APPENDIX O

Perspectives from Interviews with Tobacco Control Advocates in Asia, India, Bangladesh, and Brazil on Challenges and Opportunities in Tobacco Control for Women and Children

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Perspectives from Interviews with Tobacco Control Advocates in Asia, India, Bangladesh, and Brazil on Challenges and Opportunities in Tobacco Control for Women and Children

Overview of the Process

Interviews were conducted in October 2018 with key tobacco control advocates in Asia (Dr. Judith Mackay, Senior Advisor, Tobacco Control Policy, Advocacy and Communication at Vital Strategies), India (Dr. Mira Aghi, Behavioral Scientist, Communications Expert), Bangladesh (Farida Akhter, Executive Director UBING), and Brazil (Cristina Perez, Principal Investigator of ITC Brazil Project).

The key informants were provided with the following questions prior to the interview as a general guide to discussion topics of interest for the project.

1. How is the tobacco epidemic changing for women and children in your country/region?
   a. What are the trends in tobacco use among women and children?
   b. How are the products changing?
   c. What industry marketing tactics are used in your country to market tobacco products to women and children and how have marketing efforts evolved?
2. What progress has been made in implementing programs/policies to curb or prevent tobacco use among women and children?
3. What are the barriers/challenges to curbing the tobacco epidemic among women and children in your country/region?
4. What are the key priorities to address the needs of women and youth in tobacco control in your country?

Following each interview, a draft summary of the discussion was created based on notes taken during the interview. The draft summaries were sent to each key informant for review, revision, and sign-off.

Key Findings

The following key findings emerged from the interviews:

1. The participation of women at all levels of policy-making and implementation is a key strategy for preventing a tobacco epidemic among women, particularly in China, India, and Bangladesh where rates of smoking among women are currently low.
2. Efforts have been made to increase the participation of women in tobacco control conferences and to engage women in programs to empower them to quit tobacco use and to overcome power inequities to encourage smoke-free homes. However, more needs to be done to increase the prominence of women in policymaking, to increase the profile of discussions about gender in high-level meetings such as the WHO FCTC Conference of the Parties, and to provide supportive environments to enable women and their families to quit tobacco use.
3. High rates of smokeless tobacco use (SLT) among women in India and Bangladesh and the lack of effective policy strategies to curb its use is of great concern. For example, in Bangladesh there is a lack of awareness of regulations among law enforcing agencies and not enough provisions in the law to control the production, sale, and use of SLT. Compliance with graphic health warnings on SLT is low due to non-standardized packaging of zarda and gul and open leaf selling of sada pata. In addition, there is a

lack of cessation services and general lack of awareness of the health impacts of SLT use.

4. The high affordability of SLT products, especially zarda, sadapata and gul makes it easily accessible to people of lower income groups. Zarda packs are manufactured to be reusable, so that women purchase them once and refill them with small amounts of zarda, betel leaves, areca nut and lime. The zarda packs are decorated in the small shops in a very attractive way and those who buy small amounts are offered a combination of zardas.
5. Tobacco industry marketing directed towards enhancing the attractiveness of tobacco products to women and youth through flavours and packaging design continues to be an ongoing threat. The tobacco industry was described as “the best behavioral scientists” who meticulously look at what things are going to motivate women to use tobacco and then provide enabling environments to help them to pick it up. For example, in Bangladesh, zarda and gul have very attractive female names such as Shahzadi (Princess), Shobha (beautiful), shurovhi (fragrance, sweet smell) to attract women to the product. Natural and artificial flavors and perfumes are used as additives, as well as spices, molasses, cinnamon, menthol and other plant materials such as papaya, herbs, and saffron to increase product attractiveness.
6. In all countries, stronger implementation of the FCTC as called for in the Sustainable Development Goals provides great promise in guiding policy efforts to meet the needs of all populations. However, tobacco industry interference and lack of political commitment are major barriers to accelerating the implementation of strong FCTC policies that are needed to protect women and children from the harms of tobacco. Countries often lack the expertise to recognize and curb tobacco industry interference
7. Strong SLT control strategies are needed in India and Bangladesh focusing on regulation of the production (including prohibiting additives used to increase attractiveness and requiring health warnings on standardized packaging), supply, and sale of SLT, in combination with campaigns to increase awareness of the harms of SLT.
8. In Brazil, swift implementation of a ban on the display of cigarettes at point of sale, the menthol ban, a ban on flavor descriptors, and the implementation of plain and standardized packaging are urgently needed to prevent rising smoking prevalence among women and young adults.

Interview with Dr. Judith Mackay – October 6, 2018

Dr. Judith Mackay is an Edinburgh medical doctor, based in Hong Kong since 1967. She is Senior Policy Advisor to WHO, Senior Advisor to Vital Strategies / Bloomberg Initiative, and Director of the Asian Consultancy on Tobacco Control. Her particular interests are women and tobacco and tobacco in low- and middle-income countries. She has authored 12 health atlases. She has received many international awards, including WHO Commemorative Medal, TIME 100, and the BMJ Lifetime Achievement Award.

Acknowledging the unique vulnerabilities of women and children in the FCTC

Dr. Mackay has long recognized that women and children are particularly vulnerable to the threat of the tobacco industry. Twenty years ago, when the WHO Framework Convention on Tobacco Control was being developed, Dr. Mackay was openly critical of the idea of referring to women and children as a single group in the wording of the FCTC. She believed their needs to be quite different, especially in the policy domains of pack warnings and mass media programmes; smoke-free policies; assistance with cessation, and bans on tobacco advertising, promotion, and sponsorship. Even tobacco price policies impact differently upon women. Working through the female delegate from Vietnam on the FCTC negotiations, she was instrumental in guiding the wording of the Preamble of Convention which addresses the needs of women and children separately as follows:

> *Acknowledging* that there is clear scientific evidence that prenatal exposure to tobacco smoke causes adverse health and developmental conditions for children,
> *Deeply concerned* about the escalation in smoking and other forms of tobacco consumption by children and adolescents worldwide, particularly smoking at increasingly early ages,
>
> *Alarmed* by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies,

Preventing the tobacco epidemic among women in Asia — A major global primary prevention initiative

Smoking prevalence among women has increased in many high-income countries, but Dr. Mackay noted that Asia is extremely fortunate in that the prevalence of smoking among women is less than 5% (with the exception of chewing tobacco use among women in India). She and Sir Richard Peto predicted that smoking prevalence among Asian women would be as high as 15% by now, but it hasn't happened. The reasons for this are not clear. Dr. Mackay suggested that it may be due to traditional social morals or that women latched onto health education and promotion messages directed at boys and men. However, in the face of huge economic improvements and greater independence, and also being targeted by TAPS by the tobacco industry, women still largely have not taken up smoking. Perhaps they are more health conscious or sensible.

Dr. Mackay's concern is that if you look at data from the Global Youth Tobacco Survey (GYTS), there are indications that young people are increasingly taking up smoking. These trends are a warning that we can't be complacent. Preventing the tobacco epidemic among women in Asia is

the biggest global primary prevention initiative. The tobacco industry continues to target Asian women through Virginia Slims and other campaigns, pink packaging in Japan, slim pearly cigarettes, and cigarette giveaways.

Dr. Mackay noted “I could not find a single nurse smoking in Hong Kong in contrast to the higher rates in western countries.” In the Catholic Philippines, the tobacco industry has exploited religious themes through imagery of the religious Madonna on billboards in an attempt to attract new smokers.

Efforts to enhance the inclusion of women in tobacco control

Some countries have adopted campaigns urging women not to smoke for their children’s sake, while others promote anti-smoking messages solely or mostly directed towards among men. Increasingly, many reports and seminars have targeted the theme of tobacco and women to raise awareness of industry tactics. Dr. Mackay has strived to increase the inclusion of women in tobacco control policy development and leadership positions. Her participation on the organizing committee of the 10th World Conference in Beijing was on the condition that there be gender equity in the selection of conference chairs, speakers, and committees, including those from funded countries, particularly LMICs. Dr. Mackay has enshrined principles of gender equity in a manual of procedures that she has written to guide the organization of Asia Pacific Conferences on Tobacco or Health conferences and World Conferences on Tobacco or Health.

Barriers and opportunities for preventing and reducing the tobacco epidemic among women

Dr. Mackay noted that one of the biggest obstacles in mitigating tobacco-related risks for women and children is that health funding is still largely oriented towards curative medicine rather than prevention. Another barrier is that countries often lack familiarity and expertise in effective ways to tackle industry interference in public health.

Dr. Mackay’s view is that the FCTC and the Sustainable Development Goals provide great promise in guiding policy efforts to meet the needs of all populations. She concluded by identifying the following key strategies for preventing and reducing the tobacco epidemic among women:

- Increase the involvement of women in leadership positions in tobacco control policy development and implementation.
- Increase health promotion initiatives directed towards girls and women.
- Disaggregate the reporting of tobacco research data by males and females.
- Track tobacco industry activities (e.g. STOP project) aimed at stopping laws and targeting women through marketing, promotion, and sponsorship. For example, tobacco industry efforts to infiltrate and influence women’s groups.
- Offer women-specific cessation advice.
- Increase activities to enhance women’s empowerment such as basic interventions to enable women to ask men not to smoke in the home (e.g. Women’s Union initiative in Vietnam).

Interview with Dr. Mira Aghi - October 6, 2018

Dr. Mira B. Aghi is a behavioral scientist and communications expert whose outstanding work as a researcher, community health educator, professor, and advocate to prevent tobacco-related diseases has been honored by numerous awards, including the International Network of Women against Tobacco (INWAT) Tribute for Outstanding Service to Women in 2009 and the Luther Terry Award in 2012. She was also the first woman from Asia to receive the WHO Gold Medal. Dr. Aghi has expertise in the design and evaluation of communication and education interventions for behavioral changes with a special focus on issues of women, children, and tobacco. She obtained her PhD in Psychology from Loyola University, Chicago and has an Honorary Professorship in Behavioral Science from Universidad Del Salvador, Buenos Aires, Argentina. She is a Visiting Scientist, Harvard School of Public Health, Boston. Dr. Aghi has served as a consultant or advisor for numerous global health organizations, including WHO, International Union Against Tuberculosis and Lung Disease, IDRC, UNESCO, and UNICEF. She is a member of several task forces of the Framework Convention Alliance (FCA) and is a founding member of INWAT where she continues to serve on the board as South Asia representative.

Dr. Aghi has evolved her own theory of behavioral change which was thoroughly tested by two well-known UNICEF initiatives of which she was the Director of Research. One initiative was developed for the Girl Child of all the countries of South Asia, called Meena Communication Initiative. The second one, known as Sara Communication Initiative, was developed for the 23 countries of Eastern and Southern Africa. Numerous reports on the formative research conducted by Dr. Aghi in these countries illustrate the extensive time and commitment required to change behavior, especially among disadvantaged groups in society such as women, children, and communities in LMICs.

Dr. Aghi looks at cessation as a behavioral change process.

Dr. Aghi described the four key elements of a behavioral change approach to cessation. From the outset she emphasized that any intervention designed to change behavior must totally involve the individual seeking behavior change in the process. “My view is that the process is led by and totally driven by the person whose behavior is under the lens”, remarked Dr. Aghi.

The process has 4 distinct steps:

Step 1 is providing tobacco users with information to address knowledge gaps. It is important that they understand the rationale underlying why their behavior needs changing. The total involvement of the person will enable the counselor/interventionist to address barriers, beliefs, and misconceptions that she/he holds on tobacco use. Dr. Aghi cautioned that “information does not necessarily inform people. There is a complex process of converting information into knowledge that is needed to bring about changes in people’s behavior. Information takes on meaning and becomes knowledge only if it is relevant to the tobacco user, from a trusted source, and in a format that they can understand and internalize. It is of paramount importance that the person sees the benefits of the new behavior.”

Step 2 is increasing motivation to quit by building deep understanding and emotional involvement though information on expected gains, compelling statistics, sharing examples, and emotional stories and testimonials. Dr. Aghi noted that “Even if she understands the dangers of tobacco use, she has to be motivated to stay away from the root cause of the behavior. This will

happen when the knowledge conveyed to her has elements to increase her motivation to quit." She explained that motivation is closely linked to the nature and format of the material through which information is presented. Material is most effective when it is easy to understand, realistic, credible, interesting, practicable, educationally sound, not offensive to any segment of the population, and not harmful to anyone's sensibilities.

Step 3 is teaching skills/competencies to quit tobacco and to manage withdrawal symptoms through group discussion, role playing, storytelling, and writing. Dr. Aghi noted that "As nicotine addiction is known to be stronger than heroin, it requires specialized skills to deal with it." She has seen women who know about the dangers and who are motivated to quit, but still use tobacco because they don't have the skills and enabling environment to quit. "She needs help from a trained person—a concerned heath worker. Once this happens she will change", said Dr. Aghi."

Step 4 is encouraging supportive environments to facilitate and hasten quitting, including support from family and friends and strong tobacco control policies to curb triggers to smoking, including banning tobacco advertising and promotion and banning smoking in public places. Smokeless tobacco is a cause of a high incidence of oral cancer in India. Female tobacco users are more likely to use smokeless tobacco (18.4%) than smoked tobacco (2.9%) because of the social taboos against women to be seen smoking. Dr. Aghi believes that her behavioral approach to engaging smokeless tobacco users in a rigorous process of imparting knowledge, motivation, skills, and enabling environments is key to helping women and other tobacco users to quit.

She described an intervention which she developed and delivered involving small group counselling with women who used smokeless tobacco on a daily basis. The intervention consisted of an 11-day program beginning with a workshop around why people use tobacco, the harms of tobacco, sources of help if they want to quit, the barriers to quitting, the numerous strong triggers to tobacco use, what to expect as far as withdrawal symptoms are concerned, and how to manage these symptoms with home remedies including exercises and deep breathing and concentration.

Each session was approximately 35-50 minutes in length. For the first three days, Dr. Aghi met the women three times in a day, sometimes only for a few minutes, to discuss where they need help and strategies for facing problems and challenges encountered in quitting. Help was most needed after meals because they had been used to chewing after every meal. On the fourth day of the session, the women felt supported and empowered to reduce the frequency of Dr. Aghi's daily visits to only once in the early evening to report on their day, rather than the more frequent schedule that was initially requested by the group. For the next seven days, Dr. Aghi met with them only once each day. She was impressed with the growing improvements in their appearance and self-confidence. The women's trust in Dr. Aghi was exemplary as they shared the most intimate thoughts with her. They had engaged friends and family members in building supportive environments for quitting. Two follow up sessions were held on day 11 and after six weeks. On day 11, Dr. Aghi noticed that the women had improved their problem solving skills and developed supportive relationships with one another.

The most satisfying outcome of the intervention for Dr. Aghi was that almost all women in the group had started helping others to quit, including family members, through the formation of their own cessation groups. After six weeks, Dr. Aghi was thrilled to see that all but one of the participants had abstained from tobacco. She was very pleased that the woman who was unable to quit had indicated that she was motivated to try quitting again.

Dr. Aghi urges greater involvement of women in policymaking

Dr. Aghi concluded the interview with her perspective on barriers and the way forward to improve tobacco control for women. She identified the need to increase women's involvement in government policymaking. "It is important to involve and engage women in policymaking at each step, otherwise it won't impact them. The engagement process should not be done half-heartedly. The best way to do it is to trust other people such as NGOs to engage them and report. The reason why cessation is not as effective with women is because they do not understand the rationale for not using tobacco. Understanding the rationale is the first step in the direction of behavioral change. Ordinary women, as do ordinary men, need to be involved while policies are being made. Failing this, the policies are likely to be fractured and ineffective." Dr. Aghi added that whenever she talks about involving women in policymaking she is told that there are women in the government who sit on policymaking committees. "While this is true, they don't represent the women that we are worried about. Our focus is on the common woman who may not even go to school, or a woman who has never seen what happens to people who use tobacco, or women who use tobacco to curb hunger or postpone sleep. She has to understand the rationale for the policies and to do that you have to start with an understanding of what she already knows and how much more she needs to know."

Dr. Aghi described the tobacco industry as "the best behavioral scientists…they meticulously look at what things are going to motivate women to use tobacco and then provide enabling environments to help them to pick it up." "If we could put everything in place, even three of the four pillars, it is possible to change behavior by a small trigger of the fourth." She noted that the issue of gender and tobacco is not given the prominence it deserves. For example, at the Eighth Session of the Conference of the Parties, the governing body of the WHO Framework Convention on Tobacco Control just glossed over gender issues. "Gender issues were largely silent and lumped together with other issues such as alternative livelihoods", said Dr. Aghi.

Interview with Farida Akhter - October 19, 2018

Farida Akhter has a Masters in Economics and is the founding Executive Director at UBINIG (Policy Research for Development Alternative) established in 1984. UBINIG undertakes research, campaigns, advocacy and action programs in the field of social development, receiving awards from the Bangladesh Ministry of Health and Family Welfare in 2016 and 2017. Farida has participated in numerous studies on agriculture, women's issues, health, and other social development issues, with particular expertise in IDRC-funded research on the impact of tobacco cultivation and options for switching from tobacco to food crops in Bangladesh. She has been active in supporting tobacco farmers in Kushtia and Bandarban, the two major tobacco growing areas for alternative livelihood by providing training on alternative food production and marketing support. Farida has been assigned to draft the Tobacco Cultivation control policy as per requirement of the amended Tobacco Control Act, 2013. She is also the Convener of Alliance of Women in Tobacco Control, the Tamak Birodhi Nari Jote (TABINAJ) – the first anti-tobacco alliance of women in Bangladesh whose mission is to save women, men, and children from the hazards of tobacco. The Alliance is against smoking and use of smokeless tobacco (SLT) products which are mostly consumed by women. She has been vocal against the use of women and child labor in tobacco cultivation as well as in the hazardous biri industry. Tabinaj member organizations are working in over 64 districts of Bangladesh.

Trends in tobacco use among women and children

Farida explained that tobacco use is high in Bangladesh in both smoked and smokeless forms. She provided data to illustrate the extent of tobacco use in the country and gender differences in tobacco product use:

- Prevalence of tobacco use among adult women is 25.2% compared to 46% of adult males. Overall, 35.3% are tobacco users (37.8 million adults) according to the latest Global Adult Tobacco Survey, 2017.
- Prevalence of smoked tobacco use is 18% (19.2 million adults), with higher prevalence among men (36.2%) compared to women (0.8%).
- Prevalence of SLT use is 20.6% (22.0 million adults). 18.7% use betel quid with tobacco, 3.6% use gul. SLT use is higher among women (24.8%) and lower (16.2%) among men.

Farida expressed great concern about the use of SLT in Bangladesh and the weakness of current policies. "Over 10 million women consume zarda, sadapata and gul without any regulations on their use. Considering the threat that SLT use can pose to public health, it is of critical importance to identify and promote methods for reducing the use of SLT."
Farida explained that while tobacco use has decreased significantly overall from 43.3% (GATS, 2009) to 35.3% (GATS, 2017), the decrease among women is quite small — from 28.7% (GATS, 2009) to 25.2% (GATS, 2017). This is mostly due to higher use of SLT among women (24.8%) resulting from weak policy measures and strategies for controlling SLT use. She noted that "although there is increasing concern over high use of SLT and its related health effects on users, there is a lack of awareness among law enforcing agencies and not enough provisions in the law to control the production, sale, and use of SLT, particularly zarda, gul and sadapata which are incorporated in the law. For example, the provision in the law for graphic health warnings on SLT is constrained by non-standardized packaging of zarda and gul and open leaf selling of sada pata. In addition, there is a lack of cessation services and general lack of awareness of the health impacts of SLT use."

Farida noted that there is very little information available on trends in consumption of tobacco among children. However, smoking is often seen among children in the slums, street children, and others. The law only prohibits sales to and from minors. But children sell cigarettes and betel quid as vendors and can be seen consuming these products.

Smokeless tobacco products

Farida observed that since there are few female smokers, and those who do smoke are mostly in the cities, the products do not seem to be changing very much. However, female students from the private universities are smoking and fall prey to tobacco industry tactics. Use of e-cigarettes and sheesha are also found among the elite class young girls.
Tabinaj members have collected field data on production and use of SLT to address the information gaps. The SLT that are 'popularly' used in Bangladesh are betel quid (zarda, sada pata) and gul. Zarda is chewed with betel leaf, lime, and areca nut and have ingredients of tobacco and other additive spices; sadapata is the sun-dried or cured raw tobacco leaf. Gul is applied to teeth and gum and has tobacco powder and molasses. Other products such as Khoinee which are kept in the mouth between lips and gum and has tobacco, slaked lime, menthol, flavorings etc.

The SLT products are changing in other forms such as paan masala (without naming presence of tobacco), and other attractive, flavored and colored betel quids.
"Paan khaoya" or consumption of betel leaf with zarda and sadapata is not seen as a social nuisance or a bad manner. One can offer paan to guests, relatives, family members except to very young children. To have a "paan dani" – a designated pot of paan, zarda and sadapata is common in many households. Poor people find it very attractive to offer paan to any visitor, guests and relatives as they cannot offer tea or any snacks. But at the personal level, the consumption becomes a habit and addiction.

In the case of SLT, the industry targets users from the poorer section of society using price and the packaging. The price of SLT products, especially zarda, sadapata and gul is very low making it easily affordable to people of lower income groups. Graph health warnings (GHW) about the harms of tobacco products are mandatory on the packets, but compliance is low, particularly on zarda and gul packets due to different shapes and type of packets. One study showed that 76% of the SLT products have GHW, out of which 44% did not follow the requirement of the Law.

Addictive and harmful to health

Farida noted that all tobacco products are inherently harmful, including SLT, which contain over 2000 chemical compounds, including nicotine. There are 49,000 oral cancer, 71,000 pharynx and laryngeal cancer and 196,000 lung cancer cases in Bangladesh; out of which 3.6% of the admissions in medical college hospitals are due to cancers of oral cavity, larynx, and lung.
SLT may also cause heart disease by acutely elevating blood pressure and contributing to chronic hypertension. Associations between SLT use and fatal myocardial infarction and stroke are also found.

SLT users have very high levels of cotinine (380ng/ml [GSD:2]) compared to cigarette smokers. High cotinine concentration among SLT users and increased prevalence of SLT use in Bangladesh indicate that SLT products are highly addictive and ST users need adequate support to give up this behavior.

Other reported health problems include reproductive health problems with pregnant women delivering low weight babies and still birth etc.

The sellers and users are aware of the health impacts of cigarettes and bidi, but they know little about the harms of zarda and gul.

Marketing strategies

Zarda and gul have very attractive female names such as Shahzadi (Princess), Shobha (beautiful), shurovhi (fragrance, sweet smell) so that women are attracted to the product. Since the big zarda packs are expensive to purchase, the companies make the packs re-usable, so that women purchase it once and reuse it with small amounts of zarda, betel leaves, areca nut and lime. The zarda packs are decorated in the small shops in a very attractive way and those who buy small amounts are offered a combination of zardas.

Tobacco is the main ingredient in the SLT product. But other ingredients are added for attractiveness such as natural and artificial flavors and added perfume, natural and synthetic flavor, natural perfume; for additives over tobacco such as spices, molasses, cinnamon, menthol, saccharine, glucose, glycerine, vegetable oil, Gum Arabic, Mrigonavi (Musk). Even non-tobacco plant materials such as papaya, herbs, joyfal, jostimodhu and saffron are used. In addition, food colors are used. The ingredients are listed on the zarda packs in very small print so that they are rarely noticed by users. Most of the users are also illiterate or have low education levels.

Unregulated production of zarda and gul

The production of zarda and gul is a very unregulated and unorganized sector, mostly found as household production units, small factories without any signs and are not registered with government revenue authorities. Therefore very little information is available on actual production quantities, amount sold in the market through wholesale and retail market, and amount used by consumers. Information on the production and processing of Sadapata is even scarce. In a Tabinaj study conducted in 2013, 123 zarda factories and 23 gul factories were found in 38 districts in 8 divisions.

Progress in implementing the tobacco control law with regard to SLT

The Smoking and Tobacco Products Usage (Control) Act, 2005 (Amendment 2013) is the main basis of tobacco control in Bangladesh that includes pack warnings, advertising bans, taxes, and smoke-free zones. However, the law is limited in its application to controlling smokeless tobacco (SLT) although the number of users of SLT far exceeds smokers. The amendment of 2013 included zarda, gul and sadapata in the definition of tobacco products, which are the three most used products in Bangladesh. But the Rules for implementation are still not adequate to control use of SLT. Moreover, the production and sale of these products have also remained unregulated.

Barriers to curbing the tobacco epidemic among women and children in Bangladesh

Farida explained that the main barrier to curbing the tobacco epidemic is the widespread social acceptance of tobacco use, as well as the lack of awareness that SLT use is as harmful as smoking. The health effects of tobacco use are not discussed by women. However, dentists and the gynecologists have started discussing it with their patients. Secondly, the companies

producing SLT are also producing cigarettes/bidis and paying high taxes to the government. “The government offers awards to SLT companies for high revenue contributions. So for the government it is soft on the implementation of the law against the companies. Industry interference is very much there at the National Board of Revenue”, Farida explained.

Key priorities to address the needs of women and youth in tobacco control in Bangladesh

Farida noted that Bangladesh is the only country in the region followed by Bhutan which has higher use of SLT among women. Thailand has a very low rate of SLT use, however more use among women (5.2%) than men (1.1%). “The need for stronger regulation is even greater to reduce SLT consumption for the sake of saving women from tobacco-related health hazards”, remarked Farida.

Farida believes that further amendments are needed to strengthen the Tobacco Control Law in order to achieve the goal of a Tobacco-Free Bangladesh. In her view, the key priorities are control of production and sale and taking effective social and economic measures to curb the use of SLT. She explained that Tabinaj is actively lobbying at the grass-roots level, as well as at the national level for Amendment of the Tobacco Control Law to strengthen the effectiveness of its implementation. A Smokeless Tobacco (Control) Strategy Paper has been drafted with participation of the National Tobacco Control Cell under the Ministry of Health & Family Welfare.

Farida shared the key recommendations of the strategy paper:

1. **Regulation of Production**
   - Impose a limit on the number of produces and quantity of production of SLT products
   - License the production of SLT in order to regulate the production
   - Limit mixing/use of tobacco in other products such as betel leaf/betel nut (as per FCTC Article 9 & 10)
2. **Hygienic manufacturing practice (HMP)**
   - Make Hygienic Manufacturing Practice (HMP) mandatory in the factory/production sites
3. **Prohibit use of child labor in production**
4. **Prohibit use of sweet substances/spice/fragrant/addictive materials/color etc.**
   - Regulate the ingredients in all tobacco products to reduce consumers’ attraction to SLT
5. **Packaging (Standardardized packaging) restrictions**
   - Set the minimum pack-size and the dimension of the packets so that the pictorial warning can be visibly placed.
   - Determine the minimum weight of SLT products so that it is not readily available to consumers. The selling of SLT in loose quantities should be discouraged.
   - Prohit the packaging and marketing in polythene and sachet packets
6. **Regulation of supply, sale and consumption**
   - Regulate the number of tobacco product sellers/dealers and require licensing. In specific areas, sales should be limited to market areas
   - Prohibit hawker or mobile vendors from selling SLT products
   - Prohibit the display/sale/use of SLT in public places
   - Prohibit and strictly enforce selling/buying to and from under-aged persons by showing of voter ID card with cancellation of seller’s license as the penalty for violation

7. **Require mandatory pictorial health warnings and warnings on potentially harmful effects, disclosure of production and expiry dates and ingredients on the packet of tobacco products**
8. **Public awareness program**
    - Implement government mass media public awareness campaigns on the harms of SLT
    - Engage media/educational institutions/religious institutions/training institutes/civil society/NGOs in the development and deployment of the campaigns
9. **Banning usage of tobacco products in phases**
    - Ban the use of tobacco products in phases in consideration of protecting public health

Interview with Cristina Pérez – October 5, 2018

Cristina Pérez is a psychologist with a master's degree in public health from Fundação Oswaldo Cruz. At the National Cancer Institute, she was responsible for the Nicotine Dependence Studies Center, the Quitline, and coordination and development of the third round of Brazilian health warnings. She is the principal investigator of the International Tobacco Control Policy Evaluation Project (ITC Project) in Brazil — one of 29 countries measuring the impact of key policies of the World Health Organization Framework Convention on Tobacco Control, coordinated by the University of Waterloo in Canada.

Smoking prevalence has declined in Brazil

Ms. Pérez indicated that according to 2013 data from the Global Adult Tobacco Survey, which was included as part of the National Health Survey (PNS), the prevalence of current smoking in Brazil is 18.9% among males and 11.0% among females. Smoking prevalence rates have decreased considerably over time (between 2008 and 2013) among both males and females. However, for both genders, the proportions of heavy smokers among current daily smokers has stayed the same across all sociodemographic groups.

Cigarette packaging is attractive to young Brazilian women

Ms. Pérez noted that it is well known that the tobacco industry designs cigarettes and packaging to attract youth smokers. Studies in Brazil show that flavors, including menthol, play a role in attracting youth to become regular smokers. Females, in particular, perceive “slim” packs and “lipstick” size pack as being more attractive and less harmful than standard packs. “We have conducted experimental studies to assess how flavor descriptors and product packaging are perceived by young Brazilian women and we find that cigarette brands featuring tobacco flavors are perceived more favorably” remarked Ms. Pérez. “Slim packs are also rated more favorably and less harmful than standard-sized packs. The findings are important because they suggest that laws to ban the display of cigarettes at point of sale, to ban menthol cigarettes (delayed as a result of legal action) and flavor descriptors and to implement plain and standardized packaging are urgently needed in Brazil to prevent tobacco use among youth and young adults, particularly women.”

New restrictions on tobacco marketing at point of sale

Ms. Pérez indicated that some progress has been made to curb the marketing of tobacco products to young people in retail stores. A new resolution (RDC 213 of January 23, 2018) by the Brazil National Health Surveillance Agency (ANVISA) bans the use of illuminated product displays with features such as sound and movement effective May 25, 3018. Product displays can only contain the product itself and pictorial health warnings with text warnings about the toxic constituents of tobacco smoke (benzene, nicotine, carbon monoxide, etc.) and a message prohibiting the sale of tobacco products to people under age 18 years. The pictorial warnings should appear in the centre of each of the faces of the display that are visible to the public (effective May 25, 2019). The resolution also bans the display of tobacco products near candy, chewing gum, chocolate, ice cream, and toys to restrict visibility by children and adolescents (effective May 25, 2020)

Barriers to progress on tobacco control

Ms. Perez noted that the biggest barrier to implementing policies to protect women and youth from tobacco is relentless industry lobbying across the full chain from associations of the tobacco industry, tobacco producers, local parliamentarians of municipalities of tobacco growers, and media/journalists of tobacco growing regions. In addition, political corruption delays policy decisions on tobacco. The tobacco industry continues to argue that tobacco control policies have increased illicit trade and that new policies will further increase illicit trade and lead to negative impacts on the economy, even though the evidence suggests otherwise.

Ms. Perez noted that the policy priorities to address the needs of women and youth in Brazil are to put into practice the ANVISA resolution to restrict marketing of tobacco products at point of sale and to implement plain/standardized packaging.