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The Impact of Cultural Pressures on Tobacco Harm Reduction Efforts in Southeast Asia

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To improve global health and reduce smoking-related deaths, it is important that we go beyond the World Health Organization's Framework Convention on Tobacco Control and focus on incorporating tailored tobacco harm reduction approaches into tobacco policy.

Introduction

More than 8 million people die each year as the result of diseases associated with the overuse of combustible tobacco products, with the majority (80 percent) of deaths coming from lower- or middle-income regions of the world.[1] In Southeast Asia alone, which is one of the largest areas of tobacco production and consumption, approximately 1.6 million lives are lost to smoking-related disease each year.[2]

Tobacco harm reduction (THR) is a strategy that encourages those who choose not to quit or who are unable to quit smoking combustible cigarettes to use alternatives such as electronic nicotine delivery systems (ENDS), heat-not-burn (HnB) tobacco products and smokeless tobacco products.[3] While not risk-free, these products have been shown to convey notably less risk (up to 95 percent less) than traditional combustible products, and THR experts believe that increasing access to and acceptance of these products could help mitigate the death and disease burden associated with cigarette smoking.[4]

8,000,000+

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Many countries have adopted these types of programs successfully.[5] In Sweden, for example, a combination of tobacco control approaches, education and a culturally accepted smoking replacement (snus—an oral tobacco product), have helped decrease smoking rates from over 20 percent in 2000 to less than 6 percent in 2021.[6] Just this past year, the United Kingdom announced that it would be offering vaping starter kits to more than 1 million smokers to remove the cost barrier of switching to a lower-risk product and to help facilitate a complete transition from combustible cigarettes to reduced-risk e-cigarettes.[7] In Japan, smoking rates dropped from 33 percent in 2000 to 20 percent in 2020, which some experts attribute to higher taxes, public smoking bans and the introduction of reduced-risk cigarette replacements such as HnB tobacco products.[8] Importantly, the common thread among these approaches is that policymakers designed tobacco control and THR efforts to align with the values and preferences of their communities.

The World Health Organization (WHO) has also made efforts to reduce the tobacco-related disease and death burden.[9] The organization's Framework Convention on

Tobacco Control (FCTC) was formed in 2005 and is primarily aimed at reducing the use of tobacco products. Thus far, 181 countries have signed this treaty, including many countries in the Southeast Asia region.[10] Unfortunately, the FCTC's efforts fall short because they attempt to apply universal tobacco control strategies to all countries and do not include THR strategies. The primary tools that the FCTC promotes globally include price increases (through taxes and other price-control measures), bans on tobacco-related communication (advertising, promotion, etc.), mandates for smoke-free spaces, requirements to include health warnings on packaging and attempts to interrupt illicit trade activities.[11]

In the Southeast Asian region of the world, the measures that the FCTC promotes fail to align with individual countries' needs, as seen in the tobacco landscape reviews of India, the Philippines and Indonesia.

These efforts are not enough. This becomes especially apparent when looking at the Southeast Asian region of the world, where the measures that the FCTC promotes fail to align with individual countries' needs—in large part because of the way tobacco is tied to that region's political, cultural and financial circumstances.[12]

To illustrate this point, we sought to evaluate the tobacco landscape in the Southeast Asian region of the world, focusing on three different countries where tobacco is a key aspect of the culture and economy: India, the Philippines and Indonesia. These three countries are particularly relevant in this assessment, as they are major producers and/or consumers of tobacco products and, interestingly, represent three distinct levels of involvement in FCTC tobacco control efforts: full adoption (India), partial adoption (The Philippines) and little/no adoption (Indonesia). For each of these countries, we review their tobacco production/use, tobacco control approaches (dictated in varying degrees by the FCTC) and implementation of THR strategies to illustrate the variety of culturally sensitive THR approaches being employed and how they influence public perception and health. As a result of this review, we conclude that a single approach to tobacco control and THR policy does not seem to yield the most effective outcomes for all countries. Instead, individualized, country- and culture-specific approaches, built on key principles of THR, are needed.

FCTC Involvement:
Full Adoption

India

Tobacco Production and Use

Currently, India is the second-leading tobacco-producing nation in the world, yielding nearly 750 million kilograms of leaf per year, and the second-largest exporter of tobacco and tobacco products.[13] The Indian tobacco industry employs approximately 46 million people and generates nearly $842 million (USD) in revenue.[14]

The majority (63 percent) of the tobacco grown in India is used within the country itself.[15] It is estimated that nearly 27 percent of the Indian population uses traditional tobacco products, and the main consumers of these products are males in rural and lower-income regions.[16] The preferred tobacco products for this subpopulation are combustible products such as cigarettes and bidis (thin, hand-rolled cigarettes that contain three to five times as much nicotine as regular cigarettes).[17] Of note, bidis are often either manufactured by small companies or produced in the home and therefore tend to be unaffected by typical tobacco control initiatives.[18] Indian women typically use oral tobacco products that include betel leaf and areca nuts, which are known carcinogens. It is important to highlight the fact that tobacco products have the highest rate of use in rural areas and among individuals with lower levels of education, and these are also the subpopulations that have the poorest access to health care services and tobacco cessation products.[19] As a result, more than 1 million people are estimated to die each year from tobacco-related diseases in India.[20]

Tobacco Control

India joined the FCTC in 2005, implementing tobacco control policies nationwide.[21] The primary tobacco control initiatives included banning smoking in public and work spaces, prohibiting most forms of advertisement, requiring that products include health warnings

and imposing taxes on products—though the excise and value-added taxes imposed have had little impact on the price-per-pack in India.[22] Importantly, as legal sales have decreased, the illicit trade market has increased—India's illicit market is now estimated to be the fourth-largest in the world.[23] Additionally, although cigarettes are taxed, other tobacco-based products such as bidis generally are not, as most unbranded or self-rolled products are not included in the regulatory oversight.[24]

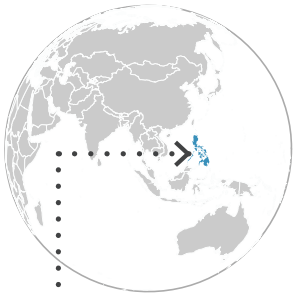
Another issue that complicates the implementation of tobacco control mechanisms in India is that the government profits from tobacco sales.[25] ITC is the largest tobacco company in India, with a market value of over $60 billion (USD). The Indian government is the second largest shareholder of ITC, with government-run insurance funds owning nearly 25 percent of the company's shares. The Specified Undertaking of Unit Trust of India (SUUTI), the group that manages the government's ITC investment, has made some effort to divest from ITC, but the process is not moving at a rate that aligns with the importance of resolving the issue.[26] This relationship between the Indian government and tobacco manufacturers has generated significant conflicts of interest within the country and violates the WHO-FCTC treaty.

Tobacco Harm Reduction

India also has unique challenges associated with implementing THR. Recently, the country banned the sale of reduced-risk products, including ENDS and HnB, as well as modern oral products. Although interested consumers can still find such products through online sources, they risk hefty fines and imprisonment if caught using them.[27] In addition, because India's THR policies are weak and the country only has FCTC-defined tobacco control policies in place, there has been little to no improvement in the rates of smoking-related disease and death over the past 20 years.[28] As a result, harm reduction advocates in India are speaking out, calling for the implementation of evidence-based approaches to address this public health challenge, including modifying current laws to legalize reduced-risk products.[29]

The Philippines

Tobacco Production and Use



FCTC Involvement:
Partial Adoption

Although the tobacco industry in the Philippines is relatively small compared to India, it is the third-largest producer in Southeast Asia.[30] In 2020, exports generated nearly $189 million (USD) in revenue and accounted for 6 percent of tax revenue and 58 percent of sin tax revenue (additional taxes placed on tobacco and alcohol products).[31] The National Tobacco Administration of the Philippines reported that over 40,000 farmers grew tobacco from 2019 to 2020.[32] Until recently, the number of tobacco farmers (and farms) had been declining, but higher demands for export and modernized farming approaches have boosted production.[33] Because of this, fewer tobacco farmers are required to obtain the tobacco yields set by the market, so the government has developed programs to help support tobacco farmers who wish to transition to other crops or alternative employment opportunities.[34]

In 2020, it was estimated that over 22.9 percent of the Philippine population used tobacco products, primarily combustible cigarettes.[35] Males used tobacco at notably higher rates than women (34.7 vs 4.2 percent, respectively), and the majority used combustible cigarettes daily.[36] The use of tobacco products is a leading health risk factor in the Philippines and accounts for $858 million (USD) tobacco-related health costs annually.[37] Smoking-related diseases such as ischemic heart disease and cancer are two of the top-three causes of death in the Philippines, accounting for 28 percent of the deaths in the country in 2022.[38]

Tobacco Control

The Philippines also signed on to the FCTC treaty in 2005 but took a different approach than India by implementing policies that better aligned with their population's specific needs and challenges. At that time, roughly 31.6 percent of the population smoked, and this percentage was predicted to rise.[39] In 2012, the Sin Tax Reform Act introduced additional taxes on tobacco, which immediately imposed a four-fold increase on the excise tax for tobacco that increased each year.[40] The additional revenue generated by this tax partially provided the funds to support the country's universal health insurance. A portion of those funds are also earmarked to help train tobacco farmers for other economic opportunities beyond tobacco.[41] The legislation has led to a nearly 78 percent increase in the costs of cigarettes in the Philippines.[42] This, in turn, has led to reduced smoking rates, from 28.3 percent in 2009, to 22.7 percent in 2015 to 19.5 percent in 2022.[43] Still, this progress came at a price, with illicit trade increasing from an estimated level of under 5 percent in 2013 to 16 percent in 2018 in low-income populations of the country.[44]

Tobacco Harm Reduction

In 2022, the Philippines government passed the Vaporized Nicotine and Non-Nicotine Products Regulation Act into law.[45] The law allows for the regulation of ENDS and other reduced-risks products in a manner that protects the health of Filipino adults and youth. Along with this law, the Bureau of Internal Revenue increased the cost of cigarettes and decreased the price of ENDS products—a practice known as risk-proportionate legislation.[46] The Filipino population has access to several forms of reduced-risk nicotine products, including ENDS (the most prevalent), heated tobacco and snus.[47] A combination of education, combustible tobacco taxation and increased accessibility of reduced-risk products provides an environment for change that can work for the Filipino population and improve health significantly, though it will take some time for the impact of these measures to be realized.[48]

Indonesia

Tobacco Production and Use

Indonesia is one of the world's largest producers of tobacco, but it also imports a significant amount of tobacco to meet the country's high demand, as it has one of the highest smoking rates in the world. In 2016, it was estimated that 39.5 percent of the country's population smoked—a rate that persisted for several years. Data also suggests that smoking rates have increased among males over the past two decades, from 56.2 percent in 2000 to 71 percent in 2020 (smoking rates among women have remained low and were estimated to be 4% in 2020).[49]

FCTC Involvement:
Little/No Adoption

The primary form of tobacco consumption in Indonesia is manufactured and hand-rolled kretek cigarettes, which are filterless tobacco cigarettes flavored with clove buds. Kretek cigarettes have higher tar levels than regular cigarettes and include additional ingredients that generate similarly harmful health outcomes.[50] The kretek industry is Indonesia's largest nongovernment employer, providing jobs for an estimated 17 million people.[51]

Tobacco Control

Indonesia has not signed onto the FCTC treaty, opting for a more independent approach. In 2018, the Indonesian government increased excise taxes (in a complicated manner to help balance the burden across the population) and enacted several laws similar to what the FCTC recommends without going quite as far.[52] For example, tobacco products are still advertised, but with certain restrictions (e.g., time, location, benign product descriptions). Pictorial labeling, health warnings and ingredient listings are required, and

some public areas have been designated as smoke-free locations.[53] Cigarettes are taxed, but at a lower rate than in most other countries, funding several vital state-controlled initiatives while keeping the cost of cigarettes comparatively low for the region.[54]

Tobacco Harm Reduction

ENDS and other reduced-risk products have been available in Indonesia since 2010 and are easy to obtain, but they are taxed at a higher rate than cigarettes, making them a less compelling alternative to traditional cigarettes in the country.[55] Additionally, the Indonesian government has recently announced a potential ban on ENDS products (though no action has yet been taken).[56]

One of Indonesia's largest challenges to THR is cultural perspectives regarding smoking. Smoking is rooted in male Indonesian cultural traditions, from medical practices like circumcision rituals to signaling maturity into adulthood and bravery.[57] These cultural norms are likely a key reason that Indonesian men, in particular, often dismiss health-related smoking-cessation messaging, commonly ignoring smoke-free zones and stigmatizing nonsmokers.[58] There is also little enforcement of current tobacco control initiatives and a growing illicit tobacco industry.[59]

Conclusion

India, The Philippines and Indonesia each take different approaches to tobacco control and THR to reduce the long-term effects of smoking-related disease and death among their populations. In surveying the policies and programs these countries have implemented, it is clear that there is no one-size-fits-all approach to such endeavors. Each country has unique cultural and historical practices that must be taken into account to meet the needs of citizens where they are and to allow for governmental negotiation of political and social pressures. There are, however, three broad strategies that can form the framework for culture-specific tobacco control and THR efforts in these (and other) countries to help lower smoking rates and improve health outcomes:

- Provide clear education on the negative consequences of smoking and how it affects local communities, taking socioeconomic and cultural norms into consideration.
- Make access to cigarettes and other more harmful tobacco products more difficult (e.g., implement excise taxes), and manage attempts to circumvent tobacco control actions (e.g., reducing access to illicitly sold tobacco products).
- Offer a wide variety of safer nicotine products (e.g., ENDS, HnB, snus), and make them readily available at a lower cost than cigarettes.

To improve global health and reduce smoking-related deaths, it is important that we go beyond the FCTC's focus on universal tobacco control measures, such as price increases, strategic taxation, illicit trade reduction and advertising restrictions, and instead focus on incorporating tailored THR approaches into tobacco policy. In fact, if the FCTC would institute policies that allow adult smokers access to affordable, reduced-risk nicotine products, millions of lives could be saved, and public health outcomes could be improved across the globe.

It is clear that there is no one-size-fits-all approach. There are, however, three broad strategies that can form the framework for culture-specific tobacco control and THR efforts to help lower smoking rates and improve health outcomes.

About the Author

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