHO FCTC and the WHO NCD Action plan in recent years could not be monitored. The Tobacco Control Act 15/2010 was enacted in 2010; however, specific regulations required for proper implementation of the Act are still not in place.

The lack of implementation of the tobacco control policies is reflected in increased tobacco imports from 2006 till date. Maldives does not produce tobacco, and imported 465,000,000 cigarettes in 2016 (Maldives Customs Service, 2016).

There is inadequate communication and collaboration between the various organizations involved in tobacco control, e.g. between HPA/MOH and WHO, between the various departments of HPA/MOH, and among the other sector organizations such as NGOs, universities, economic sector, etc. However, communication is currently improving a lot, following the establishment of the Coalition for Tobacco Free Maldives (CTFM).

Partners — The CTFM has led to significant improvement in knowledge of tobacco control among community organizations (NGOs) as well as empowerment of these organizations to advocate.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — A Multi-sectoral action plan for NCD (2016-2020) is in place and a high-level committee was formed very recently, but there is no budget allocation except for staff remuneration for tobacco control and prevention. Two staff permanently work to implement the action plan. There is no effective tobacco control and NCD prevention across all government sectors. Besides the Ministry of Health, these other sectors are not involved in tobacco control, policies or programs except one specific regulation (to establish smoke-free public places) that has been enacted but poorly implemented.

Financial sustainability — There is a small unit called the Tobacco Control Unit which has 3 staff in the Ministry of Health (MOH) under the department of the Health Protection Agency (HPA), but there is no budget allocated specifically for tobacco control and prevention. The government has not allocated any budget to monitor tobacco use and prevention, and sustainability is questionable at this stage. However, this is a smaller relative issue at this point compared to the prevalent bottlenecks that are limiting the progress of tobacco control in the Maldives.

Actual debate — Lack of political debate and discussion is notable. Only tobacco taxation was debated in parliament along with taxation of energy drinks and fizzy drinks, and general taxation. This was viewed positively, but there was no consultation on taxation with MOH/health sector, and there are still many gaps in taxation.

WHO support — WHO's major role is in advocacy, and there is generally no direct role for WHO in the enforcement of laws, but an indirect one through advocacy at the high level. For instance, post WHO's supported meeting with technical experts, Parliamentarians and the Vice President during the Regional Pre COP meeting in 2016, the Government announced an increase in tobacco taxation and strengthening of smoke-free policies. WHO's role needs to be broadened to a more active engagement with the implementation of tobacco control policies and not just limited to advocacy.

MPOWER — Score Insufficient, especially for M and W.

The MoH, the Tobacco Control Board and WHO have worked on graphic health warnings on tobacco packs but could advance this further in view of the political situation. There are no mass media campaigns on the dangers of tobacco use and exposure to SHS. Only some NGOs warn against the dangers of tobacco use. There is no quit-line available. E (Ban on advertisement and promotion) exists under the law, but there is no separate regulation, so enforcement is limited and many violations are seen. Advertisement at points of sale (POS) are rampant, and indirect promotion is increasing, even in films, which previously complied with the law.

There is also no surveillance system in place in the Maldives for tobacco use and prevention. Some data are collected only for the use of government advocacy.

Many important data are needed for monitoring and advocacy yet are not available, including prevalence, second hand smoke exposure, actual sales/utilization data for the common tobacco products, disease burden, economic burden, effectiveness of current tobacco control measures, public opinions, and KAP studies on tobacco control measures.

POLICIES — Highly Insufficient

The tobacco control policies and mechanisms specific to the implementation of article 5.3 WHO FCTC have not been enacted so far, according to the limited data available. There is no policy/regulation to protect public health against vested tobacco industry influence. Minors have easy access to tobacco products due to the lack of specific regulations. Additionally, neither are there any protocols on the illicit trade being implemented nor any tracking mechanisms in place at the borders and other entry points to catch illicit tobacco traders.

Although the Tobacco Act specifies identification of enforcement personnel to implement the fines, they are not specifically identified and fall under the broad responsibilities of the police. Currently, the Health Protection Agency with other stakeholders are working to formulate policy and guidelines for implementation of article 5.3. Additionally, the law does not have provisions to prosecute violators of health warnings.

There is increasing concern on the large scale use of betel nut and flavoured tobacco products among adults and youth.

Research — A huge gap in research on tobacco control is another challenge. There is a very small involvement of Maldivian universities in tobacco control (unlike in other countries where universities play a lead role in research and technical assistance for tobacco control). The capacities of universities have been low as well, and only now are the universities being gradually engaged and starting at least student-level research in tobacco control. Universities need to build their capacity in tobacco control and tobacco control research, going onto university level research and providing independent expertise in tobacco control to the MOH, given that this would significantly strengthen the country's technical capacity. There is no data on industry-funded research.

Cultural aspect — Being an island country with a small population seems to be a factor that contributes to a strong tobacco Industry influence and weak capacity to fight it. Not only politicians and economic ministries, but even media and possibly legal professionals of very high political level, seem to be linked with the industry, making it very challenging to overcome the interference. The current top-down political structure of governance, where the President is the ultimate decision maker, does not allow for direct open and official discussion, and limits a two-way dialogue, discussion and effective advocacy.

Willingness to quit smoking — No data. There are only two clinics that offer help to quit tobacco. Both of the clinics are in the capital island of Male.

Potential "Champion of Tobacco" in the country — According to the interviewees, the national soccer team could be a potential champion to advocate against tobacco use.

Tobacco production — No tobacco is grown in Maldives.

Challenges and opportunities — The general lack of political commitment to strengthen public health leading to inadequate budgets and consequently lack of technical and administrative capacity in the HPA and MOH for tobacco control is evident. External funding received from projects such as the Bloomberg grant are challenging to utilize due to the government's red-tape procedures. The tobacco control unit is not only understaffed but also infamous for the deplorable remuneration, which leads to high staff turnover. Since Maldives is lagging behind with regards to achievement of FCTC requirements, the task seems overwhelming.

Myanmar

Myanmar presented a prevalence rate of tobacco use of 26.1% in 2014, up from 22% in 2009, a relative increase of 18.5%. Myanmar showed also one of the strongest prevalence rate of smoking among young males in the SEAR (boys at 26%; girls at 4%; both sexes at 13.6%) in 2016 from 2011 (boys at 30%; girls at 6.8%; both sexes at 18.6% Global Youth Tobacco Survey).

Myanmar, just like Timor-Leste, showed a slight reduction in risk for mortality from NCDs (24% in 2015 to 23% in 2017), against a background of very high prevalence of tobacco smoking amongst adults.

Betel chewing (smokeless tobacco) is traditionally the most common form among people, both women and men. The prevalence is 42.8% according to the tobacco control atlas ASEAN region, and this is the highest among ASEAN countries. E-cigarettes, sheesha and hukka are available and accessible but not branded by the industry. Myanmar follows the Maldives with a prevalence among adult male of 43.8%, being one of the highest smoking prevalences among young males in the SEAR.

The implementation and enforcement of tobacco control policies are generally insufficient in the absence of mechanisms to monitor and enforce guidelines, reporting formats and good nationwide information dissemination campaign. There is a need to advance tobacco control measures including "best buys" such as raising tobacco taxes, strengthening smoke-free and TAPS ban policies, and sustained anti-tobacco media campaigns. It will be useful to implement cost effective measures such as capacity building in tobacco cessation. Myanmar should immediately ratify the Protocol on illicit trade in tobacco (to which it had signed many years back but failed to implement). Limited action has taken place to provide alternative livelihood options to tobacco farmers and others involved in supply chain.

Myanmar adopted a national tobacco control law in 2006, but there is no specific policy to protect public health against vested tobacco industry influence. The law for packaging and labelling was updated in September 2016. The current tobacco law mainly deals with smoke-free places and does not mention taxation, tobacco industry and trade.

The presence of a strong tobacco industry influenced the weak implementation results. For instance, the best selling cigarettes, Red Ruby, is produced by a corporation owned by the Myanmar Military, which is the highest authorized instiution in Myanmar. A high level of advocacy is needed to overcome the challenges of the country's political economy related to tobacco.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — In August 2017, the government published a new multi-sectoral plan for NCDs (2017-2021) although specific targets still have to be defined. Engagement of various ministries other than the Ministry of Health is needed to secure their cooperation and collaboration. Sectors outside health, like trade and commerce and the Ministry of Finance, are just passively participating in tobacco control according to the informant. In the National Health Plans (2011-2016 and 2017-2021), tobacco control was not described as a priority, which is quite a glaring gap.

There are no specific national and subnational strategic plans for tobacco control. Some state and regional governments are actively collaborating with CSOs in the field of tobacco control. Most of the state and regional governments are interested in the control of betel chewing which can contain tobacco and is therefore a smokeless tobacco product. According to GTE Myanmar 2017, subnational jurisdictions do not have authority to enforce laws that ban tobacco smoking in any or all of the smoke-free environments, tobacco advertising, promotion and sponsorship.

Sustainability — Sustainability is a major concern considering the scarce resources allocated for tobacco control. Only one agent of the MoH is dedicated (part time) to tobacco control. The financial resources come primarily from donors including the Bloomberg Initiative and with some additional funding from the Bill and Melinda Gates Foundation through a regional NGO (SEATCA).

Partners — There is only one NGO working on tobacco control in Myanmar, People's Health Foundation, focusing on MPOWER policies and tobacco industry interference. The NGO also helped advance some tobacco control laws and is currently working on taxation. PHF receives funding and technical support from The Union, WHO and SEATCA, and helped advance some tobacco control laws, currently working for reform in Myanmar's tobacco taxation.

Debate — There is currently a pro-tobacco bill in Parliament on the agenda for debate which aims to protect tobacco farmers rather than public health. This bill has the potential to roll-back the few achievements in tobacco control such as the pictorial health warnings size that is currently applied to cigarette packs. The Myanmar government accepts assistance from the tobacco industry in implementing tobacco control policies, which is a clear violation of Article 5.3 of WHO FCTC. There are no records of public officials attending any social functions of the tobacco industry nor accepting any assistance from the tobacco industry for enforcement activities.

WHO support — The WHO support in Myanmar is very limited with no specific budget or activities for tobacco control, and oriented mostly to the World Tobacco Day event. There is only one staff appointed in the NCD cluster without expertise in tobacco control. Technical support is given remotely from the regional office or under other forms such as foreign observation trips and workshops. There is a need for training workshops on certain tobacco control issues with the participation of experts in tobacco control and sharing of "best practices" through national and international fora.

MPOWER — Moderate score, except for Offer to help quit tobacco use and Raise taxes on tobacco measures that are clearly insufficient.

+ The government's priorities were Smoke-free (P), Warn about the danger of tobacco on tobacco packages (W) and Enforce bans on tobacco advertising, promotions and sponsorships (E). Only some anti-tobacco media education was done occasionally, not as a campaign, but one smokeless tobacco media campaign was done in 2017.

— There are no proper guidelines and no enforcement mechanisms in place to enforce bans on tobacco advertising, promotion & sponsorship (TAPS), except some initiatives from CSOs who reported violation cases; Warnings about the dangers of second hand smoking, voiced through mass media campaigns and other communication means must be strengthened. R also needs to be strengthened to make tobacco products less affordable; there is no cessation activity or centre (O) in either government and civil society sectors.

There is a strong "need to improve" Monitoring as there is GYTS and STEPS, but no GATS yet. FCTC is monitored by GYTS and STEPS.

POLICIES — Insufficient score, and highly insufficient for Article 5.3 of WHO FCTC; Protocol to eliminate illicit tobacco trade; alternate livelihood programs; reducing access to tobacco products for minors and tobacco control program at sub- and national levels.

+ Some efforts have been done in the area of reducing usage by minors, smoke-free areas in health environments, and pictorial warning on packaging (as they are related to MPOWER).

— No proper national tobacco control strategic plan in place beyond 2016 for both national and subnational levels; Tobacco control is not included in the National Health Plans; Myanmar law prohibits selling single cigarette sticks. But in practice, single sticks can be bought in every small retail store and tea shop. According to our observations, retailers do not know about this provision and they do not even know that a tobacco law exists, which calls for much greater sensitization efforts.

Research — The MoH conducts research only when WHO supports and facilitates the study.

Cultural aspect — A lot of cultural and religious events happen in Myanmar, so local tobacco businesses donate to these events in exchange for branding. Giving a donation is a strong cultural habit in Myanmar, even when it is sponsorship and advertisement that defeats the purpose of Article 13 of WHO FCTC (which provides for TAPS ban).

In Myanmar, betel chewing and flavoured smokeless tobacco with betel nut is the most common form and is a tradition among people. This is commonly used by both men and women.

Willingness to quit smoking — In GYTS 2017, 74.5% of current smokers tried to stop smoking in the past 12 months.

Potential "Champion of Tobacco" in the country — Currently, the People's Health Foundation is the champion in Myanmar. They mainly receive international support and have good cooperation with the MOH. They work on various aspects of tobacco control, such as monitoring, taxation, advertisement bans, smoke-free places and especially smokeless tobacco.

Tobacco production — From 1995 to 2010, the area harvested under tobacco crop decreased about 0.5 times (16, 500 hectares in 2012)[46]. In 2012, 29, 000 metric tons of tobacco leafs were produced in comparison with 50, 900 metric tons in 2000.

Challenges and opportunities — The most difficult challenge may be industry interference, as noted above, given that the best selling cigarette, Red Ruby brand, is produced by a company owned by Myanmar Military which is the highest authorized institution in Myanmar.

Some of the members of parliament have a good relation with and support traditional local industries (including local tobacco producers) in their constituency. In Myanmar's current political situation, there are other health issues that attract attention, leading to less government interest and less prioritization of tobacco issues. There is high acceptance for the use of betel nut and betel nut- based flavoured tobacco products.

---

[46] Retrieved from the WEB: http://www.who.int/tobacco/country-fact-sheets/mmr.pdf

Nepal

One can observe a reduction in smoking prevalence among male adults according to the data in STEPS 2007, STEPS 2013 and the Nepal Demographic Health Survey 2016: there is a considerable decrease from 52% in 2011 to 27% in 2016. Tobacco use among youth was 7.2% in 2015 (GSHS 2015). Previously, the GYTS 2011 reported 20.4% prevalence for tobacco use among youth.

Nepal has the Tobacco Control Act 2010, and related regulations, regulatory directives and directives for Packaging of tobacco, a Tobacco Control Strategic Plan, and an NCD Action Plan. The existing legal provisions provided by the Tobacco Products Control and Regulatory Act 2010 that came into force in 2011 is in line with the MPOWER framework for tobacco control.

Limited research is being conducted to monitor the effectiveness of the legislation. There is thus a need to create and establish monitoring mechanisms to better understand the impact of these policies and whether or not Nepal is on track to achieve the WHO NCD Action Plan targets. Incorporating tobacco control reporting into the regular reporting system is a challenge, and seems to be the major bottleneck that hampers monitoring the progress and use evidence for future strategies.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — Nepal has developed a 'Multi-sectorial Action Plan for the Prevention and Control of Noncommunicable Diseases (2014-2020)' with tobacco control as a strong component, depicting high-level commitment through the formation of a High-level committee at the Ministerial level and a National Committee at the level of the Health Secretary. The key stakeholders and partners in NCD control are mapped and the plan also foresees provisions to mobilize the non-health and non-state actors in NCD control. There is a National Tobacco Control Strategic Plan in place for both national and subnational levels that has been implemented since 2014 at subnational levels but without clear reporting mechanisms or defined targets.

Partners — A lot of CSOs are involved on a demand and service delivery basis, especially in tobacco control campaigns and events. No tobacco control alliances have been formed. Government and CSOs collaborate but without a well placed coordination framework. There is still space to allow more civil society and non-state actors to be involved in tobacco control and there may be a potential for a National Alliance for Tobacco Control.

Sustainability — There is dedicated staff allocated for Tobacco Control at the National Focal Point of Tobacco Control and a separate Budget for NCD and Tobacco Control is allocated as well.

Actual debate — With the upcoming launch of the WHO FCTC Strategy 2030, there is an ongoing debate about the positive outcomes in tobacco control. The current debate seems to define tobacco control as a health priority because of the huge health costs that stakeholders perceive. There is a need to discuss the economic and social impact in order to attract non-health key stakeholders to add to the national efforts.

WHO support — WHO has a major role in providing technical assistance and providing appropriate networking opportunities for financial and program support. WHO also has contributed significantly in drafting the policy documents and supporting the surveys. WHO has been instrumental in providing technical assistance for lobbying, networking and fostering the establishment of Tobacco Control Focal Point and Unit at the Ministry of Health and Population. WHO also has recently supported Nepal in developing the WHO FCTC 2030 strategy.

MPOWER — Moderate, except for P and O (which are insufficient).

+ There is implementation of 90% packaging in Nepal (W); there are clear provisions in law for enforcing law against TAPS (E), even if the ban in International Media not clear in law.

- Tax on tobacco has increased since last fiscal year. The latest excise duty increase on tobacco was in 2016, but is still low compared to other countries and compared to WHO guidelines. Tobacco products are still affordable, but we do not have data on sales of tobacco products.

There are neither monitoring nor enforcement guidelines in place, nor a reporting mechanism for Indicators for the Tobacco Control Strategic Plan and Strategic Communication plan. There are no data to show a reduction in mortality/morbidity due to CVDs in Nepal. The Global Adult Tobacco Survey is not yet conducted in Nepal. Tobacco control indicators are not incorporated into routine health surveys.

POLICIES — Moderate to insufficient, especially insufficient for Alternate livelihood programs for tobacco growers.

Activities to discourage tobacco farming and trade are not clearly outlined. Without guidelines in place, it is difficult to implement the Article 5.3 of WHO FCTC.

There are no programs under consideration for alternative livelihood for tobacco farmers despite the tobacco law that outlines that this should be promoted.

Research — There is limited research being conducted on tobacco control, especially to monitor the effectiveness of the programs.

Cultural aspect — A challenge for the advertising ban is the lack of familiarity with the law. Communities and organizations tend to accept sponsorships by tobacco companies because they do not know about the ban under the law. The Annual National Golf Competition for example, held in 2017, is sponsored by a tobacco company. Small shop holders also tend to accept displays for their shops with tobacco company logos.

Willingness to quit smoking — STEPS Survey 2013 reports that 26% of all smokers (27.4% men and 22.5% women) have tried to quit smoking. GYTS 2007 reports 92% of all young smokers, both boys & girls, want to quit smoking. This information was not available for smokeless tobacco users.

Potential "Champion of Tobacco" in the country — The Ministry of Health is leading tobacco control and is expected to be the future champion of tobacco reduction for Nepal.

Tobacco production — In the past two years, the production of tobacco has decreased in Nepal from 2227 tons to 618 tons and the lands for tobacco cultivation reduced from 1724 to 639 hectares. Production was typically constant or growing in the last ten years.

Challenges and opportunities — Tobacco control should not only be seen as a health priority, but also be discussed in terms of economic and social impacts, which may attract and non-health key stakeholders to the fight against tobacco. Incorporating tobacco control reporting into regular health reporting systems appears to be a challenge and is a major bottleneck for monitoring and evidence based policy development.

In January 2018, Nepal launched the WHO FCTC 2030 strategy, which offers plenty of opportunities to make progress in tobacco control. The Kathmandu Metropolitan City is a recipient of the 'The Partnership for Healthy Cities' grant aimed to enforce the smoke-free laws in Kathmandu city. The grant is supported by Bloomberg Philanthropies via Vital Strategies and started in October 2017 (and will be in place for 18 months).

Sri Lanka

Sri Lanka has a considerable number of tobacco control policies and mechanisms that are relevant for the reduction of the demand for tobacco products. But smoking prevalence rates among adults has not changed much in the past 10 years. In 2006 and 2015, the rate was 15% indicating the limited impact of initiatives taken at a national and subnational level to prevent tobacco smoking. However,

tobacco use rates (smoking and smokeless) decreased among youth from 10.5 % in 2011 to 3.7 % in 2015; among boys from 15% (2011) down to 6.7% (2015) and among girls from 5.4% (2011) down to 0.7% (2015).

The demographic health survey in 2016 showed a smokeless tobacco prevalence rate of 29% of households (one or more smokeless tobacco users by household). According to a 2012 study[47], smokeless tobacco products and its use is three-fold higher among men compared to women. Betel quid is by far the traditional form in which tobacco is a general component. Other manufactured tobacco products include pan parag/pan masala, Mawa, Red tooth powder, Khaini, tobacco powder, and Zarda. Some 8.6% of the youth were current users of smokeless tobacco.

The implementation of tobacco policies falls short, which is affecting the level of progress being made in the country relative to tobacco control. For example, a lack of strict enforcement of the laws, lack of regular surveillance by enforcement officers, insufficient awareness campaigns etc. have been significant bottlenecks.

Although there is significant commitment at the presidential level, and the government has implemented policies to overrule tobacco company interference, conflicting interests within the cabinet and the influential Ceylon Tobacco company's (CTC) interference has been a challenge to implement legislation. A few members of the Board of Directors of CTC have been simultaneously holding positions within the government, a clear violation of Article 5.3 of WHO FCTC. There should be strict rules regarding holding top government jobs while in conflict of interest situations with tobacco companies.

The CTC is a subsidiary of British American Tobacco Company, who enjoys a virtual monopoly in the manufacture of cigarettes in the country. As cigarette import is banned, they are the only legal suppliers to the market. The company has challenged tobacco control measures frequently, including a court case for the graphic health warning legislation and for the law on tobacco advertising, promotions and sponsorships of tobacco products. The company is using the clause to sponsor activities that are not prohibit by the law (e.g. in the framework of the corporate social responsibility).

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — Sri Lanka has a well thought-out NCD multi-sectoral Action plan for the Prevention and Control of NCD (2016-2020) with a coordinating mechanism at both national and subnational levels which includes Tobacco Control program at sub- and national levels too. There is no standalone national tobacco control strategic plan in place.

The President has formulated a presidential task force for drug prevention, including tobacco control where all non-health sectors are actively involved. In this taskforce, there are 10 ministries and 10 departments. However, if tobacco control would have had a standalone strategic plan, it would have been be easier to monitor and collect specific data relative to tobacco control and prevention. There are plans in an inception stage to provide support to tobacco workers and growers in moving into economically viable alternative livelihoods.

Partners — The President of Sri Lanka, who was the former health minister, is very committed to tobacco control. Under his Presidential Task Force, a district drug prevention committee has been established in each District and at a lower level, 346 Divisional drug prevention committees and Village committees have been created. CSO and Government participate in the Village committees and Divisional committees and are expected to work actively for tobacco control and report monthly to the District authorities. Every two months, the President meets all relevant sectors.

---

[47] Retrieved in the WEB: https://www.ncbi.nlm.nih.gov/pubmed/23442399 (Somatunga LC[1], Sinha DN, Sumanasekera P, Galapatti K, Rinchen S, Kahandaliyanage A, Mehta FR, Nishirani Lanka JD. Smokeless tobacco use in Sri Lanka. 2012)

Sustainability — There is a dedicated budget allocated from Health for NCDs and there is also a direct allocation to NATA, the National Authority on Tobacco and Alcohol (NATA) under the Ministry of Health (MOH) which employs nearly 10 staff; however, no data is available on how much of the health budget gets utilized for tobacco control purposes. In the direct allocation for NATA, there is a budget for monitoring. It also looks after smokeless tobacco control, tobacco industry interference, capacity building in tobacco cessation, advocacy and other aspects of tobacco control.

Actual debate — include Illegal tobacco; prohibiting selling of tobacco within 500 meters' radius of schools; prohibiting the selling of single stick of cigarettes; taxation on tobacco; dealing with illicit trade of cigarettes.

WHO support — WHO's role has been to provide technical support and expert advice, information and communication. However, some aspects need to be strengthened to assist in reducing the demand for tobacco products i.e. more funds and technical assistance are needed from the WHO to work on these issues.

MPOWER — Between Moderate and Good

Sri Lanka fully complies with health warnings; however, it does not meet content/emission standards set by WHO FCTC. Although the laws for advertising, promotion and sponsorship are implemented, full compliance has not been achieved as the legislation allows some forms of tobacco advertising, promotion and sponsorship via telephone and cellular phone and at point of sale. Although Sri Lanka taxes tobacco products above 75%, the application is complicated and people can afford to buy cigarettes even with the increase in excise duty. The smoke-free law should be amended to include all public places and not only the enclosed areas. Therefore, the legislation needs further amendment to address the deficiencies, and a focused media campaign is essential.

POLICIES — Good

Sri Lanka has good laws and effective action plans except for Regulation of content/emissions, Protocol to eliminate illicit trade, and alternate livelihood programs. For instance, the government does not provide subsidies to the tobacco growers and does not support tobacco cultivation. However, the CTC provides facilities and incentives for tobacco growing farmers and their families to allow them to continue tobacco farming. The Presidential Task force plans to provide all tobacco farmers with alternative livelihood options by 2020.

According to the stakeholders, illicit tobacco trade needs to be better controlled, and tighter customs laws need to be put in place. With only one in ten smuggled cigarettes being detected, an estimated 360 million illegal cigarettes with market value of US$ 100 million have entered the market in 2017. Import of Tendu leaf, which is used to manufacture beedis, needs to be reduced. A prohibition of selling beedis needs to be put in place also, as a high percentage of NCDs are reported due to the use of beedis, which are as harmful as cigarttes.

Research — Research carried out by NATA, Sri Lanka Medical Association (SLMA) and WHO in 2015 showed the direct and indirect cost for 36 diseases related to tobacco cost US$ 662.0 million annually. When the results were presented to the President of the country and the Minister of Health, they made the largest increase on cigarette tax in one year: evidence-based policy making in practice. On the other hand, the tobacco industry has its own research regarding tobacco.

Cultural aspect — As a small country, there can be several illegal ways to smuggle tobacco products from neighbouring countries, especially India. It is important to have strong laws to regulate to prevent using beedis, which people living in poverty tend to smoke.

Willingness to quit smoking — No data

Potential "Champion of Tobacco" in the country — Youth of the country and the civil society-led "Blue Pea" initiative highlighting the plight of tobacco victims.

Tobacco production — In Sri Lanka, the production of tobacco leaves increased from 3000 in 2014 to 4972 in 2016 (mainly Arnica species such as Mountain tobacco).

Challenges and opportunities — There is commitment from the President, but not from all cabinet ministers. The Ceylon Tobacco Company is influential and uses techniques to violate advertisement, sponsorship and promotions regulations. The challenge is to stop the use of smokeless tobacco (STL), shift farmers away from tobacco growing, and stop illicit tobacco coming to the country. However, strict enforcement of the law with random checks by officers, and creating awareness regarding adverse effects of smoking among members of parliament and cabinet ministers, might help to a certain extent.

WHO FCTC 2030 strategy in Sri Lanka is seen as a good opportunity to advance tobacco control. The country has been selected along with Nepal and Myanmar to receive additional and dedicated support through the FCTC Secretariat to reduce tobacco use. The assistance will be used to undertake a government-wide programme of work to strengthen tobacco control. The project is to run for five years, and will bring this additional support to Sri Lanka, facilitated by the WHO FCTC Secretariat, United Nations Development Programme (UNDP), and WHO. This will include expert advice, technical assistance and peer support to strengthen tobacco control action. This support is expected to reduce tobacco usage in the long run and aid Sri Lanka in meeting the NCD targets.

There is no mention about the Observatory on tobacco industry intervention in Colombo. This is supported by the Union.

Thailand

Thailand seems to have implemented the most advanced tobacco control initiatives in the region. Nevertheless, smoking prevalence among adult men has stagnated around 40%, i.e. 39.8% in 2004 to 40.5% in 2015. Smoking prevalence amongst youth has not declined, and reached 21.8% in 2015 among young males, the third worst rate in the SEAR.

In 2017, the new tobacco control act was enforced, reiterating Thailand's commitment for tobacco control and enhancing public health protection under the WHO FCTC framework. There are several measures in place in the new/amended law that are expected to reduce tobacco use further.

In Thailand, the government owns the largest share of the tobacco market through a state-owned enterprise called Thailand Tobacco Monopoly (TTM). TTM opposes all the tobacco control policies at any given opportunity - they publish articles to voice concerns against the government-led tobacco control policies. This was especially apparent before the Tobacco Control Act of 2017 was passed. TTM mobilized the farmers' association against the government by holding protests. They published many articles in the newspaper. The resistance delayed the passing of the law by two years. However, the support for the tobacco control law was overwhelming and eventually the new law was passed.

Recent data on the amount of tobacco grown in Thailand are not available; however, according to the Food and Agriculture Organisation of the United Nation's FAOSTAT, Thailand produced 72,000 tonnes of tobacco in 2013. It is a major source of tax revenue for the Ministry of Finance. Hence, there is a conflict of interest between the finance and the tobacco control sector within the government.

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — In 2010, the cabinet adopted the Thailand Healthy lifestyle strategic plan (the multi-sectoral strategic plan), intended to fight against NCDs through broader citizen interventions. The Second Thailand Healthy Lifestyle phase II (20 years 2017-2036) incorporates 9 global targets on NCD prevention and control (20 years 2017 – 2036). Some of the dedicated funding of 2% on the excise on the sale of cigarettes that goes

to Thai Health gets used for tobacco control. The Ministry of Transportation was involved in making policies for smoke-free public transport and the Ministry of Education made some tobacco free schools campaigns and spread awareness against tobacco in schools. The government takes an approach called « Triangle that moves the mountain » in reversing NCD risk factors.

The Ministry of Public Health, Bureau of Tobacco Control is responsible for the national tobacco control strategic plan in place for both national and subnational levels. The plan is available at provincial and district levels. Each province has at least one focal point for tobacco control and the village volunteers are trained on MPOWER measures. Recently, the provinces received funding of US$25,000 each to fund their tobacco control activities.

Partners — Thailand has a very active coalition non-governmental organizations working in tobacco control, guided by a unique generation of creative civil society leaders. This model has enabled Thailand to implement strong policy measures in the past and it is expected that it will continue to strengthen the implementation of current and forthcoming policies. For example, ASH (Action on Smoking and Health Foundation) Thailand was a founding member of FCA (Framework Convention Alliance), and the FCA global headquarters was based at the ASH office for many years. In 2001, ASH established the Southeast Asian Tobacco Control Alliance (SEATCA), which has become an invaluable resource for tobacco control in the region.

Sustainability — Since 2001, the Thai Health Promotion Foundation, a government body, has a sustainable funding mechanism that draws upon a dedicated funding of 2% surcharge levied on alcohol and tobacco excise tax. This fund gets utilized for tobacco control activities and research. The Bureau of Tobacco Control, which is a central organisation in the Department of Health, is responsible for tobacco control including monitoring usage and prevention and employing 30 staff. The Thai Health Promotion Foundation also has 1.5 staff dedicated to tobacco control and NCDs.

Actual debate — Recent changes in the tax system have impacted the sales of TTM products. Therefore, the MOF is losing some of its revenue; the government is trying to mitigate this situation. The implementation of the new 2017 law is also discussed.

WHO support — WHO has been providing technical support for most tobacco control activities and financial support for GYTS to MOPH. WHO has played a crucial role by advocating for tobacco control together with MOH and the civil society networks with the aim to strengthen the national tobacco control law. However, some of the stakeholders noted that WHO CO should put more efforts towards bringing the non-health sector into the tobacco control discussion, especially to achieve the WHO NCD action plan. This is especially important because the nature of Thai bureaucracy is top-down and often it is challenging for small NGOs to command the ministries to make changes to the law.

In recent years, WHO's role has shifted from conducting tobacco control activities to mostly providing technical support and advocacy towards achievement of the NCD targets. For example, the WHO CO played an important role in passing the recent law by generating leverage together with CSOs and MOPH in support of the new law. There are no more resources dedicated to tobacco control in Thailand compared to about 5 years ago. Tobacco control is now one task among many for the WCO NCD team to tackle, and they are overloaded.

MPOWER — Between good and very good

The newly promulgated tobacco law has provisions in place to further strengthen tobacco policies and legislation. Significant changes include the increase of the legal age from 18 to 20 years to purchase tobacco products, increase in tobacco taxes, restrictions on promotion of tobacco products to licensed retail premises, broad restrictions on advertisements that prohibit the display of brand names or logos of tobacco products on mass media, and extension of smoke-free jurisdictions including declaration

of additional smoke-free-zones. Additionally, there are provisions in the new law for plain packaging and declaration of additional media/locations prohibited from advertising tobacco products.

POLICIES — Moderate, but insufficient to highly Insufficient for Article 5.3, Protocol to eliminate illicit tobacco trade; regulation of content/emissions of tobacco and alternate livelihood programs for tobacco growers/retailers.

MOPH is going to launch the policy on how to deal with tobacco industry for government staff – the policy is currently in the draft stage. The current mechanisms in place to implement Article 5.3 guidelines are inadequate and will require further lobbying. The WHO FCTC guidelines on article 5.3 are currently being used to develop guidelines for government staff. Currently, no communication strategies are in place for implementation of article 5.3.

Research — A Tobacco Research Center has been established by the government. Thai Health funds the national Tobacco Research Center, which receives US1$ million per year; this funding has not been increased in the past 10 years.

Cultural aspect — Smoking has become less and less socially acceptable in Thailand. Electronic cigarettes are illegal in Thailand and the Government is considering placing a ban on ecigarettes. In July 2017, Thailand became the first country in Asia to implement a ban on tobacco industry-related corporate social responsibility (CSR) activities.

Willingness to quit smoking — No data.

Potential "Champion of Tobacco" in the country — Thai Health, Bureau of Tobacco Control in MOPH.

Tobacco production — In Thailand, production of tobacco has remained steady over the years. Despite falling sales volume and declining market share, government income from the TTM has grown continuously since the 1990s, the result of increased production of more expensive, higher-profit margin, mid- and premium-range cigarettes, as well as regular tax rate increases. In 2013, TTM total revenue of over US$2 billion (derived from US$109.5 million of profits and US$1.9 billion of taxes) ranked the monopoly second in terms of assets among state enterprises, and third among revenue providers.

Challenges and opportunities — The MOF has a conflict of interest as it runs the state owned TTM; this may present a problem because the government needs to protect TTM yet at the same time strengthen its tobacco policy. Currently, the international tobacco companies have lowered the price of tobacco products and are competing with TTM products. This has resulted in a loss of revenue for TTM and in turn for the government. MOF faces a challenge of mitigating this situation. Involvement of non-health sectors in tobacco control needs to be intensified.

Timor-Leste

Timor-Leste showed the worst rate of smoking prevalence in the region with the increase from 23.4% in 2005 to 48.6 % in 2014 (69.5% in 2014 among adult males). In 2015, Timor-Leste just introduced a comprehensive tobacco-related legislation to reduce tobacco use under one of the commitments under the Framework Convention of Tobacco Control (WHO FCTC). The country has partly enacted the national tobacco control law, implementing tobacco control and prevention in 2016, but is not yet conducting regular monitoring or evaluation. MPOWER measures and WHO FCTC policies need to be truly implemented to fight tobacco use and importation, as most of them still have to come into force in Timor-Leste. No fines are implemented for violation of laws. Current tobacco control legislation implementation remains weak, and activities, resources and results are not appropriately coordinated and monitored between MoH, other partners' ministries and CSO/NGOs. However, civil society has

a strong commitment to support to the government through advocacy and enforcement of tobacco control legislation.

Tobacco industry interference is a major challenge even for Timor-Leste, which imports its cigarettes mostly from Indonesia (tobacco is grown only in two municipalities for local consumption). Cigarette companies exploit weak laws and target young people through advertising, sponsorship and promotion, which is very evident in some public places – near schools, university and hospitals. As in Bhutan, the tobacco use by youth is worrying; 32% of male students aged 13–15 currently use tobacco products (Global School Based Student Health Survey, 2015).

Tobacco Control program/NCD action plan/Multi-sectoral Action Plan — There is no specific strategic tobacco control plan in place for either the national or subnational levels. But the NCD strategic plan is available, which contains key indicators for tobacco control. Non-health sectors are involved, such as: Ministry of Economy (MoE), Secretary of Sport, NGOs Alliance Tobacco Control, Youth Association, the Public Health Association. In addition, leaders of municipalities are also actively joining hands with tobacco control campaigns. But there is no budget allocation. The MoH has empowered municipalities to implement subnational level tobacco control programme, and work is carried out with finance backup and guidance of MoH. Municipalities are in the initial stages of tobacco control programme implementation

Sustainability — Sustainability of tobacco control program is an issue since the MoH is only supported by the WHO. The MoH/NCD for tobacco control is operational, however with only one full time staff in the NCD Department in the MoH who is responsible to monitor tobacco use and prevention.

Partners — The main partners in tobacco control are MoH, MoE, WHO, NGOs Alliance Tobacco Control, and National Council of Tobacco Control (NCTC).

Debate — New tobacco legislation has been submitted to the Council of Ministers of Timor-Leste and is currently under review; the Government intends to double tobacco taxes and intends to allocat more funds to the health sector and to reinforce and fill compliance gaps.

WHO Support — The WHO country office has been playing a pivotal role in tobacco control in Timor-Leste since the WHO has been the only institution – with rare exception from some government officers and health staff – to be able to seriously push the agenda on tobacco control. WHO support is critical, but limited. WHO has a national TGS staff who is responsible for NCD, including Tobacco Control Programme. This coordinator was assisted by the Health Policy Advisor. Their tasks included advocacy, development of new knowledge through research and assessment, and provision of technical assistance to enhance the implementation of tobacco control programmes based on the results of the first WHO STEP-survey. Complementary supports, when required, were given by Regional and HQ staff visiting Timor-Leste at their own cost to provide advocacy, training and technical assistance.

There is a very limited budget allocated by Government to monitor tobacco use and prevention, which is mainly funded by the WHO. Reliable and updated data on the effective reduction of tobacco use by the population is lacking. Timor-Leste expects WHO to conduct proper surveys, providing information on the deep factors on tobacco control and NCD issues. Through this, the country could obtain accurate data and comparisons on a yearly basis in order to help eliminate the use of tobacco products.

Challenges — Timor-Leste needs to set up national strategic tobacco control and prevention separately from the NCD Strategic plan.

MPOWER — Moderate score, except for Offer to help quit tobacco use and Raise taxes on tobacco.

+ Pictorial health warnings are now mandatory on tobacco products and there is a comprehensive ban on tobacco advertising in mass media and through billboards as well as sponsorship and promotion; Mass media campaigns to counter the influence of tobacco industry and discourage tobacco use have been implemented; Major public places are now tobacco free, even if the compliance and respect of those rules and regulations needs to improve.

− "R" of MPOWER still needs support to develop and put in place proper systems; the recent legislation to increase tax on cigarettes (R), effective since 2016, did not sufficiently raise the prices of tobacco, which is still the lowest of the region; set up of an efficient and effective surveillance system to monitor tobacco use including among adolescent, as well as establish effective tobacco cessation services in health facilities.

POLICIES − Moderate score, but insufficient for regulation of content/emissions, Protocol to eliminate illicit trade (article 5.3).

Smoking is banned at all health care facilities, including hospitals and community health centers and is well implemented in these infrastructures. The ban is also well implemented in public buildings and offices; prohibition is in place for selling tobacco products at and around schools (a perimeter is defined), at youth activity centers, and at places frequented by minors, but the measure is mostly not effectively enforced.

A policy framework on prevention of illicit trade is present and it is believed that illicit trade of tobacco products has slightly decreased, but data is unrecorded and not available; an NCD strategic plan is available with indicators for tobacco control (but no specific strategic plan is in place at either the national or subnational levels).

Research − There a clear lack of data and research in Timor-Leste and there is a need to strengthen the research capacity related to tobacco's impact on NCDs and develop a quality database available for policy making. The stakeholders expect the government to provide information on the quantity of tobacco products coming in to Timor-Leste annually and the quantity that is consumed in the country.

Willingness to quit smoking − 61.1% of current smokers tried to stop smoking in the past 12 months (GYTS 2013).

Cultural aspect − The Timorese culture accepts chewing betel's with pieces of tobacco leaf; low levels of awareness are also due to high illiteracy in the country; there are also some social and cultural factors e.g. smoking is a way to receive a guest at home or to be kind to your family, relatives and acquaintances etc. (See the Country Data Reference Notes for more details).

Tobacco production − In Timor-Leste, 100% of cigarette is imported from other countries - 90% from Indonesia and the rest from China and the Philippines. There are no local tobacco industries with the exception of local tobacco production made for local consumption.

Potential "Champion of Tobacco" in the country − The National Council for Tobacco Control (NCTC), which is led by the Prime Minister, is a future potential "Champion of Tobacco". The NCTC is a multi-sectoral body for consultation regarding anti-tobacco policies, and to coordinate and follow the implementation of this Decree-Law, as well as the Framework Convention for Tobacco Control.

Challenges and opportunities − The civil society has a strong commitment to support the government through advocacy and enforcement of tobacco legislation.

Evaluation Framework #1: Evaluation of the Tobacco Control through MPOWER measures in SEAR Member States (national and international consultants)

MPOWER / Criteria	Monitor tobacco use and prevention	Protect people from tobacco smoke	Offer to help quit tobacco use	Warn about the dangers of tobacco use	Enforce bans on tobacco advertising, promotion & sponsorship	Raise taxes on tobacco

Enabling environment	M1
	▪ Surveillance System Framework in place? (Party to the WHO FCTC, or any kind of tobacco control law see also GTCR)
	▪ Budget allocation for surveillance present?
		P1
		▪ Legislation for smoke-free environment adopted? (see GTCR)
		▪ Coverage of smoke-free policy?
		- No DSA indoor
		- Allows DSA indoor
			O1
			▪ Infrastructure for cessation strategies in place?
			▪ Supportive health policy and practice to quit? (Source: assessed by GTCR)
				W1
				▪ Any legal obligation to put message on tobacco packs? (Source: assessed by GTCR)
				  Type of warning labels?
				- Plain/standardized
				- Graphic health warning?
				- Text warning?
				▪ Laws to ban misleadiing descriptors in place?
				▪ Anti-tobacco media campaigns part of tobacco control programme/policies
				▪ Funding available for media campaigns
					E1
					▪ Laws banning tobacco advertising, promotions & sponsorships (TAPS) in place?
					  -Laws to ban the misleading terms such as "low tar", "light", or "mild?
					  -Laws to prevent the use of flavours in tobacco? (See GTCR)
					▪ Other laws prohibiting tobacco advertising or marketing?
					- CSR
					- Tobacco display on point of sale (POS)
						R1
						▪ Legislation recently increasing tax of cigarettes
						▪ Type of tax?
						- Specific tax
						- Ad valorem
						- Both specific & ad valorem
						▪ Provision for continual increase in tobacco tax present?

Implementation/ compliance	M2 ▪ Surveillance study being conducted? (see GTCR) ▪ What studies were done? - GATS? - GYTS? - Tobacco industry? ▪ Interval in between studies?	P2 ▪ Smoke-free zones implemented in: - health facilities - schools - public transport - restaurants or cafes - bars - casinos	O2 ▪ Tobacco cessation in place? ▪ Type of Tobacco cessation present? - Quit-line? - Brief tobacco intervention	W2 ▪ Provision for change in health warning present? ▪ Interval of change in health warning? ▪ Level of implementation & enforcement of health warning? Violations punished?	E2 ▪ Level of implementation & Enforcement practice? Violations punished? (See GTCR) - Full - Partial - Poor	R2 ▪ Level of taxes? (See GTCR) ▪ Tax levied is compliant with WHO recommendations

MPOWER / Criteria	Monitor tobacco use and prevention	Protect people from tobacco smoke	Offer to help quit tobacco use	Warn about the dangers of tobacco use	Enforce bans on tobacco advertising, promotion & sponsorship	Raise taxes on tobacco
		▪ Level of implementation & enforcement? - Full implementation - Partial implementation - Poor implementation	- Intensive tobacco cessation with pharmacologic? - Intensive counselling? ▪ Free or paid? ▪ Distribution network? - Nationwide? - In some areas only?	- Full implementation - Partial implementation - Poor implementation ▪ Level of implementation & enforcement of misleading descriptors? - Full implementation - Partial implementation - Poor implementation	▪ Level of fines (See GTCR)	
Implementation tools	M3 ▪ Survey implements available ▪ Data/record of quit rates available	P3 ▪ Strategic communication present ▪ Monitoring & enforcement guidelines available ▪ Enforcement through inspection and fines (citation tickets)	O3 ▪ Clinical Practice Guidelines on Tobacco cessation available ▪ Pharmacologic agents available ▪ Quit-line available ▪ Mobile cessation available ▪ Capacity building for health professionals to provide cessation available	W3 ▪ System of ensuring health warnings on tobacco packages in place (texte and graphic) (see GTCR) ▪ Strategic communications plan for counter-ads & implementation (see GTCR) ▪ Location of warnings on packets? ▪ Additional health information present in packs? What? Location? ▪ Anti-tobacco media Campaigns executed?	E3 ▪ Monitoring & enforcement guidelines available? ▪ Enforcement mechanisms in place? ▪ Dedicated law enforcers available? ▪ Punishment for violation?	R3 ▪ Proportion and types of taxes implemented? ▪ System of collection of tax in place? ▪ How? (tax stamps?)
Partner agencies	M4	P4	O4	W4	E4	R4

MPOWER / Criteria	Monitor tobacco use and prevention	Protect people from tobacco smoke	Offer to help quit tobacco use	Warn about the dangers of tobacco use	Enforce bans on tobacco advertising, promotion & sponsorship	Raise taxes on tobacco
	▪ Partners in surveillance system? - International organizations - Government agencies (health, education) ▪ Role of CDC/WHO?	▪ Partners in smoke-free advocacy and implementation? - International organizations - Government agencies (health and other) - Civil Society organizations ▪ Role of WHO	▪ Partners in tobacco cessation? - International organizations - Government agencies (health and other) - Civil Society organizations - Pharma sector ▪ Role of WHO	▪ Partners in warning labels? - International organizations - Government agencies (health and other) - Civil Society organizations - Pharma sector	▪ Partners in TAPS ban advocacy and implementation? - International organizations - Government agencies (health and other) - Civil Society organizations - Pharma sector ▪ Role of WHO	▪ Partners in raising tobacco tax advocacy and enforcement? - International organizations - Government agencies (health, finance ministry) - Civil Society organizations - World Bank; ADB ▪ Role of WHO
Impact	M5 ▪ Data from Tobacco control surveys (availability and use for policy making) - Smoking prevalence - Tobacco consumption ▪ Mortality & morbidity data - HPN - Coronary artery disease (CAD) - Stroke - Lung cancer - COPD - Diabetes	P5 ▪ Acceptability of smoke-free environments ▪ % exposure to second hand smoke - perceived compliance - air nicotine concentration or carbon monoxide studies ▪ Improvement in health indicators, e.g. reduction in mortality/morbidity due to CVDs	O5 ▪ No. of people who accessed : - Quit-line - Mobile cessation - Comprehensive smoking cessation program ▪ Number of people quitting (quit rate) ▪ Quit attempts rate	W5 ▪ Awareness level of health warning labels ▪ People who stopped smoking as a result of health warning labels ▪ % who saw anti-smoking advertisements	E5 ▪ % of tobacco advertisements/marketing still visible - In POS - CSR - Tobacco display on POS ▪ No sponsorship of tobacco products recorded ▪ No activities to promote tobacco products (say in the last one year)	R5 ▪ Tobacco consumption vis-a-vis rise in tobacco tax ▪ Reduced affordability of tobacco products ▪ Reduced sales
SCORE						

Score : 1 – 5

1 : very good 2 : good 3 : moderate 4 : insufficient 5 : highly insufficient	Score are given per MPOWER measure and per policy, hence for each column in both tables. Scoring permits to assess relative effectiveness of the measures and policies, based on the expert judgements of the consultants. Score needs to be explained by an explanatory text.

Definition of terms

Enabling environment	refers to laws/policies or infrastructure for the MPOWER
Implementation/ Compliance	refers to the level of implementation or enforcement of the MPOWER
Implementation Tools	refers to the mechanism in place to help implement MPOWER
Partner agencies	include international agencies, government agencies and non-government/civil society organization
Impact	effect of MPOWER that includes smoking prevalence, tobacco consumption, quit rate,
Full implementation	refers to very good implementation & enforcement with very minimal violations
Partial implementation	refers to implementation in some but not in all
Poor implementation	refers to implementation in few areas with many violations

MPOWER	Detailed questions (partly taken from ToR annexes B and C)
Monitor tobacco use and prevention	▪ Was there any survey on tobacco conducted? What products are monitored and which population is covered? ▪ When was this conducted? Which agencies supported the survey (by financial and technical means)? ▪ Was it specific to tobacco as part of Global surveillance? ▪ Was it part of NCD survey or any other survey system? ▪ Was it part of national surveillance system? Is there a national surveillance system for tobacco? ▪ What is the periodicity of tobacco surveillance? ▪ Is the data nationally representative?

	▪ Who are the key stakeholders involved in planning and managing tobacco surveillance?
	▪ Who are the end users of data collected by current tobacco surveillance?
	▪ Are these data used for monitoring tobacco control activities, to what extent?
	▪ And to what extent is the feedback from stakeholders fed back to the surveillance system?
	▪ Is the funding for the surveillance system secured and sustainable?
	▪ What is the role of the WHO in the surveillance of tobacco use and prevention?
Protect people from tobacco smoke	▪ Are there smoke-free policies in place?
	▪ Does the smoke-free policy bans smoking indoor (without designated smoking area)?
	▪ Is the smoke-free policy being implemented nationwide?
	▪ Is there any mechanism/agency to monitor the implementation of smoke-free places? What agency is responsible for implementation? How is it done?
	▪ Is there any mechanism in place to enforce smoke-free policies? Is it part of a national law?
	▪ What agency is in charge of enforcement?
	▪ Are there any agencies helping/supporting enforcement of these policies? How helpful is their support?
	▪ Have the smoke-free policies ever been evaluated? When and by whom? Were the results shared?
	▪ What is the role of the WHO in advancing & promoting smoke-free policy? Specify
	▪ What role did the WHO-WHO FCTC play in advancing smoke-free policy in your country? Please specify/
Offer to help quit tobacco use	▪ Does the country have tobacco cessation system/infrastructure in place?
	▪ Are there any national guidelines for tobacco cessation in place? When and who prepared these guidelines?
	▪ Are there any capacity building programmes for health professionals in tobacco cessation? Details.
	▪ List the cessation services available. What is the coverage and reach of such services?
	▪ Is there any national quit line? Is it toll-free or charged?
	▪ Is brief tobacco intervention in place? How widely used is it?
	▪ Is pharmacolos intensigic treatment of tobacco dependence offered free or reimbursable or charged? What agents are available? (NRT? Bupropion? Varenicline?)
	▪ Is intensive counselling available? How widely accessible is it?
	▪ What is the role of the WHO in the tobacco dependence treatment in the country? Specify
	▪ What role did the WHO-WHO FCTC play in the treatment of tobacco dependence? Specify
Warn about the dangers of tobacco use	▪ Are there any health warnings on tobacco products packages in the country? Type of health warnings on tobacco product packages? (Text, GHW, Standardized or Plain Packaging?)
	▪ Location of the health warnings? (upper or lower portion of the pack? Front? Back? Both front and back?
	▪ Size of the health warnings?
	▪ Is depiction of health warnings on tobacco products packages part of the national law? Are these warnings applicable to all tobacco products?
	▪ Who issues the health warnings on tobacco packages?
	▪ Is there a provision in the law allowing periodic change in health warnings? Frequency of change?
	▪ Is there any other additional information on the tobacco packs? What are they? Location?
	▪ Was there any evaluation conducted on the outcome/impact of health warnings? When? Were the results shared?
	▪ Is there any initiative to change the current health warnings on tobacco packs? What kind of change? Status

	▪ Is there any consideration to implement Plain packaging for tobacco products packs? Status. ▪ What is the role of the WHO in advancing and promoting health warnings in the country? Specify ▪ What role did the WHO-WHO FCTC play in advancing health warnings on tobacco packages? Specify
Enforce bans on tobacco advertising, promotion & sponsorship	▪ Is there any TAPS (tobacco advertising, promotion and sponsorship) ban in place in the country? ▪ Is the TAPS ban comprehensive or partial? What form of media is covered by the ban? ▪ Does the ban cover all tobacco products? ▪ Does the ban include indirect advertising? ▪ Does the ban include corporate social responsibility? ▪ Is the ban applicable to cross border ads including internet and social media? ▪ Is TAPS ban implemented and enforce? How wide is the implementation and enforcement? ▪ Has there ever been any evaluation of TAPS ban in the country? When and by whom? ▪ What is the role of the WHO in the advancing and promoting TAPS ban in the country? Specify ▪ What role did the WHO-WHO FCTC play in advancing TAPS ban? Specify
Raise taxes on tobacco	▪ Have there been increases in tobacco tax in the country? Is it part of national law? When was this enacted? Who are the key stakeholders? ▪ What is the present level of tobacco tax (% of net retail price)? ▪ Is there provision for periodic increase in tax? Frequency of increase? How much is the increase? Is it at the national or local level or both? ▪ Are all tobacco products taxed in a uniform manner? Is there different tax system for different tobacco products? ▪ What type of tax is applied? Ad valorem? Specific? Or both? ▪ Any other type of tax imposed? Specify ▪ Was any evaluation conducted on impact of tobacco taxes on tobacco use prevalence and tobacco consumption in the country? By whom? ▪ What is the role of the WHO in the advancing and promoting tobacco taxation? Specify ▪ What role did the WHO-WHO FCTC play in advancing tobacco taxation? Specify
Supply reduction measures	▪ What is the burden of illicit trade of tobacco products in the country? Please give product-wise details if possible ▪ Is there any mechanism in place to counter illicit trade of tobacco products? Specify ▪ Has the country acceded to the Protocol on Illicit trade? When? (Article 15) ▪ Is the country planning to accede to the protocol on illicit trade? When is this most likely to happen? ▪ Who is in charge of the monitoring and tracking of tobacco products? ▪ What type of monitoring and tracking of tobacco products are being done? How is its implementation and enforcement? ▪ What is the role of the WHO in advancing policies on illicit trade? Specify ▪ How did the WHO-WHO FCTC help in promoting and advancing accession to the protocol on illicit trade? Specify ▪ What are the measures adapted to prevent sale of tobacco to and by minors? Specify ▪ Any other policy or law on access restriction? Specify ▪ Is it part of the national law? ▪ What is the role of the WHO in advancing and promoting access restriction? Specify ▪ What role was played by the WHO-WHO FCTC in advancing access restriction? Specify

	- Are there any provisions to support alternative livelihoods to tobacco farmers and workers? - Is it part of the national law? - Who is/are the key player/s in promoting alternative livelihood to tobacco farmers and workers? Specify - Any other organizations (international organizations) involved? - What is the role of the WHO in advancing & promoting alternative livelihood to tobacco farmers and workers? Specify - What role did the WHO-WHO FCTC play in advancing alternative livelihood to tobacco farmers and workers? Specify
Cross cutting issues	- Is there a tobacco control unit in the country? Under what agency? - Is there a full time staff or focal point for implementation of WHO FCTC / MPOWER / national tobacco control program? Are these staff in permanent position or contractual/project-based? - Is a dedicated fund available to support tobacco control activities? Source? % of health budget (budget for TC/total health budget)? - What is the role of the WHO in promoting establishment of tobacco control unit and focal point &/or staff? Specify - Is there an effective nationwide anti-tobacco mass media campaign? What media is used? - How wide is the coverage and periodicity? - Who is in charge? - What other organizations are involved in the tobacco control mass media campaign? - Budget allocation for the mass media campaign? - Is there a national tobacco control strategic plan in place? Who are the partners in tobacco control (internal and external/ government and CSOs)? - Who is in charge of the implementation of the national tobacco control strategic plan? Is there a monitoring mechanism in place? - What is the role of the WHO in the national tobacco control strategic plan? Specify - Is there any policy protecting public health policy from the influence of tobacco industry? - What are the measures taken to prevent tobacco industry interference in tobacco control policies? (Article 5.3) - What is the coverage of this policy? - Who is in charge and who are the main players? Which MPs get lobbied by the tobacco industry? - Are tobacco industry activities being monitored? What organizations are involved in the monitoring? - Is there a mechanism of reporting tobacco industry interference? - Is the tobacco industry present in the agency implementing tobacco control? - Is there a campaign against tobacco industry interference? What medium/media is/are used? - What is the reach of the campaign? - What is the role of the WHO in promoting policies against tobacco industry interference? - What role is played by the WHO FCTC in promoting the campaign against tobacco industry interference? - How much money goes from TI to research, media? - How will you rate the existing research in tobacco in the country? Who are the partners involved?

Evaluation Framework #2   Evaluation of the Tobacco Control policies in SEAR Member States (national consultants)

Policies / Criteria	Article 5.3 of WHO FCTC	Regulation of contents / emissions of tobacco	Reducing access to tobacco products for minors	Tobacco free Health facilities	Protocol to eliminate tobacco trade	Alternate livelihood programs	Tobacco Control program at (sub-) and national levels	NCD Action plan	Involvement of non-health sectors in tobacco control
Enabling environment	Po 1.1 ▪ Policy in place to protect public health policy against vested tobacco industry influence?	Po 2.1 ▪ Norms and standards of tobacco emissions adopted? ▪ Policy on ingredient disclosure adopted?	Po 3.1 ▪ Policies restricting access of tobacco products to minors? - Ban of selling to and buying from minors - Legal age to access tobacco products - Prohibition of selling tobacco products in perimeter radius of school, youth activity centers of	Po 4.1 ▪ Regulations; what level?	Po 5.1 ▪ Accession to protocol on illicit trade? ▪ Policy framework on prevention illicit trade present	Po 6.1 ▪ Government policy/program for alternative livelihood for tobacco farmers and workers in place?	Po 7.1 ▪ National tobacco control strategic plan in place for both national and subnational levels	Po 8.1 ▪ Action plan for the control and prevention of Noncommunicable diseases (NCDs) with tobacco control as an essential component in place?	Po 9.1 ▪ Political support from President and other government agencies

Policies / Criteria	Article 5.3 of WHO FCTC	Regulation of contents / emissions of tobacco	Reducing access to tobacco products for minors	Tobacco free Health facilities	Protocol to eliminate tobacco trade	Alternate livelihood programs	Tobacco Control program at (sub-) and national levels	NCD Action plan	Involvement of non-health sectors in tobacco control
			places frequented by minors						
Implementation/ compliance	Po 1.2 ▪ Level of implementation ▪ Tobacco industry absent in agency implementing tobacco control ▪ Tobacco industry lobbying very apparent in tobacco control policy discussion	Po 2.2 ▪ Monitoring & implementation of tobacco emissions/ ingredient disclosure in place?	Po 3.2 ▪ Implementation & enforcement in place? - Full implementation - Partial implementation - Poor implementation	Po 4.2 ▪ Guidelines; Enforcement?	Po 5.2 ▪ Protocol on illicit trade being implemented?	Po 6.2 ▪ Projects and funds for alternative livelihood for tobacco farmers and workers being implemented ▪ Stage of implementation	Po 7.2 ▪ Tobacco control strategic plan available for implementation ▪ Status of implementation at subnational levels reported	Po 8.2 ▪ NCD action plan being implemented where tobacco control is an essential component	Po 9.2 ▪ Mainstreaming of tobacco control in sector policies?
Implementation tools	Po 1.3 ▪ Mechanism in place to implement Article 5.3 guidelines at various levels of governance - Directions issued for compliance	Po 2.3 ▪ Guidelines for Articles 9 & 10 ▪ WHO Tobacco Regulation recommendations ▪ Defined limits of contents/ emissions ▪ Monitoring & enforcement	Po 3.3 ▪ Random checks ▪ School awareness programs ▪ Monitoring & enforcement guidelines present ▪ Ban on sale of tobacco products near	Po 4.3 ▪ Health policy; guidelines for Health facilities? ▪ Incentives in place?	Po 5.3 ▪ Tracking Mechanisms in place at the borders and all other entry points to catch illicit tobacco traders? ▪ Use of tax stamps	Po 6.3 ▪ Project on alternative livelihood for tobacco farmers and workers for implementation	Po 7.3 ▪ Reporting mechanism on implementation of tobacco control plan ▪ Strategic communication present	Po 8.3 ▪ NCD Action Plan elaborated ▪ Unit with personnel to implement NCD action plan ▪ Budget allocation for NCD action	Po 9.3 ▪ Actions and budgets?

Policies / Criteria	Article 5.3 of WHO FCTC	Regulation of contents / emissions of tobacco	Reducing access to tobacco products for minors	Tobacco free Health facilities	Protocol to eliminate tobacco trade	Alternate livelihood programs	Tobacco Control program at (sub-) and national levels	NCD Action plan	Involvement of non-health sectors in tobacco control
	- Code of Conduct for government officials/workers available - Implementation guidelines available - Communication strategies	guidelines available? ▪ Random checks/ laboratory testing? ▪ Testing facilities present?	education institutes					plan implementation ▪ Health in all policies approach	
Partner agencies	Po 1.4 ▪ International organizations? ▪ GOs? ▪ CSOs?	Po 2.4 ▪ International organization/ agency? ▪ GOs? ▪ Scientific community?	Po 3.4 ▪ Enforcement agencies (Police, etc.)? ▪ MoH, Ministry of education ▪ CSOs ▪ Shop owners ▪ Police ▪ Schools ▪ Community - Parents groups	Po 4.4 ▪ Ministry of Health	Po 5.4 ▪ Customs ▪ Finance Ministry ▪ Health Ministry ▪ CSOs	Po 6.4 ▪ Donors ▪ Agriculture and Labor & Employment Ministries ▪ CSOs ▪ Agriculture universities ▪ Research and development institutes ▪ WHO/UN agencies (FAO; WFP)	Po 7.4 ▪ Subnational governments ▪ GOs ▪ CSOs ▪ Public health institutes ▪ WHO/UN agencies	Po 8.4 ▪ International organizations ▪ CSOs ▪ Health ministry ▪ Ministries/ sectors outside health ▪ Universities and research institutes ▪ Public health institutes	Po 9.4 ▪ GOs ▪ Non-health CSOs
Impact	Po 1.5 ▪ Laws/policies in tobacco control enacted/ issued	▪ Po 2.5 ▪ Tobacco products effectively regulated for	Po 3.5 ▪ No access for data on access for minors	Po 4.5 ▪ Increasing number of tobacco free health facilities	Po 5.5 ▪ Significant reduction of illicit trade	Po 6.5 ▪ Tobacco farmers, manufacturers and sellers	Po 7.5 ▪ Significant reduction in tobacco use prevalence	Po 8.5 ▪ Reduction in NCDs: - HPN	Po 9.5 ▪ Effective tobacco control and NCD prvention

| Policies / Criteria	Article 5.3 of WHO FCTC	Regulation of contents / emissions of tobacco	Reducing access to tobacco products for minors	Tobacco free Health facilities	Protocol to eliminate tobacco trade	Alternate livelihood programs	Tobacco Control program at (sub-) and national levels	NCD Action plan	Involvement of non-health sectors in tobacco control
	without tobacco industry interference	contents and emissions - less emissions (emission data) - no flavour added in tobacco products	▪ Significant reduction in smoking in the young (GYTS)			shifted from tobacco to other crops and products ▪ Tobacco workers shifted to another livelihood/ work	▪ Reduction in supply/production of tobacco	- Coronary Artery Disease (CAD) - Stroke - Lung Cancer - Diabetes - Chronic kidney disease requiring dialysis	across all government and sectors ▪ Acceptability of tobacco control policies/ programs
SCORE									

Score : 1 – 5

1 : very good 2 : good 3 : moderate 4 : insufficient 5 : highly insufficient	Score are given per MPOWER measure and per policy, hence for each column in both tables. Scoring permits to assess relative effectiveness of the measures and policies, based on the expert judgements of the consultants. Score needs to be explained by an explanatory text.

Evaluation Framework #3   Evaluation of OECD criteria (international consultants)

Criteria	Questions
Relevance	▪ Are there any mechanisms in place to evaluate tobacco control policies and programs in SEAR countries? ▪ Does the Global Tobacco Control Report provide a comprehensive overview of implementation of tobacco control policies and programs in the SEAR countries? ▪ Does WHO FCTC implementation report clearly reflect actual implementation of WHO FCTC at the country level?
Effectiveness	▪ Has implementation of tobacco control policies produced the expected results? Could better results be obtained by modifying / changing the policies? ▪ To what extent were activities, resources, and results appropriately coordinated, monitored, and reported? ▪ To what extent is this country on track to achieve the objectives of WHO FCTC and targets of the WHO NCD Action Plan? ▪ What were the factors influencing WHO's contribution to implementation of tobacco control policies in Member States? ▪ To what extent has WHO been appropriately engaged in the advancement and implementation of tobacco control policies in Member States?
Efficiency	▪ Have the objectives of WHO FCTC and MPOWER been obtained in a cost-effective manner? Is there any possibility of improved results at the same costs? ▪ To what extent is the utilization of funds for tobacco control supported? ▪ To what extent has the institutional organization, structure, and efficiency improved? ▪ To what extent have investments in tobacco control policies contribute to annual savings in reduced health care costs?
Sustainability	▪ Are the existing tobacco control policies and programs sustainable over time? Are the required resources available on a sustainable basis? Is there a policy earmarking funds for tobacco control? ▪ What do the stakeholders expect from WHO to sustainably support tobacco control measures? ▪ How many MPOWER strategies are in place? ▪ Presence of tobacco control unit and focal person with budget allocation for tobacco control ▪ Is there a national tobacco control framework and strategic plan? ▪ Is there an inter-agency/multi-sectoral coordination framework in place?
Impact	▪ What is the impact of the tobacco control policies and programs in reducing prevalence of tobacco use at country level (in SEAR countries)? ▪ What is the contribution of WHO in supporting implementation of tobacco control policies and programmes at the country level and ultimately in reducing prevalence of tobacco use?
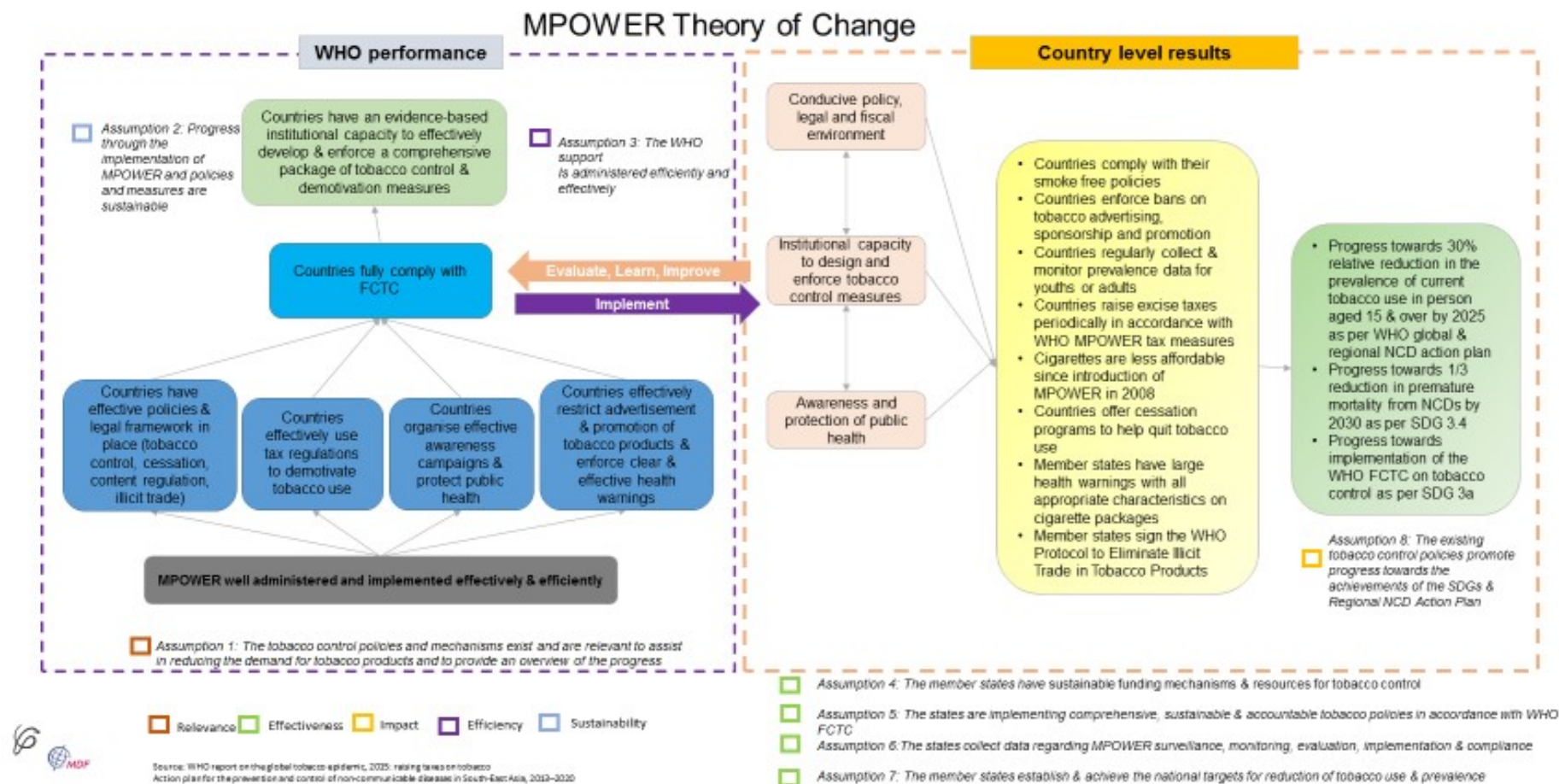
ANNEX D   FIELD MISSIONS

Field missions with associated field visits in selected region and related evaluation team member responsibilities

Countries / deep dive	Field visits	Selected sites /regions	Core Team	National Consultants
1 Bangladesh	Dhaka	Urban site visits	Dr. Eric Donelli	Dr. Mubina Tabassum from MDF
2 India	New Delhi	India Northeast India Assam + East region Rajasthan; TCC, Uttar Pradesh	Ms. Madeleine Guay; Mr. Franke Toornstra Dr. Maria Encarnita Limpin	Mr. Kishor Mogulluru Consultant
3 Indonesia	Jakarta	Depok, West Java; Denpasar, Bali, Bogor Java	Ms. Madeleine Guay	Mr. Dien Anshari from the Faculty of Public Health, Universitas Indonesia
4 Myanmar	Naypyidaw	Selected some urban areas Tamwe and Pazundaung	Dr. Maria Encarnita Limpin	DR. May Htetkyaw from MDF
5 Timor-Leste	Dili	Ermera Municipality	Dr. Eric Donelli	Norberta Belo, consultant (ex-civil servant from the Ministry of Health)
Countries	**Field visits**	**Selected sites/ regions**	**Core Team**	**National Consultants**
6 Bhutan	Thimphu	Phuentsholing (172 kms from the capital Thimphu)		Dr. Mubina Tabassum from MDF
7 DPR Korea	Pyongyang	TBC		DR. May Htetkyaw from MDF
8 Maldives	Malé	Dhamanavesh		Ms Juwairiya Saeed, Financial and Management Consultant
9 Nepal	Kathmandu	Pulchowk Biratnagar Metropolitan City; Biratnagar		Mr. Shyam Sundar Budhathoki (School of Public Health)
10 Sri Lanka	Colombo	Battaramulla, Sri Lanka		Professor Kumudu Wijewardene (U. of Sri Jayewardenepura)
11 Thailand	Bangkok	Nonthaburi	Mr. Rajan Poudel, Public Health Expert	

ANNEX E   WHO MPOWER LEGEND

		WHO legend
M_Group	1	No known data, or no recent data (since 2011) or data that is not both recent and representative (national population)
	2	Recent and representative data for either adults or youth
	3	Recent and representative data for both adults and youth
very good	4	Recent, representative and periodic data (at least every 5 years) for both adults and youth
P_Group	1	Data not reported or not categorised
	2	Up to two public places completely smoke-free
	3	Three to five public places completely smoke-free
	4	Six to seven public places completely smoke-free
	5	All public places completely smoke-free (or at least 90% of the population covered by complete subnational smoke-free legislation)
O_Group	1	Data not reported
	2	None
	3	NRT (Nicotine replacement therapy) and/or some cessation services (neither cost-covered)
	4	NRT and/or some cessation services (at least one of which is cost-covered)
	5	National quit line, and both NRT and some cessation services cost-covered
W_Group	1	Data not reported
	2	No warnings or small warnings (<30%)
	3	Medium size warnings (30%-49%) missing one or more appropriate characteristics OR large warnings (≥50%) missing four or more appropriate characteristics
	4	Medium size warnings (30%-49%) with all seven appropriate characteristics OR large warnings (≥50%) missing one or more appropriate characteristics
	5	Large warnings (≥50%) with all seven appropriate characteristics
W_MM_Group	1	Data not reported
	2	No national campaign implemented between July 2014 and June 2016 with duration of at least 3 weeks
	3	Campaign conducted with one to four appropriate characteristics
	4	Campaign conducted with five to six appropriate characteristics, or with seven characteristics excluding airing on television and/or radio
	5	Campaign conducted with ≥ 7 appropriate characteristics including airing on television and/or radio
E_Group	1	Data not reported
	2	Complete absence of ban, or ban that does not cover national TV, radio and print media
	3	Ban on national TV, radio and print media only
	4	Ban on all media as well as on some but not all other forms of direct and/or indirect advertising
	5	Ban on all forms of direct and indirect advertising (or at least 90% of the population covered by complete subnational legislation)
R_Group	1	Data not reported
	2	≤25% of retail price is tax
	3	26–50% of retail price is tax
	4	51–75% of retail price is tax
	5	>75% of retail price is tax

ANNEX F   BIBLIOGRAPHY

The Work of WHO in the South-East Asia Region, Report of the Regional Director, 1 January-31 December 2016. New Delhi: World Health Organization, Regional Office for South-East Asia; 2017.

WHO report on the global tobacco epidemic, 2017: monitoring tobacco use and prevention policies. Geneva: World Health Organization; 2017.

Noncommunicable Diseases Progress Monitor, 2017. Geneva: World Health Organization; 2017

Noncommunicable Diseases Progress Monitor, 2015. Geneva: World Health Organization; 2015 Global action plan for the prevention and control of noncommunicable diseases 2013-2020. Geneva: World Health Organization; 2013

The Regional Plan of Action for Tobacco Control (2006-2010), World Health Organization; 2006

WHO Report On The Global Tobacco Epidemic, Raising taxes on tobacco, 2015, World Health Organization; 2015

South-East Asia Regional Response Plan for Integration of TB and Tobacco – 2017–2021. New Delhi: World Health Organization, Regional Office for South-East Asia; 2017

World Health Organization and World Bank. Tobacco control in developing countries. Geneva; 2001.

World Health Organization, Regional Office for South-East Asia. Noncommunicable diseases risk behaviours among adults in the South-East Asia Region: findings from STEPS and GATS, New Delhi; 2016

WHO FCTC. Parties to the WHO Framework Convention on Tobacco Control. http://www. who.int/WHO FCTC/signatories_parties/en/

Protocol to eliminate illicit trade in tobacco products. Geneva: World Health Organization; 2013 (http://www.who.int/WHO FCTC/protocol/illic- it_trade/protocol-publication/en

WHO Framework Convention on Tobacco Control: note by the Secretariat. Fifty-Sixth World Health Assembly. Geneva: World Health Organization; 2003

The scientific basis of tobacco product regulation: report of a WHO study group. Geneva: World Health Organization; 2007 (WHO Technical Report Series, no. 945; http://www. who.int/tobacco/global_interaction/tobreg/ who_tsr.pdf

WHO Framework Convention on Tobacco Control: guidelines for implementation: Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13, Article 14. Geneva: World Health Organization; 2013

Tobacco industry interference: a global brief. Geneva: World Health Organization; 2012

Patterns of tobacco use, exposure, and health consequences. In: The economics of tobacco and tobacco control. National Cancer Institute Tobacco Control Monograph 21. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; and Geneva: World Health Organization; 2016:23–70

WHO global report on trends in prevalence of tobacco smoking 2015. Geneva: World Health Organization; 2015

WHO global report on trends in prevalence of tobacco smoking 2000–2025, Second edition, Geneva: World Health Organization, 2018

Global Adult Tobacco Survey. Fact sheet: Philippines 2015. Manila: World Health Organization Regional Office for the Western Pacific; 2017 (http://www.who.int/tobacco/surveillance/survey/gats/fact-sheet-2015.pdf)

Sustainable Development Goal 3: ensure healthy lives and promote well-being for all at all ages. In: Sustainable development knowledge platform [website]. New York: United Nations; 2017 (https://sustainabledevelopment.un.org/sdg3)

Global youth tobacco survey (GYTS). In: Tobacco Free Initiative [website]. Geneva: World Health Organization; 2017 (http://www.who. int/tobacco/surveillance/gyts/en)