The Meeting of the National Tobacco Control Programme Managers was held in Thimphu, Bhutan, from 10 to 12 July 2012. It was attended by 24 national tobacco control programme managers and representatives from the ministry of health from all Member States and also 11 representatives from partner organizations and international nongovernmental organizations working in the area of tobacco control.

Countries presented on status of tobacco control activities, legislations, regulations, challenges and ways forward. The revised Regional Strategy on Tobacco Control was discussed in detail and it was recommended for adoption following revisions suggested by participants. The Regional Strategy on Utilization of Standard Tobacco Questions for Surveys was adopted without change.

Discussions were also held on the regional positions for the fifth session of the Conference of the Parties in November 2012.
Tobacco Control

Report of the Meeting of National Programme Managers
Thimphu, Bhutan, 10–12 July 2012
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List of abbreviations

BNCA          Bhutan Narcotic Control Agency
CDC           Centers for Disease Control and Prevention (United States)
COPTA         cigarettes and other tobacco products
              (Prohibition of Advertisement and Regulation of Trade and
              Commerce, Production, Supply and Distribution)
CTFK          Campaign for Tobacco-Free Kids
COP           Conference of the Parties
DSR           designated smoking room
ENDS          electronic nicotine delivery system
GATS          Global Adult Tobacco Survey
GHPSS         Global Health Professions Students Survey
GSPS          Global School Personal Survey
GTSS          Global Tobacco Surveillance System
GYTS          Global Youth Tobacco Survey
INGOs         International nongovernmental organizations
LMIC          low- and middle-income countries
NCD           noncommunicable disease
NGO           nongovernmental organization
MoH           ministry of health
MOHFW         Ministry of Health and Family Welfare
NTCC          National Tobacco Control Cell
NRT           nicotine replacement therapy
NTCP          National Tobacco Control Programme
RA            Regional Adviser
SEA           South-East Asia
SEATCA        South-East Asia Tobacco Control Alliance
SHS  second hand smoke.
SLT  smokeless tobacco
TAPS  Tobacco Advertising, Promotion and Sponsorship
TFI  Tobacco-Free Initiative
TQS  Standard Tobacco Questions for Surveys
WHO  World Health Organization
WHO FCTC  The World Health Organization Framework Convention on Tobacco Control
WLF  World Lung Foundation
WNTD  World No Tobacco Day
VAT  value added tax
VHAI  Voluntary Health Association of India
Executive summary

The Meeting of the National Tobacco Control Programme Managers was held in the Royal Banquet Hall, Thimphu, Bhutan, from 10 to 12 July 2012. It was attended by 24 national tobacco control programme managers and representatives from the ministry of health (MoH) from all Member States and also 11 representatives from partner organization and international non-government organizations (INGOs) working in the area of tobacco control. The agenda and list of participants are in Annexes to this report.

The meeting consisted of presentations, panel discussions and group works. This report presents the highlights of the discussions. It also chronicles the output of the group works and panel discussions and the recommendations which were presented at the closing session of the meeting.

The technical sessions were conducted to meet the objectives of the meeting. Countries presented on status of tobacco control activities, legislations, regulations, challenges and way forward. The revised Regional Strategy on Tobacco Control was discussed in detail during the group works and during the closing session; it was recommended to adopt the regional strategy after the changes have been made as suggested by the participants. The regional strategy on utilization of Standard Tobacco Questions for Surveys (TQS) was adopted as such.

Discussions were also made on the regional positions for the fifth session of the Conference of the Parties (COP) in November 2012.
1. **Background**

Tobacco use is the leading preventable cause of death globally. The health, social and economic burdens of tobacco use are devastating. If current global trends continue, it is estimated that tobacco will kill more than 8 million people annually by 2030, and three quarters of these deaths will be in low- and middle-income countries (LMIC).

Some of the largest and most complex tobacco control environments in the world can be found in the South-East Asia Region. Currently, 6 million people die every year globally from tobacco use, out of which 1.3 million die in the South-East Asia Region alone. One third of the world’s smokers reside in the South-East Asia Region which is home to 250 million smokers with nearly the same amount of smokeless tobacco (SLT) users. The Region is among the largest producers and consumers of tobacco products, and the widespread use of SLT products in the Region makes the tobacco control situation even more complicated.

The WHO South-East Asia Region (SEAR) has yet to achieve 100% ratification/accession by eligible parties to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). Of the 11 Member States of the SEA Region, 10 are parties to the WHO FCTC and nine countries have comprehensive tobacco control legislation in place. Indonesia is yet to become a signatory to the WHO FCTC but has sub-national legislations.

Increasing progress has been made in areas related to Articles 6, 8, 11, 13, 14 and 15 of the WHO FCTC in most Member States of the Region.

Global Tobacco Surveillance System (GTSS) had been strongly established in Member States. In 10 out of 11 countries, several surveys including Global Youth Tobacco Survey, Global School Personnel Survey and Global Health Profession’s Students’ Survey had been conducted and repeated. The Bloomberg Initiative (BI) project to reduce tobacco use had supported Global Adult Tobacco Survey (GATS) in the four Member countries (Bangladesh, India, Indonesia and Thailand) and it has been
repeated in Thailand. Data from various GTSS surveys had been published, compiled into fact sheets and disseminated widely. It is important to discuss with the programme managers how to link data obtained from these surveys into action for effective implementation of tobacco control measures. It is also needed to discuss on the utilization of standard TQS in the Region.

The resolution on tobacco control adopted by the sixty-first session of the Regional Committee in 2008 clearly reflects the momentum and commitment that has been fostered in all the South-East Asia Member States. All WHO Country Offices in the South-East Asia Region have a tobacco control focal point. There is a very active collaboration between these offices and the tobacco control focal units/persons in all Member States. In many countries, close collaboration is also observed with non-governmental organization (NGOs) and research institutes working in the area of tobacco control.

Since the inception of the BI in 2006, the WHO Regional Office for South-East Asia (SEARO) has been providing regional and in-country leadership and using the opportunity provided by the initiative to support growing national capacity for tobacco control as well as monitoring the progress of implementation of the initiative. The initiative has been supplementing the regional tobacco control efforts and also supporting countries to effectively implement the WHO FCTC.

Despite considerable progress, some significant challenges remain to be addressed in the programme. Implementation of different provisions of the WHO FCTC needs stronger political commitment, sufficient funding and adequately trained human resources. In many countries, legislation while in place requires extensive amendment to be fully compatible with the WHO FCTC. Enforcement remains an important challenge in all policy interventions. Training of personnel and adequate funding for implementation of cessation services need to be adequately and consistently available in the countries. There is high tax differentiation among different tobacco products in the Region, facilitating product substitution. Tobacco taxation has increased mainly on cigarettes and, in general, has not taken into account the inflation rate. The tobacco industry continues to exert great influence in the Region, obstructing progress in all aspects of tobacco control. Despite political commitment, the scope of work of the tobacco control units or cells within the MoHs and the
government sector is limited. There is a lack of capacity of the tobacco control cells/units and of political capital in the MoHs to ensure enactment, amendments of legislation or issuance of regulations. This is mainly due to the fact that tobacco control is not considered a priority area vis-à-vis other health areas and other social and economic issues being faced by the countries. In addition, at regional level, there is a lack of funding to implement substantive tobacco control activities in most countries of the Region. Strategies are required to learn from and share cost-effective best practices among Member States and to build alliances beyond the traditional health sector with other agendas and sectors.

Since 2001, every alternate year, programme managers from Member States met at Regional consultations, inter-country consultations or meetings for programme managers. It is important for the programme managers to meet regularly to share country experiences and learn on recent developments.

A Regional strategy on tobacco control was developed in 2005 and discussed at the inter-country consultation on implementation of the WHO FCTC in Dhaka in 2007. Since then, new evidences had been found on what works in tobacco control; the programme managers need to review and revise the Regional strategy on tobacco control to incorporate recent developments and evidences. A draft paper on revised Regional strategy on tobacco control has been developed and disseminated to tobacco focal points at WHO Country Offices and national tobacco control programme managers in advance for their review. It is aimed at reviewing, discussing and updating the Regional strategy at the meeting for national tobacco control programme managers.

The meeting would also provide good opportunity to national tobacco control programme managers to discuss on how to strengthen the tobacco control measures in the countries. They will learn from each other updates on the recent trends in tobacco control.

2. **Objectives**

   - to review implementation of the WHO FCTC in Member States of the South-East Asia Region;
to discuss and share information on GTSS and its linkage to the implementation of the WHO FCTC;

- to discuss on the draft Regional Strategy on Tobacco Control in the context of recent developments and evidences on effective tobacco control measures and identify follow-up actions at the country level;

- to discuss on the draft protocol to eliminate illicit trade in tobacco products in preparation for the fifth session of the COP.

3. **Inaugural session**

At the inauguration, the Marchang Ceremony was conducted by Mr Phuntsho Wangdi, Director General, Bhutan Narcotic Control Agency (BNCA). Dr Nani Nair, WHO Representative to Bhutan, welcomed the participants and Dr Samlee Plianbangchang, Regional Director, WHO/SEARO gave his opening address. This was followed by the inaugural address by H.E. Zangley Dukpa, Minister for Health, Bhutan, and vote of thanks by Dr Dorji Wangchuk, Director General, Department of Public Health, Ministry of Health, Bhutan. A session for group photograph followed the inaugural session.

The opening address by the Regional Director was annexed to this report.

4. **Review of the implementation of the WHO FCTC in South-East Asia Region**

4.1 **Global perspectives**

At the UN high-level meeting on Non-Communicable Diseases (NCDs) prevention and control, Member States have recognized the contribution of tobacco control to reducing NCDs with an emphasis in price and tax policies to reduce tobacco use. The meeting was a new impulse to tobacco control. It is important to adopt the whole of government and whole of
society efforts concept. Evidence shows that prevalence goes down sharply in Member States after the implementation of the WHO FCTC.

The tobacco industry has changed its techniques recently. They are using litigation in domestic courts for threatening anti-tobacco efforts. Most cases have been favourable to public health and most court cases have mentioned the WHO FCTC to justify their decisions.

The tobacco industry has turned to trade as its new line of defence. Examples include Philip Morris (Switzerland) versus Uruguay; Philip Morris (Hong Kong) versus Australia; Indonesia versus the United States of America and Ukraine versus Australia. None of these cases involve traditional trade barriers. All rely on trade and investment provisions designed for different purposes.

Challenges include intrastate coordination of trade, investment and health policies so as to protect health while also maximizing any potential economic benefits of trade and investment and legal capacity of states to identify their rights and obligations under international trade and investment agreements.

4.2 Regional perspective

The Region is among the major producers and consumers of tobacco and tobacco products. About 250 million smokers and the same number of SLT users reside in the Region. Every year about 1.3 million die due to tobacco use in the Region. Complexity of tobacco use in the Region is a challenge to tobacco control regulations. Indigenous smoking products include bidi, cheroots, kretex, roll-your-own cigarettes, hookahs and water-pipes. SLT products impose huge challenges on tobacco regulation such as taxation and pictorial health warnings. The prevalence of use of SLT products among men varies from 1.1% in Thailand to 32.9% in India and 51.4% in Myanmar.

Smoking among men is high in the Region and women usually chew tobacco. The prevalence across countries varies significantly. Smoking among adult men ranges from 24.3% (India) to 63.1% (Indonesia) and among women from 0.4% (Sri Lanka) to 15% (Myanmar and Nepal). The low prevalence of smoking among women is because of the fact that
smoking by women is not acceptable in most of the communities in the Region. In contrast to smoking, the use of SLT is quite popular among women. The prevalence of SLT use among men varies from 1.3% (Thailand) to 31.8% (Myanmar), while for women it is from 4.6% (Nepal) to 27.9% (Bangladesh). However, the trend of tobacco use among women is on the rise because of aggressive female-targeted marketing tactics of the tobacco industry.

In the Region, 10 countries have ratified the WHO FCTC; some of the Member States are among the early ratifiers. Nine countries have comprehensive tobacco control laws in-line with the WHO FCTC. Indonesia and Timor-Leste have provisions for tobacco control and in the process of developing comprehensive laws. Major progresses are seen in smoke-free policies, ban on tobacco advertising, promotion and sponsorships, health warnings on tobacco packs and ban on sale of tobacco by and to minors. All countries have smoke-free provisions. Bhutan, India, Maldives, Sri Lanka and Thailand have relatively more stringent provisions. Almost all the Member countries have banned smoking in health-care and educational facilities. Smoking is banned in government facilities in six Member countries. Bhutan, Maldives and Thailand have completely banned smoking even in restaurants. All Member countries except Indonesia and Timor-Leste ban various forms of tobacco advertising, promotion and sponsorship. Myanmar, Nepal and Thailand have extensive ban provisions, including ads at point of sale. Seven countries except Bangladesh, Democratic People’s Republic of Korea, Indonesia and Timor-Leste have provisions on banning the sale of tobacco to minors. Selling of tobacco products near educational institutions are banned in India and Myanmar.

Thai warnings cover 55% of the packs which is more than the WHO FCTC suggested area. Bangladesh has six rotating textual warnings on cigarette packs. Nepal legislation has provisions for pictorial health warnings to cover 75% of the cigarette packages, yet to be implemented. In India, the Union Health Ministry issued the notification on 27 May 2011 which contains a set of four pictures each of lung and oral cancer. These pictorial warnings appeared on cigarette, bidi, cigar and smokeless or chewing tobacco packets from 1 December 2011.
Tobacco surveillance is very strong in the Region. Global Youth Tobacco Survey (GYTS), Global School Personal Survey (GSPS), Global Health Professions Students --Survey (GHPS) and GATS – all GTSS components plus NCD STEPS with tobacco questionnaire – reveal adult and youth data plus information on exposure to second-hand smoke (SHS), ban of Tobacco Advertising, Promotion and Sponsorship (TAPS) and access to training and cessation.

All countries are incrementally increasing taxes on tobacco products. Tobacco tax regimes are reviewed and under change process. Tax rates in Bangladesh, Sri Lanka and Thailand meet the World Bank threshold level (67–80%). Tobacco taxes are earmarked by a number of Member countries for different purposes: health, education, sports, recreation, tobacco control activities, welfare of those involved in tobacco production, etc.

Challenges include weak enforcement of tobacco control legislation, limited funds and human resources to implement tobacco control activities, lack of public awareness campaigns on existing provisions of legislations, strong lobbying by the local tobacco industry and multinationals, low tax rates on various forms of tobacco product and limited cessation facilities.

The way forward includes strengthening of comprehensive tobacco control policy and its effective enforcement, promoting public awareness, strengthening tobacco cessation, establishment of GTSS in all Member States and utilization of TQS in all ongoing health surveys, strengthening multisectoral collaboration and implementation of appropriate tax and price policies.

4.3 Country updates on the implementation of the WHO Framework Convention on Tobacco Control

Bangladesh

Bangladesh is one of the top 15 countries of the world facing heavy burden of tobacco epidemic; actually, it is a double burden of high production and high consumption. There are 11 cigarette factories and 185 biri factories which are currently running. Estimated production of sticks annually is 80 billion cigarettes and 50 billion --- biris In Bangladesh, 43.3% of people
aged 15 years and above currently using tobacco in some form or other (GATS: Bangladesh Report 2009).

Bangladesh ratified the WHO FCTC in 2004. The Smoking and Tobacco Products Usage (Control) Act was passed in parliament in 2005 and rules were formulated in 2006.

National Tobacco Control Cell (NTCC) was established in March 2007 under the auspices of the Ministry of Health and Family Welfare (MOHFW). The GATS was conducted in 2009 to generate evidence. In 2012, the National Curriculum & Textbook Board incorporated anti-tobacco write-ups in school textbooks. Government officers are regularly trained on enforcement of law; local administration runs mobile court to enforce law; cessation clinics started operating on pilot basis and public awareness programme undertaken through print and electronic media, posters, billboards and celebration of World No-Tobacco Day (WNTD).

In 2011, National Board of Revenue established dedicated “Tobacco Tax Cell” to tax tobacco more efficiently. Tax base (MRP) for cigarette is increased every year in all four tiers; Supplementary Duty (SD) is increased on cigarette, biri, gul and zarda; deferred tax payment facilities is withdrawn; duty is imposed on raw tobacco export; corporate income tax has been increased and bidi industry no longer enjoys facilities given to cottage industry. As per “Smoking & Using of Tobacco Products (Control) Act, 2005” (The law), smoking is prohibited in selected public places and public transports but the list is not exhaustive, restaurants remained out of the list and designated smoking rooms (DSR) are allowed in some places. Law amendment is in process to cover all public places. Six rotating messages approved by MoH covers at least 30% of principal display area in Bangla, the principal language of the country. Regarding alternative livelihood, as per law, government shall provide loan on easy terms to cultivate alternate crops and shall discourage setting up new tobacco industry. There should be no more bank loan for tobacco cultivation and no subsidy on fertilizers.

Bhutan

Bhutan ratified the WHO FCTC in May 2004 and banned sales of tobacco products on 17 December 2004, and declared smoke-free zones in 2005.
The Tobacco Control Act was enacted in 2010; the Tobacco Control Rules and Regulations were enacted in 2011, and the amendment of the Tobacco Control Act was endorsed in 2012.

As per the Tobacco Control Act and Rules and Regulations, tobacco and tobacco products are imposed as 100% sales tax and 100% customs duty, the highest among any legal goods in the country which has been taxed. Any person found in possession of any tobacco and tobacco products without tax even for a single piece of cigarette is imposed fine of Nu.10 000 (ten thousand ngultrum). The Act bans any form of cultivation, harvest, manufacture, sale, buy, supply or distribution of tobacco and tobacco products. Only import from other countries is permitted for personal consumption for certain amount. All tobacco products imported for personal consumption shall show the country of origin and appropriate health warnings as required by the MoH. All tobacco and tobacco products imported for personal consumption shall show printed labels displaying the information on relevant constituents and emissions. Smuggling (harvesting, cultivation, sale, manufacture, distribution or supply) of tobacco and tobacco products in Bhutan irrespective of the quantity is considered to be criminal act and liable for a minimum of 3 years to maximum of less than 5 years imprisonment. It is not compoundable by Penal Code of Bhutan. The law also bans all forms of tobacco advertisement, promotion and sponsorship.

MoH has already initiated training of the health professionals to provide effective cessation measures low level of demand for cessation support. Nicotine replacement therapy (NRT) and Bupropion (e.g. Zyban and Wellbutrin) are not available. Toll-free telephone quit line/helpline with a staff available to discuss cessation with callers is not available. An effective youth tobacco cessation programme should be developed and community-based cessation activities should be started; tobacco cessation clinics should be gradually started in the health-care facilities.

**Democratic People’s Republic of Korea**

Law on Tobacco Control was adopted on July 2005 in Democratic People’s Republic of Korea and amended on December 2009 with 33 articles, including ban of sale of tobacco products to minors, prohibition of smoking at workplaces, education facilities and public places except in DSR, and
ban on all forms of tobacco advertisement, promotion and sponsorship. WNTD is observed annually country wide to enhance awareness on the dangers of smoking through wider media coverage, including TV and radio.

There is a tobacco cessation centre in Pyongyang and two in provinces where counselling on tobacco dependence for clients, development of tobacco cessation pill and in-depth research on tobacco-free intervention are being conducted. There are designated national focal points in State Hygiene and Communicable Disease Control Board, under the Ministry of Public Health, who are in charge of developing, monitoring and implementing tobacco control action plans. They have conducted national trainings and multisectoral workshop for capacity building on tobacco control and on law enforcement. Democratic People’s Republic of Korea is planning and seeking support to conduct national survey on smoking prevalence and develop realistic strategy on tobacco control based on the survey result.

**India**

India is the second largest consumer and the third largest producer of tobacco in the world accounting for 10% of the world tobacco area and 9% of the production. Approximately 12–13 million people are engaged in tobacco sector, of which approximately 5.5 million are bidi workers engaged in bidi rolling. The GATS 2012 shows that 24.3% of males and 2.9% of females are smokers and 32.9% of males and 18.6% of females use SLT.

India adopted the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act in 2003. The Act is applicable to all products containing tobacco in any form. The Act includes prohibition of smoking in public places, prohibition of advertisement, sponsorship and promotion of tobacco products, prohibition of sale of tobacco products to minors and within a radius of 100 yards of educational institutions and display of pictorial health warning on tobacco products packs. Revised smoke-free rules have been implemented from 2 October 2008. Public places include all public and private workplaces, pubs, bars and restaurant. The first set of pictorial health warnings was implemented on 31 May 2009. The first round of rotation of the health warnings was implemented on 1 December
2011. Rules restricting display of tobacco products or their use in movies/television have been imposed w.e.f. 14 November 2011. There is also a ban on depiction of tobacco products/smoking in all promotional materials and posters. Food Safety and Standards (Prohibition and Restriction on Sales) Regulations 2011 (FSSAI) notified in August 2011 prohibits the use of nicotine and tobacco in any food product (Regulation 2.3.4). States such as Bihar, Kerala and Madhya Pradesh have issued instructions to enforce the FSSAI regulation thereby banning the sale, manufacture and distribution and storage of gutkha.

India ratified the WHO FCTC on 5 February 2004. The National Tobacco Control Programme (NTCP) was launched during the 11th five-year plan. Tobacco Control Cell was set up at the identified national-, state- and district-level focal points. National coordinating mechanism has been established under the chairmanship of Secretary (H&FW) and a dedicated National Tobacco Control Programme was launched in 2007–2008 in 42 districts of 21 states.

Taxes on cigarettes and other tobacco products are being increased from time to time. A health cess on some tobacco products has been introduced in 2005. Taxes on bidis and chewing tobacco are very low; tax enforcement is poor due to unorganized nature of these industries. In 2011, over 11 states increase value-added tax (VAT) on all tobacco products ranging from 5% to 40%.

Under the MoH/WHO collaborative programme, support was provided for establishing a network of 19 Tobacco Cessation Centres (TCCs) to provide cessation services and training on various institutions/PHCs for expanding tobacco cessation services at state/district level.

GYTS has been conducted in 2003, 2006 and 2009 to study prevalence of tobacco use among adolescents (13–15 years). GHPPSS and GSPS were conducted in 2006 and 2009. GATS was undertaken in India in 2010.

Indonesia

Indonesia belongs to the top five countries with highest tobacco consumption. Indonesia with 237 million population, as well as highly
potential market for tobacco, has high burden of tobacco use on health and socioeconomic impact. National Social Economic Survey and Basic Health National Research showed that, in 2010, 65.9% of males and 4.2% of females smoked.

Since 2007 tobacco control in Indonesia has strengthened tobacco control through policy change at national and sub-national level. New provisions were introduced for smoke-free public places and pictorial health warnings. Tobacco was defined as an addictive substance (strengthened and validated by the Judgment of the Constitutional Court in 2011). Currently, seven cities were covered under 100% smoke-free local law/regulation; five cities were covered under smoke-free local law and regulation (designated smoking area in workplaces) and 13 cities were at different stages of smoke-free policy development. Bali, South Sulawesi, West Sumatra and Yogyakarta are in the process to adopt provincial smoke-free law.

The first promoter on quit line services is University of Gajah Mada (UGM), Yogyakarta, since 2005. Clinical-based cessation therapy has been set up at several hospitals. Practical Approach to Lung Health (PAL), including the three As (Ask, Advise, Assist)and three Rs (Relevance Risk, Rewards) methods for smoking cessation counselling, within TB-Global Fund programme was implemented in three provinces during 2009–2012. Pilot smoking cessation intervention through primary health-care services is underway in Bogor; the intervention is being implemented in 25 health centres by using ABC approach (Ask, Brief Advice, Cessation Treatment).

MoH’s efforts are being continued to adopt implementation regulation (RPP) of the Health Law 2009 with at least 40% pictorial health warning on cigarette packs. The RPP is at the last stage of adoption which needs President approval. MoH and Jakarta Government have expanded public education on tobacco hazards through advertisement on busway/public transportation and giant billboard in strategic point of the Jakarta city.

Existing legislation allows partial ban of tobacco advertisement in electronic media only. Efforts are being continued to make a comprehensive ban on TAPS. Four cities have successfully banned the outdoor tobacco advertisement and promotion activities. Tobacco excise
Tobacco Control Act was passed in August 2010 5 years after becoming a party to the WHO FCTC. Regulations under the Act were drafted in 2011, but enforcement of regulations is pending due to technical, political and capacity hurdles. Certain quarters of the government have challenged some of the provisions on grounds of feasibility; government has asked the Attorney General’s Office to review the draft regulations, especially the ban of smoking in public places. However, other applicable legal measures are enforced.

There is lack of technical capacity to develop regulatory standards, especially packaging and labelling, tobacco-free public spaces and cessations services. There is limited staff and financial resources at programme level, limited capacity at atoll (island) level and very limited enforcement capacity.

Recent developments include exclusion of tobacco products from tax incentives at regional ports within the country and increasing of import tariff for tobacco products by 200% over prevailing rates. MoH has proposed earmarking of tax revenues for tobacco control. New arrangements to engage local councils in atolls are underway.
**Myanmar**

Tobacco control programme is one of the programmes of National Health Plan which has been launched since January 2000. Tobacco Control Committee was formed in March 2002 by the highest authority, chaired by MoH with members from related departments and NGOs. Myanmar has signed the FCTC on 23 October 2003 and ratified on 20 April 2004. Based on the provisions of the WHO FCTC, “The Control of Smoking and Consumption of Tobacco Products Law” was enacted in May 2006 and came into effect in May 2007. According to the law, “Central Tobacco Control Committee” was formed by the government in 2011. The law prohibits smoking at public places, public transport, health facilities and educational institutions, and bans comprehensively of tobacco advertising, promotion and sponsorship. The law also includes restriction of access to tobacco products by legal minors. In 2011, the President’s office published a regulation to prohibit tobacco use in all government offices’ compounds and buildings.

Health warning was only textual and non-specific; although it is in local language, the font size is too small and displayed only on the side of the package. The Central Committee for Tobacco Control had directed tobacco manufacturers to put pictorial warnings covering at least 30% of the surface. As a first step of institution-based tobacco cessation, “National Workshop on Tobacco Cessation Training for Health Care Providers” was held in 2010. Clinic-based cessation of tobacco can only be done in few hospitals.

In Myanmar, the commercial tax for cigarettes is levied at 75% of taxable turnover before 2011. MoH has conducted advocacy meetings for harmonious increase of tax for all tobacco products. In 2011, it was reduced to 50% for the locally produced products and increased to 100% for the imported ones. But, starting from April 2012, the taxes have been increased to 100% for both locally produced and imported cigarettes.

Challenges were identified as weak enforcement of tobacco control legislation, weak public awareness campaigns on the adoption of legislations, limited human and financial resources dedicated to tobacco control, social and cultural acceptance of tobacco use as a norm, uniform taxation on all forms of tobacco products, weak measures to reduce prevalence of SLT, weak measures on cessation of tobacco use, both community based and clinic based, and tobacco industrial influence on policy-makers and media personnel.

**Nepal**

The National Health Education Information Communication Centre (NHEICC) is the national focal point for tobacco control under the Ministry of Health and Population in Nepal (MoHP). The NHEICC has a Tobacco and NCD Control Section. The Tobacco Product Control and Regulatory Committee was established under the chairmanship of the Secretary, MoHP. Development is underway of a National Tobacco Control Plan.

Tax is levied on cigarette, bidi and other tobacco products. It is increased 10 – 20% every year with a view to demand reduction. The law has provision for health tax fund on tobacco control.

The Tobacco Product (Control and Regulatory) Act 2011 is in place. Its main features include: 75% pictorial health warnings, ban on smoking in public places, workplaces and public transportation; ban on direct and indirect tobacco advertisement, promotion and sponsorship, and ban on sale of tobacco products to minors and pregnant women. Smoking is prohibited in public places.

The manufacturers are required to furnish details of the quantity of nicotine, hazardous constituents including other prescribed information about the tobacco products to the MoHP before sale or distribution. They must also submit an annual report of the details of production and export - import of tobacco products to the MoHP.

The manufacturers must display a warning message in Nepali language on at least 75% of the total surface area of the packets, wrappers, packaging of parcels, and labels. The warning messages should be rotated.
No importer is allowed to import tobacco products which do not meet these standards stipulated by the government.

Advocacy and awareness programmes are conducted for tobacco control measures. Tobacco cessation training is provided to health workers. Training on tobacco control and MPOWER for health workers, and regional orientation workshops were conducted for tobacco control inspectors and district health chiefs. Mass education campaigns like public rallies, provision of warnings, information and notices for display in public areas were implemented in collaboration with other stakeholders. District and community level activities were conducted by 75 district public health offices.

Advertising, promotion and sponsorship of tobacco products is banned in all forms of media; there are restrictions to display tobacco advertisements at point of sale and free distribution of tobacco products.

Counselling is provided to patients quitting tobacco use by health workers trained on tobacco cessation. There are no provisions of Nicotine Replacement Therapy (NRT) for tobacco dependence.

The law mandates restriction in the sale of tobacco products to minors below the age of 18 years and pregnant women. Sale of tobacco products within the span of 100m distance from educational and health institutions, child welfare homes, child care centers, elder care home, and other public places is also restricted.

GYTS, GSPS and GHPSS 2011 were conducted with support from WHO and US Centre for Disease Control and Prevention. Nepal Demographic and Health Survey was conducted in 2011. Desk review of tobacco products, specially focusing on smokeless tobacco products; was conducted in 2011. Public opinion poll survey on tobacco control legislation and tobacco consumption was conducted in 2010. WHO STEPS was conducted in 2008.

Identified issues were: high prevalence of smoking and use of other tobacco products, low awareness of public about the policies and regulation, limited training to implement the tobacco control measures effectively, and difficulty in monitoring tobacco use.
Challenges include inadequate financial, technical and human resources for tobacco control, instances of tobacco industry interference, such as cases filed against Section 9 of the Act, provoking farmers and business communities and influencing policy-makers or creating obstacles for delaying the implementation of plans and policies.

Sri Lanka

National-level statistics show that 22% prevalence among males and <1% among females smoke; around 80% smoke cigarettes. Sri Lanka was first in Asia and fourth in the world to ratify the WHO FCTC. Sri Lanka has initiated a project called “Healthy life style without smoking”. Key activities in Sri Lanka include awareness campaign for youth, training of professionals on issues related to tobacco, strengthening the role of media in tobacco control, using the WNTD as a year-long sustainable activity, producing media materials for distribution, formulating an inter-ministerial committee and developing an implementation plan.

Guiding principle is multisectoral coordination. Expansion of the scope of activities is already in place to make them more comprehensive; to move forward for a comprehensive package of legislation and to promote cessation. The tax on cigarettes in Sri Lanka is more than 70% of the price of cigarettes. All advertising is banned. Only prices of cigarettes can be indicated in a given dimension at the point of sale. But regulations are yet to be made in regards to dimensions. All “enclosed public areas” are smoke-free. Airports, restaurants with over 30 seating capacities and hotels having more than 30 rooms may have separate rooms for smoking. Currently, only textual health warnings, viz. “Smoking causes heart attacks” and “Smoking causes cancer”, appear on all cigarette packets. Process is moving to have pictorial health warnings.

Currently, the following are strictly imposed by Sri Lanka’s tobacco control law: selling to minors (21 years and below), smoking at enclosed public places and comprehensive advertising ban.

The way forward includes raising awareness among the general public about the Act. The role of media towards the law enforcement should be strengthened.
Thailand

The National Committee for tobacco control was established in 1998 and the Tobacco Consumption Office was established in the Ministry of Public Health in 1991. Health warnings on cigarette packages date from 1973 to 2005. Ban of advertising, promotion and sponsorship was adopted in 1989. Tobacco Product Control Act was adopted in 1992 and Nonsmoker’s Health Protection Act in the same year. Tax for health policy dates from 1993 to 2005; dedicated tax for health promotion and tobacco control was adopted in 2001.

Thailand ratified the WHO FCTC ratification in 2004. Health Promotion Office was set up after adoption of the Health Promotion Foundation Act in 2001. The Act permits to use 2% surcharge of alcohol and cigarette taxes to fund for health promotion-related activities.

Thailand has regularly increased cigarette taxes since 1993 and dedicated tax for health promotion and tobacco control since 2001. The law bans smoking in all public places except bars, night club and massage parlour. Currently, there are nine rotating graphic health warnings covering 55% of cigarette packages. Ban of display of cigarette packages at the point of sale was adopted in 2005. Smoking cessation is carried out in hospital cessation services, health professional network incorporating into routine work and by action on smoking and health quit line. Affordability of the cost of treatment is a challenge.

Lack of national foci for tobacco control, including both governmental and non-governmental entities, is also a major challenge. Areas need to be strengthened include regulation of content and disclosure of tobacco product, education, communication, training, public awareness, smoking cessation, research and surveillance, and reporting system.

Timor-Leste

Timor-Leste in the beginning of its independence (20 May 2002) established a new government and adopted a National Development Plan with the goal to reduce poverty and to promote rapid, equitable and sustainable economic growth. The strategies will emphasize the importance
of primary health care, focusing on prevention and promotion in the targeting of underserved areas.

Global Youth Tobacco Survey was conducted in 2006 by MoH and WHO. Oral health survey related to smoking was conducted in 2004 by East Timor National Oral Health Project (ETNOHP). Tobacco-free zone was established in Canossa School as Pilot 2011. Smoking is partially prohibited particularly in public places, such as hospitals, airport and some schools. Timor-Leste is in the process to establish tobacco-free schools through incorporation of lessons on the negative impact of tobacco. Public awareness campaigns have been implemented. Challenges include lack of human resource at MoH, lack of funds, lack of political commitment and lack of community involvement in health development.

5. **Global Tobacco Surveillance System and its implications to the implementation of the WHO FCTC**

5.1 **Overview of Global Tobacco Surveillance System**

WHO FCTC represents the most significant step ever taken to reduce global tobacco use. Successful tobacco control by definition means reduced tobacco use. GTSS is a set of globally standardized surveys which enhance capacity to design, implement, monitor and evaluate tobacco control policies. Guiding principles of GTSS include being strategic, simple and efficient, systematic and standardized, and sustainable.

Dissemination is through public-use data release, access data by WHO MPOWER/Country, comparison of countries and monitoring outreach. There is a need to continue monitoring to manage and prevent the epidemic, actively promote knowledge diffusion and data-driven policy interventions.
5.2 **Utilization of GTSS data for implementation of the WHO FCTC in South-East Asia Region**

GTSS has been established in SEA. GYTS and GSPS have been conducted in 10 countries, GHPS in seven countries and GATS in four countries. TQS, a subset of key questions from GATS, had been developed; integrating TQS into on-going surveys is cost-effective and consistent for international comparability and overtime comparability.

Data from these surveys have been disseminated through regional programme managers’ meetings, ministers’ speeches and country reports, media coverage, peer-reviewed journals, web reports and national and international presentations.

The way forward is to continue GTSS surveys at periodic intervals, integrate TQS into on-going surveys, earmarked funding for surveillance, disseminate the findings optimally and use data for actions.

6. **Bloomberg Initiative (BI) to reduce tobacco use in the South-East Asia Region**

6.1 **Overview of the Bloomberg Initiative in the South-East Asia Region**

Major objectives of BI are:

- to refine and optimize tobacco control programmes to help smokers quit and prevent initiation;
- to support public sector efforts to pass/enforce laws and implement effective policies (tobacco taxes, SHS, prevent smuggling and change the image of tobacco);
- to support advocates’ efforts to educate communities about harms of tobacco;
- to develop rigorous system to monitor the status of global tobacco use.
Priority is given to 15 countries with the greatest number of smokers. Based on these criteria, four countries in SEAR were chosen as focus countries: Bangladesh, India, Indonesia and Thailand.

6.2 Perspectives of BI partners on their support to countries for implementing tobacco control policies and programmes

- **Campaign for Tobacco-Free Kids (CFTK):** Provides legal, media and research support to governments and NGOs for promoting, adopting and implementing tobacco control policies/laws, and monitors tobacco control activities. It partners with NGOs on political and media advocacy efforts and also co-managers BI Grants Program.

- **Centers for Disease Control and Prevention Foundation (CDCF):** Work with partners such as WHO to establish systematic, standardized global surveillance and monitor the tobacco epidemic.

- **International Union against Tuberculosis and Lung Disease (The UNION):** Provides technical assistance, capacity building/training, produces resources for tobacco control management and technical courses. Co-manages BI Grants Program.

- **Johns Hopkins Bloomberg School of Public Health (JHBSPH):** Air quality monitoring projects; develops resource materials, implements global tobacco control global leadership programme.

- **WHO:** Coordination mechanism at country level, capacity building activities, helps governments develop tobacco control plans, passes/enforces key laws and implements effective policies and tobacco control measures. Provides technical assistance and collaboration with Centers for Disease Control and Prevention (CDC) on surveillance and monitoring.

- **World Lung Foundation (WLF):** Co-managers BI Grants Program. Supports development, pre-testing and evaluation of
hard-hitting tobacco control advertisements, WLF works to build in-country capacity to develop paid mass-media campaigns and strategies to gain earned media.

- **Institute for Global Tobacco Control at JHBSPH:** Intensive 2 weeks capacity building programme: leadership to develop/implement effective tobacco control policy interventions. About 100 students from NGOs and government are selected for each year’s leadership programme. Air travel and housing are provided. Faculties are experts in policy, communications, research, advocacy and surveillance.

- **Bloomberg Grants Program:** Supports projects in LMIC that develop and deliver high-impact, evidence-based tobacco control interventions at the country level. Government ministries/agencies, NGOs and civil society from LMICs are eligible to apply for grants, which are usually awarded on a competitive basis. Grants are awarded for a period of 1–2 years. Applicants have to first submit project ideas. Those chosen are invited to submit a full proposal. In SEAR, 122 grants totalling over $27 million have been awarded till date. Successful BI Grant Proposals are those which are evidence-based and used best practices in implementation of effective population-based policies, implementation of strategies, such as training/capacity building that leads to achieving effective policies.

### 7. Reviewing and updating of Regional Strategy on Tobacco Control

#### 7.1 Draft Regional Strategy on Tobacco Control

The draft Regional Strategy on Tobacco Control was presented for discussion. (The final adopted Regional Strategy on Tobacco Control has been published and disseminated to the participants.)
7.2 Draft regional strategy on utilization of standard Tobacco Questions for Surveys (TQS) in the South-East Asia Region

The draft regional strategy on utilization of standard questions for surveys (TQS) in SEAR was presented for discussion. (The final adopted regional strategy on utilization of standard questions on tobacco surveys has been published and disseminated to the participants.)

7.3 Tobacco control as a component of prevention and control of NCD

The importance of tobacco control as a component of NCD was discussed briefly. NCDs are the number one killers in the Region; 54.6% of deaths are due to NCDs. NCDs claim younger lives in South-East Asia Region compared to the rest of the world. By eliminating common risk factors, such as unhealthy diet, physical inactivity, tobacco use and excessive use of alcohol, it is possible to prevent 80% of heart diseases and stroke, 80% of Type 2 diabetes and over 30% of cancers. Given the sky-rocketing costs of treatment of NCDs, public health policies and programmes should focus on health promotion and primary prevention to reduce the risk of people developing NCDs. Tobacco use is the major risk factor for major NCD. Multisectoral actions are imperative for addressing NCDs with involvement of many partners. Heads of State and Government Representatives recommended accelerating implementation of the WHO FCTC, the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful Use of Alcohol at the UN high-level meeting on NCDs.

7.4 Burden of smokeless tobacco (SLT) use and its rising trend in the South-East Asia Region

SLT in the Region include: betel quid with tobacco, chewing tobacco leaf either whole or broken, gudhaku (used as a dentifrice), gul (a pyrolized dry snuff), tapkheer (dry snuff), gundi/Kadappan, gutkha (a chewing product), hnatsay/huey paung, kimam (Qiwam) (chewed in betel quid), khaini (a moist snuff, kept in the mouth), mawa (chewing product), mainpuri tobacco, mishri (dentifrice), med toothpowder, tobacco toothpaste/creamy snuff, tuibur/hidakphu (for gargling), watery tobacco and zarda. India is the
main exporter. Most exports go to the Eastern Mediterranean Region of WHO and most trade within SEAR may be illegal.

SLT use is generally high among men; in India and Myanmar, SLT prevalence has become higher than prevalence of smoking. Among women, the prevalence of SLT use is higher than smoking in all Member countries, except Nepal. Populations are only superficially aware of the harms that can be caused by SLT. Quit attempts are rare. The number of users of SLT in SEAR may be close to 250 million.

7.5 **Tobacco industry interference with tobacco control**

Forms of tobacco industry interference include manoeuvring to hijack the political and legislative process, exaggerating the economic importance of the industry, manipulating public opinion to gain the appearance of respectability, fabricating support through front groups, discrediting proven science and intimidating governments with litigation or the threat of litigation.

The guidelines on implementation of Article 5.3 of the WHO FCTC recommends governments to raise awareness on addictive nature of tobacco and industry interference with control policies, to implement measure to limit interactions and ensure transparency with the tobacco industry, to reject partnership agreements and refuse funds from the tobacco industry, transparent and accurate information provided by the tobacco industry, to denormalize and regulate activities by the tobacco industry, to avoid giving preferential treatment to the tobacco industry, equal treatment for all tobacco industry and to avoid conflicts of interest for government official.

8. **Conference of the Parties (COP)**

8.1 **Main recommendation/decisions/outcome of the fourth session of the COP and obligations under the WHO FCTC**

At the fourth session of the COP held in Punta Del Spunta Del Este, Uruguay, from 15 to 20 November 2010, a new COP Bureau was elected.
Ambassador Ricardo Varela (Uruguay) was elected as President of the COP, H.E. Zangley Dupka, Minister of Health, Bhutan, as one of the Vice Presidents of the COP (Regional Coordinator for SEAR). It was decided to hold COP 5-2012 in the Seoul, Republic of Korea.

Parties reviewed the performance of the current and previous workplans; adopted the work plan and the budget for the biennium 2012–2013; adopted guidelines for implementation of Article 12: “Education, communication, training and public awareness”, Article 14: “Demand reduction measures concerning tobacco dependence and cessation”, Articles 9 and 10: “Regulation of the contents of tobacco products” and “Regulation of tobacco product disclosures”. It was decided to continue work on guidelines/protocols on price and tax policies (Article 6), economically sustainable alternatives to tobacco growing (Articles 17 and 18), protocol on illicit trade in tobacco products at the International negotiating Body (INB.), cross-border advertising, promotion and sponsorship (Article 13), comprehensive report on prevention and control of SLT/nicotine delivery systems, including electronic cigarettes, Article 19 “Liability”.

The Punta del Este Declaration:

- to strengthen the implementation and protection of public health policies in relation to tobacco control;
- to exchange information on the activities of tobacco industry that seek to subvert and undermine government policies on tobacco control;
- to engage more actively with international organizations and bodies in promoting treaty implementation and strengthening assistance to developing countries to meet their obligations under the Convention;
- special focus was placed on the integration of implementation of the WHO FCTC with the existing mechanisms for development cooperation and the “One UN” framework.
8.2 **Open discussion on the draft protocol to eliminate illicit trade in tobacco products**

Participants had a few discussions on the draft protocol to eliminate illicit trade in tobacco products and agreed on a regional status to support the Protocol at COP5.

9. **Recommendations and closing**

The Member States of the WHO South-East Asia Region, at the “Meeting of the National Programme Managers”, held from 10 to 12 July 2012 in Thimphu, Bhutan;

Considering the high burden of disease, disability and economic loss caused by the tobacco use and the exposure to SHS, mindful of the need to advance tobacco control measures in the Region, in particular the obligations under WHO FCTC, understanding the need for Regional cooperation and sharing of resources in implementation of tobacco control activities, agreed on the following recommendations:

- Regional Strategy for tobacco control was adopted in the present form, subject to any editorial modifications proposed by Member States by 31 July, after which it will be published.
- Regional Strategy for utilization of TQS in the South-East Asia Region was adopted in the present form.
- Regional position on requesting the review of the current COP decision on travel support.
- Agreed on the draft protocol on illicit trade.
- Agreed to include a recommendation under section 5 of Article 6 guidelines, for the use of revenues, as follows:
- parties should allocate a percentage of tobacco tax revenues or establish other sustainable financing mechanism to finance FCTC implementation and other health promotion activities.
Annex 1

Agenda

1. Inaugural session
2. Review of implementation of the WHOFCTC in South-East Asia Region.
   2.1 Global and regional perspectives on the implementation of the WHOFCTC
   2.2 Country updates on implementation of WHOFCTC for Parties to the Convention and tobacco control measures for non-Parties.
3. Global Tobacco Surveillance System (GTSS) and its linkage to the implementation of the WHOFCTC.
   3.1 Overview of Global Tobacco Surveillance System
   3.2 Utilization of Global Tobacco Surveillance System data for the implementation of WHOFCTC in South-East Asia Region.
4. Bloomberg Initiative to Reduce Tobacco Use (BGI) in the South-East Asia Region
   4.1 Overview of Bloomberg Initiative to Reduce Tobacco Use in the South-East Asia Region
   4.2 Perspectives of BGI partners on their support to countries for implementing tobacco control policies and programmes.
5. Reviewing and updating of regional strategy on tobacco control
   5.1 Draft regional strategy on tobacco control
   5.2 Draft regional strategy on utilization of standard Tobacco Questions for Surveys (TQS) in the South-East Asia Region
   5.3 Tobacco control as a component of prevention and control of NCD
   5.4 Burden of smokeless tobacco use and its rising trend in the South-East Asia Region
   5.5 Tobacco industry interference with tobacco control.
5.6  Group work on reviewing and updating regional strategy on tobacco control

5.7  Presentation of group works

6.  Conference of the Parties (COP)

6.1  Main recommendation/decisions/outcome of the Fourth Session of the COP and obligations under the WHOFCTC.

6.2  Open discussion on the draft protocol to eliminate illicit trade in tobacco products

7.  Recommendations and Closing
Annex 2
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Annex 3

Inauguration Address by Dr Samlee Plianbangchang
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Excellency, Lyonpo Zangley Dukpa, Minister of Health, the Royal Government of Bhutan, distinguished participants, honourable guests, ladies and gentlemen

I warmly welcome you all to the Regional Meeting of National Tobacco Control Programme Managers. I thank the Royal Government of Bhutan for hosting the meeting. This gesture of the government reflects the country’s strong commitment to tobacco control and reflects the particular importance accorded by it to the implementation of the WHO Framework Convention on Tobacco Control or the WHO FCTC. I gratefully thank His Excellency, Lyonpo Zangley Dukpa, for his gracious presence to inaugurate the meeting.

As one of the Vice Presidents of the COP on WHO FCTC, His Excellency has displayed leadership role in placing regional issues of tobacco control with the “Convention Secretariat”. Bhutan has also set an important example for the world by prohibiting the production, sale and trade of tobacco products.

Ladies and gentlemen

It is a known fact that tobacco use is the leading cause of preventable deaths. It is a global urgency that it must be put under complete control. Worldwide, tobacco use kills nearly 6 million people annually. In SEAR, the toll of death is over 1.2 million. Our Region has about 250 million smokers and nearly the same number of smokeless tobacco users.

In the SEA Region, there are different types of smoking, and there are different types of smokeless tobacco products. The Region is one of the largest producers and users of tobacco products. There are different regulations for controlling the use of different types of tobacco products. This situation makes the users switch from one type of product to another to elude the law. Against this backdrop, it has been a challenging task for
tobacco control “advocates” and “public health professionals” to promote tobacco control in the Region.

In our Region, we are yet to achieve 100% ratification and/or accession by eligible parties to the WHO Framework Convention on Tobacco Control. However, I am encouraged by the fact that Member States in the Region, one way or the other, have intensified their tobacco control activities. Enhanced support from all partners needs to be provided to all countries in the Region. Several countries have adopted “comprehensive” national tobacco control “legislations”. Many countries have established smoke-free public places and banned advertisement of tobacco products. In two countries, “pictorial health warnings” have already been put in place on packages of tobacco products; more countries are in the process of doing the same. A number of Member States have also increased taxes on tobacco products.

The resolution passed by the sixty-first session of the WHO Regional Committee for SEA in 2008 clearly reflects the strong commitment of all Member States in the Region to tobacco control. The resolution has been an important operational tool to guide Member States in their efforts to implement the WHO FCTC.

All WHO Country Offices have tobacco control focal points. I believe that all national tobacco control programme managers are actively collaborating with them. In many countries, close collaboration with NGOs is clearly observed. Many research institutes working in the area of tobacco control are also collaborating with the government programmes. In many countries of the Region, the Bloomberg Philanthropies group is supporting the formulation and implementation of national tobacco control legislations. Various partners are continuing with their efforts to strengthen national capacities to fight the tobacco epidemic.

The Center for Disease Control and Prevention (CDC), Atlanta, the United States of America, and its foundation have been our outstanding partners in the area of tobacco “surveillance”. Their support is indeed very much valued. Under this support, almost all countries in the Region have conducted “Global Youth Tobacco Surveys” and some have pursued “Global Adult Tobacco Surveys”. These surveys are important activities of “tobacco surveillance” that is being conducted here. Data and information
from these efforts have been published and disseminated widely, in the form of fact sheets and reports.

It is important to discuss at this meeting how to effectively link the data and information obtained from these surveys with our action in implementing tobacco control measures. Serious consideration must be given to the “integration” of tobacco control activities, including tobacco surveillance, into national health systems.

In order to further strengthen our tobacco control operation, WHO and CDC have developed “Standard Tobacco Questions (STQ)”. These questions need to be incorporated into the routine surveys for tobacco control in countries, in order to achieve more standardized and cost-effective results. A draft “Regional Strategy for Utilization of STQ” has been prepared and will be placed for your review during this meeting.

Ladies and gentlemen

We have spent a lot of effort on tobacco control through enforcement of laws. This was done to achieve the desired results in a rather short time. However, it should always be kept in mind that law enforcement is not an easy thing to do in our Region. It should be considered an important challenge for us. The achievements from law enforcement will be sustained in the long term only if more effective “public education” is available simultaneously.

Our attempts to take “tobacco out from man” must be commensurate with our efforts to take “man out from tobacco”. Even though the effectiveness of public education depends largely on the level of education of people in the community, we should not fail to place greater emphasis on this aspect of tobacco control.

Education, especially the right kind of education, must go hand in hand with law enforcement. We may need to pursue more research to identify more effective strategies for educating people about the harmful effects of tobacco use, as well as about the health benefit from not using any tobacco products. Education through school systems is important indeed, and this should start as early in life as possible.
Ladies and gentlemen

The fifth session of the Conference of the Parties on WHO FCTC will be held in Seoul in coming November. I am sure that our countries will again forge a common regional position under the leadership of His Excellency, Lyonpo Zangley Dukpa. We should continue to show to the world our “unwavering commitment” to tobacco control in the Region, and to share with other countries our success stories in tobacco control.

For this meeting, once again, we will have another opportunity to share information and learn from each other, and we will also review and finalize the draft Regional Strategy on Tobacco Control. With unwavering determination, let us combine our wisdom and efforts in ensuring “effective” and “long-term” results from our tobacco control efforts in SEAR. Let us intensify our efforts to save lives of our people through effective implementation of WHO FCTC.

With these words, I wish the meeting all success, and I wish you all an enjoyable stay in this peaceful city of Thimphu.

Thank you
The Meeting of the National Tobacco Control Programme Managers was held in Thimphu, Bhutan, from 10 to 12 July 2012. It was attended by 24 national tobacco control programme managers and representatives from the ministry of health from all Member States and also 11 representatives from partner organizations and international nongovernmental organizations working in the area of tobacco control.

Countries presented on status of tobacco control activities, legislations, regulations, challenges and ways forward. The revised Regional Strategy on Tobacco Control was discussed in detail and it was recommended for adoption following revisions suggested by participants. The Regional Strategy on Utilization of Standard Tobacco Questions for Surveys was adopted without change.

Discussions were also held on the regional positions for the fifth session of the Conference of the Parties in November 2012.