



IDENTIFYING THE LAST MILE: WHO IS STILL SMOKING?

Sri Lanka has seen impressive falls in smoking rates, from a male prevalence rate of 40.5% in 2005 to 28.4% in 2018. However, these percentages are higher within certain groups of the population, and tobacco continues to cause high rates of harm. The challenge for Sri Lanka is now to “go the last mile”: to sustain political commitment to tobacco control and to implement effective new policies which cut smoking rates further and keep the prevalence rate below 10%.

Smoking comes with high health, social, economic, and environmental costs. Tobacco kills more than eight million people a year, around the world, and is currently the world's single biggest cause of preventable death.¹ Every year, more than 12,300 Sri Lankans are killed by tobacco-related diseases.² Smoking tobacco exposes users to a lethal mixture of more than 7,000 toxic chemicals, including at least 69 known carcinogens.³ Health impacts of tobacco begin even before birth; pregnant women who smoke give birth to infants who are at a higher risk of congenital disorders, cancer, lung diseases, and sudden death. Other than the most common health consequences of smoking such as cancer and respiratory problems, newly identified risks like renal failure, intestinal ischemia, and hypertensive heart disease place critical health risks on smokers.

There is also a significant economic cost of smoking at every level (individual, household, country, and globally). In Sri Lanka, a smoker spent on average, Rs. 3, 000 a month on smoking in 2018.^{4,5} The total cost of tobacco in Sri Lanka was estimated to be Rs. 89.37 billion (US\$ 662 million) which accounted for 3.9 % of the total government expenditure in 2015.^{6,7} This includes direct health care costs and indirect costs related to loss of productivity due to early mortality and morbidity.

Meanwhile, the adverse environmental impacts are evident at every stage of the tobacco smoking life cycle – growing, manufacturing, distribution and consumption. Deforestation at the growing stage, greenhouse gas emission at the manufacturing

and distribution stages, toxic residue from tobacco smoke lingering in the environment and cigarette butts and toxic third-hand smoke (THS) materials polluting environment at the consumption stage are a few examples.

Socially, smoking hurts an individual's network of family and friends, as smokers expose those around them to secondhand smoke, putting their lives in danger

The policy context

By becoming a party to the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) on 27 February 2005, Sri Lanka committed to reduce its tobacco consumption. Over the years, Sri Lanka has taken price and tax as well as non-price measures to reduce the demand for tobacco. The National Authority on Tobacco and Alcohol (NATA) Act, which was passed in 2006, is the law governing tobacco control in Sri Lanka. It includes restrictions on smoking in public places, packaging and labeling requirements, regulations pertaining tobacco advertising, promotion and sponsorship, the establishment of the NATA, and penalties for offenses. The Act also authorises the Minister of Health to issue regulations in respect of any matter required by the Act. Crucial amendments to the Act were brought in 2012 (August and November), 2013, 2014, and 2015. In 2016, the Minister of Health issued regulations prohibiting the manufacture, importation, and sale of smokeless tobacco products, e-cigarettes containing tobacco, and cigarettes that are flavored, colored, or sweetened.

Data Sources

Given lack of comprehensive data on tobacco consumption, we analyze data from a variety of sources using descriptive methods, to identify current smokers. The data sources used include: Tobacco Use Spot Surveys by Alcohol and Drug Information Centre Sri Lanka (ADIC), Global Youth Tobacco Survey (GYTS) – NATA (2015) (GYTS-NATA 2015), STEP Survey- WHO/ Ministry of Health (2015) (WHO STEP 2015), Demographic and

¹ World Health Organization (2019) Tobacco Key Facts <https://www.who.int/news-room/fact-sheets/detail/tobacco>

² The Tobacco Atlas Country Sri Lanka (2019) <https://tobaccoatlas.org/country/sri-lanka/>

³ Tobacco use includes use of both smoked (cigarette, bidi, cigars, pipes) and smokeless (chewing tobacco, betel with tobacco, babul, snuff).

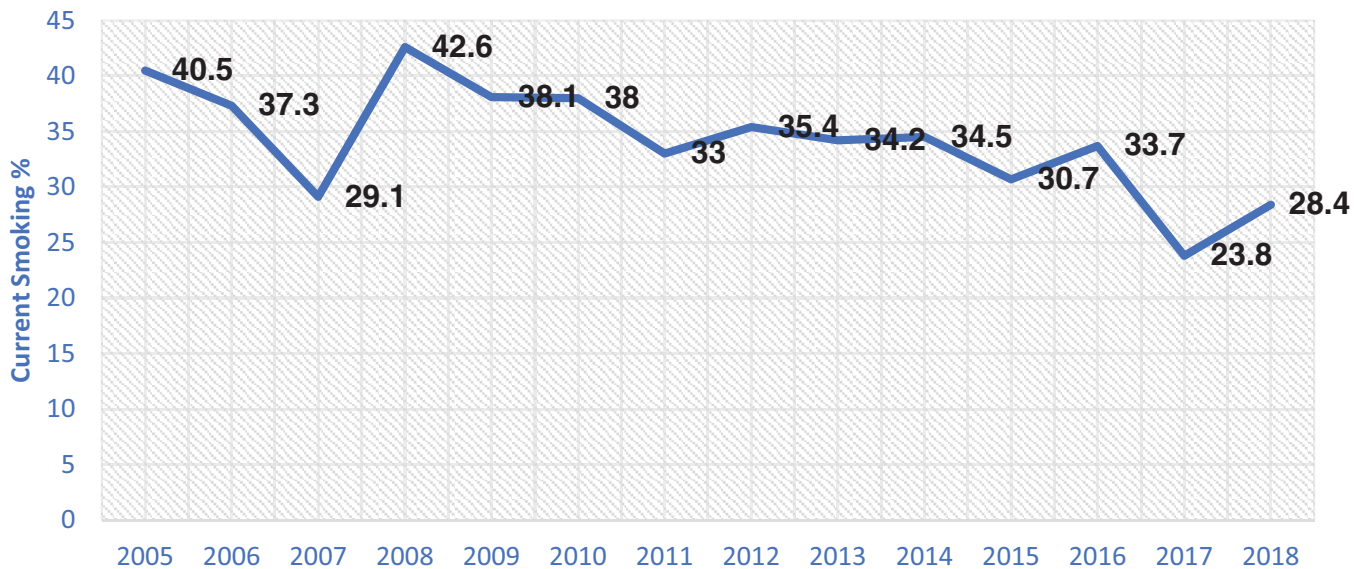
⁴ World Health Organization (2019) Tobacco Key Facts <https://www.who.int/news-room/fact-sheets/detail/tobacco>

⁵ Alcohol and Drug Information Centre (2019), Annual Trend Survey on Tobacco Smoking in Sri Lanka, ADIC, Colombo
Expenditure is for all types of smoking tobacco products.

⁶ World Health Organization, (2017), Economic and Social Costs of Tobacco and Alcohol in Sri Lanka 2015. Sri Lanka, World Health Organization

⁷ Ministry of Finance (2017), Data and Statistics Published by Ministry of Finance, <http://www.treasury.gov.lk/data-statistics-published-by-ministry-of-finance>

Figure 1: Smoking prevalence trend (2005-2018)



Source: ADIC 2017/2018

Health Survey – Department of Census and Statistics- DCS (2016) (DHS 2016), Annual Health Bulletins – Ministry of Health, (AHB), National Oral Health Survey – Ministry of Health 2015-16 (NOHS 2015-16), Self-reported Health Survey –DCS (2014) (SRHEALTH 2014), Global School-based Student Health Survey (2016) (GSHS 2016) and The Tobacco Atlas – Sri Lanka Country Profile (2018) (TOBACCO ATLAS 2018)

Who are still smoking?

Smoking prevalence has come down in Sri Lanka, but is still high among certain groups. The overall smoking prevalence rate amongst men, which was recorded as high as 40.5% in 2005 has notably fallen to 28.4% by 2018 (Figure 1). Other sources also affirm the decreasing trend in the smoking prevalence rate in Sri Lanka.

The smoking prevalence was particularly high amongst some population groups, for instance, **the above 40-year old aged group**. Smoking prevalence rates for the age categories of (15-24), (25-39) and (40 and above) are recorded as 21.5%, 28.6% and 31.9% respectively (ADIC 2018).

There is a significant difference between males and females in smoking prevalence. The WHO STEP 2015 revealed that the smoking prevalence rate among **males** was 29.4%, while the prevalence rate for females was only 0.1%. Other secondary data sources confirm the same smoking pattern between the two sexes.

Tobacco smoking prevalence is higher among the non-schooling group (15-24 years) compared to the schooling groups. In 2014, tobacco smoking prevalence of **non-schooling males** as a percentage was 23.9%, while it was only 4.3% among the schooling group (AHB 2014).

Among school children, smoking prevalence is higher for **male students in the age group of 16-17** (10.9%), compared to the

male students in the age group of 13-15 (4.2%) (GSHS 2016). In 2016, top five districts with highest percentage of detected smokers were **Nuwara Eliya, Vavunia, Mullitivu, Mannar, Kilinochchi Districts** (AHB 2016).

The percentage of households in which at least one member has smoked tobacco was recorded as 34.5% for the **rural sector** while both the urban sector and estate sector recorded 31.6% (DHS 2016).

39.7% of the households in the **lowest wealth quintile** had at least one member who has smoked tobacco. Percentage values for second, middle, fourth, and highest wealth quintiles are 37.7, 35.6, 31.6, and 23.6 respectively (DHS 2016).

To reduce tobacco use among these groups, Sri Lanka must go beyond the standard set of internationally recommended policies, which have helped drive down tobacco use over the past 15 years. Going the last mile will require targeted, innovative and locally-specific policy measures (such as continuing to increase taxation on tobacco products to reduce the affordability, banning the sale of single stick cigarettes and implementing the amendments proposed for the NATA Act) – and strong political commitment to take tough decisions, now that the easier gains have been made.

This policy brief is based on initial findings from a study on Understanding the Policy Problem: Who is the Last Mile? Under the IPS Tobacco Control Programme



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