# FACTORS INFLUENCING ADOPTION AND IMPLEMENTATION OF WHO FCTC IN MYANMAR

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**Myanmar**

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# FACTORS INFLUENCING ADOPTION AND IMPLEMENTATION OF WHO FCTC IN MYANMAR

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

by

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Myanmar

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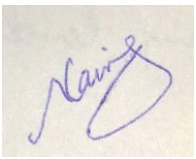
Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.
The thesis "Factors influencing adoption and implementation of WHO FCTC in Myanmar**"** is my own work.



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## LIST OF ABBREVIATIONS

| | |
|---|---|
| ASEAN | Association of South-East Asian Nations |
| BAT | British American Tobacco |
| CDC | Centers for Communicable Disease Control |
| CSR | Corporate Social Responsibility |
| CTCC | Central Tobacco Control Committee |
| DoH | Department of Health |
| GDP | Gross Domestic Product |
| GSPS | Global School Personnel Survey |
| GYTS | Global Youth Tobacco Survey |
| INGO | International Non-governmental organization |
| LMICs | Low and middle income countries |
| MIC | Myanmar Investment Commission |
| MoH | Ministry of Health |
| NCD | Noncommunicable Diseases |
| NGO | Non-Government Organization |
| NHC | National Health Committee |
| NRT | Nicotine Replacement Therapy |
| PPP | Purchasing Power Parity |
| SEA | South-East Asia |
| SEAR | South-East Asia Region |
| SEARO | South-East Asia Regional Office |
| SEATCA | South-East Asia Tobacco Control Alliance |
| SLT | Smokeless tobacco |
| TAPS | Tobacco Advertising, Promotion and Sponsorships |
| TCS | Tobacco Control Scale |
| ThaiHealth | Thai Health Promotion Foundation |
| UN | United Nations |
| USD | United States Dollar |
| VU | Vrije Universiteit |
| WHA | World Health Assembly |
| WLF | World Lung Foundation |
| WHO | World Health Organization |
| WHO FCTC | World Health Organization Framework Convention on Tobacco Control |

**ABSTRACT**

**Background:** The rising trend of NCDs mortality and prevalence of tobacco use was seen in Myanmar. Myanmar has been a signatory to the WHO FCTC since 2004.

**Objective of study:** To critically analyze factors influencing adoption and implementation of WHO FCTC in Myanmar in order to give recommendations to the Ministry of Health and other key stakeholders for improvement of tobacco control in Myanmar.

**Methodology:** The study carried out literature review using peer reviewed articles, and other published and unpublished literature. The study adapted, the Walt and Gilson's policy analysis triangle framework and used for analyzing the factors.

**Findings:** Framing the tobacco as an economic good by policy makers, low priority of tobacco control, limited human and financial resources, and limited capacity of Ministry of Health, deeply rooted socio-cultural acceptance on tobacco, high economic value of tobacco, lack of strong coalitions among network, and tobacco industry interference are important factors.

**Conclusion:** Myanmar needs much more efforts for full implementation of WHO FCTC, through building capacity and using resources effectively, growing commitment to FCTC beyond the health sector, fostering growth in anti-tobacco coalition activity, exploiting the pro-tobacco activity that may be present and garnering public support for tobacco control.

**Recommendations:** All government sectors should comply with WHO FCTC, especially article 5.3. Central Tobacco Control Committee should adopt necessary rules and procedures as soon as possible. Ministry of Health should dedicate budget and full time staff for tobacco control programme.

**Key words:** Tobacco, WHO FCTC, policy, implementation, and Myanmar.

**Word count: 12,892**

## INTRODUCTION

The World Health Organization (WHO) reported that 68% of global mortality in 2012 was attributed by noncommunicable diseases (NCDs) where 82% of it was caused by major NCDs: cardiovascular diseases, cancers, chronic respiratory diseases and diabetes (WHO, 2014). Along with the global and regional rising trend of NCDs mortality, a similar trend was also seen in Myanmar (WHO, 2014, MOH, 2011, 2012).

Among the four modifiable behavioural risk factors shared by those major NCDs, tobacco use has been globally recognized as the leading preventable cause. The WHO has estimated that about six million people have died of tobacco related diseases worldwide each year with many of these deaths occurring prematurely and about 600,000 deaths due to the effects of second-hand smoke (WHO, 2015).

To address the global burden of tobacco, the World Health Assembly unanimously adopted the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) in 2003 and it entered into force in February 2005. Myanmar has been a signatory to the WHO FCTC since 2004. For effective implementation of the WHO FCTC by the member States, WHO recommended the six MPOWER policies in 2008 (WHO, 2015). Although efforts have been made in implementing WHO FCTC and MPOWER strategies, tobacco use is still high in Myanmar.

Being a national focal point for tobacco control for more than six years at the Ministry of Health, I have observed that the high and increasing trend of tobacco use, especially smokeless tobacco use, became one of the important public health problems in Myanmar. In 2009, 73% of men and 21% of women were current tobacco users among the adult population (15 - 64 years) (WHO, 2016). In 2011, 30% of boys and 6.8% of girls among 13-15 years age group were current tobacco users (WHO, 2011).

In 2013, the World Health Assembly adopted a comprehensive global monitoring framework which included 25 indicators and 9 voluntary global targets for 2025 in order to accelerate national efforts on addressing NCDs. The agreed global tobacco target is a 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years (WHO, 2014).

Among 17 sustainable development goals set by United Nations sustainable development summit in September 2015, are two goals that are relevant to tobacco control: "to reduce premature mortality from non-communicable diseases by one third by 2030 through prevention and treatment" and "to strengthen the implementation of the WHO FCTC in all countries, as appropriate" (UN, 2015).

In view of the above problems and global targets, this thesis is intended to critically analyze the key factors influencing adoption and implementation of WHO FCTC in Myanmar and to review the evidence base on strategies to do so, in order to make recommendations to the Ministry of Health and other key actors in different sectors for improvement of tobacco control measures.

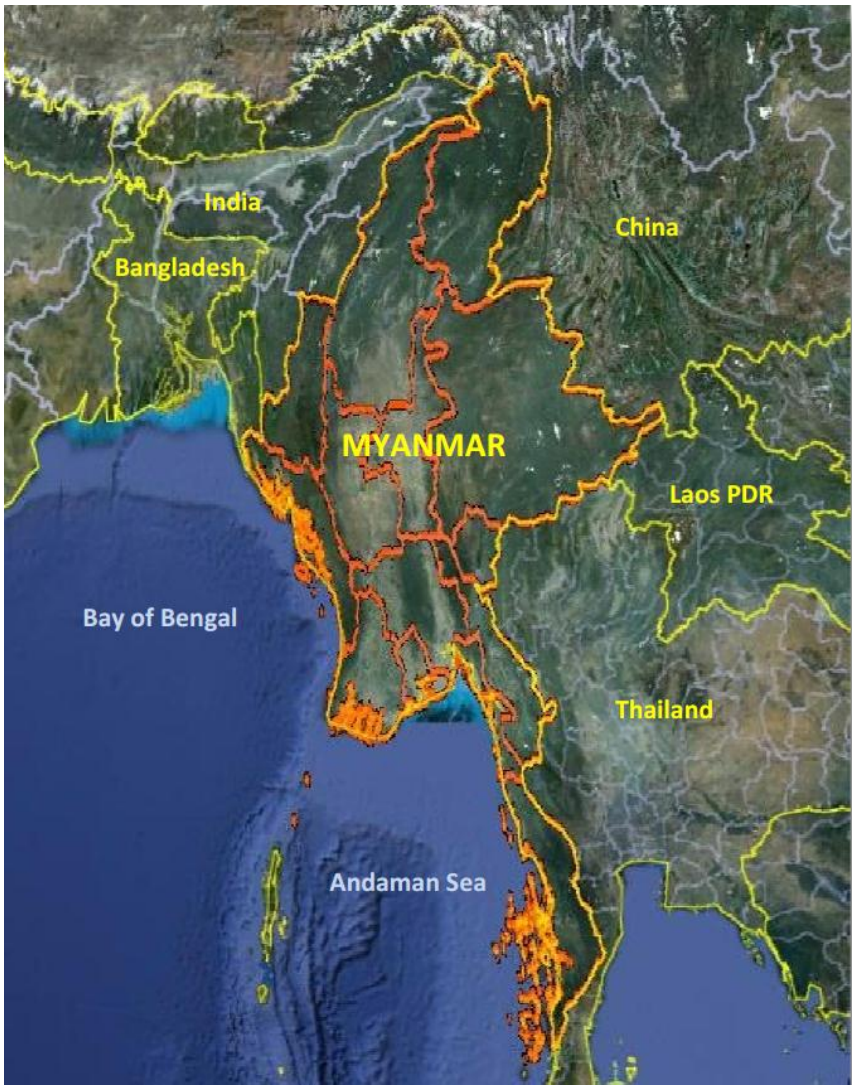
It is expected that the recommendations will contribute to decreasing tobacco related NCDs burden in Myanmar.

## CHAPTER 1: BACKGROUND INFORMATION ON MYANMAR

### 1.1 Geography

The Republic of the Union of Myanmar is located in South-East Asia region and is bounded by Bangladesh, India, China, Laos and Thailand on the landward side on west, north and east respectively (Figure 1). The coast line on the west and south is bounded by the Bay of Bengal and the Andaman Sea. It stretches 2200 kilometers from north to south and 925 kilometers from east-west at its widest point. Myanmar covers an area of 676,578 square kilometers (MOH, 2014).

**Figure 1. Map of Myanmar bounded by neighboring countries**




**Source:** http://www.moh.gov.mm/file/COUNTRY%20PROFILE.pdf

## 1.2 Socio-demography

Among the total population of 51.4 million, 70% resides in rural areas. There is similar proportion of men (48%) and women (52%). About 29% constitute under-15 years age group while 67% are working age group (15-64 years). The literacy rate is 89.5% (MOIP, 2015). Being one of the world's most diverse countries, there are 135 ethnic groups speaking over 100 dialects. Majorities (89.4%) are Buddhists and the remaining are Christians, Muslims, Hindus and Animists (MOH, 2014).

## 1.3 Political system

Myanmar is in a stage of political, social and economic transition. After several decades of military dictatorship, a broader political reform happened in Myanmar (WB, 2014). According to constitution adopted in May 2008, Myanmar has started a democratic presidential system of governance in 2011. The term of office of president is five years and shall not serve more than two terms. The country is divided administratively into Nay Pyi Taw Council Territory and 14 States and Regions (MOI, 2008).

## 1.4 Economy

The economy is dominated by services, agriculture and industry which accounted for 41.7%, 38% and 20.3% of gross domestic product (GDP) respectively in 2013. Despite its abundance of natural resources, the estimated per capita GDP was USD 1,420 in 2015 (Global Finance, 2015). The poverty rate is 37.5% in 2010. The Government Health Expenditure accounted for only 1% of GDP and 4% of General Government Expenditures in 2014 (WHO, 2014).

## 1.5 Socio-cultural context of tobacco use

The history of chewing *Kun Yar* (betel quid)* is said to have started since around 500–1000 AD in Myanmar. Traditionally, t*obacco in the forms of cigars,* cheroots or cigarettes is one of three essential delicacies served to the guests at home or any ceremonious occasions (Kyaing NN et al., 2015). Betel preparation (without tobacco) has been used as a digestive aid and mouth freshener for children. While most tobacco products are produced locally, a few popular smokeless tobacco (SLT) products are imported from India and Bangladesh (Kyaing NN et al., 2012).

*In Myanmar language, betel leaf is called *Kun-ywet*, areca nut is called *Kun-thee* and the preparation, betel quid, is called *Kun-yar . Traditionally, the betel quid is served to guests for chewing at home and any ceremonies.*

## CHAPTER 2: PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVES, METHODOLOGY AND CONCEPTUAL FRAMEWORK

### 2.1 Problem Statement

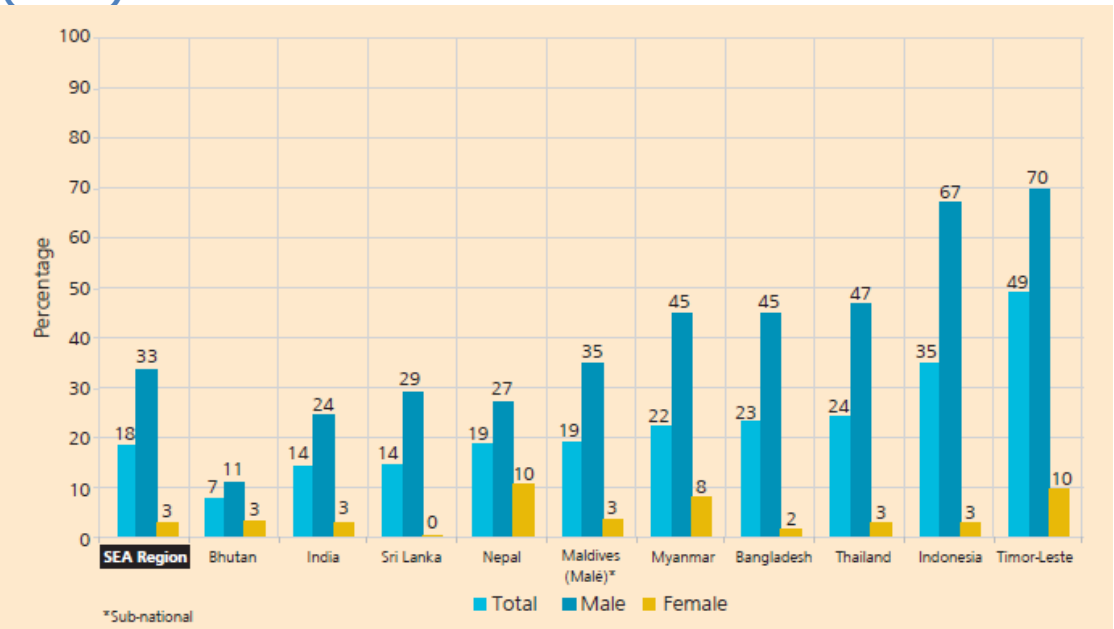
Noncommunicable diseases (NCDs) are the leading cause of death in the WHO South-East Asia Region. It is estimated that 7.9 million lives are lost (55% of all deaths) due to NCDs in 2008. Besides, South-East Asia Region has a higher proportion of premature NCD deaths than other WHO regions. In 2008, the proportion of NCD deaths occurring among people under the age of 60 was 34%, compared to 23% in the rest of the world (WHO, 2013).

Like other member countries in the region, Myanmar is experiencing increasing trend of NCDs. According to hospital statistics, the proportional morbidity and mortality due to NCDs increased from 34% and 42% in 2010 into 36% and 43% in 2012 respectively (MOH, 2011, 2012). Tobacco was responsible for 25% of all NCD related deaths of those over 30 years of age. Overall, 38% of all deaths from malignant lesions, 21% of deaths from cardiovascular conditions and 55% of deaths from respiratory diseases were related to tobacco in Myanmar (WHO, 2015).

Developing countries including Myanmar will have to face a substantially higher economic burden of healthcare expenditures attributable to tobacco use in the future unless they implement effective tobacco control measures (WHO, 2011). Sung et al. (2006) estimated that the smoking-attributable healthcare cost accounted for 3.1% of national health expenditures, and that the total economic cost of smoking was approximately 0.5% of GDP in 2000 in China (Sung HY et al., 2006). Ross et al. (2007) estimated that the inpatient healthcare cost caused by smoking represented 4.3% of Vietnam's total health expenditures and 0.22% of GDP in 2005. But those estimations could be an underestimation of true smoking costs since the developing countries were in an earlier stage of the tobacco epidemic at that time and the limited access and quality of medical care in low-income and middle-income countries possibly lead to the underestimation of true smoking costs (Ross H et al., 2007).

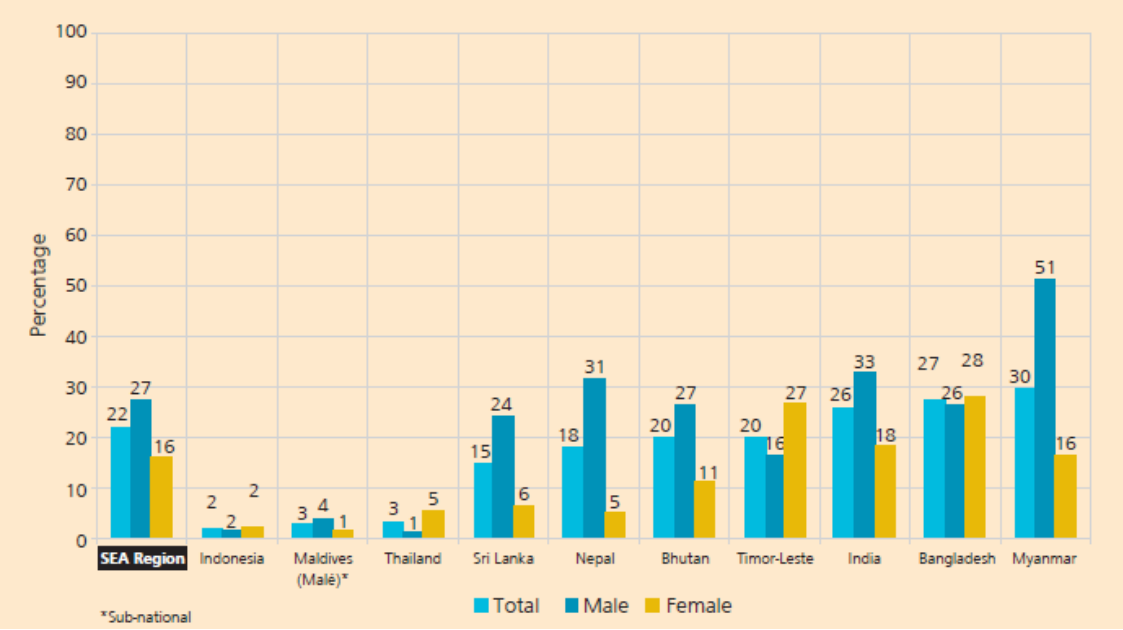
South-East Asia Region is the residence of nearly 250 million smokers and an equal number of smokeless tobacco users. About 90% of the world's smokeless tobacco users live in the region (WHO, 2013). According to WHO NCD STEPS Survey 2009, 22% of 15-64 years age group (45% of men and 8% of women) were current smokers and 30% (51% of men and 16% of women) were current smokeless tobacco users, while 39% were exposed to environmental tobacco smoke in work places in Myanmar (Figure 2, 3 and 4) (WHO, 2009, 2015). The use of SLT is highest in Myanmar in South-East Asia region and amongst Association of Southeast Asian Nations (ASEAN) (SEATCA, 2013, WHO, 2015).

## Figure 2. Percentage of current smokers in South-East Asia Region (2015)



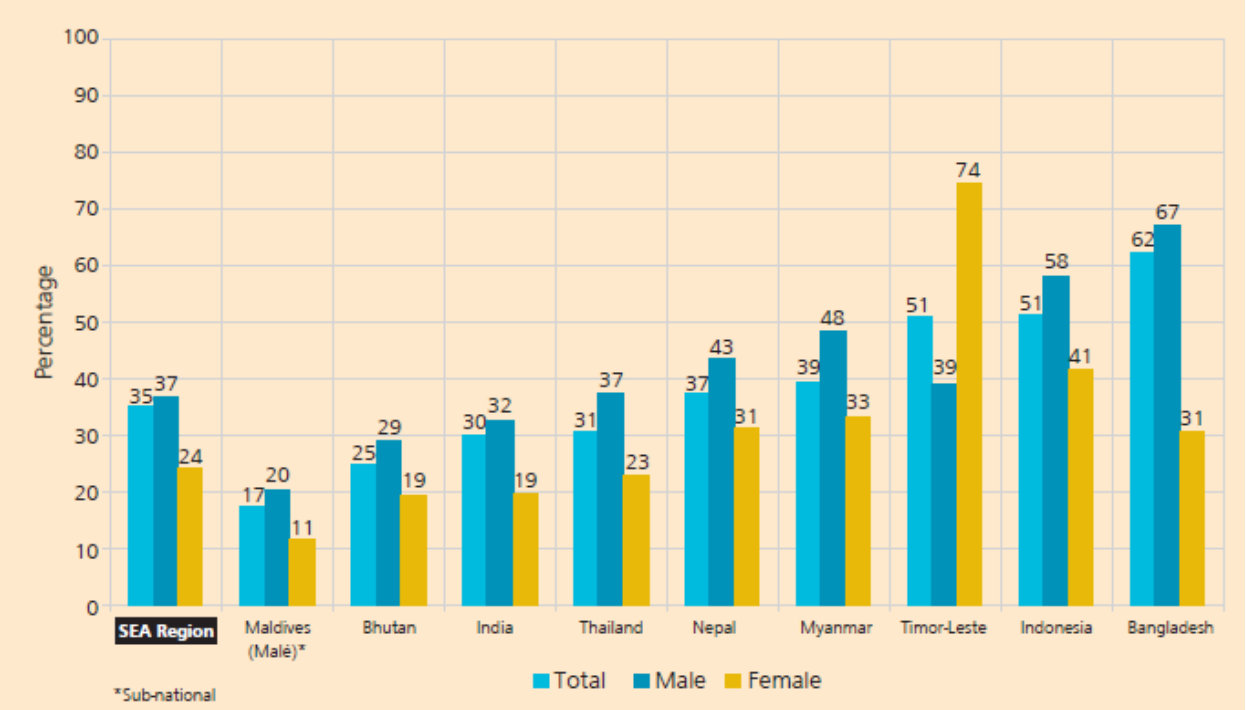

Source: WHO SEARO, Monitoring tobacco control among adults in selected Member States of South-East Asia Region – at a glance, 2015

## Figure 3. Percentage of current smokeless tobacco users in South-East Asia Region (2015)




Source: WHO SEARO, Monitoring tobacco control among adults in selected Member States of South-East Asia Region – at a glance, 2015

**Figure 4. Percentage of persons exposed to secondhand smoke at work places in South-East Asia Region (2015)**




Source: WHO SEARO, Monitoring tobacco control among adults in selected Member States of South-East Asia Region – at a glance, 2015

Myanmar people use a variety of tobacco products. WHO NCD STEPS Survey, 2009 also showed that only 27.4% of men and 1.4% of women among daily smokers used manufactured cigarettes, while cheroots and cigars were more widely used. Oral and nasal use of snuff, chewing tobacco and betel quid chewing was almost equally seen (WHO, 2009). The deeply rooted cultural practice has contributed to an alarmingly high prevalence of SLT users in Myanmar. Women chewing raw tobacco or consuming betel quid with SLT is generally accepted by rural society. While there are sufficient evidence that smokeless tobacco causes oral cancer and pancreatic cancer, and contributes to cardiovascular diseases (IARC, 2007), there is a common conception that SLT products are less harmful than smoking tobacco, resulting in use of SLT as a smoking substitute and aid for smoking cessation. The gap in knowledge on effects of tobacco use is markedly greater in lower socioeconomic groups, where the proportion of tobacco usage is significantly higher (Kyaing NN et al., 2012).

Like in adult population, similar pattern of tobacco use is found among youths. Global Youth Tobacco Survey, 2011 showed that about 7% of school youths (13% of boys and 0.5% of girls) were currently smoking cigarette while 17% (28% of boys and 7% of girls) were currently using other tobacco products (WHO, 2011). There was increasing trend of both smoking and SLT

use among boys from 2004 to 2011 while the decreasing trend of smoking but increasing trend of SLT use was seen among girls (WHO, 2014). When they became aware of the health risks, most tobacco users want to quit but find it difficult to stop due to the addictiveness of nicotine. About 9 in 10 current users wanted to quit and tried to stop smoking during the year before survey (WHO, 2011) but not succeeded yet.

Myanmar has local production of cigars and cheroots by a number of small and medium local cottage industries, while cigarette production is dominated by joint-venture private companies with major tobacco multinationals such as Phillip Morris, British American Tobacco, Japan Tobacco, and Hongyun Honghe Group – China's second-largest tobacco company. The tobacco industries delayed the policy development process regarding graphic health warnings (WHO, 2015). The national tobacco control law prohibits tobacco advertisements, promotion and sponsorship, but various forms of indirect advertising and promotions are still visible (MOH, 2014).

## 2.2 Justification

Despite a large body of robust evidence showing that tobacco in all its forms kills its users, and smoking cigarettes kill non-users, people continue to smoke, and deaths from tobacco use continue to rise, especially in low and middle-income countries (WHO, 2014). In order to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure, Myanmar had signed the WHO FCTC in 2003 and made some efforts to implement the FCTC according to the provisions, but still has a high and increasing trend of tobacco use (WHO, 2015).

The WHO FCTC is ratified by 180 Parties by March 2015, covering about 90% of the world's population (WHO, 2015). In the South East Asia region, all countries except Indonesia are members of WHO FCTC. While the FCTC itself contains a 'comprehensive' set of measures to reduce the demand for, and supply of, tobacco products worldwide, the implementation status and outcomes are different and uneven among countries. The WHO pointed out that successful tobacco control requires strong political commitment as well as the participation of civil society. Achievement of tobacco control goals require coordination among many government agencies, academic institutions, professional associations and civil society organizations at the country level, as well as the coordinated support of international cooperation and development agencies (WHO, 2008).

Although many studies have been done in the developed world, there is a scarcity of studies examining the factors influencing the effective implementation of WHO FCTC in developing countries where the burden of tobacco use is high like in Myanmar. In order to meet the global targets on reduction of tobacco use and NCDs morbidity and mortality, it is important

to identify the key influencing factors for effective tobacco control and apply the evidence-based best practices of the leading countries to Myanmar.

## 2.3 Objectives

### 2.3.1 General objective

To critically analyze factors influencing adoption and implementation of WHO FCTC in Myanmar in order to give recommendations to the Ministry of Health and other key stakeholders for improvement of tobacco control in Myanmar.

### 2.3.2 Specific objectives

1. To identify and critically analyze key factors influencing adoption and implementation of WHO FCTC in Myanmar.
2. To review the evidence base on implementation of WHO FCTC focusing on applicability to the Myanmar context.
3. To formulate recommendations for the Ministry of Health and key stakeholders in order to improve policy and practice.

## 2.4. Methodology

The methodology for this study is a literature review. In addition, Tobacco Control Scale (TCS) is applied to identify leading countries in South-East Asia region. The TCS is a new scale developed by Luk Joossens and Martin Raw (2013) with the help of a panel of experts in 2004 in order to quantify the implementation of tobacco control policies at country level in Europe (Joossens L and Raw M, 2006). It is based on six policies described by the World Bank (WB, 2011). Although their scores were based on the responses and judgment of the countries' representatives on structured questionnaires, this study has only used the information received from "Country profiles on implementation of the WHO Framework Convention on Tobacco Control in the WHO South-East Asia Region" published by WHO SEARO in 2015 (WHO, 2015), "WHO Report on the Global Tobacco Epidemic" (WHO, 2015) and countries' reports to WHO FCTC which are accessible at WHO FCTC web site.
Since they have calculated the score for cigarette price based on the Europe's average price, the first author – Luk Joossens was consulted and according to his suggestion, the scores in this study were calculated based on SEA regional average price of Marlboro cigarette packs in Purchasing Power Parity (PPP) instead of Europe's average price. Besides, the information regarding amount of spending on public information campaign in SEA countries are not available from existing literatures, and thus, the total scores were calculated based on the remaining five policies.

### 2.4.1 Search strategy

PubMed, Scopus and the e-Library databases of the VU (Free University of Amsterdam) were searched to find peer-reviewed literature about tobacco control policies and programs. Those articles were screened by reading the abstracts.

Hand searching was also conducted among references of identified articles. In addition, websites of WHO, WHO FCTC, World Bank, United Nations, the United Nations Development Programme and the Southeast Asia Tobacco Control Alliance were examined for finding policy documents, guidelines, toolkits, reports, fact sheets and research articles. The internal websites such as the website of Ministry of Health, Ministry of Information, and Ministry of Population and Immigration were also searched for finding internal documents. Search words were used to find publications as indicated in table 1.

**Table 1. Search Table**

| Source | Search words used |
|---|---|
| VU e-library<br>PubMed<br>Scopus | "tobacco", "tobacco control", "policy", "politics", "context", "process", "program", "implementation", "political", "political economy" "socioeconomic", "institution", "cigarette tax", "smoking cessation", "health warning", "smoke-free law", "South-East Asia Region", "Myanmar", "Thailand", "Sri Lanka", "Nepal", "India", "Bangladesh", "Maldive", "Bhutan", "Temor Leste", "Indonesia", "ASEAN" "low and middle income countries" |
| Websites of<br>Ministry of Health,<br>Ministry of Information,<br>Ministry of Population and Immigration | "tobacco control", "demography", "population", "economy", "religion", "constitution" |
| Websites of WHO, WHO FCTC, World Bank, United Nations, the United Nations Development Programme and the Southeast Asia Tobacco Control Alliance | "tobacco", "tobacco control", "policy", "politics", "context", "process", "program", "implementation", "political", "political economy" "socioeconomic", "institution", "cigarette tax", "smoking cessation", "health warning", "smoke-free law", "South-East Asia Region", "Myanmar", "Thailand", "Sri Lanka", "Nepal", "India", "Bangladesh", "Maldive", "Bhutan", "Temor Leste", "Indonesia", "ASEAN" "low and middle income countries" |

**Inclusion and exclusion criteria:**
For international publications, only those presented in English were used. Some relevant official letters and documents in Myanmar language and some unpublished reports from Ministry of Health were also used. Most of the articles published between 2006 and 2016 were used, but some relevant policy related books and documents published before 2006 were also used.

### 2.4.2 Limitations of research
There was limited number of publications regarding the policy environment for tobacco control in Myanmar, other neighboring countries and in South East Asia Region. So, the publications of other low and middle-income countries and some developed countries' experiences were used for this study; in doing so, implications were drawn with due consideration for the applicability to the context of Myanmar.

### 2.4.3 Conceptual framework
In order to study the factors influencing adoption and implementation of WHO FCTC, theories and frameworks related with policy analysis were searched. One of the common frameworks is 'Policy Analysis Triangle Framework' proposed by Walt and Gilson (1994). It helps to analyze the factors (content, process, context and actors) affecting policy and the interrelations among these factors systematically (Buse K et al., 2007). This is a highly simplified model of an extremely complex set of interrelationships. The actors are influenced (as individuals and as members of interest groups or professional associations) by the context within which they live and work, at both the macro-government level and the micro-institutional level. Context is affected by many factors such as instability or uncertainty created by changes in political regime or war; by neo-liberal or socialist ideology; by historical experience and culture. The process of policy-making (how issues get on to the policy agenda) in turn is affected by actors, their position in power structures, their own values and expectations. And the content of policy will reflect some or all of the above dimensions. Walt and Gilson (1994) argue that focusing on dimensions of process, actors and context can make the difference between effective and ineffective policy choice and implementation rather than focusing on the content (Walt and Gilson, 1994).
Experiences of leading countries suggested that for the success of the FCTC, it is crucial to understand the policy environments for tobacco control policies, particularly in low and middle-income countries. In a study done by Cairney and Mamudu (2013), they compared the level of implementation of WHO FCTC of all member countries and identified the factors required for effective implementation of WHO FCTC (Cairney and Mamudu, 2013).

**Policy environments conducive to policy implementation**

Cairney and Mamudu (2013) identified the characteristics of an environment conducive to sustained policy change. **'Policy environment'** refers to a number of factors which combine to produce the context in which policymakers operate. To conceptualise an environment they focused on what John (John P, 2012) calls, 'the relationship between the five core causal processes' in public policy: 'institutions, networks, socioeconomic process, choices, and ideas'. These are the factors used by major policy theories to explain change.

**'Institutions'** refers to regular patterns of policymaking behaviour and the rules, norms, practices and relationships that influence such behaviour (Cairney P, 2012). These patterns differ within government. Political systems contain multiple institutions and disperse power across levels and at multiple levels of government. The successful implementation of policy may depend on giving primary responsibility, for the development of tobacco policy, such as a health department sympathetic to the international agreement's aims (Cairney P et al., 2012).

**'Networks'** refers to the relationships between actors responsible for policy decisions and the 'pressure participants' (Jordan G et al., 2004), such as interest groups, with which they consult and negotiate. Government departments may have particular operating procedures that favour particular sources of evidence and some participants over others; the power of interest groups will depend to a large extent on the department with primary implementation responsibility. The way the health network is organized is also of vital importance. Coalitions can be more or less effective depending not only on their structure, but also on the various approaches or techniques it uses to carry out its tasks (Rathjen H, 2001).

**'Socioeconomic process'** refers to the conditions that policy makers take into account when identifying problems and deciding how to address them. Broad relevant factors include a political system's demographic profile, economy and mass attitudes and behaviour. The prevalence of smoking in a population, the economic benefit (including tax revenue) of smoking, and public opinion on tobacco control are the specific factors important to tobacco control policy makers (Pacheco J, 2012).

**'Ideas'** is a broad term that can describe several related processes: agenda setting, beliefs, and the production and transfer of policy solutions.

**Agenda setting** refers to the way that a problem is framed or understood, and therefore how much attention it receives and how it is solved.

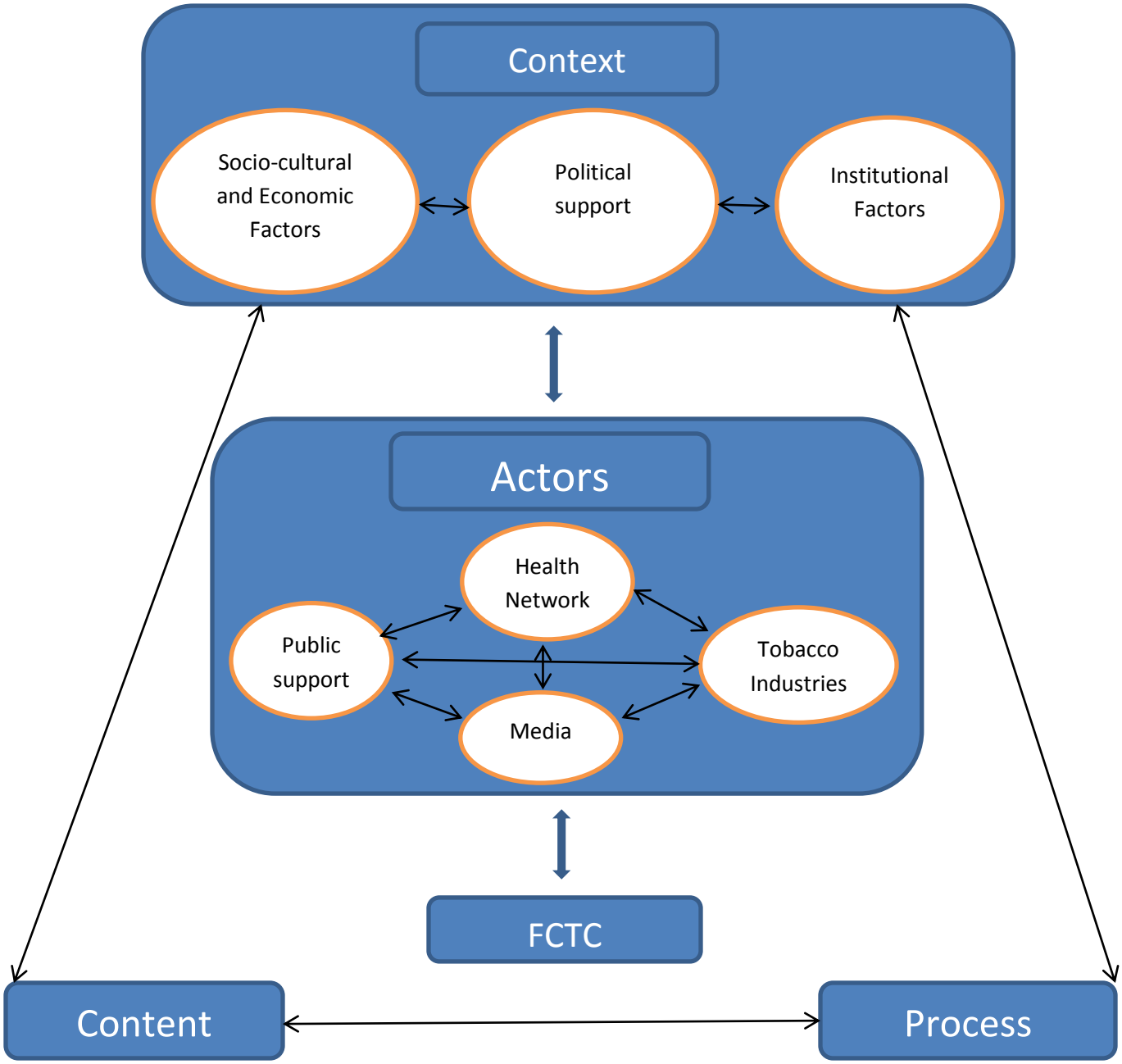
**Beliefs** refer to the knowledge, world views, and language that actors share when addressing a policy problem.

**Policy solutions** are the ideas put forward to solve a problem. In the case of the FCTC, these solutions are also shared internationally as countries learn from the experiences of others (Mamudu HM et al., 2009). The mutually reinforcing interaction between these factors could produce policy environments more or less conducive to certain policy changes.

**The actors related with tobacco control** contain health network, media, public and tobacco industries. Health network includes governmental and non-governmental, and the key intergovernmental actor is the World Health Organization (WHO).

So, this study will be carried out based on the framework adapted from the Walt and Gilson's (1994) Framework (see at annex 1) and the factors identified by Cairney and Mamudu (2013). The adapted framework is presented in figure 5.

**Figure 5. Conceptual framework adapted from Walt and Gilson's policy analysis triangle framework** (**Source:** Walt and Gilson, 1994)



# CHAPTER 3: STUDY FINDINGS

This chapter is organized into two parts. The first portion includes analysis of the factors influencing adoption and implementation of WHO FCTC in Myanmar, based on the adapted conceptual framework. The second portion includes the review of evidence based practices in implementation of WHO FCTC of leading countries in the South-East Asia Region and other ASEAN countries focusing on applicability to the Myanmar context.

## 3.1 Factors influencing adoption and implementation of WHO FCTC in Myanmar

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first legally-binding international treaty for public health. It sets a framework for guidelines and protocols to reduce tobacco consumption and tobacco supply through evidence-based interventions (WHO, 2011). Key cost-effective interventions include increasing tobacco tax, timely dissemination of information about the health risks of tobacco use through awareness campaigns (including pictorial health warning), restrictions on smoking in public places and workplaces, and comprehensive bans on advertising, promotion and sponsorship (Jamison DT et al., 2006). WHO noted those interventions as the 'best buys' and providing tobacco users with treatment for tobacco dependence as a 'good buy' for reducing tobacco use and preventing NCDs (WHO, 2014).

This section presents an analysis of the policy environment related with the above mentioned policy interventions in Myanmar.

### 3.1.1 Political support

The political support for tobacco control in Myanmar was analyzed in terms of how the tobacco problem was framed or understood by decision makers, how much attention it received and how it was solved (agenda setting), and how the knowledge and world views of the policy makers affected on their decisions.

The Ministry of Health (MoH) started health education activities on dangers of tobacco in 1980s (MOH, 2004). The National Health Committee (NHC), the highest inter-ministerial advisory group of all concerned ministries at the national level, headed by Secretary-1 of State Peace and Development Council, was formed on 28 December 1989 as part of the policy reforms (MOH, 2006).

It was evident that tobacco was understood as an economic good (providing jobs, exports and tax revenue) rather than a public health issue by the government. Cigars and cheroots were produced traditionally by local cottage industries and local production of cigarettes started in mid-1960s by two state-owned factories in Myanmar. After economic liberalization policy was adopted in early 1990s, multinational tobacco companies came to invest in Myanmar (Kyaing NN et al., 2005). Kyaing NN et al. (2005) revealed that

there was rapidly increased cigarette consumption, especially among adolescent and adult males through vast investments on advertisements and promotions, and lack of tobacco control legislation restricting youths' access to tobacco products (Kyaing NN et al., 2005). The cigarette production rocketed from 853 million in 1995-1996 to 2.5 billion in 1999-2000 and continued to rise up to 3.1 billion in 2005-2006 (Maung NS, 2012). The MoH seriously concerned about the increasing tobacco use and raised up its health education activities on dangers of tobacco (Kyaing NN et al., 2005).

Along with the global movements, the tobacco control policy came up on the agenda in the late 1990s in Myanmar. In July 1998, WHO reorganized its tobacco control efforts within a new structure, the Tobacco Free Initiative (TFI) and it greatly enhanced the momentum of anti-tobacco activities in Myanmar. The NHC issued guidelines for prevention and control of smoking related diseases at its 26$^{th}$ meeting held in September 1998. According to its guidance, the National Tobacco Control Programme was officially launched in January 2000 with drafting and approval of the 'National Policy on Tobacco Control and Plan of action'. The National Tobacco Control Committee was formed in March 2002, headed by the Minister for Health and included heads of related departments and chairpersons of national non-governmental organizations (NGOs) as members (MOH, 2004).

The knowledge of decision makers on magnitude of tobacco problem among youths and the international efforts for solving the problem, shared by MoH, seemed affected on their decisions on adoption of WHO FCTC and National tobacco control law in Myanmar. MoH conducted the Global Youth Tobacco Survey (GYTS) in 2001 and the results showed high prevalence of cigarette smoking and high accessibility to tobacco products among school youths (MOH, 2004). In May 1999, the World Health Assembly adopted a resolution (WHA 52.18) paving the way for starting multi-lateral negotiations on the WHO FCTC and possible related protocols. Myanmar actively participated in the negotiating process and hosted the 4$^{th}$ inter-country consultation meeting on FCTC in August 2002. Representatives of MoH who participated in negotiations, reported back to the national authorities with strong recommendations for signing and ratifying the convention. The 34$^{th}$ meeting of NHC held in April 2002 principally agreed the provisions of WHO FCTC and approved for becoming Party to the Convention (MOH, 2004).

The WHO FCTC was adopted in May 2003 and opened for signature on 16 to 22 June 2003 (WHO, 2003). Myanmar signed it in October 2003, ratified in April 2004 and became the 11$^{th}$ member country of the WHO FCTC (MOH, 2009). According to a review made by Kyaing NN et al. (2005), drafting of tobacco control law led by MoH started in 2002, and the momentum of drafting process was increased and the scope of contents of the legislation was widened by ratification of WHO FCTC (Kyaing NN et al., 2005).

However, the reluctance of decision makers on increasing tax and price issue was found with the reason that it might increase burden on the poor. It was noted as a major challenge in the drafting process of the legislation and finally, the legislative draft failed to include any measures on price and tax (Kyaing NN et al., 2005). It implies that the framing of tobacco as a public health issue by health personnel was neglected in some way by the economic view.

After four years of drafting process, "The Control of Smoking and Consumption of Tobacco Product Law" was approved and enacted by the Government in May 2006 and it came into effect in May 2007 (MOH, 2014). The law includes most of the demand reduction measures such as designation of smoke-free areas, banning sale of individual or small packets containing less than 20 cigarettes, banning direct and indirect tobacco advertisements, promotion and sponsorship, establishment of warning labels on tobacco packages, and promoting health education and tobacco cessation programmes, and the supply reduction measure such as restriction on sale of tobacco and tobacco products to and by minors (below 18 years of age) of WHO FCTC (The Republic of the Union of Myanmar, 2006).

Delayed implementation of the law seemed to be started from delayed establishment of central board by the government. According to the law, government has to form the multisectoral central board (now called as the central tobacco control committee (CTCC)) chaired by Minister for Health (The Republic of the Union of Myanmar, 2006), but it was not happened until more than 4 years after enactment of the law (MOH, 2013).

It was found that with unstable political and administrative system, together with less capacity of health sector contributed by natural disaster, implementation of tobacco control law was not in the priority list of political agenda. According to the military government's order, all government Head offices moved from former capital city, Yangon in lower Myanmar to newly built capital, Naypyitaw in Central Myanmar in late 2005 (Myoe MA, 2006). Then, Cyclone Nargis, which believed to be the worst recorded natural disaster in Myanmar's history, struck on 2 May 2008. With significant damage of health care facilities, there was a severe impact on the health system and its capacity for delivering essential services (The Republic of the Union of Myanmar, 2014).

A new constitution was ratified in May 2008. According to the constitution, the first national election in 20 years was held on 7 November 2010 and the new presidential democratic government was formed in 2011 (The Republic of the Union of Myanmar, 2014). Along with the above mentioned political, administrative and structural changes in Myanmar, the CTCC was formed only in January 2011, just before transforming to new democratic presidential governance system and after nearly 5 years of enactment of the law (The Republic of the Union of Myanmar, 2011).

### 3.1.2 Institutional factors

Cairney and Mamudu (2013) pointed that political systems contain multiple institutions and disperse power across levels and at multiple levels of government (Cairney and Mamudu, 2013). According to them, 'Institutions' mean regular patterns of policymaking behaviour and the rules, norms, practices and relationships that influence such behavior. Those factors related with adoption and implementation of tobacco control policies in Myanmar were analyzed in this section.

In the era of military government, the NHC chaired by secretary-1 of State Peace Development Council had a high power for setting policies. As per the NHC's guidance, the respective ministries such as MoH, Ministry of Information and Ministry of Home Affairs banned the cigarette advertisements by issuing ministerial orders in 2002. The Ministry of Sports issued a ministerial order to gradually reduce sponsorship of sports by tobacco industries, and a total ban at later dates. In the same year, the NHC directed to delete tobacco promoting scenes from films, videos, and any other commercial programs (Sein T, 2013).

According to new government system started from 2011, the parliament's approval is needed for adoption of new law or amendment of the existing law while the respective ministry has to initiate and develop the legislation (MOH, 2008). It was found that the president's office can issue necessary notifications, for example, in 2011, the president's office notified all governmental organizations that smoking and smokeless tobacco use must be strictly prohibited in all office buildings and compounds while those were partially smoke-free areas according to the law (MOH, 2013).

According to the law, the cabinet has decision power for adoption of new rules and procedures (The Republic of the Union of Myanmar, 2006). The CTCC is chaired by the Minister for Health and the Deputy Minister for Health is the vice-chair. The members include Deputy Ministers of Ministry of Finance and Trade, Deputy Attorney General, Head of Myanmar Police Force, and Directors General from other related Departments (The Republic of the Union of Myanmar, 2011). The law defined the functions and duties of the CTCC including setting policy and giving guidance for tobacco control activities (The Republic of the Union of Myanmar, 2006).

Among the institutions of the CTCC, Ministry of Health (MoH) is found as a major institution for adoption and implementation of the tobacco control policies. The law defined the functions and duties, and authorities of MoH and Department of Health (DoH) for issuing necessary notifications, orders and directives (The Republic of the Union of Myanmar, 2006). According to the organizational and functional structure, all the tobacco control activities have to be initiated by DoH including organizing the CTCC meeting. However, the limited human and financial resources dedicated for tobacco control in MoH seemed to be important contributing factor for delayed adoption and implementation of tobacco control policies in Myanmar. There

was neither separate tobacco control unit nor full time staff for tobacco control up to 2013. Only one focal person assigned in DoH, was responsible for both tobacco control program and primary designated post (WHO, 2014). So, although some time-bound activities could be conducted during 2011-2012 (MOH, 2012), the first meeting of CTCC could only be organized in June 2012 (MOH, 2013). It was found that drafting of the rules could be started only in December 2013 (MOH, 2014) although it was recommended by CTCC since its first meeting in June 2012 (MOH, 2013).

Lack of government spending and sustainable funding mechanism for tobacco control was also found in Myanmar except spending for voluntary assessed contributions to WHO FCTC (SEATCA, 2015, WHO FCTC). Most of the tobacco control activities were relied on WHO support, except public educations through state owned mass media such as TV, radio and newspapers which were free of charge (WHO, 2007).

Along with the receipt of Bloomberg grant for two-year' tobacco control project (2013-2015), some structural changes were made in DoH. In July 2013, MoH assigned the tobacco control focal points both at central and state/regional level, and a tobacco control cell comprising 6 members from different divisions was formed in DoH (MOH,2013). Three full time staffs were appointed and one short-term legal advisor was hired by the project in 2014 (WHO, 2015).

A regular monitoring and reporting mechanism on tobacco advertising, promotion and sponsorships (TAPS) was established in July 2013 (WHO, 2014). With the technical support of legal advisor and the Union (the fund manager of the Bloomberg grant), the MoH developed and issued two notifications on smoke-free policy in March 2014 (MOH, 2014). The notification on pictorial health warning was also issued in February 2016 (The Republic of the Union of Myanmar, 2016). According to WHO FCTC obligation, Myanmar has to implement that policy in 2008, within 3 years of enforcement of WHO FCTC, but it could only be implemented after 8 years of delay.

In the low resourced setting, implementation of cessation policy is also found to be weak in Myanmar where the tobacco cessation services were mainly provided by public health facilities at primary care level and some secondary and tertiary hospitals. The services were still limited to simple advice in most facilities and group counseling in some hospitals. The trainings for health professionals were not widely covered yet. The national guideline for tobacco dependence treatment and the telephone quit lines were still not in place in Myanmar. Nicotine Replacement Therapy (NRT) and Bupropion were not in the essential drug list and NRT was not widely available. Although the community-based tobacco cessation activities were started in pilot townships in 2004, the sustainability and expansion were not noted (MOH, 2009, WHO, 2014).

Although the law defined smoke-free areas, low public compliance and weak enforcement were seen. According to GYTS 2011, two in five students were exposed to second-hand smoke in enclosed public places (WHO, 2011). The law defined the duties of the respective administrator or owner of the area or building or office is responsible for monitoring and taking action for violations of smoke-free policy (The Republic of the Union of Myanmar, 2006). The low public compliance and weak enforcement might be contributed by less effective public education program since only 50% of school youths knew that second hand smoke affect others' health (WHO, 2011) and a study showed that more than one-third of people did not aware of the current tobacco control law (MOH, 2015). There is still lack of surveillance system for enforcement of smoke-free policy in Myanmar although the law required establishing supervisory committees at all levels (The Republic of the Union of Myanmar, 2006).
The GYTS 2011 also showed low compliance and violations on (TAPS) policy by the tobacco industry while the law comprehensively banned (WHO, 2011). Although the law defined the penalties for offences, and gave authority to Myanmar police force as the law enforcer (The Republic of the Union of Myanmar, 2006), no rules and procedures for enforcement actions were in place. Although MoH established a regular monitoring and reporting mechanism, just local actions such as educating were made and any direct action on tobacco industries was not taken yet (WHO, 2016). Lack of necessary rules and procedures, lack of awareness raising and training of law enforcers, less capacity of MoH for doing those activities and lack of civil society involvement were noted as factors for weak law enforcement in Myanmar.

The inter-ministerial cooperation between MoH and different institutions were noted. For example, collaboration with Ministry of Education and Ministry of Sports for banning smoking in basic education schools, sports stadiums and sports fields in 2002, collaboration with Ministry of Information for public education through mass media (MOH, 2009, Kyaing NN et al., 2005), collaboration with Ministry of Education for conducting Global Youth Tobacco Surveys and Global School Personnel Surveys (MOH, 2013), and collaboration with Ministry of Sports for implementing tobacco-free SEA Games when Myanmar hosted the 27$^{th}$ SEA Games in December 2013. For strengthening collaboration and cooperation among stakeholders, MoH conducted multisectoral advocacy workshops every year at central and State/Regional level (MOH, 2014).
MoH and Ministry of Finance collaborated for harmonious raising of tax on tobacco products. The MoH conducted advocacy workshops for tax and revenue personnel, and discussed the importance of issue from public health perspectives. The Ministry of Finance raised the tobacco taxes gradually from previous commercial tax levied on cigarettes of 50 % into 100%, and

that of cheroots, cigars and smokeless tobacco (10%, 20% and 25% respectively) into 50% in April 2012 (MOH, 2014). According to new Union tax law, the tax for cigarettes was increased to 120% and other tobacco products to 60% starting from 2015-2016 fiscal year (WHO, 2016). However, WHO pointed that Myanmar's tax rate on cigarette in 2014 was still 50% of the retail price while the World Bank recommends a tax burden of 65 - 80% of retail price, and WHO recommends at least 70% of retail price should be excise. The price of cigarettes in Myanmar was still the lowest among SEA countries in 2015 (WHO, 2015).
Although MoH is in the major role for implementing tobacco control measures, the power and voice seemed to be less than the trade sector. It was seen in the cases of tobacco companies' proposals for tobacco cultivation and establishment of new tobacco factories, submitted to the Myanmar Investment Commission (MIC) where MoH's remarks for objection were mostly neglected. MIC and Ministry of Trade were also used by tobacco companies as a facilitator for negotiation with MoH for the tobacco control regulations, for instance, when MoH was developing the notification on pictorial health warning during 2014-2015 (MOH, 2014, MIC, 2015).

### 3.1.3 Socio-cultural and economic factors

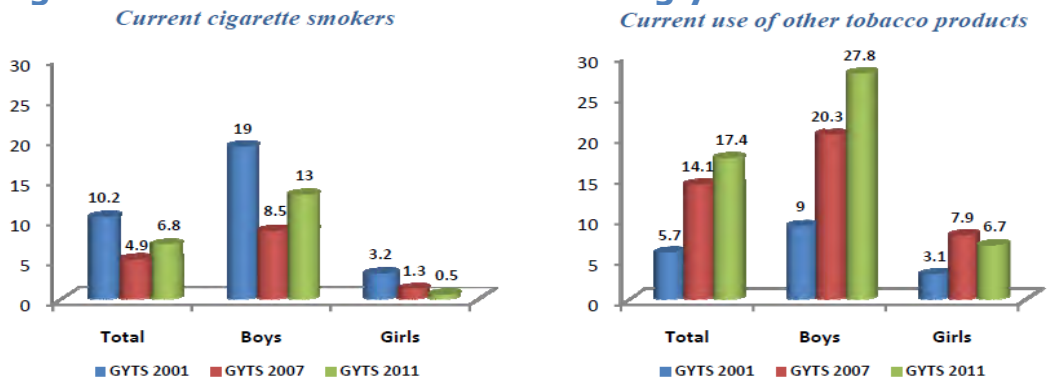
According to Cairney and Mamudu (2013), the prevalence of smoking in a population, the economic benefit (including tax revenue) of smoking and public opinion on tobacco control are the specific socio-economic factors important to tobacco control policy makers (Cairney and Mamudu, 2013). In Myanmar culture, tobacco use was socially and culturally accepted since ancient times and became an element of social norms (Kyaing NN et al., 2012). So, the cultural factor is also an important factor that needs to be accounted for tobacco control in Myanmar.

Traditionally, the first three items offered to the guests as hospitality were cheroots/cigarettes, a special container made of lacquer consisting betel leaves, areca nuts, slake-lime, catechu, cured tobacco and other condiments to be prepared as *Kun yar* (betel quid) for mouth-freshening, and a plate of fermented tea leaves mixed with variety of fried beans. Those were served with the hot Myanmar green tea drink. Thus, no ceremony or occasion was (and still so in large parts of the country) considered complete without those three things and refusing that offering might be considered as impolite, particularly in the rural area (Kyaing NN et al., 2012). That cultural factor still reflected in WHO NCD STEPS Survey 2009 where only 27.4% of men and 1.4% of women of daily smokers used manufactured cigarettes, while majority of them used cheroots and cigars. Oral and nasal use of snuff, chewing tobacco and betel quid chewing was also as high as cigars and cheroots smoking (WHO, 2009).

The figure 6 showed the findings of Global Youth Tobacco Surveys conducted in 2001, 2007 and 2011 (MOH, 2013). Among boys, the prevalence of smoking was highest in 2001, decreased in 2007 and increased again in 2011 while the prevalence of other tobacco products use was increased tow-folds in 2007 and three-folds in 2011 compared to 2001. Among girls, the prevalence of smoking was in decreasing trend while the prevalence of other tobacco products use was doubled in 2011 compared to 2001 (MOH, 2013). There was high potential of rising smoking prevalence among youths since GYTS 2011 showed almost 15% of non-smoking youths were likely to start smoking next year (WHO, 2011).

According to surveys done in adult population (over 15 years) in 2003 and 2009, and (over 25 years) in 2014, the decreasing trend of smoking prevalence was found in both men and women (Figure 7) (but some points increased in women) (MOH, 2009, WHO, 2009, 2014). Although the data on smokeless tobacco use was not available for 2003, the increasing trend was found in both men and women between 2009 and 2014. The increasing trend of smokeless and other tobacco use was found among young and adult males. It showed that Myanmar needs to solve the smokeless tobacco problem together with the smoking control.

**Figure 6. Trend of tobacco use among youths**

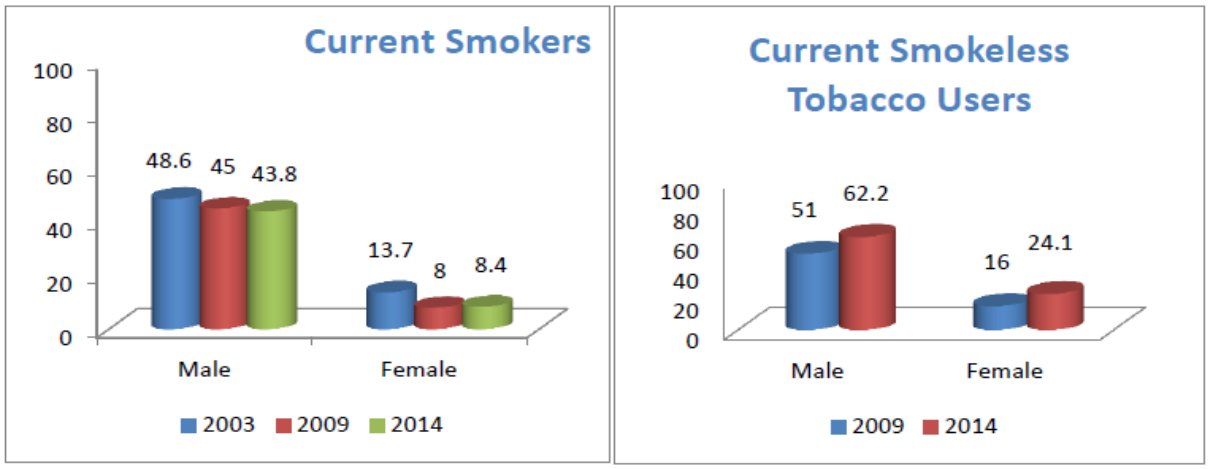



**Prevalence of tobacco use among school youths**

*Source: Global Youth Tobacco Surveys 2001, 2007 and 2011*

Source: Ministry of Health, Health in Myanmar 2013

## Figure 7. Trend of tobacco use among adults




**Prevalence of tobacco use among adults (over 15 years)**

Source: World Health Survey 2003, NCD STEPS Survey 2009 and National Survey on Diabetes Mellitus and Risk Factors for Noncommunicable Diseases (NCDs) in Myanmar, 2014.

Although the prevalence of smoking and smokeless tobacco use was high among both young and adult population, a high public support for tobacco control policies (MOH, 2013) was found in Myanmar. A study showed that 92% of people supported banning smoking in public places while just 50% supported banning smoking in indoor workplaces. Most of them supported complete banning of promotion (94% adults and 90% students), restriction of selling to youth under 18 years old (95%), banning misleading information (92%) and implementing pictorial health warning on the tobacco packages (90%). The support for policy on raising tax and price of tobacco products was relatively low (70% adults and 58% students) and the lowest support (13%) was found for policy on banning point of sale advertisements. Overall, adults, those with higher education and non-smokers supported the tobacco control policies more than students, those with lower education and ever smokers (MOH, 2013).

Myanmar is found to be highly dependent on tobacco tax revenues. Although the official data was not available, it was estimated that tax revenues from tobacco products have increased annually from 2009 to 2014 in Myanmar. Taxes collected on cigarettes in fiscal year 2013-14 contributed nearly Kyats 31 billion (USD 24 million with exchange rates at that time) to government revenues (Myanmar Times, 2015). The country had also faced with huge health care costs for diseases that could have been prevented by curbing tobacco use. With the lack of recent evidence, some old study showed that the estimate of health-care costs for 9 diseases in Myanmar was 13.2 (USD in million) while the average tobacco tax revenue was 41.74 (USD in million) in 1999. It means that almost one-third (31.62%) of the tobacco tax

revenue had to spend for the health-care costs for 9 diseases in 1999 while it should be considered conservative, as it did not account for all tobacco-related diseases and the factor like under reporting of morbidities with underdeveloped health surveillance system (SEATCA, 2015).

### 3.1.4 Health Networks and relationship between different actors

Different departments under Ministry of Health, the tobacco control teams in state/regional, district and township level, anti-tobacco NGOs and INGOs, and WHO are involved in health networks for tobacco control in Myanmar. The state/regional and township health departments and basic health staffs seem to have important roles since they are main implementers of tobacco control activities at their respective levels (MOH, 2013). Some active academia such as University of Public Health is also involved in the network and collaborated with DoH in ECT activities, campaigns and workshops.

Participation of media and national non-governmental organizations (NGOs) were found in advocacy and community awareness campaigns including WNTD celebrations (WHO, 2014). It is found that multisectoral involvement and the spirit of volunteerism play very important roles in the tobacco control implementation in Myanmar.

Before 2013, there was no strong civil society or pressure groups that lead or provide technical assistance to MoH. In 2013, a national NGO, called "People's Health Foundation", composed of retired public health professionals was established. It initiated certain tobacco policy change process and implementation such as smoke-free schools and universities, pictorial health warning and tax policy reform through policy papers, seminars, forums, workshops and meeting with high level political leaders and parliamentarians (Sein T, 2013).

One international NGO, South-East Asia Tobacco Control Alliance (SEATCA), based in Thailand, also initiated the technical and financial support in 2012-2013 for implementation of smoke-free policy in Myanmar and currently, it is supporting for establishment of smoke-free cities and smoke-free heritage sites in Myanmar (MOH, 2015).

Along with the receipt of Bloomberg grant for (2013-2015) project, the Union, the fund manager for the grant, also provided technical support to MoH for strengthening of the tobacco control policy. Among others, WHO is the oldest partner that provided the technical and financial support to Ministry of Health since the beginning of the National tobacco control program in Myanmar. Apart from support and collaboration of those organizations in the health network, the involvement of private sector and other community based organizations was still low in tobacco control program in Myanmar.

Like most countries in the world, MoH's efforts for tobacco control were also interfered by tobacco industries in Myanmar. While cigars and cheroots are produced by local cottage industries, cigarettes are produced by joint-

venture private companies and foreign companies (such as British American Tobacco (BAT), Myanmar Japan Tobacco), and have dominated the domestic cigarette market.
The corporate social responsibility (CSR) activities of tobacco industries like supporting community education or social welfare and a lot of violations on the TAPS policy were made by the tobacco industry (WHO, 2011). While the WHO FCTC suggested member countries to protect the public policies from commercial and vested interests of the tobacco industry (WHO, 2003), the tobacco industry interference, particularly by BAT and Myanmar Japan Tobacco, were found when MoH was developing the notification on pictorial health warning (MOT, 2014). They made complaints through Ministry of Trade and Myanmar Investment Commission (MIC) about the large size of health warning that MoH was intending to adopt, and tried to negotiate with MoH. They challenged MoH and warned using the example of Australia that is facing with the law suit for plain packaging and they suggested alternative solutions other than the pictorial health warning (MIC, 2015). Using their words, MIC suggested MoH to negotiate with the investors for the regulation. So, the process of notification development took more than 2 years, but finally, the notification was approved by the cabinet and issued in February, 2016 (WHO, 2016).

## 3.2 Evidence base on implementation of WHO FCTC in selected countries

From the findings in section 3.1, a number of factors influencing adoption and ineffective implementation of WHO FCTC in Myanmar were identified. Framing the tobacco as an economic good by policy makers, low priority of tobacco control among other competing issues, limited human and financial resources dedicated for tobacco control and limited capacity of MoH, deeply rooted socio-cultural acceptance on tobacco, high economic value of tobacco in the country, lack of strong coalitions among network for tobacco control, and tobacco industry influence on policy makers and policy making process are found as important factors among others.
While analyzing the influencing factors, the gaps in policy and implementation were also identified. Ineffective public education program and cessation program, weak law enforcement especially on smoke-free policy and banning TAPS policy, and low tax and price of tobacco products were identified as the gaps that need to be focused in future implementation. Based on those gaps, this section presents the review of evidence based interventions implementing in leading countries in SEAR and other ASEAN nations considering the similar context with Myanmar.

The evidence shows that comprehensive tobacco control programmes reduce smoking prevalence (WB, 2011). However, few attempts have been made

for systematic measurement of the implementation of tobacco control policies at country level. The Association of European Cancer Leagues conducted a study in 28 European countries in 2004 using a new Tobacco Control Scale (TCS) (Joossens L, 2006). It was repeated in 2005, 2007 and 2013 (Joossens L, 2012). The TCS was used to quantify the implementation of tobacco control policies at country level, and was based on six policies described by the World Bank (WB, 2011) that should be prioritized in a comprehensive tobacco control programme. The TCS based on six policies and explanations on the scoring are mentioned in table 2 and 3. (See the complete table at annex 2)

### Table 2. The Tobacco Control Scale 2013

| No. | Policy | Score |
|---|---|---|
| 1. | Price of cigarettes | 30 |
| 2. | Smoke-free work and other public places | 22 |
| 3. | Spending on public information campaigns | 15 |
| 4. | Comprehensive bans on advertising and promotion | 13 |
| 5. | Large direct health warning labels | 10 |
| 6. | Treatment to help smokers stop | 10 |
| Total score | | 100 |

## Table 3. Short Notes and explanations on the scoring of the TCS

| **Price** |
|---|
| The price of a pack of Marlboro or other premium brand in Purchasing Power Parity (PPP). (PPP = Gross Domestic Product per capita)<br>The score is calculated based on the regional average price. |
| **Bans on smoking in public and work places with no exemptions and no smoking rooms** |
| Only total bans work well and comply with Article 8 of the WHO FCTC. |
| **Smoking rooms**<br>A smoking room is a closed indoor premise with ceilings, floor and walls. Norms for smoking rooms may vary. In some countries, very strict conditions apply to smoking rooms (size, ventilation norms, closure of the doors, cleaning), which makes it almost impossible to build them. |
| **Meaningful restrictions: workplaces**<br>It means smoke free legislation that only applies to some regions of the country, the legislation contains exceptions, or allows smoking in indoor premises which are not defined as closed (such as places and areas). 'Enforced meaningful restrictions' means that at least 50% of those who work indoor are never or almost never exposed to tobacco smoke at work. |
| **Meaningful restrictions: bars and restaurants**<br>It means smoke free legislation that only applies to some regions of the country, the legislation contains exceptions (such as bars, small size establishments or during specific hours) or allows smoking in indoor premises which are not defined as closed (such as places and areas). 'Enforced meaningful restrictions' means that at least 50% of the bars and restaurants are smoke free. |
| **Spending on public information campaigns** |
| Government funding at national level in 2012 for mass communication campaigns, tobacco control projects, educational programs, support for NGOs. |

## Table 4. Leading European countries ranked by total TCS score in 2013

| 2013 ranking (2010 ranking) | | Country | Price (30) | Public place bans (22) | Public info. campaign spending (15) | Advert-ising bans (13) | Health warnings (10) | Treat ment (10) | Total (100) |
|---|---|---|---|---|---|---|---|---|---|
| **1** (1) | – | **UK** | 27 | 21 | 3 | 10 | 4 | 9 | 74 |
| **2** (2) | – | **Ireland** | 24 | 21 | 1 | 12 | 5 | 7 | 70 |
| **3** (4) | ▲ | **Iceland** | 20 | 17 | 12 | 12 | 4 | 1 | 66 |
| **4** (3) | ▼ | **Norway** | 20 | 17 | 3 | 12 | 4 | 5 | 61 |

Table 3 shows the 2013 TCS scores of 4 leading EU countries, in rank order, with their 2010 ranking shown for comparison.

Since TCS was originally developed and used for measuring the implementation of EU countries, and evidence on application of that scale in Asian context was not noted, it was tried to apply the scale for SEAR in this study. Using the latest available data of the countries from WHO 2015 report and applying TCS, the South-East Asian countries were ranked (table 4). Since the information regarding amount of spending on public information campaign in SEA countries were not available from existing literatures, the scores were calculated based on the remaining five policies.

### Table 5. Leading SEA countries ranked by total TCS score (2015)

| Ranking | Country | Price (30) | Public place bans (22) | Public info. Campaign spending (15) | Adver-tising bans (13) | Health warn-ings (10) | Treat-ment (10) | Total (100) |
|---|---|---|---|---|---|---|---|---|
| **1** | Thailand | 28 | 12 | | 12 | 6 | 10 | 68 |
| **2** | Sri Lanka | 30 | 10 | | 12 | 6 | 10 | 68 |
| **3** | India | 30 | 12 | | 9 | 4 | 3 | 58 |
| **4** | Nepal | 23 | 12 | | 12 | 6 | 1 | 54 |
| **5** | Maldives | 24 | 9 | | 12 | 1 | 0 | 46 |
| **6** | Bangladesh | 15 | 11 | | 9.5 | 4 | 1 | 40.5 |
| **7** | Timor Leste | 30 | 1 | | 0 | 1 | 1 | 33 |
| **8** | Myanmar | 10 | 9 | | 9 | 1 | 1 | 30 |
| **9** | Indonesia | 19 | 3 | | 0 | 4 | 1 | 27 |
| **10** | Bhutan | 0 | 12 | | 12 | 0 | 1 | 25 |

According to the TCS score, Thailand, Sri Lanka, India and Nepal are found as the leading countries in the SEA region. According to WHO 2015 data, it is also found that the smoking prevalence in those countries except Thailand is lower than Myanmar. Here, Bhutan is an exception since it has a unique tobacco control effort as all sorts of tobacco production, distribution, sale and advertisements were completely banned (WHO, 2015). So, there was no data on price and no policy on health warning, resulting low score.

#### 3.2.1 Raising tobacco tax and establishing sustainable funding for tobacco control and health care

Evidence showed that a 10% increase in tobacco taxes decreased tobacco consumption by 5% in low and middle-income countries and 4% in high-income countries on average (WHO, 2015). The World Bank recommends a

tax burden of at least 65% of retail price, while WHO recommends at least 70% of retail price should be excise (SEATCA, 2015). According to WHO 2015 data (WHO, 2015), Bangladesh has the highest tax burden as a percentage of the retail price charged on a pack of cigarettes (76%), followed by Sri Lanka (74%) and Thailand (73%) among SEA countries while the cigarette price in Bangladesh was the lowest (WHO, 2015).

Bangladesh is in similar context with Myanmar with high poverty rate and high prevalence of tobacco use. They also have local tobacco cultivation and cigarette and bidi manufacturing as in Myanmar. The cigarette tax structure in Bangladesh is complicated, with a tiered structure which imposes different ad valorem taxes based on retail cigarette price slabs. As a result, cigarette prices in Bangladesh are among the lowest in the world although the tax has been increased over time (Barkat A et al., 2012).

Based on the findings of International Tobacco Control Bangladesh Survey 2009 and 2010, Nargis N et al (2014) calculated the total price elasticity and total income elasticity for the full sample and suggested that the poorer people are more price sensitive than the rich and can thus achieve greater health gain from increased tax and prices of cigarettes, revealing a behavioral response pattern consistent with the global evidence (Nargis N et al., 2014).

Nargis N et al (2014) assessed the possible impact of tax policy changes on cigarette consumption and revenue simulating three alternative tax structures. Overall, the annual projection revealed that cigarette consumption can be reduced and cigarette tax revenue can be increased significantly by the simulated changes in the tax rates and structure. The uniform specific tax system resulted the highest price increase and decreases in the number of smokers and annual cigarette consumption, while the highest revenue gain and tax share in the retail price was found under the uniform ad valorem tax system. Thus, it showed that the revenue goal is better served with ad valorem tax system while the public health outcome is improved under specific tax system. They pointed that the ad valorem with a specific minimum could achieve greater reduction in consumption than the uniform ad valorem excise system and could also narrow the price gap between the lowest and the upper price bands (Nargis N et al., 2014).

Many countries in the SEAR and ASEAN such as Thailand, India, Nepal, Philippines and Vietnam established the sustainable funding for health care and tobacco control along with the implementation of price and tax policy. Thailand is one of the pioneers among ASEAN countries implementing innovative financing for health promotion by utilizing dedicated taxation on tobacco and alcohol products (Sein T, 2011). An autonomous public agency, called as Thai Health Promotion Foundation (ThaiHealth) was established by the government under the direct control of the Prime Minister. Using a 2%

surcharge tax on tobacco products and alcoholic beverages, ThaiHealth supported 13 different programs, engaging civil society for massive community mobilization on tobacco and alcohol control, injury prevention mainly road traffic injuries, health promotion for elderly, and community capacity strengthening (Srithamrongsawat S et al., 2010 cited in Sein T, 2011). Thailand reviewed the tax rate every year and gradually increased over the past two decades. It experienced a decline in smoking prevalence rate along with increased tobacco tax revenues, and implemented various public health promotion campaigns out of its USD 100 million annual budget (Visaruthvong C, 2010).

### 3.2.2 Enforcing 100% smoke-free policy step-by-step or by sub-national approach

Article 8 of the WHO FCTC suggested adopting and implementing measures for protection from exposure to tobacco smoke in indoor public places, workplaces, public transport and other public places (WHO, 2003). Although almost all countries in SEAR and ASEAN have adopted the smoke-free policies, the weak enforcement is still a common issue. Since Thailand and India have similar context with Myanmar having wide land area, different approaches for enforcement of smoke-free policies in those countries were reviewed.

Thailand implemented 100% smoke-free policy through a step-by-step process, beginning in 1992 and gradually making additional venues smoke free (Zolty BC, 2012). In 2010, smoking was banned in all indoor public and workplaces and open air public places such as markets. The only indoor designated smoking rooms (DSRs) allowed were in international airports. The implementation of the smoke free law relied mainly on public pressure as "self-enforcing". Law enforcement was still a problem as smoking was not perceived as an important violation by the law enforcers. According to WHO, less proportion (31%) of people were exposed to second hand smoke in workplaces in Thailand compared to regional average (35%) and Myanmar (39%) (WHO, 2015).

Some countries such as Maldives, India and Indonesia implemented smoke-free policy through a sub-national approach (Zolty BC, 2012). In India, the first national tobacco control law was adopted in 2003. The law enforcement was started by a local action in 2005 in Chandigarh, one of the seven union territories under the direct administration of the national government of India, with nearly one million people (Kashiwabara M et al., 2011). Burning Brain Society (BBS), a Chandigarh-based civil society organization, started activities by organizing workshops for young people and police officers and media briefing, and sending the requests to nearly 300 government offices

asking the enforcement status of the tobacco control provisions. Within one year, 1800 signboards were placed in government offices and that initiative raised awareness of the officials on existing provisions and triggered a partnership between the city and civil society.

In early 2007, a road map for smoke-free city was prepared by BBS and a joint meeting of all city departments and enforcement agencies was organized; guidelines were developed; a multisectoral unit comprising members from civil society, health care, media and the city was established; and responsibility were defined. Following the meeting, the city's intention to become smoke-free by July 2007 was announced and guidelines for different stakeholders were disseminated through media. The counter acts for possible challenges by the tobacco industry were prepared. Enforcement activities were assigned to the police and the food and drug inspectors of the DoH as a routine task. BBS organized a workshop for police to aid understanding of the provisions as well as enforcement procedures. As a result, more than 800 requests for fines were issued between May 2007 and November 2008.

A survey conducted in 2009 reported a high level of compliance with the smoke-free provisions in the city: 99% compliance from hotels, restaurants and public offices on mandatory signboards display, nearly 94% compliance on smoking in enclosed public places, and 82% compliance on smoking in open public places. In addition, a random sample study in 2008 indicated a decline in individual tobacco consumption among 20% of smokers.

The example of Chandigarh was copied by other civil society and expanded the smoke-free cities. The smoke free rules were revised in 2008 to make all indoor public places smoke-free, although DSRs were allowed in limited circumstances (Kashiwabara M et al., 2011). By 2015, mechanism for enforcement of smoke-free rules was established in 76% of 21 states while only 47.6% were successful in collecting fines for violations (Sebastian ST and Johnson T, 2015).

### 3.2.3 Effective mass media campaign and package warning

An intensive, well-funded and sustained national mass media campaign to build awareness of the health effects of tobacco is necessary to advance tobacco control and change social norms (Zolty BC et al., 2015). Since India has similar context with Myanmar in using mass media as the main source of public education, speaking multiple languages, and having high prevalence of smokeless tobacco use and related oral cancers problem, the evidence base on India’s practice was reviewed. The Government of India launched the National Tobacco Control Programme in 2007-08 (Kaur J, 2012). According to a WHO report, India is one of the few countries to have a dedicated budget for tobacco control mass media campaigns (WHO, 2011). Since 2008, at least three national campaigns on television, radio and print were conducted in India each year. Most were aired with technical support

from World Lung Foundation (WLF) using an evidence approach including vigorous pre testing, and were aired in multiple languages across India. For cost-efficiency, those campaigns included spots originally developed in other countries and adapted for use in India.

With WLF support, the sustained mass media campaigns on the harms of SLT and bidi were conducted, using the patients of targeted age group. The television campaign was supplemented by a website and SMS campaign. Sub-national media campaigns were also conducted for reinforcing national efforts (Kaur J, 2012).

An innovative effort, named as "Voice of Tobacco Victims (VoTV)" was also made by a surgeon at Tata Memorial Hospital for sharing patients' and their families' heart-wrenching stories with the media and policy makers. The victims, many of whom were disfigured by their disease, well presented the impact of tobacco on their lives and lobbied the members of parliament, ministers and other policy makers, and sensitized media and the public on the consequences of tobacco use on them and their families. It raised the profile of SLT and created support for a *gutka* ban (Sarin A et al., 2012).

Evidence showed that graphic health warnings & plain 'standardized' packaging are effective in communicating risks, especially important in countries with low literacy (Asma S, 2014). Article 11 of the WHO FCTC suggested the countries to implement those warnings and messages on 50% or more of the principal display areas and to include pictures or pictograms (WHO, 2003). Among the SEAR and ASEAN countries, Thailand (85%), Brunei Darussalam (75%) and Nepal (75%) implemented the largest health warnings on tobacco packages. Knowing the effectiveness of that intervention, the tobacco industries blocked the adoption of legislation arguing that it compromises their trademark rights under international treaties: Thailand was sued by Japan Tobacco, Philip Morris International filed claim against Uruguay, and Australia's plain packaging was challenged by major tobacco companies. However, Australia approved the effectiveness of intervention showing the decreased smoking rates (Asma S, 2014).

### 3.2.4 Providing smoking cessation services in different settings by different approaches

Article 14 of the WHO FCTC suggested the countries to take effective measures for promoting cessation of tobacco use and adequate treatment for tobacco dependence by designing and implementing effective programmes (WHO, 2003).

Malaysia has similar context with Myanmar in providing cessation services mainly in primary health care facilities. Smoking cessation services were provided as part of its primary care since 2000, offering both pharmacological treatment and education and counseling. Smoking cessation services were provided at nearly 80% of more than 900 health clinics in 2015 in Malaysia and achieved quit rates of between 15–17% (WHO, 2015).

A quit smoking infoline was launched in January 2007 for supporting and strengthening the national anti-smoking program, and about 20% of Infoline callers could maintain cessation after six months (WHO, 2015).

India set up tobacco cessation clinics in district hospitals, specialty hospitals and in NGO settings with support of WHO country office. Both behavioral counselling and pharmacotherapy were provided (Murthy P et al., 2010). By 2015, 29 out of 42 districts (69%) have tobacco cessation facilities in India (Sebastian ST and Johnson T, 2015).

In Thailand, smoking cessation services were provided at four settings: in health care settings, pharmacy, the Thai Health Professional Alliance Against Tobacco, and the helpline (WHO, 2009). Cessation is promoted through multidisciplinary teams and through the use of both mass media and individual or group communication sessions. Bupropion and Nortriptyline are included in the "Primary Drug List" and available by prescription. The Thai Health Professional Alliance Against Tobacco network implements smoking cessation activities for several specific target groups. Helplines are provided by NGOs. The Ministry of Public Health integrated the smoking cessation helpline with the hotlines for other drug addictions. In 2009, a national smoking cessation services network was established and set up a national quit line (1600) which was printed on the cigarette package labels (WHO, 2009).

# CHAPTER 4: DISCUSSION

A number of factors influencing adoption and implementation of WHO FCTC along with the gaps in current policy and program were identified in chapter 3. The TCS was applied and the implementations of SEA countries were measured. The evidence base on the practices of other countries in the SEAR and ASEAN were also reviewed, exploring their ways and approaches. Based on these findings, the key factors influencing the adoption and implementation of tobacco control in Myanmar and the gaps that need to be focused in future implementation are discussed in this chapter.

**Usefulness of the framework to the study:** The framework adapted from Gill Walt and Lucy Gilson's Framework and the factors identified by Cairney and Mamudu (2013) was used for analysis of factors in this study. It could guide well for exploring and analyzing the factors for meeting the study's objective. It also helped to analyze the relation between influencing factors and the implementation gaps.

## 4.1 Key factors influencing the adoption and implementation of WHO FCTC in Myanmar

### 4.1.1 Political Factor

As findings showed, tobacco was framed as an economic good by policy makers rather than the public health issue. It was proved by increasing trend of cigarette smoking among youths from 1990 to 1999 and the rise of cigarette production from 1999-2000 to 2004-2005. While production of cigarettes was increasing on one hand, the CTCC was established and gave guidance for tobacco control on the other hand. However, it was fortunate to follow the global movement by the policy makers. Along with the active involvement of health sector, Myanmar could ratify the WHO FCTC and adopt the national tobacco control law relatively earlier than most of the neighboring countries in the region (SEATCA, 2015). The international treaty could serve as a guide for national policymaking process. Although the local evidence on the amount of problem was very limited, it helped to raise the awareness and knowledge of policy makers. Since the production and dissemination of the scientific evidence linking smoking and secondhand smoke to ill health among government and policy makers is important for adopting the policies and transferring across countries, Myanmar needs to improve the research capacity for promoting tobacco control on the policy agenda.

### 4.1.2 Institutional Factor

Myanmar has been lagged behind in implementation of the tobacco control. One of the institutional factors contributed to that laggard state was low priority of tobacco control among other competing issues. While solving the double burden of communicable and noncommunicable diseases with limited

resources, MoH itself could not set the tobacco control in the higher priority. Although MoH was in major role for tobacco control in the law, limited human and financial resources dedicated for tobacco control led to limited capacity of Ministry of Health and many gaps were resulted in program implementation. It was evident that along with some technical, human and financial support, some progress such as development and issuing of smoke-free regulations and health warning notification has made.

Since less power and voice of Ministry of Health was found in cases of tobacco companies' proposals, it supported to the view of Mamudu (2011) to a certain extent that "in the laggard countries, health departments are often key players, but they may lack capacity and their voices are often drowned out by other departments, such as agriculture, finance and trade" (Mamudu (2011) cited in Cairney, 2013). However, much strong collaborations were made among different institutions in Myanmar.

### 4.1.3 Socio-cultural and economic Factor

Among the socio-cultural and economic factors, deeply rooted socio-cultural acceptance on tobacco was the major influencing factor for tobacco control in Myanmar. Although MoH has conducted public education activities especially through mass media since 1980, the social norm on tobacco has not much changed yet. That reflects on increasing smokeless tobacco use among adult males and females, and higher cheroots and cigar smoking rather than cigarette smoking. Using various types of tobacco is also one of the challenges for tobacco control in Myanmar, especially when implementing the tax and price policy and pictorial health warning policy. Although WHO FCTC has focused on smoking, Myanmar needs to adapt the national law taking into account the local preference on smokeless tobacco.

The increasing prevalence of smoking and smokeless tobacco use among youths is also an important problem for Myanmar since it was known that starting smoking in young age is more difficult to quit. In addition, the youths want to test everything and they have a peer pressure, especially for bad behaviors. Knowing that behavior of youths, the tobacco companies are focusing their advertisements and promotion on young people. Increasing tobacco use among youths might increase the tobacco related morbidities and mortalities among working age group, resulting in loss of productivity and a huge financial burden on family and country.

Tobacco growing and manufacturing is still an important source of jobs and revenue in Myanmar. The high economic value of tobacco is also an influencing factor for tobacco control in Myanmar. Article 17 of WHO FCTC suggested countries to provde support for economically viable alternative activities for tobacco workers, growers and, if possible, individual sellers.

### 4.1.4 Health Network

One of the influencing factors was the lack of strong coalitions among health network for tobacco control in Myanmar, especially before 2013. In addition to strong political commitment, the participation of civil society and media involvement is important for tobacco control. The evidence shows a vibrant civil society coalition is necessary to strengthen communication channels. They are able to bring the very latest developments in terms of new legislation, new approach or new achievement on the tobacco control front to discussion tables at district, state or regional level. Media is an important ally for any advocacy campaign to influence policymakers, build opinion and garner support.

In many countries in the region, initiatives and active involvements of civil society were widely found and even they were taking a leading role for tobacco control in the countries. In Myanmar, although there are many NGOs, INGOs and other community-based organizations working for communicable disease control and medical care, the ones working for tobacco control are less than a hand-full number. So, the program needs to advocate the civil society for more collaboration for tobacco control.

### 4.1.5 Tobacco Industry Interference

The tobacco industry interference was found as an important factor among others. Article 5.3 of WHO FCTC suggested the countries to protect the public health policies from commercial and vested interest of tobacco industry. In addition to health sector, all related ministries and organizations need to be aware and follow the guidelines for effective protection of tobacco industry interference in the country. The CTCC should establish the specific guidelines for all government organizations for complying the article 5.3.

WHO pointed that the powerful global industries spend billions of dollars annually on marketing and employs highly skilled lobbyists and advertisers to maintain and increase tobacco use (WHO, 2015). Women and young adults in developing countries have been specifically targeted by the tobacco industry as having the greatest potential for increasing tobacco industry sales and profits. In Myanmar, tobacco companies are also violating the TAPS policy and the potential of increasing smoking prevalence is found among the youths. Although the regular monitoring and reporting system was established, the specific actions could not be taken up till now. So, the adoption of necessary rules and regulations, and taking effective actions are urgently required. Since the tobacco industry is a key player in the global spread of tobacco, it needs to be controlled through transnational efforts. Bump and Reich (2013) pointed that understanding how transnational tobacco companies operate at the global level and within national boundaries is essential to tobacco control policy, especially in the growing markets of the LMICs (Jesse BB, 2013).

## 4.2 Gaps in policy and programme implementation in Myanmar and approaches of selected countries

### 4.2.1 Low tax rate and price of tobacco products

Raising price of tobacco products through tobacco tax with a simple tax structure and effective tax administration is an important measure of the comprehensive tobacco control law to resource tobacco control implementation (WHO, 2015). Myanmar has low tax rate on cigarettes (50% of the retail price) and other tobacco products and the price of cigarettes is lowest among SEAR countries. So, it still has much more room for raising price and tax in order to meet the WB's recommended rate of at least 65% of retail price. There are strong evidences of relation between increased tobacco tax and price and reduced tobacco consumption, and evidence of being most cost effective measures compared to others (WHO, 2015). It is also known that youth and low-income smokers are more sensitive to price increase. Since the price strongly influence smoking initiation in youth, price increases could significantly reduce long-term trends in cigarette consumption. In addition to reducing cigarette consumption, tobacco taxes typically generate higher tax revenues (WHO, 2015). Being the residence of tobacco users who are using various types, tax increase should be applied across all tobacco products in order to close the price gap between product types and thus prevent users from product shifting or substitution. Since raising tobacco tax and price is a simple and effective tobacco control measure, it is the most relevant policy for Myanmar having low resources for tobacco control program.

The tax structure and tax administration is also a bit complicated in Myanmar. Learning from Bangladesh's experience, the ad valorem with a specific minimum was suggested to achieve greater reduction in consumption and to also narrow the price gap (Nargis N et al., 2014), and it combines the strengths of both types of taxes while limiting their weaknesses (Barkat A et al., 2012). According to Nargis N et al. (2014), it is a win-win-win situation and thus, Myanmar should apply that kind of tax structure for both public health benefit and country's revenue.

WHO FCTC Article 26 suggested the countries to fund and resource the implementation of national tobacco control plans, priorities and programs to attain the objectives of the Convention. WHO has steadily advocated for introduction of earmarked or dedicated tax on tobacco and alcohol to generate additional revenue for health, especially for health promotion. Establishing a sustainable health promotion funding mechanism is the most cost-effective way to generate a reliable long-term funding for promoting and improving population health. So, Myanmar should implement the tax and price policy and establish the sustainable funding mechanism for tobacco control and health promotion. Learning from Thailand's experience, it will need government's initiative or high commitment, and an autonomous public agency for running the program and managing the fund. Currently,

Myanmar has civil society organizations like "People's Health Foundation", which has close contacts with high level personnel and parliamentarians, and implementing various public health promoting programmes. So, it would be possible to advocate the government and implement the programme by that organization.

### 4.2.2 Weak law enforcement especially on smoke-free policy and banning TAPS policy

Although Myanmar has comprehensive law and regulation for smoke-free policy, weak public compliance and weak enforcement was still a big issue. Some contributing factors such as ineffective public education campaigns, lack of necessary rules and regulations, and lack of awareness raising and training for law enforcers and lack of civil society involvement were identified. WHO pointed that completely smoke-free environments with no exceptions are the only proven way to fully protect people from the harms of secondhand tobacco smoke. Evidence showed that the countries are implementing the smoke-free policies in different ways depending on their law and capacity.

Implementing the smoke-free environment is considered as the first step towards the control of tobacco use since it can change the social norms. It also encourages smokers to reduce tobacco use and helps those who want to quit succeed over the long term. In different settings, different agencies/stakeholders took the lead role.

Learning from India's experience, the evidence shows the vital role of administration, political leadership and multisectoral approach in smoke free efforts for ensuring compliance and sustainability. There was a well-structured collaboration of government and civil society to carry out those initiatives. The partnership and collaboration were gradually spread to other stakeholders like media, civil society organizations, health institution, other government departments and the community members. The sensitization and training of public place managers and enforcement officials from various departments, and their engagement in the process was found to be important for ensuring compliance.

### 4.2.3 Ineffective public education program

In Myanmar, MoH conducted public educations on dangers of tobacco since 1980s, mainly through public mass media. But with the limited human, financial and technical resource, the education campaigns seemed to be less effective, reflecting the low public compliance on smoke-free policy and high tobacco consumption. The effective mass media campaigns that can change the social norms are required in Myanmar.

Since Myanmar is a very diverse country using a wide range of languages, the media messages need to be adapted accordingly. India's experience

showed that the well planned and well tested media campaigns can get a wide coverage of target groups and the real patients' examples are the hard-hitting education means. The clinicians' initiative and engagement in tobacco control is also effective for public education and lobbing for policy makers and stakeholders. The dedicated budget for tobacco control mass media campaigns and the technical support of civil society were also important for making effective media messages. But, for cost-efficiency, the spots originally developed in other countries can also be used and adapted. Media campaigns targeting mostly used tobacco products such as SLT, cigars and cheroots should be conducted. Since there are concrete evidence on effectiveness of graphic health warnings and plain packaging, especially for low literate and children, Myanmar should also focus it as a priority activity for public education.

### 4.2.4 Ineffective cessation program

Myanmar has provided the cessation services mainly at the primary health care level by basic health staff and at some secondary and tertiary hospitals. While the pharmacotherapy was not widely available, simple advice with education were mainly provided. Since the counseling training for health professionals were not widely covered, MoH should increase the training coverage in collaboration with civil society and should develop the standard treatment guidelines as a first priority. MoH should also try to have Bupropion and Varenicline in essential drug list and should be made available by prescription. Learning from selected countries' practices, it was found that both smoking cessation measures including counseling or other behavioral treatment and pharmacotherapies were used in all countries and both measures are effective. The services can be provided at both primary care clinics and hospitals. Government only, civil society only and public-private partnership approaches were used. Since private sector involvement for tobacco control and cessation program is still weak in Myanmar, MoH should encourage for their wider involvement. Since wide involvement of pharmacy sector was found in Thailand's experience, Myanmar should also try that approach for wider coverage.

# CHAPTER 5: CONCLUSION AND RECOMMENDATION

## 5.1 CONCLUSION

With the objectives of protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure, Myanmar has adopted and implemented the WHO FCTC since 2004. Recognizing the high prevalence of tobacco use and even rising potential among youths in Myanmar, this study was done to identify the key factors contributing to ineffective implementation of WHO FCTC in Myanmar. Referring to findings of Cairney et al. (2012), it is clear that Myanmar is a laggard country in implementing the tobacco control policies since it has high smoking prevalence, still less capacity of MoH, still limited strong NGO and anti-tobacco network for opposing and eventually superseding the influence of tobacco growing and manufacturing interests, and still limited research findings and policy instruments. Myanmar still has weaker regulations, regulatory capacity and monitoring systems, and more reliance on external donor funds. The range of barriers experienced in Myanmar include less capacity and resource constraints, tobacco industry interference, limited anti-tobacco civil society involvement, limited political commitment and awareness of government officials, and limited local research and monitoring.

Countries' experiences proved that the private sector either for-profit or not-for-profit organizations, large or small, are important players in tobacco control, and partnerships between public and private sectors have changed the policy environment. Furthermore, policy is increasingly shaped and influenced by forces (such as global civil society) outside state boundaries. It is noted that multisectoral action is essential, and a national coordination mechanism and the integration of tobacco control programmes in country health-care systems are key.

The global morbidities and mortalities by NCDs are increasing, mainly contributed by tobacco. Implementing the evidence-based, legally binding provisions of WHO FCTC to their fullest extent represents the world's best chance of reducing this toll. It also recognizes and calls for provision of financial support for national tobacco control activities (Articles 2, 26). The World Health Assembly stressed the need for full implementation of the WHO FCTC by all Member States as a key policy measure for meeting the WHO global voluntary target of a 30% relative reduction in prevalence of current tobacco use among persons aged 15 years or older.

In conclusion, Myanmar needs much more efforts for full implementation of WHO FCTC, through building capacity and using resources effectively, growing commitment to FCTC beyond the health sector, fostering growth in anti-tobacco coalition activity, exploiting the limited pro-tobacco activity that may be present and garnering public support for tobacco control.

## 5.2 RECOMMENDATIONS

### For Government and Parliamentarians

1. The government and parliamentarians should be aware of and comply the provisions of WHO FCTC, especially the article 5.3. MoH together with civil society should prepare and make brief presentation at parliament within 3 months.

### For CDC, WHO and MoH

1. MoH should conduct GYTS, GSPS surveys every 3 years, and CDC and WHO should provide financial and technical assistance.

### For CTCC and MoH

1. The CTCC should develop and disseminate the specific guidelines for all government organizations for complying the article 5.3 within 3 months.
2. MoH should develop and adopt necessary rules, regulations and procedures as soon as possible for effective implementation of the national tobacco control law.
3. MoH should dedicate some amount of budget and assign full time staff for tobacco control programme, and should manage for improvement of its legal capacity.
4. Since the notification on pictorial health warning has already issued in February, 2016, MoH, related ministries and civil society should monitor and take necessary actions for enforcement.

### For MoH and Academia

1. MoH and Academia should make arrangement for improvement of the research capacity of its staff and strengthen collaborations for promoting tobacco control on the policy agenda through tobacco related researches.
2. Research on political economy related with tobacco cultivation, production, distribution, sale and control should be conducted at least 3 yearly.
3. Scientific studies on the link of tobacco use and secondhand smoke to ill health should be conducted every year and the findings should be disseminated among government and policy makers.

### For DoH and Civil society

1. DoH, in collaboration with civil society and media, should develop well planned, pre tested effective media messages and conduct effective public education campaigns regularly (at least every 6 months). Media

campaigns should also target mostly used tobacco products in Myanmar such as SLT, cigars and cheroots.

2. DoH, in collaboration with civil society, should develop national standard treatment guidelines for tobacco dependence treatment within a year and should train all health professionals. Community-based cessation programme should also be expanded and should try for pharmacy sector involvement in cessation activities.
3. After MoH has adopted the rules and procedures, DoH, in collaboration with civil society, should conduct sensitization workshops and training for law enforcers for effective implementation and enforcement of smoke-free policy and TAPS policy. Advocacy workshops should be conducted for strengthening collaborations with local governments and related ministries, and active involvement of civil society organizations and media.
4. Civil society organizations, for example, People's Health Foundation, should advocate government and parliamentarians for applying earmarked tax on tobacco and alcohol beverages, and implementing various public health promotion programmes including tobacco control.

**For Ministry of Finance**

1. Ministry of Finance should review the current tax system, raise the excise tax on tobacco products as least 65% of retail price and apply the ad valorem with a specific minimum tax structure for both public health benefit and increasing country's revenue.

**For Clinicians**

1. The clinicians should initiate the innovative public education programs using the real patients' examples as a hard-hitting education mean. The clinicians should engage in tobacco control since they can influence more on policy makers, media and public.

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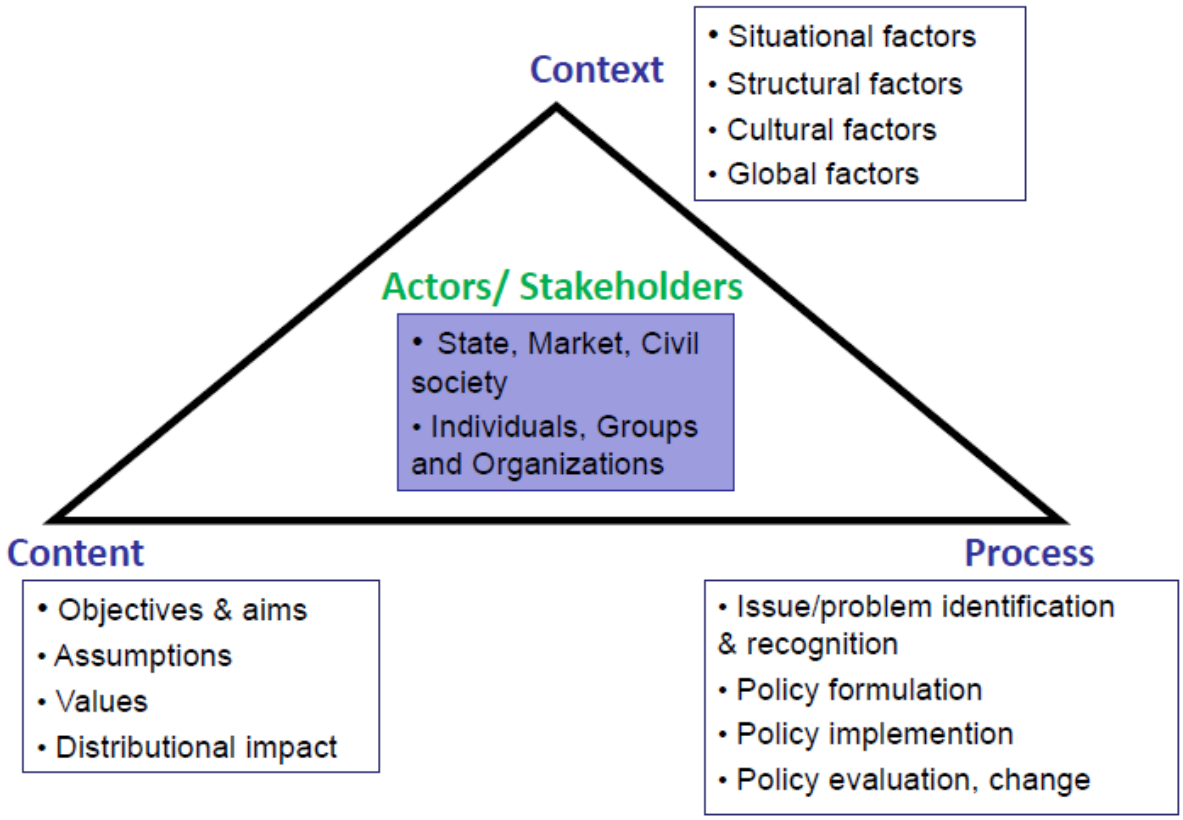
**ANNEXES:**
**Annex 1. Walt & Gilson's policy analysis triangle framework**




**Source:** Walt and Gilson, 1994

## Annex 2
## Table 2. The Tobacco Control Scale 2013

| | |
|---|---|
| **Price of cigarettes.** | **30** |
| The Weighted Average Price for cigarettes in July 2013 | |
| The price of the Weighted Average Price (WAP) for cigarettes in July 2013, taking into account Purchasing Power Standards (PPS). The country with a WAP of €8.50 a pack and an EU average Purchasing Power Standard receives 30 points (see Table 3).<br>In countries without WAP information the price used is the price of a pack of 20 Marlboro in July 2013 minus 10%, taking into account the PPS. | 30 |
| **Smokefree work and other public places** | **22** |
| Workplaces excluding cafes and restaurants – **one only** of | **10** |
| Complete ban without without exceptions (no smoking rooms); enforced (see Table 3) | 10 |
| Complete ban, but with closed, ventilated, designated smoking rooms under very strict rules; enforced (see Table 3) | 8 |
| Complete ban, but with closed, ventilated, designated smoking rooms (not areas or places); enforced (at least 75% of the workplaces are smoke free) | 6 |
| Meaningful restrictions; enforced (more than 50% of the workplaces are smoke free) | 4 |
| Legislative restrictions, but not enforced (less than 50% of the workplaces are smoke free) | 2 |
| Cafes and restaurants – **one only** of | **8** |
| Complete ban; enforced | 8 |
| Complete ban, but with closed, ventilated, designated smoking rooms (not areas or places); enforced | 6 |
| Meaningful restrictions; enforced (50% of bars and restaurants are smoke free) (see Table 3) | 4 |
| Legislative restrictions, but not enforced ( less than 50% of the bars and restaurants are smoke free) | 2 |
| Public transport and other public places – additive | **4** |
| Complete ban in trains without exceptions | 1 |
| Complete ban in other public transport without exceptions | 1 |
| Complete ban in educational, health, government and cultural places without exceptions, including prisons, hotel rooms, psychiatric units, residential care etc **OR** ban in most educational, health, government and cultural places | 2<br>1 |
| **Spending on public information campaigns** | **15** |
| Tobacco control spending per capita by the government in 2012, expressed in Power Purchasing Standards. A country which spends 2 euro per capita, based on the EU average GDP per capita expressed in PPP receives 15 points (see Table 3). | |

| **Comprehensive bans on advertising and promotion** | **13** |
|---|---|
| Points for each type of ban included – additive | |
| Complete ban on tobacco advertising on television and radio | 2 |
| Complete ban on outdoor advertising (eg. posters) | 2 |
| Complete ban on advertising in print media (eg. newspapers and magazines) | 1 ½ |
| Complete ban on indirect advertising (eg. cigarette branded clothes, watches, etc) | 1 |
| Ban on display of tobacco products at the point of sale | 2 |
| Ban on point of sale advertising | 1 |
| Ban on cinema advertising | 1 |
| Ban on sponsorship | 1 |
| Ban on internet advertising | ½ |
| Standardized cigarette packaging (only one standard form and size of cigarette pack) | 1 |
| **Large direct health warning labels** | **10** |
| Plain packaging (the removal of trademarks, logos, colours and graphics, except for the government health warning, and brand name presented in a standardized typeface) in combination with pictorial health warnings on the front and the back of the tobacco product package | **4** |
| Size of warning – **one only** of | **3** |
| 50% or less of packet | 1 |
| 51–79% of packet | 2 |
| 80% or more of packet | 3 |
| Pictorial health warnings – additive | **3** |
| Pictorial health warnings on cigarette packs | 2 |
| Pictorial health warning on hand rolling tobacco | 1 |
| **Treatment to help smokers stop** | **10** |
| Recording of smoking status in medical notes | **1** |
| Legal or financial incentive to record smoking status in all medical notes or patient files | 1 |
| Brief advice in primary care | **1** |
| Family doctors reimbursed for providing brief advice | 1 |
| Quitline | **2** |
| National quitline or quitlines in all major regions of country<br>**ADDITIONAL POINT FOR**<br>Quitline counselors answering at least 30 hours a week (not recorded messages) | 1<br>1 |
| Network of smoking cessation support and its reimbursement – **one only** of | **4** |
| Cessation support network covering whole country, free | 4 |
| Cessation support network but only in selected areas, e.g., major cities; free | 3 |
| Cessation support network covering whole country, partially or not free | 3 |
| Cessation support network but only in selected areas, e.g. major cities, partially or not free | 2 |
| Reimbursement of medications – **one only** of | **2** |
| Medications totally reimbursed or free to users **or**<br>Medications partially reimbursed | 2<br>1 |

## Table 3. Notes and explanations on the scoring of the TCS 2013

| **Price** |
|---|
| Gross Domestic Product per capita can be expressed in PPS (Purchasing Power Standard). PPS per capita has been used to take account of the real purchasing power in different countries. In the EU the GDP per capita expressed in PPP varies from 47 in Bulgaria to 75 in Greece, 120 in Belgium and 267 in Luxembourg. The EU average = 100. The country with a weighted average price of €8.50 a pack, based on the EU average PPP (100), receives 30 points. Belgium, for instance, would receive 30 points if the price of a pack was 8.5 x 1.20 = €10.20. In Bulgaria, if the price of a pack would be 8.5 x 0.47 = €4,00 |
| **Bans on smoking in public and work places with no exemptions and no smoking rooms** |
| Only total bans work well and comply with Article 8 of the WHO Framework Convention on Tobacco Control (FCTC) and Council Recommendation on Smoke Free environments of 30 November 2009 (2009/C 296/02) |
| **Smoking rooms**<br>A smoking room is a closed indoor premise with ceilings, floor and walls. Norms for smoking rooms may vary. In some countries, very strict conditions apply to smoking rooms (size, ventilation norms, closure of the doors, cleaning), which makes it almost impossible to build them (examples France, Italy and Finland). |
| **Meaningful restrictions: workplaces**<br>We have given points for "meaningful restrictions" but emphasise that this means that the legislation is imperfect, and thus is not encouraged. 'Meaningful restrictions: workplaces' means smoke free legislation that only applies to some regions of the country (eg. in federal countries like Germany and Switzerland), the legislation contains exceptions, or allows smoking in indoor premises which are not defined as closed (such as places and areas). 'Enforced meaningful restrictions' means that at least 50% of those who work indoors are never or almost never exposed to tobacco smoke at work. |
| **Meaningful restrictions: bars and restaurants**<br>'Meaningful restrictions: bars and restaurants' means for example that the smokefree legislation only applies to some regions of the country (eg. in federal countries like Germany and Switzerland), the legislation contains exceptions (such as bars, small size establishments or during specific hours) or allows smoking in indoor premises which are not defined as closed (such as places and areas). 'Enforced meaningful restrictions' means that at least 50% of the bars and restaurants are smoke free. |

| **Spending on public information campaigns** |
|---|
| Government funding at national level (for federal countries the sum of all |

funding by governments of the different regions, but **not** of the local communities) in 2012 for mass communication campaigns, tobacco control projects, educational programs, support for nongovernmental organizations. Tobacco control spending from sources other than the government, such as the private sector, is **not** included in our figure. Funding for tobacco dependence treatment (including reimbursement of medications and quitlines) and enforcement of legislation are **not** included in our figure. A country which spends 2 euro per capita on tobacco control, based on the EU average GDP per capita expressed in PPP, receives 15 points.

In the EU the GDP per capita expressed in PPP varies from 47 in Bulgaria to 75 in Greece, 120 in Belgium and 267 in Luxembourg. The EU average = 100. Belgium, for instance, would receive 15 points, if the spending was €2 x 1.20 = €2.40 per capita. In Bulgaria if the spending was €2 x 0.47 = €0.94 per capita.