Tobacco in South Asia

The World Bank South Asia Human Development, Health, Nutrition, and Population Unit

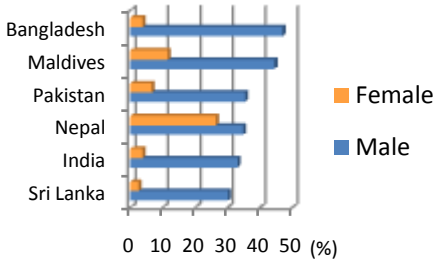
1. Burden of Tobacco Use

Globally, tobacco use is a **major risk factor for noncommunicable diseases** (NCDs) especially cardiovascular diseases (CVD), cancers, and lung diseases, making it a major public health threat. It kills 5.4 million people a year -- one in ten adult deaths worldwide. Tobacco use is decreasing in developed countries, but increasing in developing countries, where 80% of tobacco-related deaths will occur within a few decades. This shift is partly a result of the global tobacco industry's marketing strategy targeting young people and adults in developing countries. **Second-hand smoke** (SHS) also causes adverse effects to smokers and the people around them who are passively exposed to the smoke. WHO estimates that approximately 700 million children -- almost half the world's children breathe air polluted by tobacco smoke. In addition, **spending on tobacco products** crowds out other household expenditures which has a severe impact on poor families.

In South Asia, approximately 1.2 million people die every year from tobacco use. South Asia, where more than half of the world's poor live, is also the single largest area on the globe for production and consumption of tobacco products. In addition to cigarettes, the region has various other tobacco-based products, including bidi, kretek, cheroots, and a variety of smokeless tobacco products that are chewed. **Box 1** shows age-standardized adult smoking prevalence in selected countries in South Asia.

* The World Bank South Asia region (SAR) includes Afghanistan, Bangladesh, Bhutan, India, Nepal, Maldives, Pakistan, and Sri Lanka

Box 1: Adult smoking prevalence rate (%) in selected SAR countries, 2008



Source: WHO MPOWER: Appendix III, table 3.5b, 2008

Note: data for Afghanistan and Bhutan are not available. The data are age-standardized and relate to all forms of tobacco smoking patterns, including cigarettes, cigars, pipes, bidi, etc.

Like in the rest of the world, male smoking rates are much higher than female ones except for Nepal, where both are high. A nationally representative study of smoking in India, which analyzes adult deaths from 2001 to 2003, revealed that smoking among those between the ages of 30 and 69 years causes approximately one in five deaths in men and one in twenty deaths in women. Tobacco use among young people is also becoming a severe problem in the region. The Global Youth Tobacco Survey (GYTS) conducted in selected countries in the region revealed that one in ten students (13-15 year-olds) smokes.

All eight SAR countries* have signed and ratified the WHO **Framework Convention on Tobacco Control** (FCTC – see **Box 2**). However, they face severe obstacles with FTCT implementation and their tobacco control efforts, mostly due to lack of national capacity, including inadequate and weak infrastructure, legislation, regulations and acts, in addition to a shortage of financial and human resources. All these issues are hampered by fragile mechanisms to enforce existing tobacco control measures.

Tobacco control is a multisectoral issue and national anti-tobacco efforts require cross coordination among various sectors.

Box 2: FCTC - *The Framework Convention on Tobacco Control*

The FCTC was unanimously adopted by WHO member countries in May 2003. Countries that ratify it commit to eliminate all tobacco advertising, promotion and sponsorships within 5 years, require warning labels covering minimum 30% of the area of cigarette packs, forbid misleading tobacco product descriptors, and protect nonsmokers from SHS in public places. The FCTC also urges strict regulation of tobacco product content, high tobacco taxes, global coordination against tobacco smuggling, and promotion of tobacco prevention, cessation and research programs.

2. What Can Be Done – MPOWER

The WHO Report on Global Tobacco Epidemic 2008 endorses a policy package, known as **MPOWER** (essential policy interventions to confront the tobacco epidemic), to successfully achieve the goals of the **WHO FTCT**. This section reviews MPOWER's six recommended policies along with lessons learned in South Asia.

1. Monitoring tobacco use and prevention

A regular and comprehensive assessment of tobacco use and its impact is critical for tobacco control efforts. There are four global initiatives for data collection on tobacco use among various age and professional groups; 1.**Global Youth Tobacco Survey** (GYTS), 2. **Global School Personnel Survey** (GSPS), 3. **Global Health Professional Students Survey** (GHPSS), and 4. **Global Adult Tobacco Survey** (GATS). These surveys provide countries with valuable feedback to assess and improve national action plans and to formulate plans where they do not exist. Nevertheless, several SAR countries have yet to conduct these surveys. Recent GYTS and GHPSS surveys in some SAR countries have revealed alarming prevalence of tobacco use among youth and health professional students. One in ten students (13-15 year-olds) smokes cigarettes or other forms of tobacco and three in ten school teachers use tobacco products. Tobacco products are sold to more than 60% of students in violation of the law in many SAR countries.

2. Protecting people from tobacco smoke

Second-hand smoke (SHS) is a threat to people's health particularly in South Asia. The FTCT mandates implementation of effective legislative, executive, administrative and other tools to provide protection from exposure to tobacco smoke in indoor work places, public transport, and various other public places. In South Asia, several countries have developed such measures. **Bangladesh**, **India**, and **Sri Lanka** have enacted tobacco control legislations banning smoking in public places such as schools, hospitals and workplaces. **Bhutan**, **Maldives** and **Nepal** have legal instruments in the form of executive orders, decrees or administrative orders to protect people from SHS. Since December 2004, it is illegal in **Bhutan** to smoke in public and sell tobacco. Bhutan is the first country in the world to enact this kind of practice. Extensive and broad-based support and participation in the anti-tobacco campaign has contributed to the country's tobacco control efforts.

3. Offering help to quit tobacco use

Countries' public health systems hold primary responsibility for treating tobacco dependence. In reality, there is insufficient help offered by the governments in South Asia to people who would like to quit tobacco use. Some non-governmental organizations are involved in this area. For example, in **Nepal**, the Nepal Cancer Relief Society, which is particularly active in tobacco control efforts, has a community-based tobacco control programs including providing a "Tobacco Quitline" service for helping people who wish to quit tobacco use.

4. Warning people about the danger of tobacco

Governments need to prevent the use of misleading and deceptive packaging terms such as "light" and "low-tar," none of which in fact reduces health risks. **India** and **Sri Lanka** have formulated legal plans to address such strategies. However, their implementation remains a major challenge. **Bangladesh** has developed six different types of specific rotating textual warnings covering at least 30% of the surface area of the cigarette packets. Images warning users of the ill health effect of tobacco are an integrated part of Government strategies. Examples are found at http://www.tobaccolabels.ca/labelima

5. Enforcing bans on tobacco advertising, promotion, and sponsorship

Governments must control aggressive tobacco advertising efforts by the industry. Most SAR countries have banned direct advertisement of tobacco products on national television, radio, magazines, newspapers, and billboards. Still, GYTS findings show that there has been intense exposure of students to tobacco advertisements in the region. **Maldives** has banned all forms of tobacco advertising since 1994. However, the level of implementation of these bans on the promotion and sponsorship of tobacco products is still insufficient. **Pakistan** announced on World No Tobacco Day on May 31, 2009 that tobacco companies would not be allowed to offer free goods, cash rebates, or discounts to promote their tobacco products from July 1, 2009.

6. Raising taxes on tobacco

Taxation has proven to be an effective policy tool that reduces demand and consumption of tobacco products. Increasing tobacco taxes by 10% generally decreases tobacco consumption by about 5% in low- and middle-income countries. In Pakistan, it is estimated that the sales of cigarettes would fall by 18% if the average consumer price per pack was increased by 33%. India has a complex tax regime on cigarettes, with higher tax rates for longer/filtered cigarettes. However, raising taxes does not reduce smoking as much as it might, as consumers have the option of shifting to cheaper and lesser taxed cigarettes and other tobacco products. This includes bidi, which accounts for 54% of tobacco consumption in India. Higher taxes that raise the prices of chewing tobacco and bidi, as well as the simplification of taxation of cigarettes, are urgently needed to reduce tobacco consumption and improve health, but face two obstacles: the difficulty of collecting taxes from small producers, and concern about employment opportunities for bidi workers.

Despite the obvious burden of tobacco and the excellent knowledge of the types of policies that are effective, implementing control policies proves to be a challenging long-term endeavor. Public health institutions are often unable to rival the vested interests of transnational tobacco companies (TTCs),

local tobacco sellers, smugglers and consumers. Their strengthening can be a key to achieving successful tobacco control programs. Success hinges on strong government commitment at all levels of administration, sustainability of financial and human resources, involvement of the local communities, and, most importantly, a well-coordinated multisectoral approach.

In South Asia, various NGOs, academic and research institutions, and international organizations are actively working on the tobacco control agenda. The Bloomberg Global Initiative (BGI) to Reduce Tobacco Use, launched in 2006, is a $125 million fund that is committed to scaling up tobacco control efforts in developing countries where the health burden from tobacco use is highest (this initiative includes India and Bangladesh in the region). The WHO Regional Office for South Asia (SEARO) provides guidance to national institutions, coordinates efforts at the regional level, and monitors the progress of BGI. In close coordination, the World Bank supports governments through investment projects and analytical work. It is currently conducting a regional study on noncommunicable diseases (NCDs), particularly tobacco related, to identify feasible policy options for prevention and control.

Regional cooperation can efficiently complement national efforts. Tobacco smuggling, a problem that accounts for more than 10% of global cigarette sales and about $40 to $50 billion in lost annual government revenues, can be partly curbed through better cross-border coordination efforts. Regional policymakers and tobacco control advocates are encouraged to forge alliances. Strong networks can connect decision-makers with local and global practitioners, foster the exchange of helpful evidence and good experiences, as well as unite efforts against TTCs and their supporting governments in international negotiations.

References:

Associated Press of Pakistan, Govt committed to ensuring Tobacco-free environment: Minister, May 31, 2009 http://www.app.com.pk/en_/index.php?option=com_content&task=view&id=77553&Itemid=2

Jha P, Jacob B, Gajalakshmi V, et al, A nationally representative case-control study of smoking and death in India. N Engl J Med. 2008 Mar 13; 358(11):1137-47

Public Health Foundation of India in collaboration with the Ministry of Health & Family Welfare, Comparative analysis of FCTC and Indian Laws relating tobacco http://www.whoindia.org/LinkFiles/Tobacco_Free_Initiative_Demand_Reduction_Provisions-FCTC.pdf

Nepal Cancer Relief Society http://www.ncrs.org.np/programs.php

The Ministry of Health & Family Welfare, government of India, Report on Tobacco Control in India, 2004

World Health Organization Office for South-East Asia, Free Tobacco Initiative http://www.searo.who.int/en/Section1174/Section2469.htm

World Health Organization Regional office for South-East Asia, Tobacco Free initiative news letter vol. 1 (No.1-3), Vol2 (No.1), 2008-2009

World Health Organization "Tobacco fact sheets 10 facts on the tobacco epidemic and global tobacco control" http://www.who.int/features/factfiles/tobacco_epidemic/tobacco_epidemic_facts/en/index.html

World Health Organization Report on the Global Tobacco Epidemic, 2008 - The MPOWER package, Age standardized prevalence estimates for WHO Member States http://www.who.int/tobacco/mpower/en/index.html

The World Health Organization, Excise Duty Assessment on Cigarettes in Pakistan – An analysis, 2009& FBR Pakistan

The World Bank, Public Health At-A-Glance series "Tobacco Control" July 2003, "Smoke-free Workplaces" October 2003, " Tobacco Pack Information" December 2003, "Tobacco Quitlines" May 2004. Available at: www.worldbank.org/tobacco

The World Bank, South Asia Human Development, Responding to Non-communicable Diseases (NCDs) in South Asia: A Framework for Developing Regional and Country Policy, expected to be published in late 2009

The World Bank, Towards a Political Economy of Tobacco Control in Low- and Middle-Income Countries, JB Bump, MR Reich, O Adeyi, and S Khetrapal, 2009

Ugen S. Bhutan: The world's most advanced tobacco control nation? *Tobacco Control, 4*: 431–433. December 2003

This document is available on the World Bank Health, Nutrition, and Population website: *http://go.worldbank.org/AI1CANUER0*