TOBACCO SMOKING IN SRI LANKA: IDENTIFYING AND UNDERSTANDING THE LAST MILE SMOKERS

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SUNIMALEE MADURAWALA, CHATHURGA KARUNANAYAKE AND CHAMINI THILANKA

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Abbreviations

ADIC - Alcohol and Drug Information Centre

AHB - Annual Health Bulletin

CCT - Centre for Combatting Tobacco

CTC - Ceylon Tobacco Company

DCS - Department of Census and Statistics

DHS - Demographic and Health Survey

FCTC - Framework Convention on Tobacco Control

FGDs - Focus Group Discussions

GATS - Global Adult Tobacco Survey

GDP - Gross Domestic Product

GHO - Global Health Observatory

GYTS - Global Youth Tobacco Survey

IPS - Institute of Policy Studies of Sri Lanka

KII - Key Informant Interview

LKR - Sri Lankan Rupee

MICs - Middle-income Countries

NATA - National Authority on Tobacco and Alcohol

NCDs - Non-communicable Diseases

PHM - Public Health Midwife

PPP - Purchasing Power Parity

RDHS - Regional Director of Health Services

SLMA - Sri Lanka Medical Association

THS - Third-hand Smoking

WHO - World Health Organization

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Executive Summary

Tobacco smoking is a dangerous epidemic claiming eight million lives globally and is currently the world's single most significant cause of preventable death. In Sri Lanka, more than 20,000 people are killed every year by tobacco-related diseases. Sri Lanka has experienced a substantial fall in the overall smoking rate among males, from 40.5 per cent in 2005 to 28.4 per cent in 2018 (Alcohol and Drug Information Centre, 2019). However, the fact that still, more than one in four males in Sri Lanka use tobacco is quite concerning (Karunanayake & Thilanka, 2020). It is also worthy of gaining insights on why people continue with smoking. The challenge for Sri Lanka now is to 'go the Last Mile' by identifying groups where smoking prevalence is highly concentrated and thereby put efforts to reduce the high prevalence in the remaining stock of current smokers; henceforth referred to as the 'Last Mile Smokers.'

In this respect, the present study identifies who the Last Mile Smokers (the current stock of remaining smokers) are, examines (a) reasons behind smoking initiation and continuation, (b) their efforts in quitting smoking, (c) awareness on the adverse impact of tobacco smoking and current policies, and (d) identifies a required set of policy measures that facilitates reaching the last mile smokers. The study adopted a mixed-method approach where quantitative and qualitative methods were applied and primary and secondary data used.

Analysis of secondary data sources confirmed that although smoking prevalence has lowered in Sri Lanka, in certain population groups, smoking rates are still high. Smoking prevalence is considerably high among **Males.** The prevalence rate among males is as high as 30 per cent, whereas the prevalence rate among females is only 0.1 per cent (Ministry of Health, Nutrition and Indigenous Medicine and WHO, 2015). Among males, those who are in the **above 40-year old** age category record the highest smoking prevalence rate (Alcohol and Drug Information Centre, 2019). Among **youth (15 - 24 years old),** tobacco smoking prevalence is higher among the non-schooling group compared to the schooling groups (Ministry of Health, Nutrition and Indigenous Medicine, 2016). Among school children, smoking prevalence is higher for **male students in the age group of 16-17** compared to the male students in the age group of 13-15 (World Health Organization, 2016). Top five districts with the highest percentage of detected smokers were **Nuwara Eliya, Vavunia, Mullaitivu, Mannar, Kilinochchi Districts** (Ministry of Health, Nutrition and Indigenous Medicine, 2016). The percentage of households in which at least one member has smoked tobacco was highest for the **rural sector** compared to urban and estate sectors (Department of Census and Statistics, 2017). **Households in the lowest wealth quintile** had the highest percentage of at least one member who has smoked tobacco compared to the households from the second, middle, fourth, and highest wealth quintiles (Department of Census and Statistics, 2017). There are more current smokers under '**Skilled agricultural and fishery workers**' and '**Craft and related workers**' occupational groups compared to other occupational groups (Alcohol and Drug Information Centre, 2019).

The main findings of focus group discussions (FGDs) with the smokers, the short survey conducted among the FGD participants[1] and key informant interviews (KIIs) with stakeholders are summarised below:

- The majority of participants were **daily smokers** who smoked only cigarettes; on average, 1-5 sticks per day. While cigarette intake has reduced over time, most of the current smokers buy cigarettes or beedi in the form of single sticks - only 1 per cent of participants reported buying whole packets.

[1] This survey is not based on a representative sample and the numbers derived from the survey are only to provide an approximate numerical idea.

- Participants had **started smoking at a young age**. The survey carried out with the FGD respondents revealed that 64 per cent of the current smokers initiated before the age of 21 years.
- **Smoking initiation:** The dominant drivers behind smoking initiation are; perceiving it as a remedy for loneliness and distress, curiosity to experiment new things, to break the monotonous nature of their jobs, peer pressure and following family members or community.
- **Smoking continuation:** Most frequent reasons stated by the participants for continuing smoking are; smoking has become a habit, to break the monotonous nature of their occupation, lack of incentives and lack of self-control to stop smoking.
- **Shifting from packs to single sticks -** Participants confirm that price is a crucial factor in their decision to smoke. As smoking has become relatively expensive in recent years, particularly for estate sector workers and low-income groups, many smokers have switched from buying an entire pack to buying single sticks. The price increases have reduced the intensity of smoking and made smokers consider quitting provided further price increases in the future.
- **Switching between smoking products** - Some groups (construction workers, drivers and the youth group) stated that they would never shift from cigarette to beedi despite any further price increases (mainly due to 'bad smell' and 'poor quality' of beedi). However, some participants from the rural, estate, 40+ years of age and Kilinochchi group indicated that they would shift to beedi, given further price increases in cigarettes.
- **Quitting Smoking -** The majority of participants wanted to quit and had attempted to do at least once. Most of the FGD participants stated that they like to quit smoking, but they cannot do so, as they lack will power and self-control. Health concerns, personal commitments, responsibilities and economic constraints are the main reasons which have motivated them to consider quitting.
- **Cessation Support -** Most of the smokers opined that self-determination is pivotal in quitting smoking. Family and close network support, shifting to substitutes that are healthier than smoking tobacco, are some common methods used for the purpose of quitting. Reaching for formal cessation support was minimal, and very few smokers have sought for professional or medical help. Lack of awareness on the existing formal cessation channels was the primary reason behind it.
- **Awareness -** Almost all the respondents were aware of the health and economic impacts of smoking, but their awareness of environmental impact was considerably low. Similarly, most of the smokers had a good understanding of 'first-hand smoking' and its adverse health effects. Except for some participants from drivers and 40+ groups, the rest lacked understanding of second-hand smoking. Almost all the FGD participants were unaware of third-hand smoking. In general, FGD participants had a good knowledge of current policies and regulations about tobacco smoking in the country.
- **Exposure to tobacco marketing -** Movies shown on television, direct and indirect promotional activities by shop and restaurant owners and online promotions were highlighted as promotional activities on smoking. Further, respondents identified the '*Abhisheka*' programme as an indirect promotional activity by the Ceylon Tobacco Company (CTC).
- **Controlling tobacco smoking** - FGD participants stressed that supply restrictions would be more practical rather than demand-side control measures. Supply-side restrictions suggested by the participants include; banning the sale of cigarettes, closing the operations of CTC, and strengthening the government's involvement. They also suggested the importance of having demand-side controls in place, such as school-level awareness programmes.

Findings of this study can be translated to the following recommendations:

1. **Introduce targetted and specific policy interventions** that reach the Last Mile Smokers: Existing programmes do not adequately reach the Last Mile smokers who have specific needs and features. Novel approaches that are more targetted and especially tailor-made are needed to reach out and influence them. Further, most of the remaining smokers are from the informal sector - a sector that often goes unnoticed and is not captured adequately by the existing health service networks. Hence, it is vital to make sure that these interventions reach such sectors.

2. **Respond to unmet demand for smoking cessation –** The study findings indicate that most smokers want to quit, and there is substantial unmet demand for smoking cessation support. Emphasis should be placed on approaches that support smokers' self-determination in quitting smoking.

3. **The price increase should be continued as a crucial policy intervention for controlling tobacco smoking –** As the price increases in smoking products have forced some crucial changes in smoking behaviour (e.g. reducing the intensity of smoking and quitting smoking), price increases must continue and are inflation-adjusted to make the smoking products less affordable.

4. **Single stick ban –** The vast majority of participants reported buying their cigarettes as single sticks and, as such, banning the sale of single sticks could have a significant impact on bringing down the prevalence rate among 'Last Mile' smokers.

5. **Ban continued promotion by the tobacco industry –** The tobacco industry continues to promote tobacco use through a range of methods, including the entertainment and social media platforms, and indirect promotion methods such as '*Abhisheka*' programme. Firm and direct actions are needed to stop promoting of tobacco smoking products. Smoking initiation mostly happens at young ages, and the tobacco industry exerts intense pressure to attract young people as new smokers. Preventing smoking promotions that are aimed at young people is crucial.

6. **Consider broader smoking bans –** There was widespread support for much more stringent supply-side measures to control tobacco, including a total ban on tobacco and CTC activities. Therefore, prompt action should be taken to explore the potential for broader restrictions or bans on tobacco sales.

7. **Strengthening the awareness creation –** Last Mile smokers lacked knowledge on specific aspects of smoking (second-hand smoking, third-hand smoking, and the environmental and social impacts of smoking). It is recommended that current awareness programmes are further expanded, focussing more on the detriments of smoking so that it would discourage young people from smoking initiation.

1. Introduction

The tobacco epidemic is one of the serious public health threats that the globe has ever faced. As World Health Organisation (WHO, 2020) notes, tobacco kills up to 50 per cent of its users, and there is no safe level of exposure to tobacco. Tobacco smoking comes with high health, societal, economic, and environmental costs.

The most important reason for concern is the adverse health effects caused by tobacco. Globally, tobacco kills more than eight million people a year. In Sri Lanka, tobacco-related diseases kill more than 20,000 people every year (RTI International, Ministry of Health, Sri Lanka, United Nations Development Programme, WHO FCTC Secretariat, World Health Organisation, 2019). Smoking tobacco causes exposure to a lethal mixture of more than 7,000 toxic chemicals, including at least 70 known carcinogens. Furthermore, pregnant women who smoke generally tend to give birth to infants who are at higher risk of congenital disorders, cancer, lung diseases, and sudden death. Cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD) which includes emphysema and chronic bronchitis, are some of the critical health risks of smoking (Centres for Disease Control and Prevention, 2020; Madurawala, 2020). Second-hand smoking (passive smoking) is also considerably high in Sri Lanka.

> "In responding to the current challenges, ensuring a sustainable political commitment towards tobacco control, implementing a set of compelling new policies that cut smoking rates further and maintaining the overall prevalence rate below 10 per cent is essential."

According to the available statistics, 23.5 per cent of adults (aged 18-69) are exposed to second-hand smoking (World Health Organisation, 2018a).

The economic burden imposed by tobacco use and its related costs is another critical aspect that stresses the need for tobacco control. There is a substantial economic impact of smoking at every level (individual, household, country and globally). In 2016, tobacco use cost the Sri Lankan economy Sri Lankan Rupees (LKR) 213.8 billion, equivalent to 1.6 per cent of its GDP. Tobacco-related health expenditures totalled LKR 15.3 billion. The economy experienced LKR 198.5 billion in indirect productivity costs due to tobacco-attributable premature mortality, disability and workplace smoking (RTI International, Ministry of Health, Sri Lanka, United Nations Development Programme, WHO FCTC Secretariat, World Health Organisation, 2019).

The natural environment is also affected by tobacco smoking. The adverse environmental impacts can be seen in every stage of the tobacco smoking life cycle - growing, manufacturing, distribution and consumption. Deforestation at the growing stage of tobacco plants due to clearing of land, greenhouse gas emission at the manufacturing and distribution stages, toxic residue from tobacco smoke lingering in the environment, cigarette butts and toxic third-hand smoking (THS) materials polluting environment at the consumption stage are few examples. Smoking brings societal concerns too. It hurts an individual's network of family and friends, as smokers are putting people close to them in danger by exposing them to second-hand smoke. Further, tobacco smoking hurts family relationships because of the economic burden

to households and family wellbeing issues brought on by sexual disfunction caused by tobacco smoking.

Sri Lanka has experienced a significant fall in the overall smoking rate among males, from 40.5 per cent in 2005 to 28.4 per cent in 2018 (Alcohol and Drug Information Centre, 2019). However, tobacco smoking prevalence is still high in certain groups. In responding to the current challenges, ensuring a sustainable political commitment towards tobacco control, implementing a set of compelling new policies that cut smoking rates further and maintaining the overall prevalence rate below 10 per cent are essential. Reducing smoking prevalence among the Last Mile of smokers would save costs for the public health care system by lowering the prevalence of early mortality and morbidity, ensuring a labour force that is healthy, fit and productive and enabling to achieve a less polluted environment. This would make Sri Lanka an international beacon in terms of effective health policies, reaping benefits from a healthier population and corresponding revenue gains.

Sri Lanka has taken significant efforts to control tobacco consumption in the country, especially after becoming a signatory to the World Health Organisation's Framework Convention on Tobacco Control (WHO FCTC) on February 27, 2005. Over the years, Sri Lanka has taken price measures as well as non-price measures to reduce the demand for tobacco including, passing the National Authority on Tobacco and Alcohol (NATA) Act in 2006, restrictions on smoking in public places, packaging and labelling requirements, regulations about tobacco advertising, restrictions on promotion and sponsorship, the establishment of the NATA and imposing penalties for offences. Subsequently, crucial amendments to the Act were incorporated. These include regulations prohibiting the manufacture, importation, and sale of smokeless tobacco products, e-cigarettes containing tobacco, and cigarettes that are flavoured, coloured, or sweetened introduced in 2016.

With regard to tackling tobacco smoking strategically, the need to identify the persons who are still smoking- i.e. the Last Mile smokers becomes crucial. As such, identifying the principal demographic and socio-economic background, as well as understanding the contextual factors which encourage them to continue smoking are pivotal in targetting and reaching out to them.

In this context, this study focusses on achieving three main objectives; (1) Identifying the Last Mile Smokers in Sri Lanka (2) understanding the Last Mile smokers; reasons for smoking initiation, continuation, cessation, accessibility, affordability and awareness and, (3) recommending policies or a mix of policies that are needed to reach the Last Mile and reduce their tobacco use. The study adopted a mix of quantitative and qualitative methodological approaches in answering the research questions and analysed published secondary data in identifying the Last Mile of Smokers in Sri Lanka. Furthermore, this study incorporated primary qualitative (from Focus Group Discussions- FGDs and Key Informant Interviews - KIIs) and quantitative data (from questionnaire survey) in understanding the Last Mile of Smokers. This study undertook focus groups with 121 participants in eight locations to gain a deeper understanding of the smoking behaviours and attitudes of the 'Last Mile' groups, who are still smoking. A survey was conducted among the FGD participants by using a short and simple questionnaire.

The outline of the study report is as follows. Section one provides an introduction to the study: it states the study objectives and sets the background to the study. Section two discusses the research questions, methodological approach of the study and describes the research tools used in carrying out the study. Section three gives a background to the study, and it covers broad areas related to the study, including the global context, South Asian context and a brief literature review on smoking initiation and continuation and examples from the international literature on policy responses for various settings. Section four on tobacco smoking in Sri Lanka has three main subsections; the policy context, tobacco smoking trend in Sri Lanka, and the profile of the Last Mile of smokers in Sri Lanka derived from secondary data analysis. Section five, which focusses on understanding the Last Mile Smokers, presents the findings from the primary data sources (FGDs, KIIs and questionnaire survey). Section six concludes the paper with policy recommendations.

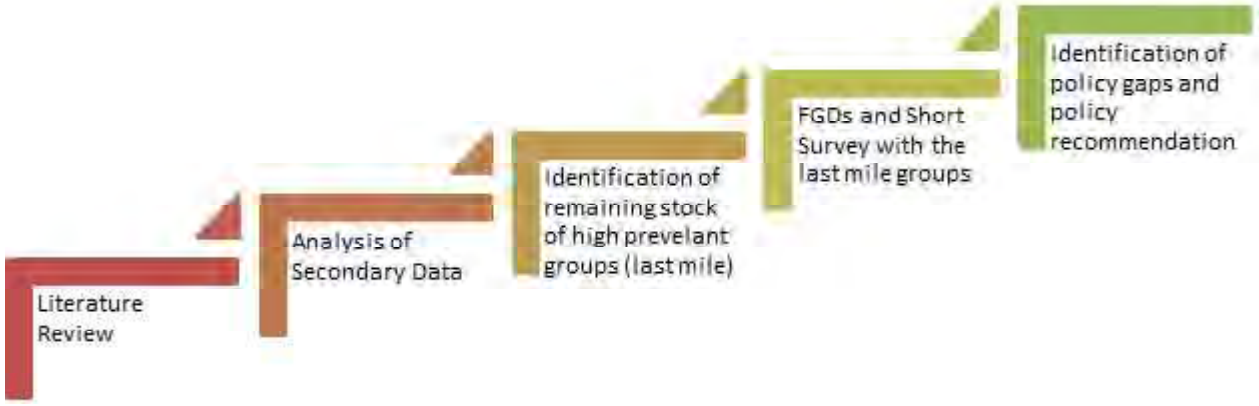
2. Research Questions, Methodology and Data

The three main research questions are as follows;

- ***Who are the Last Mile smokers in Sri Lanka?***
- ***What are the main features of the Last Mile smokers? - understanding the last mile smokers; reasons for smoking initiation, continuation, accessibility, affordability, smoking cessation and awareness***
- ***What policies or a mix of policies are needed to reach the Last Mile and reduce their tobacco use?***

The study adopted a mix of quantitative and qualitative methodological approaches in answering the research questions. Figure 1 depicts the research approach used in this study. Table 1 summarises the methodologies and data sources used for each research question.

Figure 1
Research Approach



Source: Authors' illustration.

2.1 Qualitative Data

2.1.1 FGDs

Based on the findings from the secondary data analysis and expert inputs from the stakeholders, this study carried out eight FGDs with the following groups at respective locations.

2.1.1.1 FGD Guide Preparation and Areas Covered

The FGD guideline developed by the IPS researchers with inputs from the Alcohol and Drug Information Centre, Sri Lanka (ADIC) and KIVU, UK is presented in Annex 2. The guideline covered the following themes.

- Initiation and continuation
- Access and affordability
- Quitting
- Awareness on impact of smoking, regulations and policies on smoking, and cessation services
- Suggestions for new policies

2.1.1.2 Inclusion Criteria

The main inclusion criteria for the FGDs were participants' smoking status. Only those who were smoking at the time of carrying out the FGDs were taken into consideration and included in the study. Out of this, those who belonged primarily to high prevalence groups, as identified by secondary data analysis were chosen. As such, this inclusion criteria ensured having a variation among the participants in each FGD, as much as possible. For example, the FGD with the rural community had smokers of different age groups, different occupations, educational levels, etc. All FGD participants were males. The number of participants varied between 8 to 20 for different FGDs.

Table 1
Methodology, Tools and Data Sources

Research Question	Methodology	Data Sources
Who is the Last Mile?	Analysis of quantitative data to identify the high prevalence of smoking groups	• Tobacco Use Spot Surveys - ADIC • Global Youth Tobacco Survey (GYTS) - NATA (2015) • STEP Survey - WHO/ Ministry of Health (2015) • Demographic and Health Survey (DHS) 2016 - Department of Census and Statistics (DCS) • Annual Health Bulletins (AHB) - Ministry of Health • National Oral Health Survey - Ministry of Health (2015-16) • Self-reported Health Survey - DCS (2014) • Global School-based Student Health Survey WHO (2016) • The Tobacco Atlas - Sri Lanka Country Profile (2018)
What are the main features of the Last Mile smokers? - reasons for smoking initiation, continuation, access affordability, smoking cessation and awareness	Analysis of qualitative and quantitative data	• Focus Group Discussions (FGDs) • Key Informant Interviews (KIIs) • Questionnaire Survey
What policies or a mix of policies are needed to reach the Last Mile?	Brainstorming sessions/ consultations with expert stakeholders Literature review	• Brainstorming sessions/ consultations • Findings from the study

Source: Authors' illustration.

Table 2
FGD Groups and Locations

Group	District	Location
40 + males	Gampaha	Negombo
Youth - Non schooling	Gampaha	Dompe
Construction workers	Colombo	Colombo
Drivers	Colombo	Colombo
Rural	Kurunegala	Mahawa
Estate	Nuwara Eliya	Hatton
High prevalence area	Kilinochchi	Dharmapuram
Low-income	Monaragala	Buttala

Source: Authors' illustration.

2.1.1.3 Field Coordination, Organising and Moderating the FGD Sessions

The ADIC facilitated the field coordination for FGDs with the help of their community representatives at the respective sites. Experienced ADIC officers moderated the FGD sessions, whereas IPS researchers were the facilitators and record keepers.

2.1.1.4 Sampling Procedure

The present study deployed the Purposive sampling strategy in recruiting participants for the FGDs. Participants were selected based on above mentioned two criteria. Field-level knowledge of the ADIC on the study population was applied to select the sample in a non-random manner (a sample of elements that represents a cross-section of the population). In some instances, the Snowball sampling method was also employed, where research participants themselves identified eligible participants for discussions. Participants were briefed on the objectives of the research. In addition, their verbal consent was sought prior to having discussions with them and also to record the same.

2.1.1.5 Data Management

Except for the FGDs at Killinochchi and Nuwara Eliya, all other FGDs were conducted in Sinhala. FGDs at Killinochchi and Nuwara Eliya were conducted in Tamil language. For transcribing purposes, the moderator subsequently explained responses of the participants to IPS researchers in English. All FGDs were audio-recorded with prior approval of participants. Except for FGDs held at the said locations, remaining FGDs were transcribed in Sinhala upon completion. Thereafter, these were translated from Sinhala to English. The ones held at Kilinochchi and Nuwara Eliya were translated from Tamil to English. All audio files, transcripts and notes are stored in a secured location at the IPS.

2.1.1.6 FGD Data Analysis

The process for analysing the transcripts took a deductive reasoning approach based on the themes and sub-themes (Annex 1). The codification process was done manually. Two dominant methods were used to analyse the data obtained from FGDs.

First, to organise, systemise and analyse the information for each theme and sub-theme, the process of 'coding' was used. The frame of reference for data analysis was to identify research questions at the conceptual stage and consider these at the designing stage of the FGD guide. Data were organised, emphasising the research questions that fall under each sub-theme. The researcher read through each interview transcript with each research question in mind to gather related information. Once responses relevant to a particular question are gathered, these are analysed to check if the responses occur frequently. Likewise, specific patterns of answers were identified, depending on the other characteristics of respondents. For this purpose, frequently used words and phrases and ideas conveyed through responses of the interviewee were identified. Thereafter, these were organised into codes or categories.

Figure 2
Visualisation and Ranking Exercise



Source: Created by authors.

2.1.1.7 Visualisation Exercise

Data visualisation technique was deployed to provide a pragmatic analysis of the data when attempting to understand the Last Mile of smokers. Using a data visualisation technique in qualitative research is useful for several reasons. These methods are a systematic means of gathering information, allowing group members or different individuals to express their views quickly, comprehensively and creatively in a non-verbal manner (Mathie, 2005). Further, in a group setting, visual information can be readily discussed and modified by the group so that a consensus can be reached about the findings. The discussion itself elicits data that can be used to enrich information gathered and its analysis. This approach often leads to an element of informality to the research activity. As such, this technique is less intimidating and more stimulating to the subjects than other more formal techniques.

The FGD facilitator wrote the answers for four main questions from the participants in flashcards during the FGD. The four key questions were;

- Why have you started smoking?
- Why are you continuing to smoke?
- If you have considered quitting smoking, what were the reasons for that?
- What should be done to control smoking?

After the discussion, participants were asked to discuss again among themselves, add or remove any answer, and rank flashcards.

2.1.2 Key Informant Interviews

Six KIIs (face to face) were carried out with a combination of policymakers, academicians, health professionals and other respective professionals.

The aims of the KIIs were; (a) to understand the remaining stock of smokers based on different socio-demographic antecedents, (b) to identify reasons behind smoking initiation, smoking continuation and smoking cessation, (c) to identify the most viable ways to reach the Last Mile group and (d) identify gaps in current policies and areas for new policies. The interview lasted for 30 to 45 minutes, and the personal details of the victims/smokers were not questioned or discussed at the event owing to ethical reasons.

The questionnaire covered the following areas;

- Socio-demographic cohorts of current smokers
- Reasons behind initiation in smoking and continuation in smoking based on different socio-demographic aspects
- Most suited practices in terms of reaching the remaining stock of smokers
- Areas for Improvement in terms of controlling the tobacco epidemic in the country
- Suggestions for new policies

2.1.2.1 Inclusion Criteria

The selection process of key informants included identifying and listing out a list of potential key informants who are aware of both the subject matter and the field. A diverse set of representatives with different backgrounds and from various sectors was covered to make sure results are not one-sided or biased (Annex 2). Conditions for being a suitable interviewee were (a) having substantial experience in the field or (b) having a broad spectrum of knowledge.

2.1.2.2 Data Management

Responses gathered from the interviews were audio-recorded with the consent of the interviewee, enabling the interviewer to engage freely in the conversation without worrying about note-taking. The interviewer took brief notes on the crucial segments during the interview; in addition, deployed the tape recording to fill in information gaps and specific details in the process of transcribing data. All recordings were compiled and saved in a secured location at IPS.

2.2 Quantitative Data

Quantitative data needed for this study were extracted from various secondary data sources and from the short survey, which was conducted among the FGD participants. The most frequently used vital secondary data sources are listed in Table 1 above. The short survey, which contained 30 close-ended questions (Annex 3), was conducted among the FGD

participants. One hundred and four FGD participants responded to the survey. The survey covered the following main areas such as details pertaining to socio-economic aspects, smoking, quitting, awareness and exposure to prevention programmes. It should be noted that the survey is not representative. However, with the delay in obtaining Global Youth Tobacco Survey (GATS) survey data, it was decided to conduct a short survey among FGD participants, mainly to obtain an approximate numerical idea on essential aspects related to tobacco smoking in Sri Lanka. Even though the survey is useful in summarising views of the participants, it is rationale to say that survey value is limited due to the small sample size and lack of representativeness. Table 3 provides a profile summary of the smokers who participated in FGDs.

Table 3
Socio-demographic Information of the Respondents

	Category	Percentage of Smokers
Age	15>=	3
	16-20	11
	21-30	22
	31-40	31
	41-50	17
	51-60	10
	60+	6
Marital status	Never Married	30
	Married	67
	Widowed	2
	Divorced	0
	Separated	1
Ethnicity	Sinhala	55
	Sri Lankan Tamil	34
	Indian Tamil	7
	Sri Lankan Moor	4
Education qualifications	Grade 1-5	10
	Grade 6-10	42
	Passed O/L	32
	Passed A/L	12
	Diploma	1
	Degree or above	1
	Vocational Training	1
	Special Education	0
	No Schooling	1
Monthly income	Less than LKR. 15,000	26
	LKR. 15,000- LKR. 20,000	21
	LKR. 20,001- LKR. 30,000	18
	LKR. 30,001- LKR. 40,000	19
	LKR. 40,001- LKR. 50,000	10
	LKR. 50,001- LKR. 60,000	3
	LKR. 60,001- LKR. 70,000	3
	More than LKR. 70,000	0

3. Background

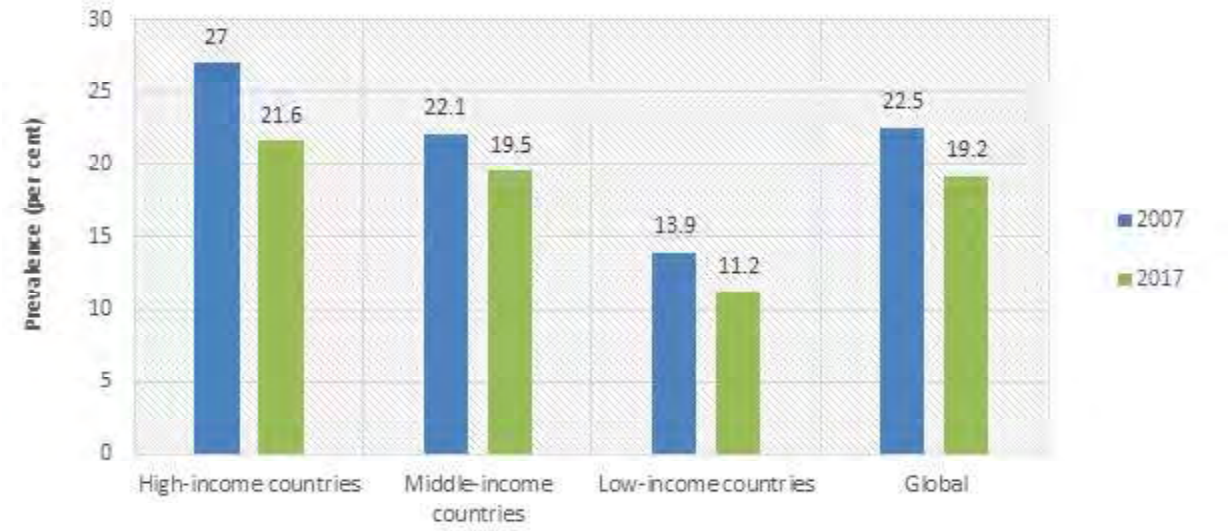
3.1 The Global Context

The most common medium of global tobacco consumption is 'smoking,' and people smoke in multi-faceted ways such as manufactured cigarettes, hand-rolled cigarettes, cigars, pipes, water pipes, kreteks and beedis (Asma et al., 2015). Furthermore, the latest evidence available on this conduct indicates that the present global tobacco smoking rates have declined over the past decade.[2]

According to the WHO (2019a), smoking rates have decreased from a global average of 22.5 per cent to 19.2 per cent from 2007 to 2017, indicating a reduction of 3.3 percentage points over a decade (Figure 3). When considering tobacco smoking among adults based on the income levels of countries worldwide, the latest available data assert that there is a difference in terms of the income category of the country. As reported in WHO (2019c), around 80 per cent of the world's 1.1 billion smokers live in low-income and middle-income countries (MICs). However, in terms of tobacco smoking prevalence among adults (15 years and over), adults in high-income countries are more prone towards tobacco smoking than those in the middle-income and low-income countries, which are 19.5 per cent and 11.2 per cent, respectively (World Health Organization, 2019b).

"The smoking rates have decreased from a global average of 22.5 per cent to 19.2 per cent from 2007 to 2017, indicating a 3.3 per cent point deduction over a decade."

Figure 3
Global Current Tobacco Smoking Prevalence Among Adults by Income Level 2007 - 2017



Source: World Health Organization. (2019b). *WHO Report on the Global Tobacco Epidemic, 2019*. Geneva: World Health Organization.

[2] However, quite contrary to the overall global situation, the tobacco smoking prevalence appears to be rising in the WHO Eastern Mediterranean Region and the African Region (World Health Organization, 2015a).

There is a significant difference between males and females with regard to smoking prevalence. In 2017, the global smoking prevalence is 32.7 per cent among males and 5.8 per cent among females. The prevalence has decreased by 4.4 per cent among males and by 3.8 per cent among females compared with 2007 (World Health Organization, 2019b). As asserted in the GATS Survey 2015, among men, 11 GATS countries have a prevalence of 40 per cent or above while in terms of women, the case is much different (Asma et al., 2015). According to the survey findings, among women, 11 countries have a prevalence of more than 5 per cent (Asma et al., 2015, p. 37).

The latest report on the Global Tobacco Endemic of the World Health Organization has forecasted the future prevalence of smoking and its expected trend. The tobacco smoking rates are expected to reach around 17 per cent in high-income and MICs, respectively. In contrast, the tobacco smoking rates are projected to fall under 10 per cent in low-income countries by year 2030, provided the countries under income levels mentioned above endure on their current trajectories without further increasing the smoking rate and worsening the situation (Figure 4). Furthermore, according to the report, global projections of smoking among men and women demonstrate a significant contrast between females and males. The rates among females are estimated to fall to around 4 per cent by 2030.

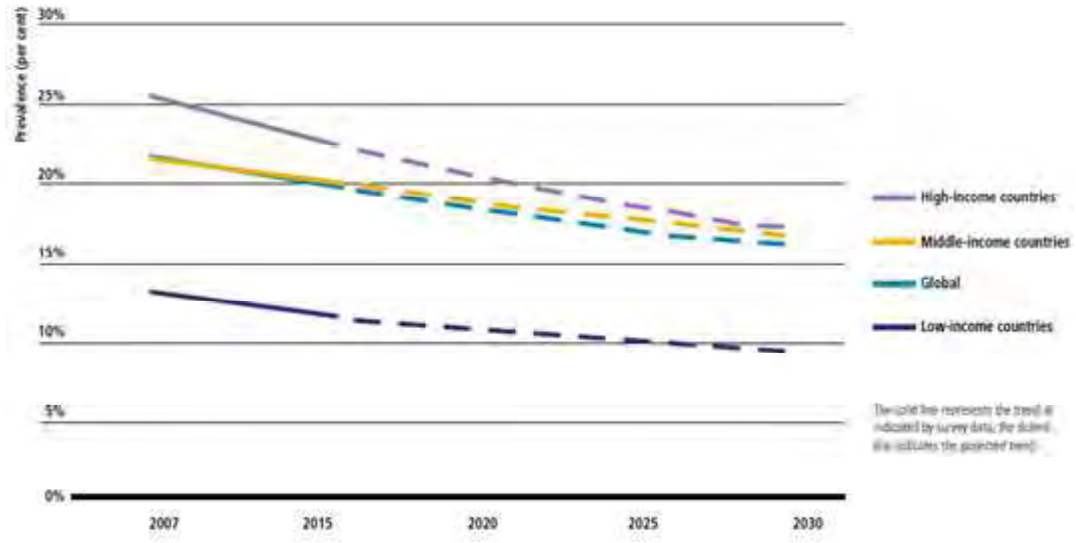
In contrast, rates among males are projected to prevail high at 28 per cent. The report further asserts that this would result in a future incline in the actual numbers of global male tobacco smokers owing to growth in population up from 908 million in 2017 to 913 million in 2030. As such, MICs should mainly be cautious to prevent their people from getting victimised in the tobacco epidemic, where the number of smokers could reach 750 million by 2030.

Furthermore, as asserted by Perez-Warnisher et al. (2019), both individual-level and system-level factors affect tobacco smoking prevalence at the global level. For instance, socioeconomic status, education, tobacco control policies and regional economic development are some examples.

3.2 The South Asian Context

A recent study revealed that Asian countries as a whole are in the initial stages of a tobacco smoking epidemic with smoking habits reflecting those of the United States from previous decades. These pave the way towards an increase in deaths

Figure 4
Estimated Trend in Current Smoking Prevalence



Source: World Health Organization. (2019b). *WHO Report on the Global Tobacco Epidemic, 2019*. Geneva: World Health Organization.

triggered by tobacco smoking, in future (Vanderbilt University Medical Center, 2019). Similarly, World Health Organization (2018c) claims that the Southeast Asia region is amongst the largest consumers of tobacco products. As such, some countries in the region for instance; India, Bangladesh and Thailand are among the highest tobacco users globally.

However, in terms of tobacco smoking prevalence among males and females, research shows that there is a clear gender gap. For instance, the latest research studies conducted in the context of South Asia reveal that smoking prevalence among females is very much lower than that of males in all countries (Islami et al., 2015) and the share of women who smoke is decreasing (Figure 5). Tobacco smoking, in general, has a significant connotation with higher age, lower education attainment and poverty in the South Asian context (Sreeramareddy et al., 2014).

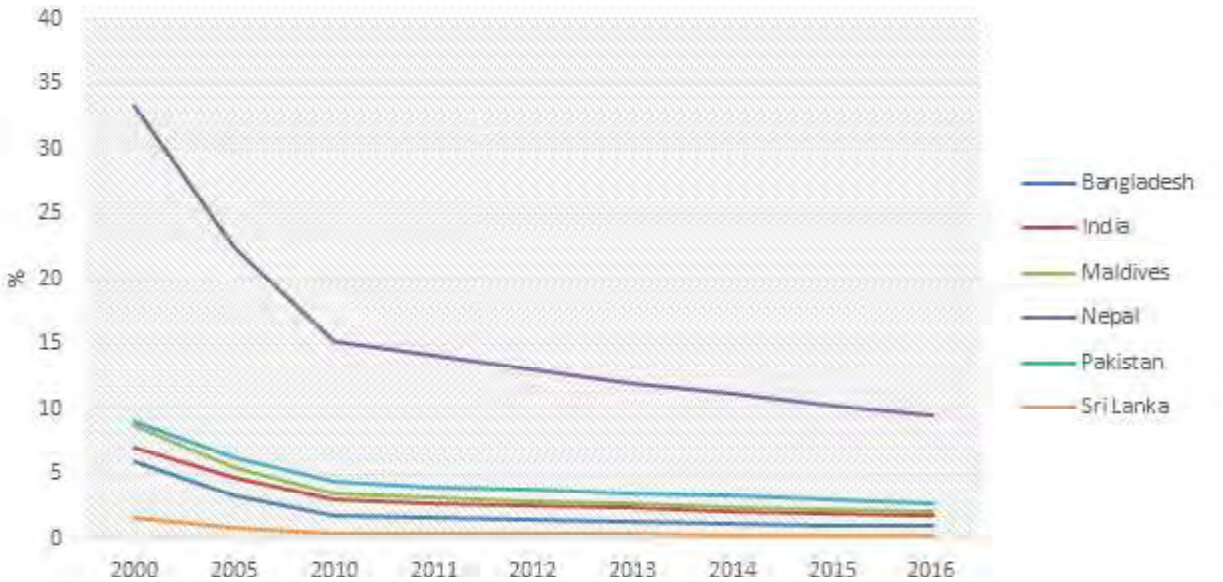
The highest overall tobacco smoking prevalence rate (15 and above) in the South Asian region is recorded from the Maldives, while Sri Lanka indicates the lowest prevalence rate (Table 4). Similar to the global scenario, a notable difference in the smoking prevalence rate between the two sexes is visible among the South Asian countries as well.

3.3 Smoking Initiation, Continuation and Cessation

Smoking initiation could trigger due to many reasons. Smoking among friends, siblings, relatives and parent-teen conflicts, parental monitoring and discussion in the family about smoking hazards are significant predictors of smoking stages; this is revealed in a study conducted among secondary school students (Jeganathan, Hairi, Al Sadat, & Chinna, 2013). Surrounding influence, stress, and fun were significant reasons for smoking initiation, as asserted by Chezhian et al., (2015).

According to So and Yeo (2015), factors affecting early smoking initiation are; being a male, having a positive subjective health status, body image, having an average happiness level/ stressfulness. Besides, consuming alcohol, having suicidal ideation, having low or average academic grades are said to be crucial. Furthermore, having a parental education level

Figure 5
Share of Women Smoking - South Asia



Note: *Share of women aged 15 years and over who smoke any form of tobacco, including cigarettes, cigars, pipes or any other smoked tobacco.*

Source: Roser, M., & Ritchie, H. (2019). *Smoking- Our World in Data*. Retrieved August 27, 2019, from Our World in Data https://ourworldindata.org/smoking#empirical-view

Table 4
Current Daily Tobacco Smoking Prevalence Rates in South Asian Countries

Country	Tobacco Smoking Prevalence (%) (Age above 15 years)			Reference Year
	Overall	Male	Female	
India	10.7[1]	19[1]	2.0[1]	2017
Bangladesh	18.0[2]	36.2[2]	0.8[2]	2017
Maldives	22.2[3]	43.2[3]	1.6[3]	2016
Nepal	17. 1[3]	27.8[3]	7.6[3]	2016
Afghanistan	NA	21. 4[4]	7.0[4]	2015
Sri Lanka	9.7[3]	20.3[3]	0.2[3]	2016

Sources:

1) World Health Organization. (2018b). Fact Sheet - India. doi:https://apps.who.int/iris/bitstream/handle/10665/272672 wntd_2018_india_fs.pdfjsessionid=7FE97F5A5984A5F31F53F4372525261F?sequence=1
2) Bangladesh Bureau of Statistics. (2018). Global Adult Tobacco Survey - 2017. Bangladesh: Statistics and Information Division, Ministry of Planning.
3) World Health Organization. (2018d). WHO Global Report on Trends in Prevalence of Tobacco Smoking 2000-2025.
4) American Cancer Society. (2016). Factsheet- The Tobacco Atlas. American Cancer Society and Vital Strategies. Retrieved July 23, 2020 from The Tobacco Atlas https://files.tobaccoatlas.org/wp-content/uploads/pdf/afghanistan-country-facts-en.pdf

of high school or below, not taking a family trip in the previous 12 months, and having a family that approves of smoking inside homes, are other examples.

As cited by Lochbuehler et al., (2016), adolescents initiate smoking through the influence of friends' smoking in both direct and indirect ways, while parental smoking affects indirectly, for them to initiate smoking.

Moreover, data reveal that in terms of smoking escalation, friends' and parents' smoking can influence the decision only through indirect ways. A study conducted by West (2017) mainly reveals that friends were the primary means of the first smoke, particularly for those who are above 15 years of age. Pleasure, followed by stress and curiosity, were the main reasons to start smoking, as pointed out by the selected group of smokers. Although two-thirds of smokers intended to quit smoking in the future, the main reasons that they did not want to quit were social attitudes, addiction, and not knowing how to quit smoking. These findings are in line with those of the present study, which will be discussed later in this report.

Further, a study by Hanewinkel and Mongenstren (2011) supports the notion of a content-related effect of cigarette advertisements. It underlines the specificity of the relationship between tobacco marketing and teen smoking. Accordingly, they found that exposure to cigarette advertisements is associated with smoking initiation.

In terms of factors that influence smoking initiation and continuation, (Chulasiri et al., 2017) assert that factors which associate with smoking in adult males in Sri Lanka are mostly modifiable. As such, the major modifiable predisposing factors for being an ever smoker are low educational level, unemployment and unfavourable attitudes that promote smoking. Meanwhile, the modifiable reinforcing factors identified were: having a father and/or relative who smoked, having friends who smoked and having frequent invitations to parties where smoking took place during the participant's youth. In addition to these factors, the study identified easy accessibility to tobacco products as an enabling factor that can be easily modified to prevent smoking among adult males of Sri Lanka.

Empirical evidence reveals that compilation and implementation of proper policies can reach the Last Mile considering its contextual basis. Notably, such measures or policies are mainly driven by gender, age, and ethnic group basis with aiming at the socio-economic background.

Research suggests that there are some significant differences in the pathways of friends' influences among the ethnic groups; Whites, Blacks, Hispanics, and other ethnic groups (Goings, Hidalgo, & McGovern, 2017; El-Toukhy, Sabado, & Choi, 2019). Gender and cultural differences play a dominant role in smoking influences, which suggest that smoking prevention and intervention programmes need to be sensitive to culture and gender (Goings, Hidalgo, & McGovern, 2017).

Smoking cessation helps people to stop continuation and delay initiation. As such, it plays a pivotal role in effective control of tobacco smoking. The WHO estimates that there is an 84 per cent increase in the chance of quitting successfully after being intensively advised by a physician (WHO, 2019a). In Sri Lanka, 51.8 per cent of the current smokers[3] has made quit attempts, and 35 per cent of users[4] to quit tobacco by health care providers (World Health Organization, 2018a). However, quitting remains to be a massive challenge for many, as they have to simultaneously stop their addiction, abandon comforting rituals and change their daily routine (Percival, 2009). Weak dissemination of unappealing cessation products relative to the tobacco industry's rigorous and attractive marketing, result in many smokers harbouring misinformation on various aspects. Some of these prevarications include; misinformation on the safety and efficacy of treatments and smokers tending to simultaneously believe that new cigarette products may be less harmful (Abraham, 2007).

3.4 Literature on Policy Interventions

3.4.1 Policy Interventions Aimed at Reducing Affordability

A growing body of research indicates that there exists a strong linkage between restricted affordability and low tobacco smoking prevalence (Chung-Hall et al., 2019). The WHO (2018) notes that raising tobacco taxes to make these 'deadly products' unaffordable is the most cost-effective measure to reduce tobacco use among individuals and communities. Similarly, European Commission (2020) asserts that affordability is one of the critical indicators for tobacco control. Affordability of cigarettes and fine-cut tobacco has decreased in most E.U. countries over the last decade, primarily in connection with tax increase trends. Weerasekera and Thilanka (2020) suggest that increasing and simplifying excise taxes are the most cost-effective tools that governments can employ to reduce smoking rates. According to revelations by Ho et al. (2018), the WHO FCTC has had a significant influence on reducing global tobacco consumption through taxation policies by controlling consumers' affordability.

The World Bank's Global Tobacco Control Programme has assisted 16 countries in the adaptation of tobacco taxation policy reforms to reduce consumption, improve public health and increase countries' tax base. For instance, in the case of developing countries with low-income and middle-income levels, these price increases are beneficial in lowering the intake as the poor prone to be more responsive to higher cigarette prices and hence reduce consumption (The World Bank, 2018). For instance, in the case of the Republic of Moldova, tobacco excise policy has been beneficial to a greater extent in the decline of tobacco consumption, which was driven by the reduction of tobacco affordability (Krasovsky, 2016). In the case of the Philippines, the 'Sin Tax' reform (an excise tax now GST) specifically levied on certain goods such as alcohol and tobacco) has created fiscal space to increase the budget threshold of the Department of Health. It has also made cigarettes more expensive to obtain, thereby discouraging smokers (Kaiser, Bredenkamp, & Iglesias, 2016). Furthermore, in the case of Columbia, as a part

[3] Among current smokers and former smokers who have been abstinent for less than 12 months in the past 12 months.

[4] Among those smokers who visited a healthcare provider in the past 12 months.

of its broad fiscal reform package, the new taxes on tobacco (with annually adjusted inflation) are expected triple prices and thereby reduce affordability and consumption (The World Bank, 2018).

It is essential that whatever the imposed taxation policy is, it possesses the ability to reduce affordability so that it reduces consumption. For instance, in most of the lower-income and MICs, the wages are rising at a higher rate relative to the price increase in smoking products, and as a result, tobacco smoking products become more affordable for consumers (as the purchasing power has increased owing to increase in income). This would increase consumption, unless tobacco taxes rise even faster. Effective strategies require involving a combination of significant initial tax increases with recurrent hikes over time, ensuring that the cigarette prices will climb more steeply than per capita real income growth (including inflation) (Marquez & Moreno-Dodson, 2017).

3.4.2 Policy Interventions Aimed at Reducing Availability and Accessibility

Policymakers can adopt and implement various supply-side policies to limit access and exposure to tobacco. For instance, increasing the minimum age of sale, limiting the number or type of tobacco outlets, or banning the display of tobacco products are some of the measures that have been able to successfully restrict the accessibility and availability of cigarettes (Kuijpers et al., (2019). Similarly, findings from Tam et al., (2018) indicate that imposing a minimum age of legal access would prevent and delay the initiation of smoking among adolescents and youth adults. Policy interventions that regulate who and how tobacco smoking produts can be purchased, where these are to be used (i.e., smoke-free policies in restaurants, bars, and other public places) are beneficial in controlling tobacco use among the youth (National Institute on Drug Abuse, 2020). Furthermore, according to Tam et al., (2018), smoke-free air policies that prohibit smoking in designated areas are effective in reducing smoking prevalence and increasing quitting rates in both youth groups and employed people irrespective of the age. For instance, prohibiting smoking in workplaces (private and public), restaurants and bars at the state and local levels are practical. In addition to the policies above, 'Tobacco Free Village' programmes conducted in Maharashtra state in India claim to be successful in reducing smoking prevalence as it restricts access to tobacco products in rural areas (Chatterjee, Patil, Kadam, & Fernandes, 2017). Additionally, Tobacco Free Kerala (2018) notes, initiating smoke-free villages has enabled shutting down of six shops (out of 13), which used to sell tobacco and facilitated smokers to reduce their cigarette intake; this ultimately contributed to stop smoking by creating barriers in terms of accessibility.

3.4.3 Policy Interventions Aimed at Increasing Awareness

Evidence-based awareness interventions are the main components of comprehensive tobacco prevention (Centres for Disease Control and Prevention, 2017). Control efforts such as mass-reach health communications campaigns in the form of multiple media formats and hard-hitting graphic images that are intended to effect a shift in knowledge, beliefs, attitudes, and behaviours affecting tobacco use are essential. It is also vital that these graphics provide information on resources on how to quit. Practices that affect the behaviour of people (such as mass media campaigns, comprehensive community programmes, and comprehensive statewide tobacco control programmes) not only prevent initiation of tobacco use but also, reduce the prevalence of tobacco use among youth and adults (U.S. Department of Health and Human Services, 2014). For instance, programmes such as "Stoptober" which was initially started in the UK to encourage people to stop smoking for 28 days in October has proven to be successful in creating a national collective effort as a stepping stone for permanent cessation in smoking (Kuipers, West, & Beard, 2019). This programme has improved quitting rates and quit attempts in October, even though this requires sufficiently a high budget for the implementation of the programme. Furthermore, a community-based smoke-free home programme in Indonesia,

which is also the first one to be initiated in South East Asia, affirms that the programme redefined smoking as a health issue among women and children, incorporated family welfare to core cultural values, and offered women a leadership role in tobacco control and thus was successful (Padmawati et al., 2018).

3.4.4 Policy Interventions Aimed at Tobacco Smoking Cessation Support

Behavioural treatment approaches to smoking cessation (such as individual, group and telephone counselling) are useful when delivered across a wide variety of settings. For example, such treatment methods can be made available through several platforms and to a diversity of populations such as low-income populations and populations with behavioural health conditions (U.S. Department of Health and Human Services, 2020). As Chung-Hall elt al. (2019) note, policy interventions that are focussed on youth access laws prevent smoking initiation, decrease the prevalence and promote cessation. Comprehensive smoke-free policies substantially help smokers to quit, as asserted by Centres for Disease Control and Prevention (2017). According to the National Institute on Drug Abuse (2020), tobacco cessation interventions that take place at the school or community level, restrictions on advertising and mandatory health warnings on packages are effective in smoking cessation among youth and individuals in the lower-income cohort. Furthermore, implementing a toll-free national portal that links callers to their state quitline based on their area code and having an electronic telecommunications device for the deaf or for those who have hearing disorders are effective in terms of helping these smokers to quit (U.S. Department of Health and Human Services, 2020). Cessation interventions, which include the corporation and involvement of health care providers such as doctors and nurses are efficacious in encouraging people to quit smoking as they are influential (Karjalainen, Ollila, & Lipponen, 2020). Further, using social media and influencers to reach and engage teenagers in dialogue about smoking has proven to be useful in quitting among the target group (Larsen, 2020).

According to a IPS research, Sri Lanka's current efforts in tobacco cessation focus on changing the behaviour of people, by conducting diversified programmes that target different groups. These include; educative sessions, training, one to one counselling, a national quitline, and awareness campaigns via electronic and print media (Madurawala & Karunanayake, 2020). Furthermore, as asserted by Karunanayake (2020), cessation support has a vital role to play in reducing smoking prevalence, especially when combined with other policy interventions. As such, policy interventions that aim smoking cessation will be more successful if these involve a combination of various interventions (which align and complement with smoking cessation inverventions) that were discussed previously.

4. Tobacco Smoking in Sri Lanka

4.1 The Policy Context

Sri Lanka became a Party to the WHO FCTC on February 27, 2005. The WHO FCTC is the first global public health treaty. It is an evidence-based treaty that reaffirms the rights of all people to the highest standard of health, adopted by the 56th World Health Assembly held in Geneva, Switzerland, on May 21, 2003. The signatories to the convention are required to take measures on demand reduction provisions stipulated in the convention. The core demand reduction provisions in the WHO FCTC are in two forms; price and tax and non-price measures to reduce the demand for tobacco. Non-price measures include; protection from exposure to tobacco products, regulation of the contents of tobacco products, regulation of the tobacco product disclosures, packaging and labelling of tobacco products, education, communication, training and public awareness, tobacco advertising, promotion and sponsorship and demand reduction measures concerning tobacco dependence and cessation (World Health Organization, 2003). After becoming a signatory to the WHO FCTC, Sri Lanka has taken some crucial steps in reducing and controlling tobacco usage.

The National Authority on Tobacco and Alcohol (NATA) Act, which was passed in 2006 is the law governing tobacco control in Sri Lanka (National Authority on Tobacco and Alcohol Act, No. 27, 2006). The Act includes measures relating to restrictions on smoking in public places; packaging and labelling requirements, tobacco advertising, promotion, and sponsorship; establishment of the National Authority on Tobacco and Alcohol; and offences and penalties. The Act also authorises the Minister of Health to issue regulations under the law. The Minister issued regulations regarding the content and display of the required health warnings in August 2012 and amendments to these regulations in November 2012, February 2013, and May 2014. Because of litigation brought by the tobacco industry, these regulations did not enter into force until January 1, 2015. The National Authority on Tobacco and Alcohol (Amendment) Act was passed in March 2015 which increased the size of health warnings to 80 per cent of the front and back of tobacco product packages. In 2016, the Minister issued regulations prohibiting the manufacture, importation and sale of smokeless tobacco products, e-cigarettes containing tobacco and cigarettes that are flavoured, coloured, or sweetened. As such, current tobacco controlling laws in Sri Lanka are as summarised in Table 5 below.

4.2 Tobacco Smoking Trend in Sri Lanka

This sub-section discusses the trend of tobacco smoking in Sri Lanka. This report summarises the best evidence available at the time of writing the report.

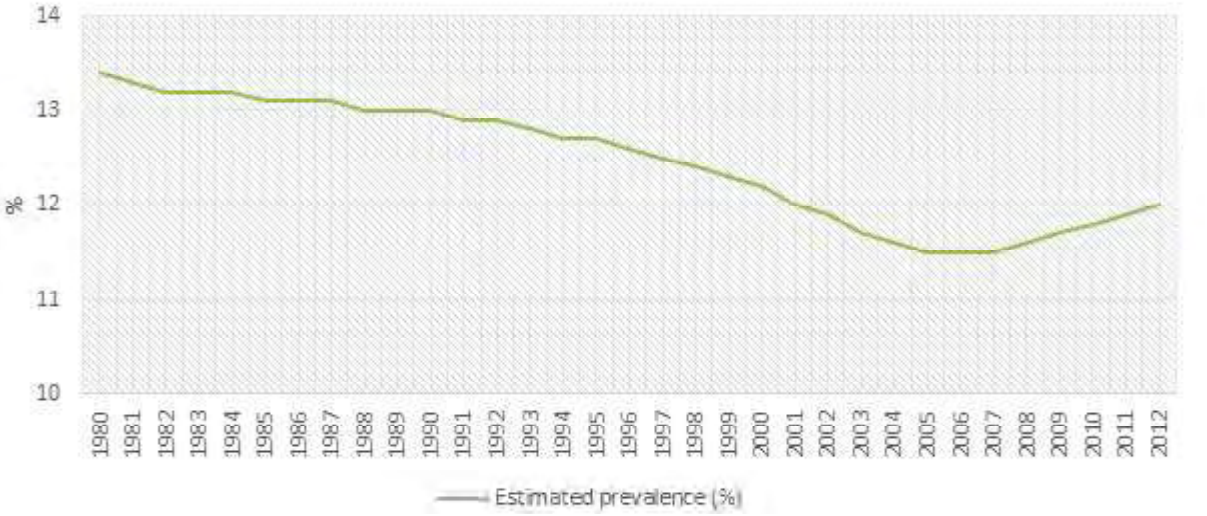
The share of people who smoke every day shows a decreasing trend with small fluctuations from 1980 to 2012 (Figure 6). However, the share has decreased only by around 1.5 per cent points (from 13.5 per cent to 12 per cent) during the period under consideration. The lowest prevalence rate was recorded in three consecutive years, 2005, 2006 and 2007 as 11.5 per cent. Afterwards, it started to rise slightly showing an increasing trend of the prevalence.

Table 5
Tobacco Control Policies in Sri Lanka

Reducing Affordability	Increasing Awareness	Reducing Availability/Access
• *Increasing price through tobacco taxation* [Tobacco Tax Act No. 8 of 1999] There shall be charged, levied and paid on every cigarette, cigar, beedi and every kilogramme of pipe tobacco manufactured in Sri Lanka. Furthermore, a duty of LKR 5/= is levied on every imported cigarette	• *Tobacco Packaging and Labeling* [Act No. 27 of 2006 on National Authority on Tobacco and Alcohol (NATA)] Smoking tobacco product packages are required to have pictorial and text health warnings that cover 80 per cent of the top front and back of packages and rotate every six months. Misleading packaging and labelling, including terms such as 'light' and 'low' is prohibited, but it is unclear if the prohibition also includes trademarks and figurative and other signs. It is prohibited to manufacture, import, or sell smokeless tobacco products, e-cigarettes containing tobacco, and cigarettes that are flavoured, coloured, or sweetened.	• *Smoke-Free Places* [Act No. 27 of 2006 on National Authority on Tobacco and Alcohol (NATA)] Smoking is prohibited in many indoor public places, private government departments, hospitals, residential health care facilities, public areas, schools, universities, educational institutes and public transport. However, smoking is permitted in smoking areas or spaces in airports, hotels having 30 rooms or more, and restaurants having a seating capacity of a minimum of 30 persons.
	• *Tobacco Advertising, Promotion and Sponsorship* [2014 Regulation Amending the Tobacco Products (Labelling and Packaging) Regulations, No. 01 of 2012 & National Authority on Tobacco and Alcohol (Amendment) Act, No. 3 of 2015] Advertising, through most forms of mass media, is prohibited. There are some restrictions on tobacco sponsorship and the publicity of such sponsorship.	• *Sales Restrictions [National Authority on Tobacco and Alcohol (Amendment) Act, No. 3 of 2015]* The law prohibits the sale of tobacco products via vending machines. The law also prohibits the sale of smokeless tobacco products. The sale of tobacco products is prohibited to persons under the age of 21.
		• *Prohibition of Tobacco Products* [National Authority on Tobacco and Alcohol (Amendment) Act, No. 3 of 2015] This bans the manufacture, import, and sale of smokeless tobacco products, e-cigarettes containing tobacco and flavoured, coloured, or sweetened cigarettes.

Source: Tobacco Control Laws. (2019, September 18). *Tobacco Control Laws, Legislation by Country, Sri Lanka*. Retrieved July 22, 2020 from Tobacco Control Laws: https://www.tobaccocontrollaws.org/legislation/country/sri-lanka/summary.

Figure 6
Share of People Who Smoke Every Day, Sri Lanka

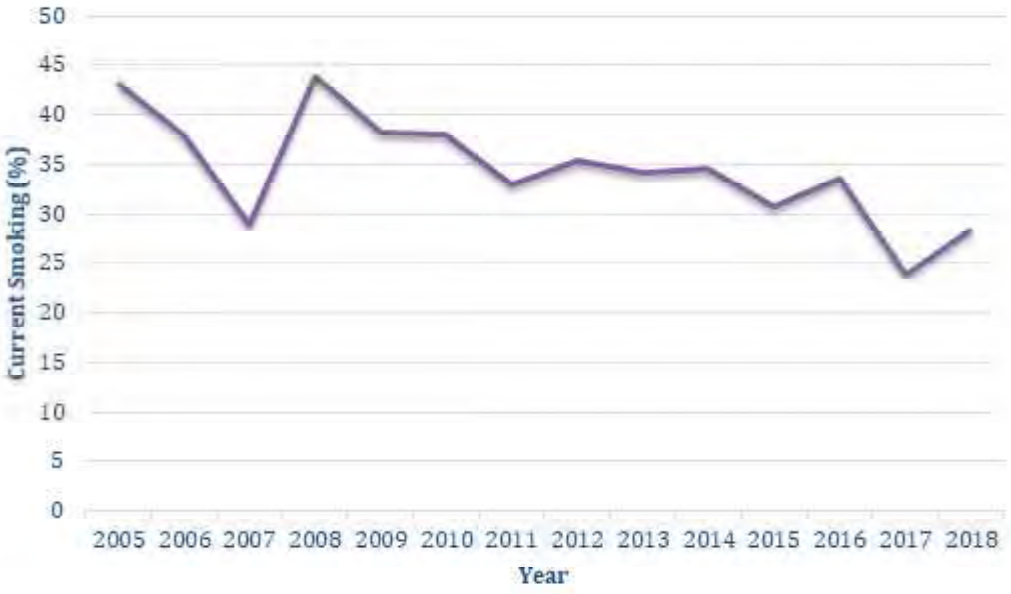


Note: Estimates of the prevalence of daily smoking, defined as the percentage of men and women, of all ages, who smoke daily.

Source: Roser, M., & Ritchie, H. (2019). *Smoking - Our World in Data*. Retrieved August 27, 2019, from Our World in Data https://ourworldindata.org/smoking#empirical-view.

More recent data on tobacco smoking prevalence are given in Figure 7 below. The smoking trend indicates a decreasing trend with some fluctuations over the period reporting 43.1 per cent in 2005 and 28.4 per cent in 2018.

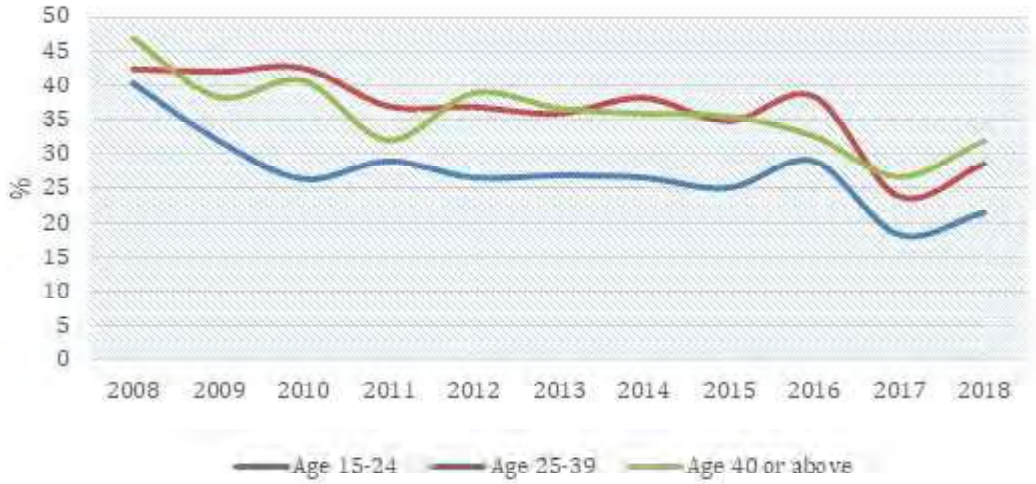
Figure 7
Overall Current Tobacco Smoking Trend (2005 - 2018)



Source: Alcohol and Drug Information Centre. (2019). *Trend Survey on Tobacco, Annual Trend Survey on Tobacco Smoking in Sri Lanka-2018.* Colombo: Alcohol and Drug Information Centre.

The highest rate of smoking prevalence was recorded from the age of group 40 or above years compared with the other two age groups of (15-24) and (25-39), except for 2012 and 2014 (Figure 8). However, the overall trend of smoking prevalence rate has declined among all three age groups.

Figure 8
Current Tobacco Smoking Trends by Age Categories (2008 - 2018)



Source: Alcohol and Drug Information Centre. (2019). *Trend Survey on Tobacco, Annual Trend Survey on Tobacco Smoking in Sri Lanka-2018*. Colombo: Alcohol and Drug Information Centre.

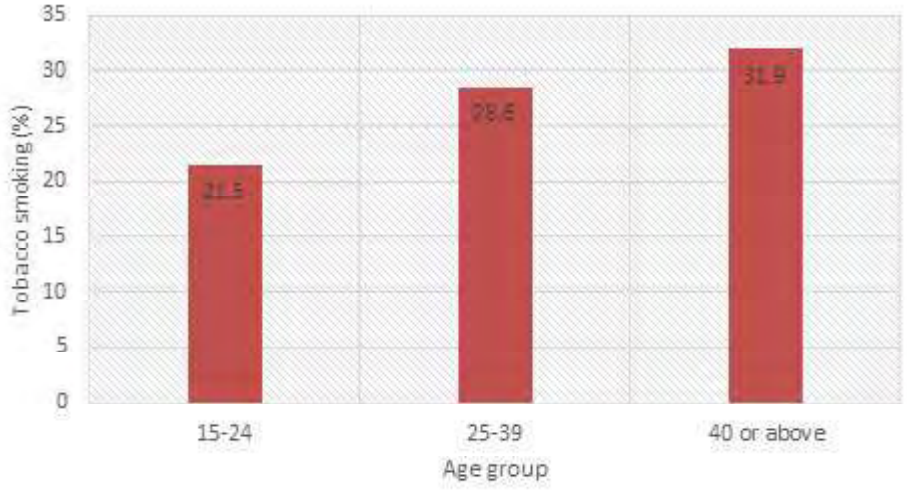
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4.3 The Last Mile Smokers in Sri Lanka

4.3.1. Age

Figure 9 demonstrates that in the year 2018, smoking prevalence is highest among people who are 40 years and above, which is 31.9 per cent.

Figure 9
Current Tobacco Smokers as a Percentage of Agewise Population (2018)



Source: Alcohol and Drug Information Centre. (2019). *Trend Survey on Tobacco, Annual Trend Survey on Tobacco Smoking in Sri Lanka-2018*. Colombo: Alcohol and Drug Information Centre.

4.3.2 Sex

Sex disaggregated data on smoking prevalence indicate a significant difference between the two sexes, where the female smoking prevalence rate is at a low level.

The WHO STEP Survey (2015) data reveal the difference between the two sexes in tobacco smoking prevalence (Table 6). According to this survey data, 29.4 per cent of the males in the 18-69 age category has been identified as 'current smokers' whereas in terms of females it is only 0.1 per cent. Further, there also a considerable difference between the two sexes in the mean age of smoking initiation. Males tend to initiate smoking at a younger age, whereas females tend to start smoking in their middle-age. It is also important to note here that unlike tobacco smoking, the percentage of females using smokeless tobacco is relatively high.

"Sex disaggregated data on smoking prevalence indicate a significant difference between the two sexes, where the female smoking prevalence rate is at a low level."

4.3.3 Geographical Location

Annual Health Bulletin (AHB) published by the Ministry of Health Nutrition and Indigenous Medicine has data on the percentage of smokers detected by the Regional Director of Health Services (RDHS) area level. Data extracted from the National NCD (Non-communicable Diseases) Programme conducted by the Ministry of Health covered all districts with a total number of 548,250 screened in 2016.

AHB 2016 was the latest available AHB (at the time of writing this publication) with the percentage of detected smokers by the RDHS area level. In 2016, Nuwara Eliya, Vavuniya, Mullaitivu, Mannar and Kilinochchi districts were the top five RDHS areas with the detected smokers in 2016. Kegalle, Malate and Matara RDHS areas recorded the lowest percentage of detected smokers. Figure 10 shows the comparison

Table 6
Tobacco Use in Sri Lanka

Adults Ages 18-69	Both Sexes	Males	Females
Currently smoke tobacco (%)	15.0	29.4	0.1
Currently smoke tobacco daily (%)	10.2	19.9	0.1
Currently use smokeless tobacco (%)	15.8	26.0	5.3
Currently use smokeless tobacco daily (%)	11.7	19.0	4.1
Currently use tobacco in any form (%)	25.8	47.7	5.3
For Those Who Smoke Tobacco Daily			
Average age started smoking (years)	20.7	20.5	46.2
Per centage of daily smokers smoking manufactured cigarettes	82.9	82.4	0.0
The mean number of manufactured cigarettes smoked per day (by smokers of manufactured cigarettes)	3.7	3.7	0.0

Source: World Health Organization. (2015b). *Sri Lanka STEPS Survey 2015*. Retrieved July 29, 2020 from World Health Organization. https://www.who.int/ncds/surveillance/steps/STEPS-2015-survey-Tobacco-Fact-Sheet-Sri-Lanka.pdf

of the detected smokers (in percentage) by the RDHS area for 2012 and 2016. It is interesting to observe that in certain areas, the change is so significant where some areas indicate a drastic increase (e.g. Killinochchi, Vavunia, Nuwara Eliya, Hambantota and Anuradhapura) and areas like Batticaloa shows a considerable decrease.

Some explanations behind this increase, especially in the conflict-affected areas, were discussed during the FGD at Killinochchi. According to the participants, before 2009, when the Tamil separatists ruling most of the Northern and Eastern regions of the country, there were strict restrictions on selling and smoking cigarettes. With the end of the armed conflict in 2009, those regulations were relaxed, and cigarettes became easily accessible. The road network of those parts of the country renovated and along with this, many new by-roads were developed. Many new roadside boutiques and eateries opened in towns and remote areas which started selling cigarettes. Commencement of large construction projects in these areas, saw the migration of construction workers known as high smoking groups from other parts of the country. Furthermore, findings revealed that the tobacco company had launched their promotion campaign in those areas rigorously to capture the new market that had open up after the armed conflict.

ADIC tobacco spot survey (2018) carried out covering only 11 districts indicates the highest smoking prevalence rate from the Hambantota district (48.5 per cent), followed by Jaffna district (35.9 per cent) (Figure 11). Hambantota, Jaffna, Mannar, and Colombo recorded higher smoking prevalence rates than the overall rate, which was 28.4 per cent.

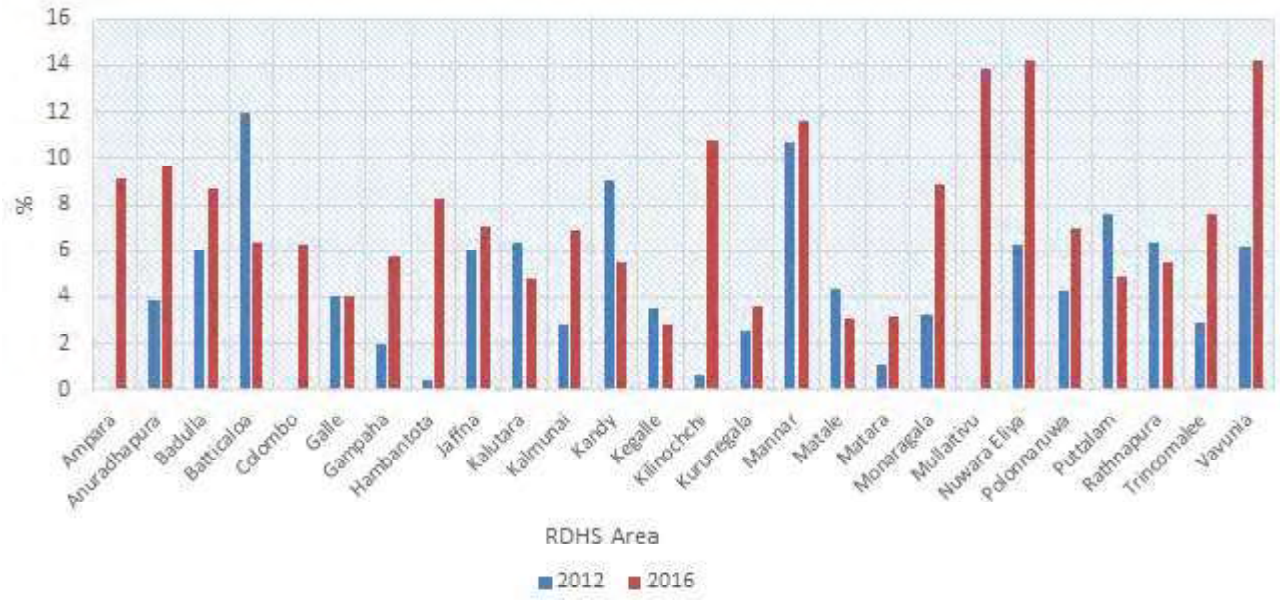
4.3.4 Schooling Status

According to AHB 2016, among those who are in the 15-24 age category, a higher tobacco smoking prevalence was recorded from the non-schooling group compared with the schooling group. Tobacco smoking prevalence of non-schooling males was 23.9 per cent, while it takes only 4.3 per cent among schooling groups (Ministry of Health, Nutrition and Indigenous Medicine, 2016).

4.3.5 Smoking Among School Children

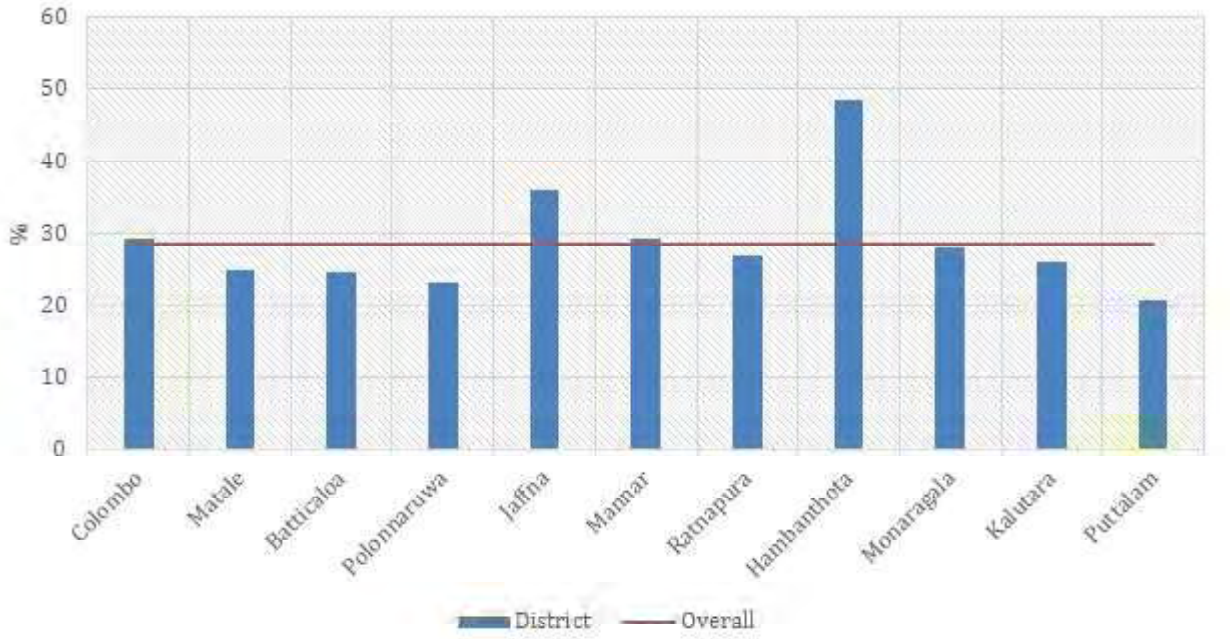
In terms of school children who engage in smoking, the prevalence was relatively high among male students compared to very low prevalence among female students. As demonstrated in Figure 12, in the year 2016, smoking prevalence is higher amongst male students in the 16-17 age category (10.9 per cent) compared to the male student in

Figure 10
Detected Current Tobacco Smokers by RDHS Area (%) - 2012 and 2016



Source: Ministry of Health, Nutrition and Indigenous Medicine. (2016 & 2017). *Annual Health Bulletin*. Colombo: Ministry of Health, Nutrition and Indigenous Medicine.

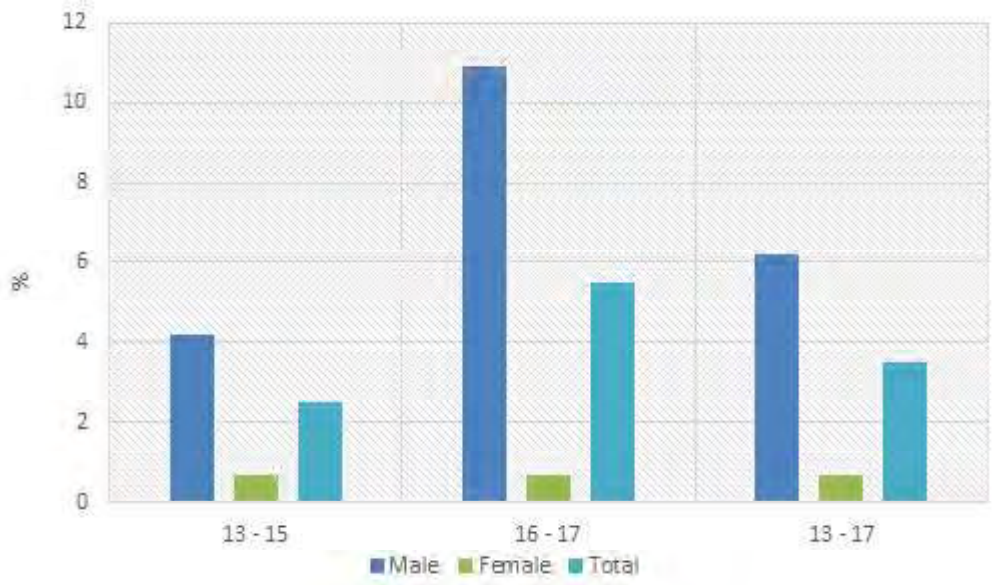
Figure 11
Prevalence of Current Tobacco Smokers as a Percentage of District Population - (2018)



Source: Alcohol and Drug Information Centre. (2019). *Trend Survey on Tobacco, Annual Trend Survey on Tobacco Smoking in Sri Lanka-2018*. Colombo: Alcohol and Drug Information Centre.

the 13 -15 age category (4.2 per cent). As such, this explains the situation where male students might smoke despite the prohibition imposed by law. Smoking prevalence among female students is as low as 0.7 per cent and thereby points to a glaring sex difference in smoking prevalence rates among schooling children in Sri Lanka. However, overall smoking prevalence among school children irrespective of gender is 3.5 per cent which, is still a concerning factor.

Figure 12
Percentage of Students who Currently Smoked Cigarettes



Note: Percentage of students who smoked cigarettes at least one a day during the 30 days before the survey.

Source: World Health Organization. (2016). *Global School-based Student Health Survey: Sri Lanka- 2016 Fact Sheet*. Geneva: World Health Organization.

4.3.6 Sector

The rural sector has a higher share of households with at least one smoker at 34.5 per cent compared to 31.6 per cent in each estate and urban sectors (Figure 13). The data further show that there is no significant difference between smoking prevalence across sectors in the country.

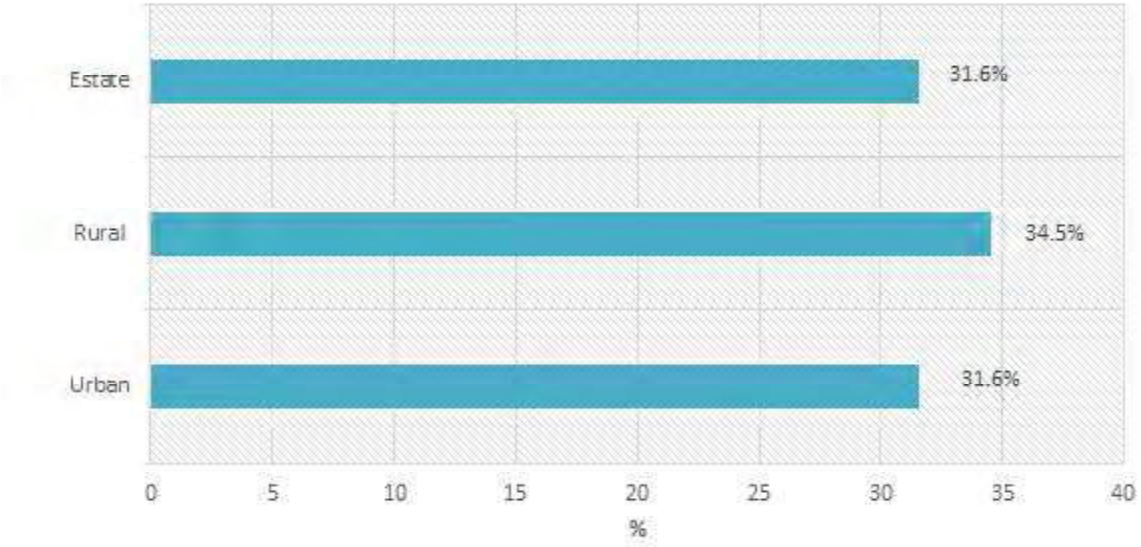
4.3.7 Income Status

In terms of wealth, 39.7 per cent of the households in the lowest wealth quintile (i.e., the poorest households) have at least one member who smokes tobacco. This wealth quantile records the highest rate of smoking among others. There is a strong correlation between income level and smoking.

4.3.8 Occupation

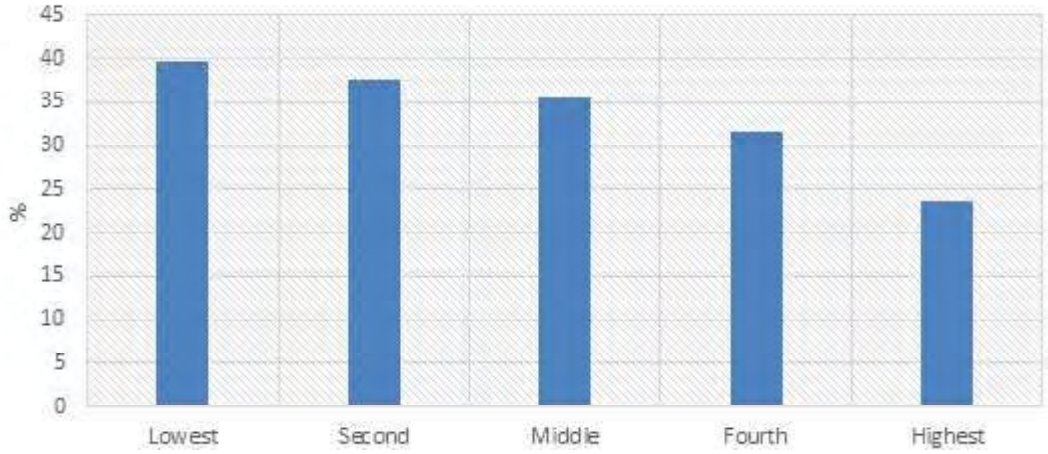
'Skilled agricultural and fishery workers' and 'Craft and related workers' occupational groups have more current smokers over the other occupational groups (Figure 15). 'Technicians and associate professionals' and 'service workers and shop and market sales workers' are the two occupational categories recording the lowest share of current smokers.

Figure 13
Percentage of Households in which at Least One Member has Smoked Tobacco, Based on the Sector



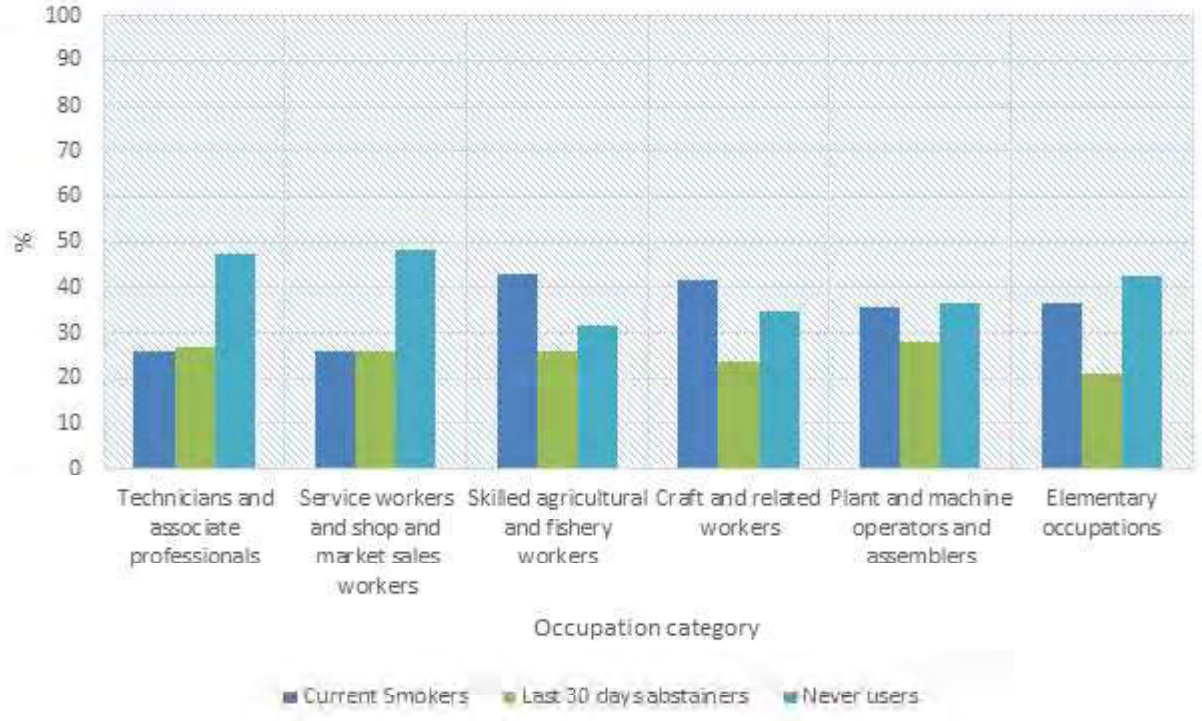
Source: Department of Census and Statistics. (2016). *Demographic and Health Survey 2016*. Colombo: Department of Census and Statistics.

Figure 14
Percentage of Households in which at Least One Member has Smoked Tobacco Based on Wealth Quintile



Source: Department of Census and Statistics. (2016). *Demographic and Health Survey 2016*. Colombo: Department of Census and Statistics.

Figure 15
Share of Different Categories of Tobacco Smokers, by Occupation Group



Note: Definition for last 30 days abstainers: Who have ever smoked in their lifetime but have abstained for the past 30 days at the time of the survey.

Source: Alcohol and Drug Information Centre. (2019). *Trend Survey on Tobacco, Annual Trend Survey on Tobacco Smoking in Sri Lanka-2018*. Colombo: Alcohol and Drug Information Centre.

The Last Mile Smokers in Sri Lanka



Men aged 40 and above



Men from poorer households



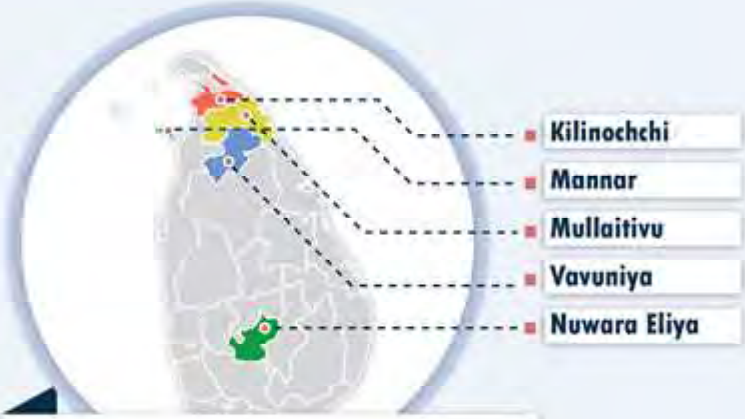
Men from rural areas



Youth from non-schooling background



Agriculture, fisheries and craft workers



High prevalence districts

5. Understanding the Last Mile Smokers

The FGDs were conducted in eight locations of the country with nine different groups of Last Mile smokers to collect qualitative data. Altogether, 121 smokers participated in FGDs and shared experiences and expressed views on smoking initiation, continuation, quitting, access and affordability, awareness, and suggestions for new policies.

5.1 Smoking Initiation

The dominant drivers behind smoking initiation are; perceiving smoking as a remedy for loneliness and distress, being curious to experiment with new things, breaking the monotonous nature of their jobs, peer pressure, and imitating other smokers in the family or community. In some groups, influence from popular characters is also a prominent factor in stimulating people to start smoking.

Interestingly, findings also suggest that the type of occupation (especially when night shifts are compulsory) provokes people to have their first smoke and that smoking habit gets integrated into their working routine.

"*I started smoking when I was working at the harbour. Cigarettes were available frequently, and most of the time, I got them for free through friends who are dealing with ships*."
- *FGD participant from low-income category, Moneragala*.

“The dominant drivers behind smoking initiation are; perceiving smoking as a remedy for loneliness and distress, being curious to experiment with new things, breaking the monotonous nature of their jobs, peer pressure, and imitating other smokers in the family or community. In some groups, influence from popular characters is also a prominent factor in stimulating people to start smoking.”

"*I started to smoke because of my occupation. I used to drive a lorry and do night shifts. My friend recommended me to have a cigarette as it helps to be awake during the night when driving the vehicle, and it has been helpful ever since then when I drive in the nights*."
- *FGD participant (Driver) from Colombo*.

"*I started smoking because of farming. I want to have one whenever I am exhausted during work (farming) and when it is cold. Since then, I have been continuing to smoke*."
- *FGD participant from high prevalence area Killinochchi*.

FGD respondents also revealed that the influence of celebrities, famous characters in teledramas and movies (mainly in Tamil and Hindi Movies) provoked them to start smoking. While recalling how most of the famous actors and villains in movie characters engaged in smoking in different manners, respondents were of the view that this tempted them to start smoking.

"*I still remember how different actors used to smoke differently. They had their style of smoking. For instance, some were emitting smoke from their nose while others created various designs such as clouds and spirals when emitting smoke. This provoked us to start smoking. Those actors were our heroes back then, and even now, we appreciate their acting*."
- *FGD participant from the estate sector, Hatton*.

'These findings are interesting when considering how tobacco companies are now paying social media influencers to promote smoking as fashionable and standard, to encourage a new generation of smokers.

Peer pressure has been identified as a significant factor that stimulated the current smokers to start smoking. Smoking, according to the FGD participants, enabled them to get conformed to a specific crowd, find new friends, increase the circle of friends, maintain social status and to be a part of a specific clique with peers and adults.

"*I started smoking to get involved in the clique of friends. Had I not smoked, I would have been left behind. Thus, to be a part of the group, I had to do what others did. Gradually, it became a habit*."
- FGD participant from the 40+ group, Negombo.

Most of the smokers participated in FGDs stated that their curiosity to experience new things at the younger age was one of the significant reasons to experiment cigarette or beedi for the first time.

"*Curiosity made us experience cigarettes, and then we got addicted to it. We can understand that the social status and persons who kept the company at that time induced us to start smoking. Another reason is the motivation caused by the adults around us. When we saw adults were smoking, we also wanted to smoke and have a new experience*."
- FGD participant from youth group, Dompe.

Findings also indicate that smoking initiation is further fuelled up by seeing people from their community smoking frequently and noticing them throwing away their cigarette buds after use. For instance, as stated by one of the respondents in the low-income group:

"*I had a desire to experience cigarettes as I witnessed smoking in the community quite often, and that was of close vicinity. One day, I kept an eye on the cigarettes that are thrown away after use, and the very next day, I picked those cigarette buds and started trying them out by smoking the remaining parts of those buds. I managed to hide them from my family when doing so*."
- FGD participant from low-income category, Moneragala.

In addition to reasons elaborated above, factors such as for fun/ pleasure, to feel like an adult, stimulated by seeing the smoking elders (especially father, grandfather or brother smoking at home and assisting them in lighting up their cigarettes), owing to its 'good smell' (as they call it), and due to mental trauma caused by a negative life incident (such as a critical accident) have influenced them to start smoking.

FGD participants stated that smoking promotion and glamorisation done portraying famous movie stars or other popular social figures had affected them a lot in initiating their smoking habits.

"*We as people in the Tamil community watch a lot of Tamil and Hindi movies from India. We see these celebrities as our role models and superheroes smoke in different styles. Each actor has a unique style that motivates us to smoke. We often imitate these actors*."
- FGD participant from the estate sector, Hatton

"*I still remember how those superheroes in films used to fight against the villain after having a smoke. We believed it to be something, which gives him strength and courage. Even now, when we have a smoke during work, we feel much better, and we get energy. Moreover, if it was awful for health, why would famous people smoke*?"
- FGD participant from the estate sector, Hatton

Table 7 below gives a summary of the findings of the FGDs on smoking initiation.

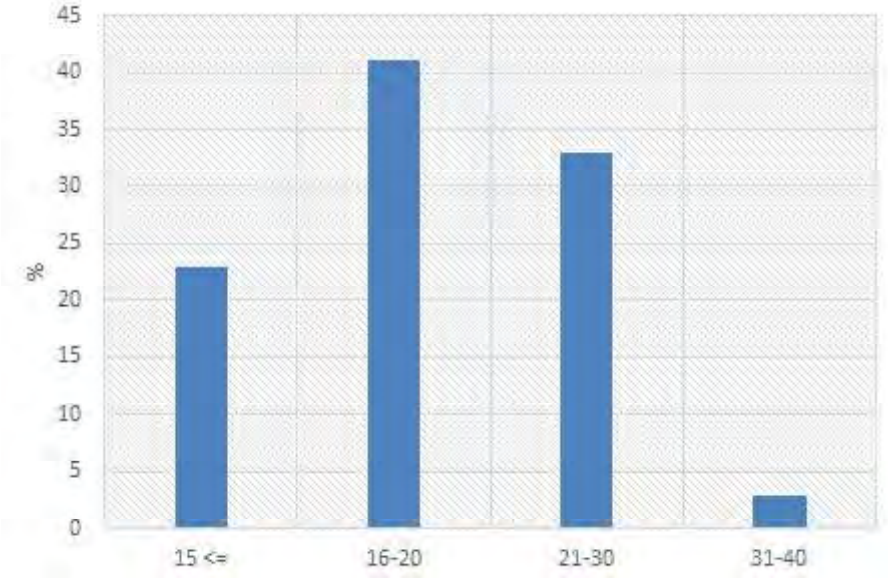
The survey carried out with the FGD respondents revealed that 64 per cent of the current smokers started smoking before the age of 21 years (Figure 16), and smoking initiation mostly occurred at the age category of 16-20, which amounted to 41 per cent of the smokers. In contrast, the least number of smokers started smoking at the age category 31-40. These findings highlight the importance of interventions to ensure that young people do not fall into the habit of smoking.

Table 7
FGD Participants on Smoking Initiation

Smoking Initiation	Reasons to Start Smoking										
FGD Groups	Keen on experimenting with new things	Quitting sports	For pleasure/ Fun	To overcome loneliness/ remedy for distress	To feel like an adult	Influence by family members	Peer pressure	At a special occasion	Occupation	Seeing community smoke	Good smell
Construction workers	✓	✓	✓	✓					✓		
Drivers	✓				✓	✓	✓	✓	✓	✓	
40 years and above	✓			✓		✓		✓		✓	
Youth	✓		✓	✓	✓					✓	
Low-income group	✓		✓	✓			✓			✓	✓
Rural sector	✓		✓				✓	✓	✓		
Kilinochchi				✓			✓	✓	✓		
Estate sector							✓		✓	✓	

Source: Compiled by the authors based on findings.

Figure 16
Smoking Initiation by Age Category as a Percentage of Current Smokers



Source: FGD participants' survey.

5.2 Smoking Continuation

In terms of factors affecting smoking continuation, almost all sectors interviewed had similar opinions. Findings suggest that the most common reasons for continuation are; continuing to smoke as a habit, continuation owing to the nature of the occupation, due to lack of incentives to stop smoking and lack of self-control to stop smoking.

The majority of the smokers had specific times of having cigarettes (e.g. as soon as they wake up, after having tea, before and after each meal, before going to the washroom, before sleeping, while working and during breaks at work). However, some smoked only on special occasions; when having alcohol, at a funeral, at a party or a wedding. Furthermore, there were few respondents from each sector who smoke continuously throughout the day.

"*Smoking has become a habit now as it is part of our daily routine. We smoke before having meals, after having meals, before going to the washroom, in the washroom, before we sleep. It has made our lives much easier*."
- FGD participant (construction worker), Colombo

For some smokers, tobacco smoking has become an addiction. A participant from the construction sector explains his perception of smoking, and how he uses it to overcome unpleasant situations in life, indicating his addiction to smoking.

"*Cigarette is more than a friend to me. Even though there are chances that my family and friends leave me, my cigarette will never leave my side. Thus, the cigarette is my only companion in both good times and bad times*."
- FGD participant (construction worker) from Colombo

Furthermore, respondents also revealed that if they are to stop smoking and quit this habit or to delay taking a cigarette, they face many challenges in terms of health and mood swings. For instance, they were getting headaches quite frequently, unfitness, inability to concentrate, difficulty in secretion, feeling distressed and getting upset quite often.

"*I have a particular time for smoking; every day at 6.00 pm, if I delay a minute, I suffer from severe headache*."
- FGD participant from the estate sector, Hatton

Discussions also revealed that the nature of occupation plays a significant role in smoking continuation.

"*When I do my work (masonry), I go for a smoke to take breaks in between and as an excuse to ditch work. It helps us as a time passer*."
- FGD participants from the 40+ age group, Negombo

"*We, as fishermen, do not like quitting, as it will be a disadvantage for our job. For us, smoking is useful when going on fishing at night. During fishing, we smoke from very early in the morning because it is cold*."
- FGD participants from the 40+ age group, Negombo

The link between smoking behaviours and certain occupations is impressive and reflected in the smoking prevalence figures, which shows that smoking rates are much higher in particular occupations. It suggests that cessation support needs to be tailored to address the specific factors, which encourage individuals in different occupations to continue with the habit of smoking.

The role of peers, both in influencing smokers to begin smoking and in continuing to smoke, also points to the potential effectiveness of community or group-based support.

Quite interestingly, discussions also revealed that not having robust, convincing modes of spreading awareness about the dangers of smoking have kept smokers attached to continuation.

"*We know the adverse health effects of smoking, and it is mentioned on the cigarette packet also, saying smoking causes cancer. However, we do not take it seriously*."
- FGD participant from the low-income sector, Monaragala

"*We have witnessed many healthy people suffering from various diseases than the ones who do not think much of health. Therefore, we feel like cigarettes do not affect our health adversely, and it induces us to continue. Moreover, we will live only a short period, so that it is no point in stopping smoking now. You die even if you don't smoke, and everyone who gets cancer does not smoke*."
- FGD participant from the low-income sector, Monaragala

Table 8
Smoking Continuation

Smoking Continuation	Reasons Behind Smoking Continuation									
FGD Groups	As a habit	Addiction	Has become a necessity in life	As a time-passer	Lack of incentives to stop smoking	Occupation	Lack of self-control	As a remedy for stress/ loneliness	For relaxation	Influence from society and community at large
Construction workers	✓	✓	✓	✓	✓	✓	✓			
Drivers			✓		✓	✓				✓
40 years & above	✓			✓	✓	✓		✓		
Youth			✓		✓		✓	✓		✓
Low-income group	✓						✓	✓		
Rural sector	✓	✓				✓	✓			
Kilinochchi	✓		✓		✓		✓		✓	
Estate sector	✓	✓				✓	✓		✓	

Source: Compiled by the authors based on findings.

When probing into the factors that make people attached to the continuation, most of the FGD groups pointed out that lack of self-determination and lack of self-control to stop smoking has made them attached to smoking.

Table 8 gives summarised findings of the FGDs on reasons for smoking continuation.

The KIIs with the stakeholders highlighted that smoking initiation is generally rooted upon curiosity, negative feelings, peer pressure and societal influence and is continued owing to the gaps in legislation, lack of proper cessation programmes and insufficient cessation help.

Evidence from the FGDs also revealed that low education and inadequate knowledge on long-term health effects of smoking are reasons for continuation. This situation indicates that the current awareness programmes haven't reached these smokers adequately. As such, intensifying and widening the outreach of health awareness creation are needed. Further, the participants also suggested that since school days, adverse effects of tobacco and the importance of refraining from smoking should be inculcated among students (specially for students who are in the Ordinary Level and Advanced Level should be educated on the adverse effects of smoking).



5.3 Smoking Cessation

Most of the FGD participants stated that they like to quit smoking, but they cannot do so due to lack of will power and self-control. Health concerns, personal commitments and responsibilities (e.g. being married, having kids, having to look after elderly parents), and economic constraints have motivated them to consider quit smoking. The survey carried out among the FGD participants reveals that 78 per cent of them had attempted quitting smoking at least once.

Financial reasons were another common reason cited for quitting smoking, across groups in different locations. This reason supports international evidence that increasing the price of cigarettes motivates some smokers to give up.

"*We feel guilty when our family members complain about not having sufficient money to buy food provisions. My mother once said there is no money to buy provisions, and I felt terrible and sad at the same time because had I not wasted money on cigarettes, we could have used that money for daily costs at home. So, I decided to quit.*"
- *FGD participant from drivers' group, Colombo*

"*I stopped smoking because of financial difficulties. Our salary is low, and the cost of living is high. We spend most of our daily wages on buying cigarettes. It is not worth it.*"
- *FGD participant from the estate sector, Hatton*

Another key reason for stopping smoking was due to health impacts. Several participants explained the impact of smoking

“Most of the FGD participants stated that they like to quit smoking, but they cannot do so, as they lack will power and self-control. Health concerns, personal commitments, and responsibilities (e.g. being married, having kids, having to look after elderly parents), and economic constraints have motivated them to consider quit smoking.”

on health and how this had motivated them to give up, despite the difficulties in doing so.

"*When I used to smoke, I felt tired all the time; I used to cough quite often. I was a great sportsman in my young days, and I soon realised that I was unable to engage in sports activities like I used to do in the past owing to my addiction to smoking. Therefore, I decided to stop smoking with great difficulty as it is not good for my health*."
- FGD participant from the estate sector, Hatton

"*I stopped smoking after I got to know that I have cancer. I was shocked when I heard about it. I know it is too late now to quit; however, I decided to do so because I do not want my condition to worsen. It is heartbreaking to go to the cancer hospital in Maharagama and see what people are going through*."
- FGD participant from Killinochchi

Some of the smokers have quit smoking with medical support, such as advice from doctors and the nurses in the nearby hospital. In contrast, others have quit smoking owing to encouragement by close relatives, self-realisation of hazards of tobacco smoking and noticing the disrespect rendered towards their habit of smoking by the community and being rejected by people in the society.

Few admitted that they do not like to stop smoking even if they had to pay off with their lives.

"*Cigarette is more than a friend to me. The cigarette is my only companion in both good and bad times and is the only thing that I trust in this world. I will continue to smoke, even if I die and will smoke until I die*."
- FGD participant (construction worker) from Colombo

"*We will not give up this habit, which keeps us going in life. The moment we stop smoking, we will die. It has become part of our lives, and we cannot live without it. We will not stop smoking at any cost*."
- FGD participant from low-income group, Monaragala

Others recognised the danger of their smoking behaviours which might influence children to start smoking. This sense of risk in their mindsets persuaded themselves to set a good example by giving up.

"*Since children around me witness smoking, and there is a chance/probability for them to get used to it as they grow older. Therefore, I quit smoking*."
- FGD participant from the estate sector, Hatton

Overall, the impact on family and friends was significant in influencing participants to stop smoking. This finding points to the importance of involving family and the broader community in cessation support.

Table 9 and Figure 17 below; summarize the responses from the FGD participants on quitting smoking.

The discussions with the current smokers revealed that giving up smoking is challenging for them even though they want to quit smoking. Further, smokers also said that they want more support in quitting smoking.

5.3.1 Supporting Channels of Quitting Smoking

One's efforts, such as willingness to stop by own through self-control, family support, especially by wives and kids and shifting to substitutes which are healthier than smoking tobacco, helped smokers in quitting smoking.

Most of the respondents agreed that self-control plays a pivotal role in enabling them to stop smoking.

"*I think self-control plays a major role and, as such, is the most important driver behind quitting smoking. It is our lack of self-determination that leads to the continuation of smoking*."
- FGD participant from construction workers group, Colombo

Family and close network support is a vital factor for smokers in quitting smoking successfully. Words of encouragement, motivation, and appreciation are essential in helping them to quit smoking.

"*I used to have so many arguments with my wife as she was always showing displeasure towards smoking, and I did not want to give up smoking at any cost either. However, my wife was able to change me. When she told me the adverse effects smoking could bring in to my wife's life and kids' lives, I was quite upset. I stopped smoking systematically, and now I spend that money on my kids' education and family's well-being*."
- FGD participant from the rural sector, Mahawa

Discussions revealed that smokers had used various substitutes such as areca nuts, chewing gums, dried palmyra sprouts (known as 'kotta kilangu' in Sinhala), and brushing teeth with extra toothpaste to reduce the intensity of smoking and quitting smoking. - *FGD*

"*There was an areca nut called 'Maawa' in our area. I used to eat it for years to stop smoking, and I never smoked during the days I had 'Maawa.' It helped quit smoking*."
- FGD participant from construction workers' group, Colombo

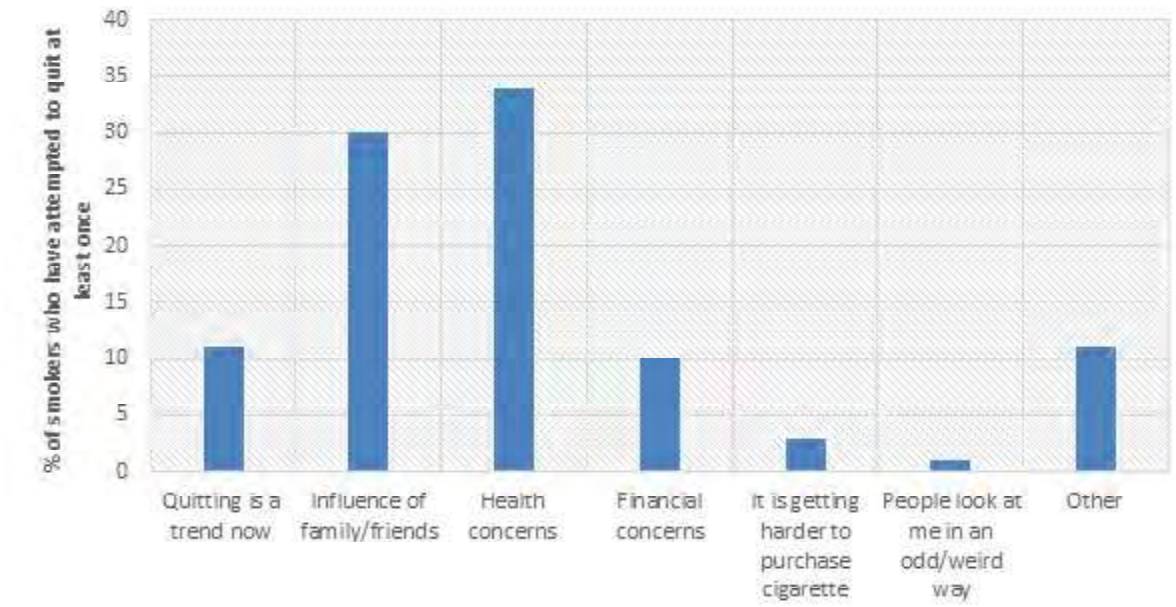
"*I have kept a packet of Palmyra sprout in my vehicle to have few whenever I get the urge to smoke. This way, it has helped me to forget cigarettes, and it helps me keep going with my work*."
participant from drivers' group, Colombo

Table 9
Reasons for Quitting Smoking

FGD Group	Reasons for Considering Quitting Smoking						
	Health Concerns	Economic Constraints	Medical Advice	Family Members	Relatives	Self-realisation	Disrespect from Society
Construction workers	✓			✓		✓	
Drivers		✓		✓			
40 years & above	✓	✓				✓	
Youth	✓						
Low-income group		✓		✓	✓		
Rural sector		✓		✓		✓	
Kilinochchi	✓		✓	✓			✓
Estate sector	✓	✓	✓	✓			✓

Source: Compiled by authors based on FGD findings.

Figure 17
Reasons Behind Quit Attempts Among Those Who Have Tried to Quit Smoking at Least Once



Source: FGD participants' Survey.

In addition to the dominant channels explained above, respondents have also employed techniques such as approaching counselling programmes and seeking medical advice to quit smoking.

Only a small number (26.4 per cent)[5] of participants had received any formal support to quit smoking. However, many participants stated that they would like to have support to help them stop smoking.

"*There are no professional help services where we reside. I wish we had enough professional assistance in our area to overcome this habit. This one is the first-ever programme that I have participated in where I can talk about my habit publicly*."
- FGD participant from 40 years and above group, Negombo

"*We have neither heard about cessation support nor have we participated in such programmes. It is our first time getting to know such support programmes that exist for those who like to quit the habit. There have been many instances where we wished that there was someone or some support that would encourage or motivate us to stop smoking. We like to stop this habit, but we do not have access to such programmes*."
- FGD participant from the estate sector, Hatton

Most participants were not aware of how to access support. The KIIs confirmed that there are few cessation programmes targetted at Last Mile smokers, and many existing support programmes are centred in Colombo and are therefore unlikely to be accessible.

According to the findings, those who have sought medical help have approached nurses and doctors in the village hospitals. Findings suggest that respondents are comfortable following the instructions given by professional bodies, as they are very confident about what doctors and nurses recommend. Respondents are thus, more prone to take medical

[5] Based on the short survey conducted among the participants of the FGDs.

professionals' advice in terms of quitting smoking.

"I once went to get medicine for breathing difficulty, from our village hospital, and the first question she asked me was whether I smoke. She spoke with me on my smoking behaviour, how I started it and for how long I have been smoking. The nurse who treated me asked me to stop smoking immediately due to the damage it has brought into my lungs. She explained the negative impacts of smoking and elaborated on how it could worsen my condition. I was seriously worried about it, as I was not ready to die. Since then, I have not smoked a single cigarette."
- FGD participant from the estate sector, Hatton

These findings lead to the inference that, Sri Lanka faces three pressing concerns in terms of prevailing tobacco control programmes in the country.

- Firstly, the current cessation programmes do not reach the remaining stock of smokers, as they are not tailor-made according to the socio-demographic cohort they fall into; a majority of smokers are not aware of the existence of such programmes.
- Secondly, the tobacco control programmes that are currently available are not sufficient enough to cater to a wide range of current smokers. As such, only a few people access formal channels of cessation support.
- Thirdly, there is significant unmet demand for cessation support from current groups of Last Mile smokers.

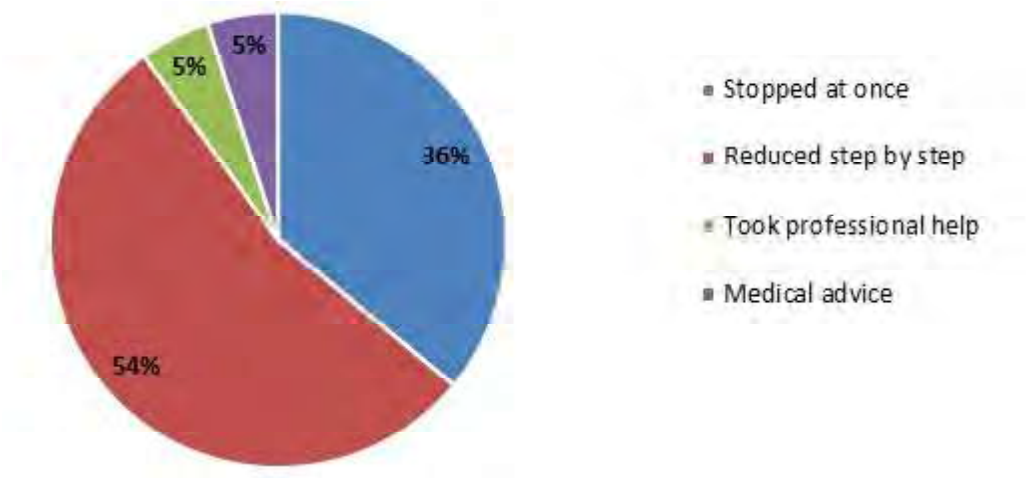
Table 10 and Figure 18 summarise and present the cessation channels and methods used by FGD participants.

Table 10
Cessation Channels

FGD Group	Cessation Channels						
	Shifting to Substitutes	Control Programmes Such As counselling	Medical Advice	Self-control	Support and Encourage-ment by Family	Imprison-ment	Rehabili-tation Centre
Construction workers	✓		✓		✓		
Drivers	✓	✓		✓			
40 years and above				✓		✓	✓
Youth				✓			
Low-income group			✓		✓		
Rural sector	✓			✓	✓		
Kilinochchi				✓			
Estate sector	✓	✓	✓		✓		

Source: Compiled by the authors based on findings.

Figure 18
Quitting Procedure Among Those Who Have Tried to Quit Smoking at Least Once



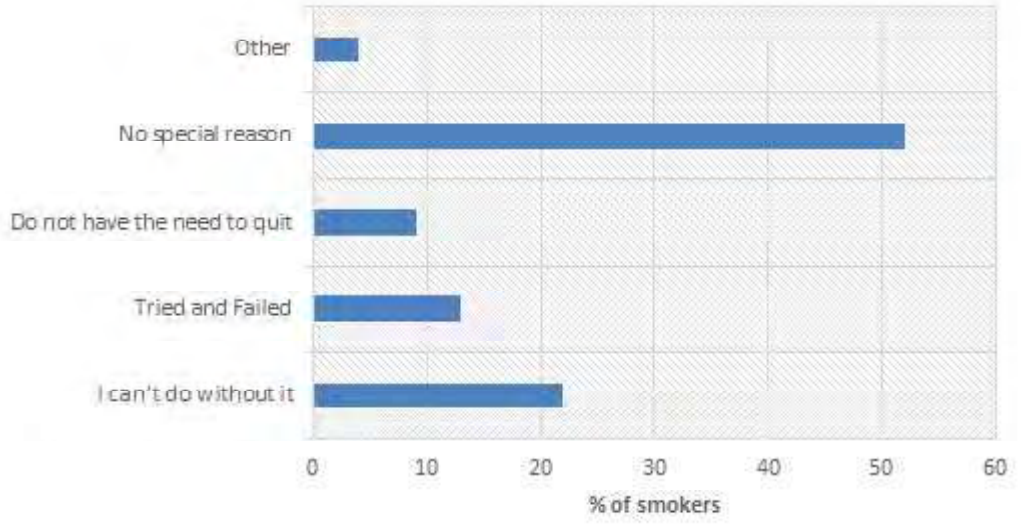
Source: FGD participants' survey.

There are some FGD participants (i.e., current smokers) who haven't made any attempt to quit smoking. According to the FGD survey, this amounts to 22 per cent. The discussion as well as the survey, directed questions to them on why they haven't made any attempt to quit smoking. Answers are graphically presented in Figure 20. For the majority of them, there is no specific reason for not quitting smoking.

Interviews with the stakeholders also affirm that quitting is successful when it is accomplished through one's self-control in the Sri Lankan context. Limited support was available for medical methods to support cessation, such as nicotine replacement therapies.

"*In Sri Lanka, quitting is mostly done by self-control. We at ADIC, see this as a positive condition and do not wish to change this situation. We feel that making the*

Figure 19
Reasons for Refraining from Quitting



Source: FGD participants' survey.



process of quitting a formal procedure will make smokers believe that quitting is a long process and a burden. At the same time, it will also give, a misleading impression that quitting cannot be done on one's own, and it should be done only with medical treatments."
- Director of Human Development and Administration ADIC

While many stakeholders agreed that self-motivation and determination have brought in positive results in terms of stopping smoking, there can be instances where it does not work for everyone. In such cases, interviewees asserted that cessation should be carried out systematically, adopting a holistic approach.

For instance, in terms of encouraging youth to stop smoking, the negative impacts smoking brings into one's appearance will be more provoking than discussing the health and economic impacts. However, when talking to older categories, discussing the monetary losses caused by smoking, discussing the adverse health effects it could bring into family members and children are helpful.

"*Both individual-level interventions, as well as policy-level interventions, are needed for cessation…The efficacy of pharmacological treatments like nicotine therapy and nicotine patches is not yet proven in a real-world setting similar to ours (Sri Lanka). Therefore, it is*

advisable to have community-level intervention and spontaneous quitting programmes in the country as they will be more effective."
- *NATA Consultant*

Furthermore, introducing community-based cessation programmes that would reach the grass-root level people in all areas, in general, was a crucial suggestion that came from the discussions.

"*In Sri Lanka, community cessation has been identified as more cost-effective as it caters to many people at once, and a large number of people will quit tobacco use within a short period. As such, community-level cessation programmes such as* '*tobacco-free villages*' *will be very effective in terms of tackling the smoking prevalence among the remaining stock of smokers in the country*."
- *NATA Consultant*

5.4 Access and Affordability

When considering access to cigarettes, there is no barrier in terms of purchasing cigarettes as there are shops near where they reside and work. A majority of the respondents did not have any specific place to purchase their daily cigarettes and as such, they usually buy them from any shop where they have a cup of tea and at the time, they feel like having a smoke.

However, some of the FGD participants who represented the drivers' groups revealed that there are specific shops, which sell two types of cigarettes ('low-quality and high-quality' or 'foreign and local' types as they called them) of the same brand. In such cases, smokers decide from which shops they will be buying cigarettes.

"*There are certain shops that sell the local cigarettes stating that they are original ones (by appearance, these are the same). There is a difference in the taste in original ones and the local ones. If we come across cases like that, we stop buying from those shops. We have experienced that in some shops. Other than buying from such shops, we are okay to buy from any shop*."
- *FGD participant from drivers' group, Colombo*

Furthermore, many drivers stated that they avoid going to shops, which do not give them the exact balance money once they have paid for purchase of cigarettes.

"*There are shops which do not give us the balance (5 rupees) and instead, give us a toffee, which is 3 rupees. We avoid going to such shops*."
- *FGD participant from drivers' group, Colombo*

In general, participants reported that cigarettes are still affordable to them. Respondents revealed that their income had increased more than the price of cigarettes, and therefore cigarettes remain affordable.

"*We don't think of quitting smoking. We would buy cigarettes, although the price increases up to 100/= per stick, in the future, and we hope that our income increases too, along with the price increase. In such a case, we don't anyway have to reduce the level of cigarette consumption. Because even now, even though the price of a cigarette has risen, we still can afford it as the price increase is not much when compared to the relative income increase*."
- *FGD participant from youth group, Dompe*

The above statement is made by a participant from the youth group also indicates that this particular youth considers smoking is a heroic act. He is not motivated to quit because he believes that cigarettes will remain affordable.

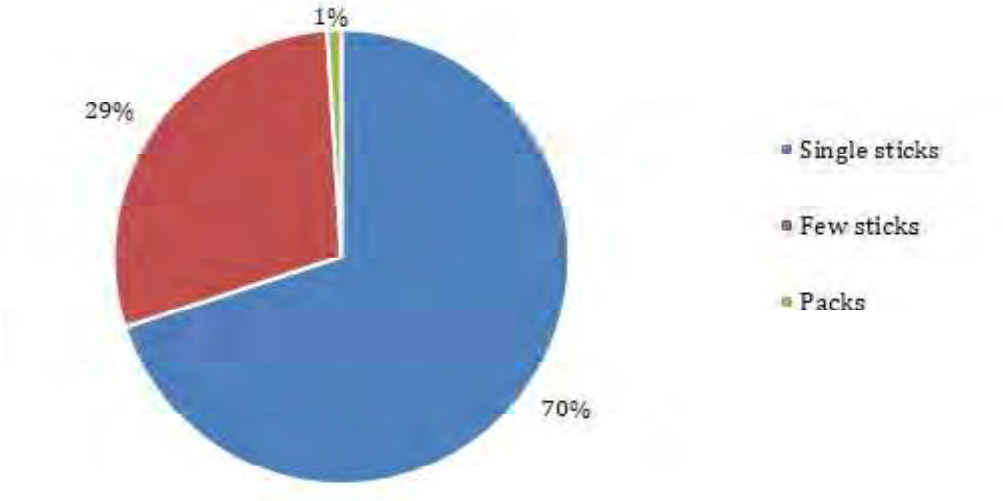
5.5 Impact of Price Increases

The majority of the current smokers who participated in the FGDs buy tobacco smoking products as single sticks (70 per cent).

During the focus groups, participants were questioned about price increases and the impact of that on their smoking behaviour. These questions have prompted a spectrum of responses from tobacco users:

Moving to purchase single sticks: In terms of affordability of cigarettes, everyone stated that prices had increased relative to the times they initiated smoking, and as a result, they have switched from buying an entire pack to buying single sticks. Only 1 per cent of the participant across all of the focus groups reported buying cigarettes in a pack. These findings suggest that a ban on selling single sticks could have a substantial impact on smoking behaviours.

Figure 20
Current Buying Pattern of Smoking Products



Source: FGD participants' survey.

Reducing intake: Overall, all sectors affirm that smoking has become more expensive compared to past years and respondents specifically from the estate sector and the low-income group stated that they hardly could afford a cigarette at present.

"*Smoking cigarettes has become quite expensive now. Our salaries are meagre, and the price of cigarettes is relatively high. Some of us even shifted to beedi, because the cost of living is very high now, and we cannot increase the intake of cigarettes at the going rate*."
- FGD participant from the estate sector, Hatton

"*Our cigarette consumption has reduced over time, owing to the constraints in purchasing power. We had shifted to buying single sticks now, and have given away the idea of buying an entire pack, unlike those days when cigarettes were quite easy to afford. If this comes to worse, we will have to manage our consumption by having only a cigarette per day, and instead buy beedi from the remaining money (even though most of us do not like that idea) as they are more affordable*."
- FGD participant from the low-income group, Monaragala

"*Smoking cigarettes has become a bit expensive. We, however, manage to save a sum from the daily wage for our cigarettes. We at least save money for two cigarettes*."
- FGD participant from construction workers' group, Colombo

Switching to cheaper smoking products: Respondents from sectors, namely; construction, driving and the youth group, stated that no matter how high the price increases but they would never shift from cigarettes to beedi owing to reasons as associated with its bad odour and poor quality. However, participants from the rural, estate, 40+ years of age and Kilinochchi affirmed that they would shift to beedi given that the prices of cigarettes further increase.

Quitting smoking: Several participants stated that the financial costs of smoking had motivated them to quit.

"*I used to smoke around 20 cigarette sticks per day many years ago, but now owing to financial barriers, I have stopped smoking. My family is happy about it because I contribute more to provisions*."
- FGD participant from the rural sector, Mahawa

The discussions also revealed that people sell cigarettes at higher prices than the authorised price on special occasions (e.g. when people stay overnight at funeral houses).

"*Cigarettes are available for 100/= in funerals (authorised price is 65/= per stick). However, we tend to buy those even at any higher price because most are under the influence of alcohol, and we somehow need to have cigarettes with it*."
- FGD participant from youth group, Dompe

"*One stick (Gold Leaf) is sold for 250/= in funerals at night. The person who wins card games at the funerals is willing to buy cigarettes at any price, and it is pointless if we can't smoke a cigarette at that time*."
- FGD participant from the low-income group, Monaragala

5.6 Awareness

5.6.1 Awareness on the Adverse Impact of Smoking

FGD participants were questioned on their awareness of the adverse effects of smoking on health, economic, social and environment. Further, they were questioned about their understanding of first-hand smoking, second-hand smoking and third-hand smoking. The FGDs were also inquired about their status of awareness on current policies related to smoking.

Almost all smokers from different sectors were aware of the health and economic impacts of smoking (98 per cent of the smokers as per the FGD survey).

"*Smoking has had adverse effects on my brother. My brother died of a heart attack. He was a heavy smoker and got a heart attack owing to smoking*."
- FGD participant from construction worker group, Colombo

"*I am currently under treatment for cancer. We spend the best part of our lives smoking, and now, in the middle age is gone for paying off its negative effects. You start to think of quitting when you get seriously ill, and by that time, it is too late*."
- FGD participant from high prevalence area, Kilinochchi

"*I am married and have children. It is hard to finance my family's daily expenses; I do not save what I earn at all. I spend my entire income on buying provisions for home, other daily expenses and on cigarettes*."
- FGD participant from 40+ group, Negombo

All participants were aware of the adverse health impacts such as cancer, neurological issues, NCDs like coronary diseases, respiratory diseases, difficulty in vision, tuberculosis (TB), unfitness, damaging of cells, inability to work hard, low immunity and low stamina.

Some participants had witnessed their immediate family members such as father, son, brother suffering from adverse effects of smoking, as well as their friends dying from cancer (especially oral cancer) and tuberculosis.

Even though the FGD participants were aware of the negative health impacts of smoking, the degree of understanding and acceptance of it, varied among the participants. For instance, not everyone who knew smoking is bad wanted to accept it is true. Those who did not accept the danger of smoking rationalised their reasons for continuation (e.g. by saying that smoking does not affect one's health as much as it is said to be and hard to stop as it has become a habit or part of their lives). Those who had a better understanding of the adverse effects of smoking wanted to quit smoking to avoid further risks:

"*Since we die anyway die, whether we smoke or not, might as well smoke and die*."
- FGD participant from drivers' group, Colombo

"*We have witnessed that healthy persons are suffering from various kinds of diseases than the others who do not think much of health. Not all those kids and women in the cancer hospital, are hard smokers. Therefore, we feel that cigarettes do not affect our health adversely, and it induces us to keep continuing. Moreover, we will live only a short period so that it is no point in stopping smoking now*."
- FGD participant from low-income group, Monaragala

Respondents who are already victimised by smoking and those who do not want to risk their lives in the future had quit the habit:

"*I stopped smoking because I suffered a lot from cough and have faced enough difficulties. I do not want to suffer more and risk my life further*."
- FGD participant from youth group, Dompe

"*When I used to smoke, I felt tired all the time; I used to cough quite often. I was a great sportsman in my young days, and I soon realised that I was unable to engage in sports*

activities like I used to do in the past owing to my addiction to smoking. Smoking has ruined my immunity and strength. I decided to stop smoking with great difficulty as it is not good for my health."
- *FGD participant from the estate sector, Hatton*

Many of them were unaware of the adverse effects of it on the environment. For instance, drivers, low-income people, youth, rural and the estate community were not aware of the adverse effects of smoking on the environment. Most of the smokers stated that even though they have heard about air pollution, they were not aware of how it happens through smoking. It appears that they have not grasped the gravity of the environmental effect of smoking seriously.

Most of the smokers knew about 'first-hand smoking' and its adverse health effects. Except for some participants from drivers and 40+ groups, the rest of the respondents didn't have a good understanding of second-hand smoking. All most all the FGD participants didn't have any idea on third-hand smoking and heard it for the first time. Elaboration and an in-depth explanation of third-hand smoking were required to explain the idea.

5.6.2 Awareness of Policies and Laws

In general, respondents were aware of current policies on tobacco smoking in the country. All participants were well aware of smoke-free places, the ban on tobacco advertisements, the ban on sponsorships, the pictorial warnings through various channels (e.g. through the community, internet, posters, word of mouth, newspapers, the news on television). They got to know about actions taken recently by various governments, through the police and health officers in respective areas.

Respondents who buy cigarettes as packets revealed that they are aware of pictorial warnings on the cigarette packs; however, they do not give much attention to it. Rather, they pull out a cigarette from the pack as soon as they purchase without giving much notice to warnings. They are now used to messages shown on the packs and don't feel afraid of harmful impacts it can cause, when they see it as in the initial few times. However, those who generally purchase single sticks revealed that they do not come across pictorial warnings often, but whenever they see pictorial warnings, they get a bit worried and tensed. Therefore, standardised packaging and banning of single stick sales should be coupled if to have a full impact on motivating smokers to quit.

Table 11 summarises the FGD participants' responses to awareness on the adverse effects of smoking and policies related to smoking.

The most common source of getting information on the effects of tobacco smoking and tobacco-related policies is medical persons, including doctors, Public Health Inspectors (PHIs), and Public Health Midwives (PHMs) (Figure 21).

In terms of awareness on promotional activities on tobacco smoking, a majority of participants revealed that movies on television, direct and indirect promotional activities conducted by shop owners and waiters in the restaurants and online promotions play a significant role in promoting cigarettes, at present.

Discussions also highlighted that the blurred visuals, and warning messages on the screen when telecasting a smoking scene such activities in a way also provoke people to smoke, especially the youngsters.

Ongoing tobacco promotion

Participants confirmed that tobacco companies are still findings ways to promote their product. Another dominant promotional activity prevailing at present is the online promotion on social media and mobile apps. A majority of the respondents confirmed that they see jovial posts about smoking on the internet, especially on social media that provoke people to engage in smoking.

"*We see many promotional activities online. For instance, there are many posts and visual graphics on Facebook and shared on WhatsApp, which encourages youngsters to smoke, stating that if we do not smoke, we are not manly enough. We are motivated to smoke by such online posts and visual graphics as we tend to think smoking is cool*."
- *FGD participant from the youth group, Dompe*

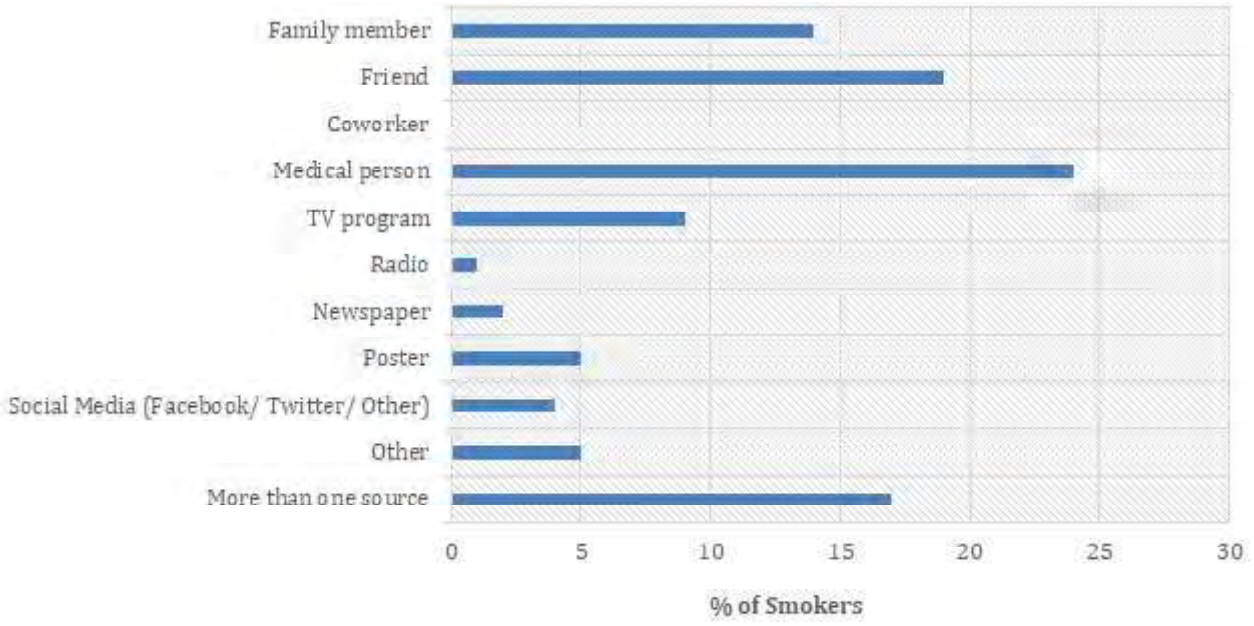
It was mentioned at the FGD with the drivers' group in Colombo that waiters in some of the shops openly promote smoking.

Table 11
Awareness on Adverse Effects of Smoking and Policies

	Awareness of the Adverse Impact				Awareness of Prevailing Policies			
FGD Groups	Health impacts	Economic impact	Societal impact	Environmental impact	Smoke-free places	Tobacco-related advertisements	Promotion and sponsorship	Packaging, labelling of cigarettes
Construction workers	✓	✓	✓		✓	✓	✓	✓
Drivers	✓	✓			✓	✓	✓	✓
40 years & above	✓	✓	✓	✓	✓	✓	✓	✓
Youth	✓	✓			✓	✓	✓	✓
Low-income group	✓	✓	✓	✓	✓	✓	✓	✓
Rural sector	✓	✓		✓	✓	✓	✓	✓
One of the top five most tobacco prevalent districts	✓		✓	✓	✓	✓	✓	✓
Estate sector	✓	✓	✓		✓	✓	✓	✓

Source: Compiled by authors based on findings.

Figure 21
Sources of Information



Source: FGD participants' survey.

Table 12
FGD Participants' Awareness of the Smoking Promotion

FGD Group	Promotion of Smoking				
	Movies on Television	Advertisements on Television	Promotion by Shop Owners and Workers (direct and indirect)	Promotional Activities by CTC	Online Promotions
Construction workers	✓	✓		✓	
Drivers			✓	✓	✓
40 years and above	✓	✓		✓	
Youth	✓			✓	✓
Low-income group			✓		✓
Rural sector			✓		✓
Kilinochchi	✓	✓	✓		✓
Estate sector	✓	✓	✓		✓

Source: Compiled by the authors based on findings.

"*The shops near the bus stand in Bastian Mawatha, Colombo have their waiters staying outside and asking people to come for lunch and have a meal from their shop. They also provoke people to buy cigarettes from them. They say, 'you can eat and have a cigarette also and go' when they invite us to the shop.*"
- FGD participant from drivers' group, Colombo

Similarly, as revealed by the respondents, especially the drivers in Colombo, they were aware of another indirect promotional effort of the Ceylon Tobacco Company (CTC).[6] The CTC is giving a certificate called 'Abhisheka' to their loyal customers (in this case, cigarette sellers) to encourage them to sell more cigarettes. According to them, this certificate has a unique logo, which is displayed in a prominent place in the shop. It helps them to identify the shops where cigarette sales take place. On top of the aforementioned promotional activities, most of the respondents, especially in Colombo (urban area), stated that CTC indirectly promotes tobacco smoking in their communities.

"*I have been to promotional programmes conducted by Ceylon Tobacco Company. They invited me to test cigarettes many times.*"
- FGD participant from drivers' group, Colombo

Further investigation is needed into the ongoing promotional activities of tobacco companies, and their impact on smoking behaviors.

Table 12 summarises findings on the respondents' awareness of the current promotional activities.

5.7 Controlling Tobacco Smoking in Sri Lanka

FGD participants were asked to give their suggestions on controlling tobacco smoking in the country. Banning the sale of cigarettes and closing the operations of CTC were two main suggestions that came unanimously from all the groups.

[6] Ceylon Tobacco Company PLC (CTC) is a Sri Lankan tobacco company engaged in the manufacture, marketing and export of cigarettes. It is a subsidiary of British American Tobacco. The CTC enjoys a virtual monopoly in the manufacture of cigarettes in the country.

“The FGD participants claimed that instead of trying to control the demand, the best and easy way is to control the supply.”

The FGD participants explained that despite many forms of efforts and measures by the government and different other organisations to control tobacco smoking among people, there are still a considerable number of smokers in the country and each day many young people start smoking. The FGD participants claimed that instead of trying to control the demand, the best and easy way is to control the supply (i.e., complete banning of the selling and smoking cigarettes and closure of the CTC). All FGD participants expressed that they would give their fullest support to the government to implement firm decisions of this kind.

This suggests that even among existing smokers, there is considerable support for more robust tobacco control measures and that firm and direct government action would prove to be politically popular.

"*If someone expects us to stop smoking or control smoking in Sri Lanka, the only way to do so is by banning cigarettes. If the Government bans cigarettes, people will definitely stop smoking. Thus, the sole responsibility of controlling smoking depends on the decision of the Government*."
- *FGD participant from drivers' group, Colombo*

"*In our opinion, cigarettes should be banned, and the CTC should be closed down. The government should intervene to prevent the young generation/new users from smoking by restricting their accessibility for smoking through the approaches mentioned above*."
- *FGD participant from youth group, Dompe*

Discussions further highlighted the need for stern government intervention in controlling tobacco smoking. Participants were of the opinion that the government turns a blind eye to ongoing promotional activities by the industry. They emphasised the need to implement current regulations by addressing any exiting gaps.

Participants had mixed views about the effects of increasing prices. There was a general agreement that raising prices would decrease the intensity of smoking as smokers are likely to cut down the number of cigarettes bought in such a scenario. There were some worries that addicted smokers would continue to smoke, even at a very high price' Table 13 gives a summary on FGD participants' views on smoking control.

Table 13
FGD Participants on Controlling Smoking

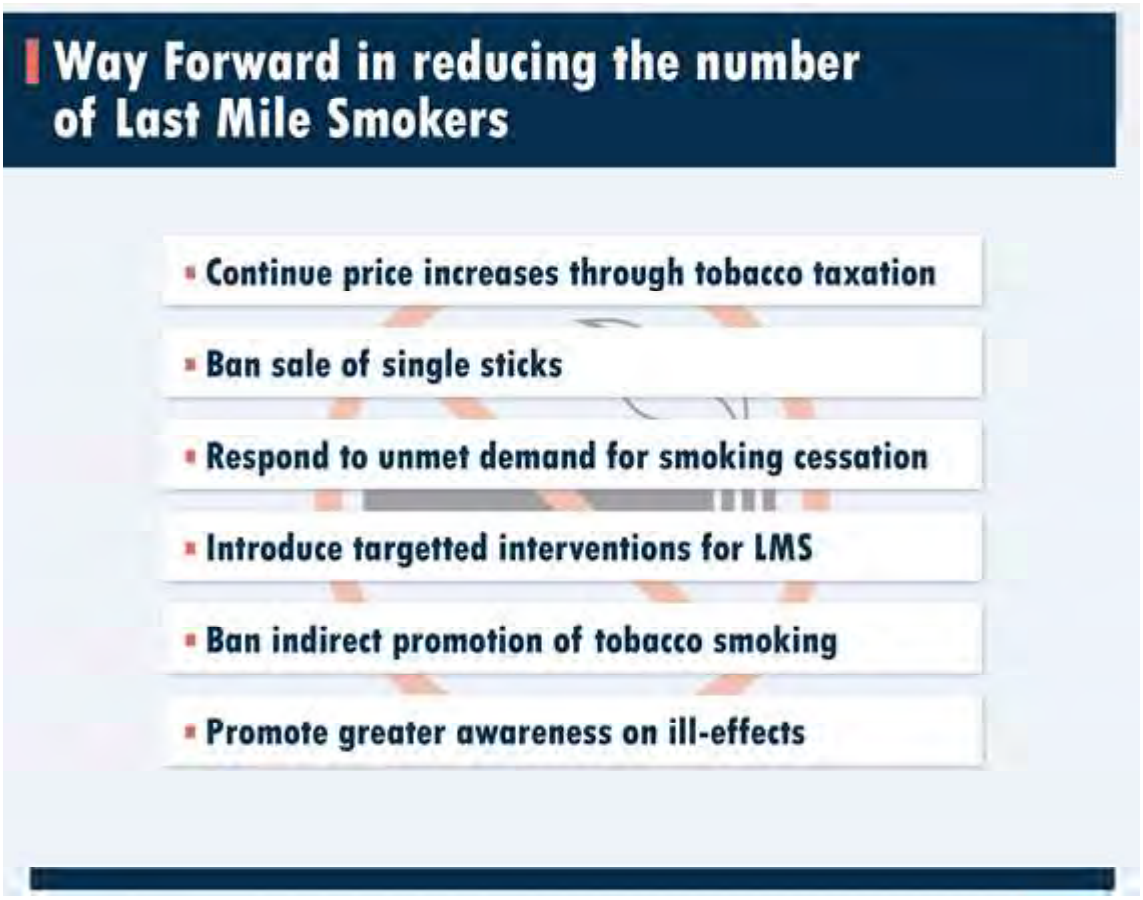
Controlling Smoking in Sri Lanka	Way Forward								
FGD Groups	Ban cigarette sale	Everything related to tobacco to be banned	Introducing a substitute for cigarettes	Closure of CTC	Price increase	Addressing policy gaps by strengthening government intervention	Introducing sufficient tobacco control programmes	Improve knowledge on the adverse effects of smoking	More educative programmes at school levels
Construction workers	✓			✓			✓	✓	✓
Drivers	✓	✓		✓		✓			
40 years and above	✓	✓		✓		✓	✓		✓
Youth	✓		✓	✓		✓	✓	✓	✓
Low-income group	✓			✓	✓	✓			✓
Rural sector	✓			✓		✓	✓		✓
Kilinochchi	✓			✓	✓	✓			
Estate sector	✓			✓					✓

Source: Compiled by authors based on findings.

6. Conclusion & Policy Recommendations

Tobacco smoking prevalence in Sri Lanka has shown a declining trend over the past years; however, it is still high and concentrated among specific population groups, identified as 'Last Mile smokers' in this study. The present study focussed on (a) identifying the Last Mile smokers and exploring their socio-demographic cohorts, (b) analysing their smoking behaviour which includes; reasons for smoking initiation, continuation, smoking cessation, awareness, accessibility and affordability, and finally, (c) recommending a mix of policies that will be beneficial in the policy response in tackling the last mile smokers and reducing the prevalence rate below 10 per cent.

Analysis of secondary data sources affirmed that although smoking prevalence has declined in Sri Lanka, in certain population groups, smoking rates are still high. There is a significant gender disparity in smoking prevalence, where smoking is significantly higher among males compared to females. Among males, smoking prevalence is highest amongst 40 years plus males compared to the other younger age groups. Among those who are in the 15-24 age category, the non-schooling group recorded a higher tobacco smoking prevalence compared to the schooling group. In the schooling group, smoking prevalence among males is higher in the 16-17 age category compared to the 13-15 age category. Smokers are more likely to come from the poorest households. Across occupation categories, 'skilled agricultural and fishery workers' and 'craft and related workers' record high prevalence rates than the other occupation categories. The percentage of households in which at least one member has smoked tobacco was highest for the rural sector compared with the urban sector and the estate sector; Nuwara Eliya, Vavuniya, Mullaitivu, Mannar and Kilinochchi districts recorded the highest percentage of detected smokers in 2016.



The main findings from the FGDs and KIIs are as follows;

Smoking initiation: Most of the smokers have initiated smoking before the age of 21 years (between 16 to 20 years of age), and only a few of them have started smoking at a much older age, i.e., between 31- 40 years of age. As such, it leads to the inference that it is essential to have interventions in place that can refrain young people from getting into the habit of smoking during the best times of their lives. Furthermore, findings lead to the inference that dominant drivers behind initiation among a majority of smokers are; loneliness, distress, curiosity to experiment new things, occupation, peer pressure and seeing others (mostly elders) smoke. Further, factors like fun/ pleasure, to feel like an adult, seeing and motivated by the smoking elders, owing to its perceived 'pleasant smell' and adverse life events, have induced them to start smoking. Furthermore, FGD participants revealed that smoking-related promotional activities and glamorisation done using celebrities, famous movie stars or other popular social figures had affected them significantly in initiating their smoking habits.

Smoking continuation: According to the study findings, the most common reasons are; as a habit, as a way of breaking the monotonous nature of the occupation, lack of incentives and lack of self-control to stop smoking. The majority of smokers had their specific times of smoking. Some of them smoked only on special occasions. Quite interestingly, discussions also revealed that not having robust, convincing modes of spreading awareness about the dangers of smoking have kept smokers attached to continuation. Evidence from the FGDs also revealed that low education and inadequate knowledge on long-term health effects of smoking are reasons for continuation.

Smoking Cessation: A majority of the FGD participants stated that they like to quit; however, they fail in doing so owing to lack of will power and self-control. Health concerns, personal commitments, and responsibilities (e.g. being married, having kids, having to look after elderly parents), and economic constraints have motivated them to consider quit smoking. While some of the smokers have quit smoking owing to medical support such as advised by doctors and the nurses in the nearby hospital, others had done it through encouragement by close relatives, self-realisation of hazards of tobacco smoking and noticing the disrespect and displeasure in the community. Overall, the impact on family and friends played an important role in influencing participants to stop smoking. As such, it is important to involve family and the broader community in cessation support.

Supporting channels for smoking cessation: Self-control, family support, especially by wives and kids and shifting to substitutes which are healthier than smoking tobacco has assisted smokers in quitting smoking. Also, respondents have employed techniques such as approaching counselling programmes and seeking medical advice to quit smoking. However, most participants were not aware of how to access formal support in quitting. The KIIs confirmed that there are only a few cessation programmes targetted at Last Mile smokers, and those too are centred in Colombo and are therefore not accessible. Moreover, findings suggest that respondents are comfortable following the instructions given by professional bodies, as they feel highly confident about what doctors and nurses recommend. These findings lead to the inference that, Sri Lanka faces pressing concerns in terms of prevailing tobacco control programmes in the country. One such serious issue is; the lack of targetted cessation support that is tailor-made to reach the socio-demographic aspects of the Last Mile smokers and not being aware of the existence of such programmes. Another concern does not have cessation channels that are sufficient to cater to a wide range of current smokers, and as such, only a few can access formal channels of cessation support.

Awareness in the adverse effects of smoking: The majority of smokers are well-aware of the dangers of smoking, yet the degree of understanding and acceptance varied among the participants. For instance, not everyone who knew smoking is bad wanted to accept it as true. Those who did not accept the danger of smoking rationalised their reasons for continuation. In contrast, those who had a better understanding of the adverse effects of smoking wanted to quit smoking to avoid further risks.

Most of the smokers knew about 'first-hand smoking' and its adverse health effects. Except for some participants from drivers and 40+ groups, the rest of the respondents didn't have a fair understanding of second-hand smoking. Almost all FGD participants didn't have any idea of third-hand smoking. Furthermore, the participants also suggested that the adverse effects of tobacco and the importance of refraining from smoking should be inculcated more intensively to children since school days (Responsible bodies should educate students who are in higher grades on the harmful effects of smoking).

Access to smoking products: FGD participants mentioned that there were no barriers in terms of purchasing smoking products (cigarettes were readily available and easily accessible for purchase). The estate worker group from Hatton mentioned that sometimes, they have to travel a long distance to buy cigarettes/ beedi when the nearest shop is closed or has gone out of stock.

Buying patterns of smoking products: Everyone who participated in FGDs affirmed that the price had relatively increased from those days when they initiated smoking. Those specifically from the estate sector and the low-income groups stated that they could hardly afford a cigarette at present. As a result, most of the respondents who found it hard to afford cigarettes have also shifted from buying an entire pack to buying single sticks. Furthermore, there was a general agreement that raising prices would decrease the intensity of smoking as smokers cut down the number of cigarettes bought. Participants also asserted that the high financial costs of smoking had motivated them to consider quitting smoking. These findings yield evidence to suggest two possible vital measures that could be followed to lower the prevalence. Firstly, the price of cigarettes can be further increased systematically, through income and inflation-adjusted taxation, so that the affordability of cigarettes does not increase. Secondly, the proposed ban on selling single sticks would have a substantial impact on bringing down the current smoking prevalence. Findings also suggest that there is no uniform price for cigarettes as they are being sold at higher prices than the authorised price on exceptional times, such as late night and early morning when all shops are closed. Thus, there arises a need to be firm with prevailing regulations and take steps to address these policy gaps. However, those who are highly addicted affirmed that they would continue to smoke, even at a very high price. In such cases, cessation support can be used, which includes community-based cessation support, tobacco-free villages, counselling programmes and educative sessions.

Awareness of prevailing policies: Respondents were aware of current policies on tobacco smoking in the country. For instance, all participants were well aware of smoke-free places, the ban on tobacco advertisements, the ban on sponsorships, the pictorial warnings through channels such as through the community, internet, posters, word of mouth, newspapers, through the news on television primarily the actions taken by various governments, through the police and health officers in respective areas.

Tobacco promotions: Smokers who participated in FGDs pointed out the fact that tobacco companies are still finding ways to promote their products by bypassing prevailing laws and policies. Another dominant promotional activity prevailing at present is the online promotion on social media platforms. Respondents, especially the youth, confirmed that they see jovial posts about smoking on the internet, especially on social media that provoke people to engage in smoking. Similarly, participants were aware of the indirect promotional effort of the CTC (e.g., 'Abhisheka' programme). Most of the respondents from Colombo stated that CTC indirectly promotes tobacco smoking in their communities.

Controlling Tobacco in Sri Lanka: Banning the sale of cigarettes and closure of operations of CTC were the two leading suggestions that came unanimously from all groups. The FGD participants claimed that instead of attempting to control the demand, the best and easy way is to control the supply (i.e., a complete ban on selling and smoking cigarettes and closure of the CTC). This viewpoint suggests that even among existing smokers, there is considerable support for more robust tobacco control measures and that enforcement of law, firm and direct government action would prove to be politically popular. As such, discussions highlighted the need for strong government

intervention in controlling tobacco smoking. The participants were in the opinion that the government turns a blind eye to ongoing promotional activities by the industry at the community as well as national levels. They emphasised the need to implement current regulations by addressing any exiting gaps.

The study findings point towards the following recommendations:

1. **Introduce targetted and specific policy interventions that reach the Last Mile Smokers -** Analysis of secondary data revealed that even though the overall smoking prevalence rate has fallen gradually in Sri Lanka, it remains at high levels within specific groups. As such, this implies that the past interventions on tobacco smoking had not sufficiently reached these groups. Reaching the Last Mile of smokers will substantially bring down the country's overall smoking prevalence rate. More focused interventions are needed to reach the Last Mile smokers. It is also crucial to tailor-make these interventions and equally important to consider the socio-economic characteristics and specific requirements sought by the Last Mile Smokers. The Last Mile smokers face difficulties in accessing tobacco cessation programmes. Lack of awareness of existing formal support services (such as clinics, counselling and educational sessions), limited engagement with the conventional media channels, not having programmes that suit their requirements are some such problems they face. These barriers prevent them from reaching the mainstream modes of tobacco smoking control policies and programmes.

"Reaching the last mile of smokers will substantially bring down the country's overall smoking prevalence rate. More focussed interventions are needed to reach the Last Mile smokers."

Furthermore, the study findings indicate that the Last Mile smokers mostly comprise of people from the informal sector (e.g. construction workers, drivers, youth groups those who are not in schools or any other education institute). Existing standard programmes do not reach most of these segments. Therefore, when designing tobacco smoking control programmes, the ways and means that include informal and other hard to reach segments should be given focus and priority.

2. **Respond to unmet demand for smoking cessation -** Almost all smokers who participated in discussions indicated that they want to quit smoking. The survey done among them indicates that 78 per cent of them had attempted quitting smoking at any point in time after they have started smoking. Out of this 78 per cent, only 10 per cent has reached any formal smoking cessation service. Most of the current smokers who attempted quitting smoking believed self-control is the best way to do so. Most of the participants were not aware of the available formal smoking cessation supporting channels. Only a limited number of smokers have participated in any programme on tobacco control. These findings strongly stress the urgency of strengthening awareness of the exiting cessation programmes, in ensuring that these programmes reach and cover the Last Mile smokers, and serve the unmet demand for smoking cessation support.

3. **The price increase should be continued as a key policy intervention in tobacco smoking control** - Price increases in smoking products have made some crucial changes in smoking behaviour (e.g. reducing the intensity of smoking and quitting smoking). In this regard, Sri Lanka should regularly increase tax rates to adjust for inflation and income effects to make cigarettes less affordable for both potential and current users by (Arunatilake & Thilanka, 2019; Verité Research, 2019). Further, there won't be a

significant shift from cigarettes to beedi due to cigarette price increase as claims made by the industry.

4. **Single Stick ban** - The vast majority of participants reported buying their cigarettes as single sticks. This suggests that banning the sale of single sticks could have a significant impact on bringing down the prevalence rate among 'Last Mile' smokers. In this regard, the study emphasises the importance of implementing the proposed ban on single stick cigarette sales in Sri Lanka without any further delay.

5. **Ban continued promotion by the tobacco industry** - The tobacco industry continues to promote tobacco use through a range of methods, including the entertainment and social media platforms, and indirect promotion methods such as 'Abhisheka' programme. Much firm and direct actions such as; enforcing the law, taking strict action against those who violates tobacco control regulations especially, illegal promotion and sponsorship of tobacco products, investigating policy and regulation gaps that allow such indirect promotions and taking necessary actions to close any such gaps) are essential to stop this. Smoking initiation mostly happens at young ages, and there is intense pressure from the tobacco industry to attract young people as new smokers. As such, it is vital to take action against smoking promotion among young people.

6. **Consider more comprehensive smoking bans** - There was widespread support for much more stringent supply-side measures to control tobacco, including for a total ban on tobacco and/or CTC activities. As such, this prompts to explore the potential for tighter restrictions or bans on tobacco sales.

7. **Strengthening the awareness creation** - The Last Mile smokers lacked knowledge of certain aspects of smoking (second-hand smoking, third-hand smoking, and the environmental and social impact of smoking). Further, awareness creation on the detriments of smoking would discourage attracting young people in initiating smoking.

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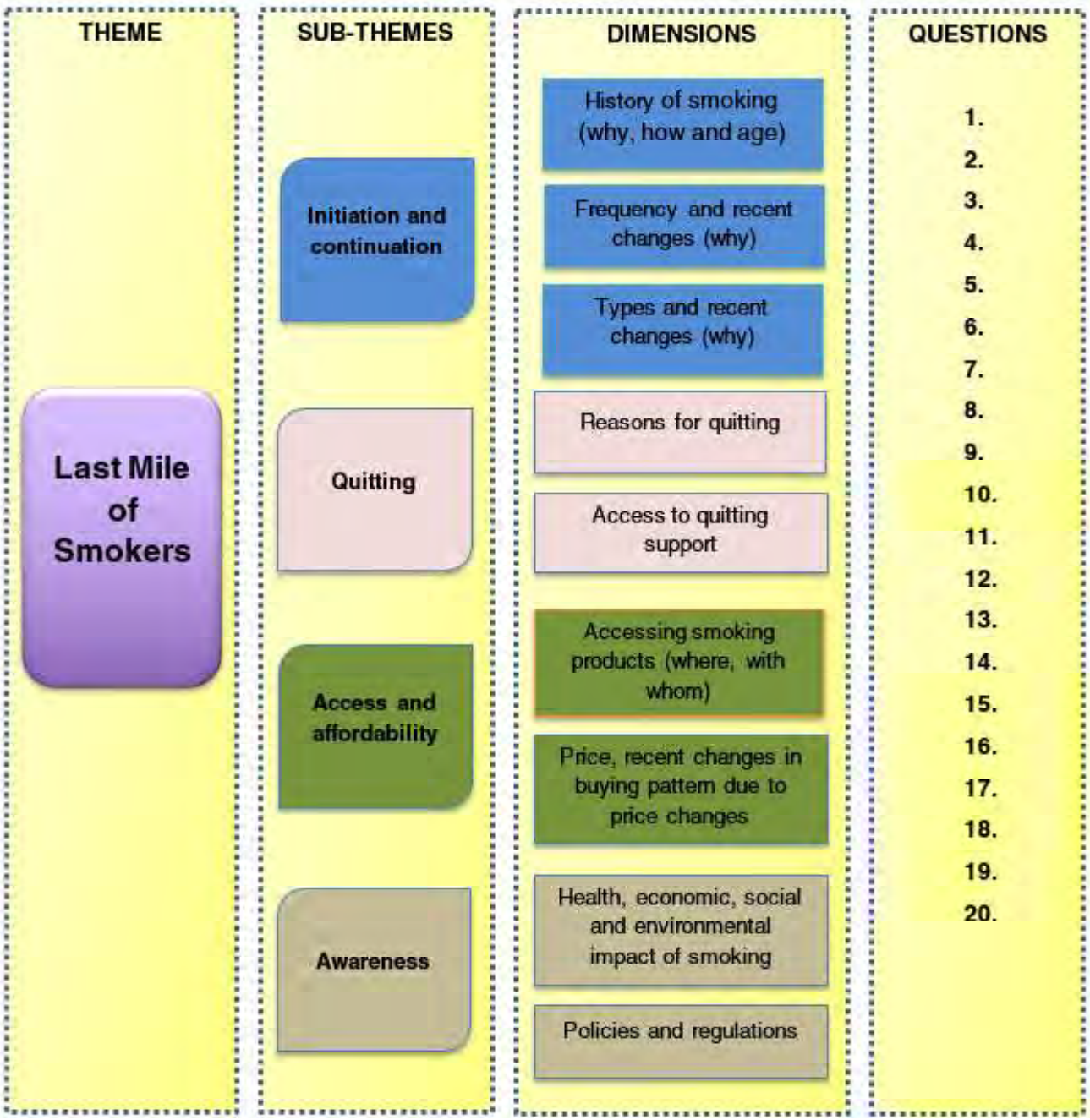
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Appendix

Annex 1
Operationalisation of FGD Data Gathering



Annex 2
List of Key Informants

	Name of the Interviewee	Affiliation	Designation	Expertise
1	Mr. Prasad Gunawardene	Sumithrayo (Government approved Charity Organisation)	Senior Programme Officer	Psychology/ Psychotherapy/ Counselling
2	Mr. Sampath De Seram	ADIC	The Director of Human Development and Administration	Experience in the Field
3	Dr. Manuja Perera	Faculty of Medicine - University of Kelaniya and CCT	Senior Lecturer in Public Health, and Specialist in Community Medicine	Senior Lecturer in Public Health, and Specialist in Community Medicine
4	Dr. Sajeewa Ranaweera	NATA	Consultant to NATA, WHO, Member of Committee on Tobacco and Alcohol & Sri Lanka Medical Association (SLMA)	Experience in the Field/ Chairperson NATA
5	Ms. Sachintha Fernando	Verite Research	Team Leader Economic Research at Verite	Research in Tobacco Control in Sri Lanka
6	Name to be remained unpublicised upon the request of the interviewee owing to confidentiality reasons	Public Health Inspector - Ministry of Health Sri Lanka	Public Health Inspector	Experience in the Field

Annex 3
Short Survey Questionnaire

Year	
Month	
District	
Serial Number	

Socioeconomic Details					
1.	Age	1.	15 >=	.....	1
		2.	16-20	.....	2
		3.	21-30	.....	3
		4.	31-40	.....	4
		5.	41-50	.....	5
		6.	51-60	.....	6
		7.	60+	.....	7
2.	Marital Status	1.	Never married	.....	1
		2.	Married	.....	2
		3.	Widow	.....	3
		4.	Divorced	.....	4
		5.	Separated	.....	5
3.	Ethnicity	1.	Sinhala	.....	1
		2.	Sri Lankan Tamil	.....	2
		3.	Indian Tamil	.....	3
		4.	Sri Lankan Moor	.....	4
		5.	Malay	.....	5
		6.	Burger	.....	6
		7.	Other	.....	9
4.	Education qualifications	1.	Grade 1-5	.....	1
		2.	Grade 6-10	.....	2
		3.	Passed O/L	.....	3
		4.	Passed A/L	.....	4
		5.	Diploma	.....	5
		6.	Degree or above	.....	6
		7.	Vocational Training	.....	7
		8.	Special Education	.....	8
		9.	No Schooling	.....	9

5.	Occupation	1.	Managers, Senior Officials and Legislators ..	1
		2.	Professionals	2
		3.	Technical and Associate Professionals	3
		4.	Clerks and Clerical support workers	4
		5.	Services and Sales workers	5
		6.	Skilled Agricultural, Forestry and Fishery workers..	6
		7.	Craft and Related Trades workers	7
		8.	Plant and Machine Operators and Assemblers	8
		9.	Elementary occupations	9
		10.	Armed Forces Occupations	10
		11.	Other	11
6.	What is your monthly income?	1.	Less than LKR 15,000	1
		2.	LKR 15,000 - LKR 20,000	2
		3.	LKR 20,001 - LKR 30,000	3
		4.	LKR 30,001 - LKR 40,000	4
		5.	LKR 40,001 - LKR 50,000	5
		6.	LKR 50,001 - LKR 60,000	6
		7.	LKR 60,001 - LKR 70,000	7
		8.	More than LKR 70,000	8
Smoking				
7.	Age when starting smoking	1.	15 >=	1
		2.	16-20	2
		3.	21-30	3
		4.	31-40	4
8.	Reasons for initiation	1.	No special reason	1
		2.	Pleasure	2
		3.	To socialise	3
		4.	Influence of others	4
		5.	To be a member of a group	5
		6.	Other	6
9.	Current Type	1.	Cigarette	1
		2.	Beedi	2
		3.	Cigar	3
		4.	Pipe	4
		5.	Other (please mention)	5
10.	Frequency	1.	Daily	1
		2.	few days a week	2
		3.	Occasionally	3

11.	On average, how many cigarette / beedi / cigars you smoke per day (daily users) / weekly (weekly users)	1.	1-5	.....	1
		2.	5-10	.....	2
		3.	More than 10	.....	3
12.	Usually, from where do you buy your cigarettes?	1.	Shop/ grocery	.....	1
		2.	Supermarket	.....	2
		3.	Eatery/ boutique	.....	3
		4.	Mobile eatery	.....	4
13.	How do you buy?	1.	Single sticks	.....	1
		2.	Few sticks	.....	3
14.	On average, how much do you spend on cigarettes daily / weekly?	1.	LKR	.....	(daily / weekly)
15.	Where do you usually smoke?	1.	Home	.....	1
		2.	Office	.....	2
		3.	Hotel / restaurant	.....	3
		4.	Eatery	.....	5
		5.	Other	.....	5
16.	Usually, with whom do you smoke?	1.	Alone	.....	1
		2.	With friends	.....	2
		3.	Coworkers	.....	3
		4.	Other	.....	4
17.	Is any of your family membe rs smoking?	1.	Yes	 1	Go to Q.18
		2.	No	 2	Go to Q. 19
18.	If Yes to Q 17, who is that?	1.	Father	.....	1
		2.	Brother (elder)	.....	2
		3.	Brother (younger)	.....	3
		4.	Other (please mention)	.....	4
19.	Have you visited a doctor or any other medical person to get advice/ treatment for smoking-related illnesses within the last two months?	1.	Yes	1	Go to Q. 20
		2.	No	 2	Go to Q. 21
20.	If Yes to 19, How much did you spend on the last visit?	1.	No money was spent	.....	1
		2.	Less than LKR 100	.....	2
		3.	LKR 101 - LKR 500	.....	3
		4.	LKR 501 - LKR 100	.....	4
		5.	More than LKR 1000	.....	5

Quitting				
21.	Have you ever attempted to quit smoking?	1. Yes 1		Go to Q. 22
		2. No 2		Go to Q. 24
22.	If Yes to Q. 21, why did you did so?	1. Quitting is a trend now		1
		2. Influence of family and friends		2
		3. Health concerns		3
		4. Financial concerns		4
		5. It is getting harder to purchase cigarette		5
		6. People look at me in an odd/weird way		6
		7. Other (please mention)		7
23.	If yes to Q 14, What was the method you used?	1. Stop at once		1
		2. Reduce step by step		2
		3. Sought professional help (Counselling or advice)		3
		4. Due to medical advice		4
		5. Other (please mention)		5
24.	If No to Q. 21, why don't you want to quit smoking?	1. I can't do without it		1
		2. Tried and Failed		2
		3. Do not need to quit		3
		4. No special reason		4
		5. Other (please mention)		5
Awareness				
25.	Do you know any adverse effects of smoking?	1. Yes 1		Go to Q. 26
		2. No 2		Go to Q. 28
26.	If Yes to Q 25 from where did you get that information?	1. Family member		1
		2. Friend		2
		3. Coworker		3
		4. Medical person (doctor/ PHI/PHM)		4
		5. TV programme		5
		6. Radio		6
		7. Newspaper		7
		8. Poster		8
		9. Social Media (Facebook/ Twitter/ Other)		9
		10. Other (please mention)		10

27.	If Yes to Q 18, can you name some of the adverse effects of smoking	1.	Heath Problem (Heart Attack, Cancer)	1
		2.	Sexual Impotence	2
		3.	Financial problem	3
		4.	Become Ugly	4
		5.	Bad Smell	5
		6.	Others may think the user is a fool	6
		7.	Other (please mention)	7
Exposure to prevention programs				
28.	Have you ever participated in any tobacco control programme?	1.	Yes ..... 1Go to Q. 29 and Q 30	
		2.	No	2
		3.	Can't remember	3
29.	If yes to Q 28, who has organised the last event you participated in?	1.	MOH office	1
		2.	School	2
		3.	Police	3
		4.	Other organisation (please mention)	4
		5.	Don't know	5
30.	If yes to Q 28, Do you see the last event you participated as a success?	1.	Yes	1
		2.	No	2

Annex 4
Focus Group Discussion Guideline

Date:	
Time:	
Venue:	
Group:	
The number of participants:	
Moderator:	
Facilitator:	
Record Keepers:	

FGD participant Selection Criteria - The basic participant recruiting criteria is 'currently smoking males, who are aged more than 40 years (use in appropriation to the FGD group). The maximum participants recruited for an FGD would be 15, and the minimum would be eight.

Facilitator's Skills and Competencies - In addition to general FGD skills, someone competent and experiences as a facilitator in the prevention field is required to avoid promoting wrong messages and validation of internal beliefs among other participants.

Introduction:
Before we begin our discussion, I would like to introduce ourselves and the purpose of today's discussion. I am XYZ, moderator of this discussion, and I am working as a XX at the XXX. This is XYZ1 who is the facilitator, and XYZ23 will be the record keepers of this discussion.

Introduction to IPS, ADIC and the research
The Institute of Policy Studies of Sri Lanka (IPS) is a semi-government institute which comes under the Ministry of Economic Reforms and Public Distribution. Our main mandate is to do socio-economic policy researches. ADIC is a non-government institute which is a well-recognised Resource Centre, promoting drug demand reduction. They are helping IPS to do the field level discussions. The IPS is implementing a research programme on Tobacco Control with the technical and financial support of the KIVU International, a research institute based in the UK.

Today we are having this discussion with you as a part of the study 'IPS Tobacco Control - who is the Last Mile? This study aims to identify Sri Lanka's stock of smokers, why they still smoke and come up with the most appropriate policy responses in controlling smoking in Sri Lanka.

Please remember that there are no right or wrong answers, we want to know only differing points of view of yours on smoking and some related issues.

the anonymity of the participants and confidentiality of the information will be protected. Wht we discuss here will be used for research purposes only.

We requested permission from respondents for using the tape recorder, to record their response.

Warm-up and Ice Breaking

We would like to know all of you. Please introduce yourself briefly. Your age, your marital status, occupation

1. Smoking - Initiation and Continuation

Thank you for the introduction. Now, as we know each other, we can start our discussion. To start with, I would like to ask a few questions about smoking. Can you please tell us on;

1.1 Why did you start smoking? (History of smoking)

1.2 When did you start smoking? How old were you then? (History of smoking)

1.3 How frequently do you normally smoke? -Daily/ few days a week / occasionally (on special occasions only) (frequency)

1.3.1 And has this changed recently? Are you smoking more or less frequently than you used to? Can you say what explains this change?

1.4 What type of tobacco do you smoke? (You may prompt this question with options: cigarettes, beedi, cigars, pipe, other) (type) Have you changed the type of tobacco you smoke recently (e.g. from cigarettes to beedi)? If so, what explains this?

1.5 What brand of cigarette do you smoke? Have you changed the brand recently? If so, what explains this change?

1.6 How many cigarettes do you smoke a day/week? (Quantity) Are you smoking more or less than you used to? Can you say what explains this change?

2. Access and Affordability

2.1 Where do you buy your tobacco from? Have you always got your tobacco from here, or has this changed recently? If it has what explains this?

2.2 Roughly speaking at what time of the day, and where do you smoke? Who do you smoke with? Has this pattern changed much recently?

2.3 For those that smoke cigarettes, do you tend to buy a single stick, or do you buy packs? What explains your choice?

2.3.1 Can you say if you have recently shifted from packs to single stick, and if so, what explains this?

2.4 And roughly what do you pay for the cigarettes you smoke? Has smoking got more expensive?

2.5 Would you say that smoking is still affordable for you?

2.6 Would you consider quitting smoking if the price went up further?

2.6.1 Would you consider shifting to other forms of tobacco (e.g. beedi) if the price went up?

3. Quitting

3.1 You said that you have started smoking XXX years ago. Can you tell say why you still smoke?

3.2 What are the factors keeping them attached to continuation? Probe peer pressure/affordability/lack of information

3.3 Would you like to stop smoking?

3.4 Have you ever tried to quit smoking? (YES/NO)

3.5 If yes, what was the main reason you tried to quit (probe: health concerns, affordability, pressure from family and friends, social stigma, inconvenient, life event (e.g. getting married, having a child)?

3.6 How did you approach trying to quit? Where were the difficulties and challenges you faced?

3.7 Did you seek help from anyone to help you quit - family/friends/co-workers

3.8 What about professional help? (prompts on counselling - in person and by phone etc.)

3.9 Did you access any government or other programmes to help you quit (counselling, quitlines, support groups, health professionals, self-help, brochures etc.)

3.10 OR were you mostly unaware of these programmes - would you say you had enough or insufficient help to try and quit?

3.11 If no ask why and ask whether they are aware of different programmes?

3.12 Do you feel like you have enough information on how to stop smoking?

3.13 If yes, why have you not tried to quit? Probe Don't see any positive effect on quitting/ no/ lack of support (services, networks), cost of quitting services/ lack of self-determination/ fear of losing social status/ other

4. Awareness

4.1 Do you know that there are adverse effects of smoking?

4.1.1 If yes, can you please name a few, you know? - probe on health, economic, environmental and societal effects

4.1.2 Has smoking had adverse effects on your health or on anyone you know?

4.2 Do you know what meant by first-hand smoking? Second-hand smoking? And third-hand smoking? If yes, can you please briefly tell us what is meant by them?

5. Smoking Promotion

5.1 Can you think of instances where you are encouraged to smoke? Does anyone promote cigarettes to you? (probe on informal promotion, e.g. Abhisheka by CTC, smoking scenes in teledramas/films)

5.2 Do you see smoking promoted online?

5.3 Show a picture of health warnings on packets and ask if they have seen these before and how it makes them feel?

5.4 Are you aware of the following policies that are in place in Sri Lanka?

smoke-free places,
tobacco advertising,
promotion and sponsorship,
tobacco packaging and labeling

If yes, how did you get to know about them (family members, friends, medical persons, other government officers (who- police officer, PHI, PHM, other)? media (what)

6. Suggestions for new policies and programmes to control smoking

6.1 Above, we just described a series of government policies intended to discourage people from smoking (health warnings, ban in public places, bans on tobacco advertising). But still, there are many people who continue smoking and new smokers joining especially young people. Why do you think this is the case?

6.2 Do you think you would smoke less or even quit if you couldn't buy single stick cigarettes?

6.3 What reforms do you think would have the most impact on stopping people smoking?

7. Any other additional comments

7.1 Do you have any other comments to add?

7.2 Do you have any clarifications to be made from us?

8. Conclusion

Thanking the participants for their time and information

Annex 5
KII Information Summary

	Interviewee	Institution's Role	Programmes by the Institute	Gaps and Suggestions	Remarks
1	**Mr. Prasad Gunawardene - Sumithrayo**	• Now functioning as a dropping centre for alcohol/ drug and tobacco users	• Rehabilitating (earlier), counselling, and referring users for medical treatments (government hospitals) • Follow-ups	• The wording in the warning messages should be changed. The wording is obselete now, and people are used to them. It is recommended to have some preventive/ positive messages rather than having messages which scare users. • There are implementation gaps, also. Even though there are policies and laws on tobacco/ alcohol control, yet people don't feel them. Their effectiveness is questionable. More needed to be done for people to feel those efforts better. • There are practical problems in enforcing them (e.g. not selling cigarettes to those who are under 21 years). • More measures to reduce the demand for tobacco or/ and stop manufacturing/ importing cigarettes (control the supply) • The government should take stern decisions on tobacco control without thinking about the tax revenue it brings	• 'Using tobacco/ alcohol is not an illness, it is a behaviour issue • Three main reasons for initiation; curiosity, negative feelings and social/ peer pressure. • Self-control is the most crucial thing in quitting smoking. • Pharmacological treatments are less effective. • Family support/ network support is very crucial in smoking cessation. • In approaching the Last Mile, talking about prevention side first is important
2	**Mr. Sampath De Seram- ADIC**	• ADIC Looks at the smoking issue scientifically and tries to address people on why they have started and continue smoking, knowing the harmful effects of it.	• Education and training (e.g. school children general public, armed forces, policymakers, media personnel, university students, youth (YAN)) • Policy advocacy and litigation • Research	• There are implementation gaps in existing policies and laws. • Further development in existing policies are needed (e.g. single sticks, public smoking, rational tax policy, implementation mechanism • Addressing and facing the tobacco industry is also a considerable challenge. • In reaching the hard to reach groups, it is vital to introduce new laws - e.g.	• Different approaches are used in reaching different groups (e.g. when addressing the young people, we usually discuss how the industry, media have used them but for the many elder groups we focus on health and economic aspects of smoking). • High prevalence occupation groups include forces, drivers, labourers. Smoking prevalence is high among

	Interviewee	Institution's Role	Programmes by the Institute	Gaps and Suggestions	Remarks
		• Attacks on the social image created around smoking • Lobby for policy formulation	• Public campaign • (traditional media and social media) • TOTs • Delay initiation is one approach for youth • Pre-school children • Referring	• compulsory sessions for construction workers on tobacco/ alcohol to be conducted by the contractor, employer. • Cessation should be further improved. 1948 quitline should be given more publicity • There should be a 'national tobacco prevention campaign' which is an evidence-based, technically correct, scientific and long-term one • More intensive campaigning is needed.	• young executives, too; however, this is a created one. • Smoking prevalence is higher among the hard to reach groups. • Hard to reach groups are daily paid workers, mainly those who are not captured by any formal structure or institution (e.g. construction workers, drivers, '*nattamees*'). Reaching them is difficult for many reasons; they do not use phones, and those who have phones use feature phones, they don't time to engage with common media channels – watching TV, reading papers. • We take different efforts to demand reduction and as well as to supply reduction, but demand reduction is the most sustainable way of controlling tobacco. If you don't have a demand, gaps in the policy/law enforcement are not a big issue. • In Sri Lanka, quitting is mostly done by self-control. And we as ADIC don't want to change this situation. We feel that, if we make the quitting a formal process it will become a burden for the smokers and it will also give the wrong message that quitting cannot be done on one's own and it should be done with medical treatment
3	**Dr. Manuja Perera- University of Kelaniya & CCT**	• Acting as a tobacco observatory • The primary mandate is to	Monitoring tobacco industry interference and activities in Sri Lanka Monitoring implementation of the FCTC Article 5.3 in Sri	• Steps should be taken to make smoking extremely difficult (e.g. by increasing prices/taxes in par with the affordability, single stick ban). It is one way of encouraging quit (i.e., to make smokes to	• One of the main factors behind the reduction in smoking in Sri Lanka is the deglamorization of smoking, especially after 1999. • In Sri Lanka, we haven't done so

	Interviewee	Institution's Role	Programmes by the Institute	Gaps and Suggestions	Remarks
		monitor tobacco • industry and investigate the interferences and links of the industry • Helping other partner organizations (NATA, SLMA, ADIC) in tobacco control activities. • CCT doesn't directly engage with smokers or prevention and cessation • We also monitor the policy formulation process	Lanka and South Asia region	• think 'if it is so hard to smoke, why should I smoke?' • Community advocacy in reaching the hard to reach group is important- engaging with smokers by discussing and arguing and make them realise to stop smoking • Even though PHIs are currently working on tobacco control, they were also overburdened with work. In this context, it is needed to have a dedicated person for tobacco control at the MOH level.	• much on cessation, but the main • reason behind the falling smoking rate is the low initiation. • Currently, there is no established network for quitting or cessation support. • The community programmes should be adjusted according to the context/ setting. • Rural and estate people are likely to be more vulnerable for industry tactics • The hardest thing in approaching the high prevalence groups is reaching the people employed in the informal/unorganised sectors. Most of them are not living with their families, internally migrated – new and different approaches should be taken in reaching out to them. • Traditional counselling sessions won't be practical. A holistic approach where the socioeconomic background of the smoker is taking into account in the quitting process is much appropriate. • We don't believe in people spending in other addictive substance (nicotine patches, nicotine replacement therapy) – it is again a tactic of the tobacco industry
4	**Dr. Sajeewa Ranaweera – NATA**	• NATA is the government agency which has the powers to implement tobacco control law in the country.	• NATA works on public health at the national level	• Singlestick policy would be beneficial in smoking cessation in Sri Lanka • Optimum tax system and single stick ban are crucial policy measures that the country should take immediately • Approaching different groups in diversified manners is essential – (e.g.	• Individual-level interventions, as well as policy-level interventions, are needed for cessation • We do not promote individual-level pharmacological treatments/ interventions • Most of the cessation studies have

	Interviewee	Institution's Role	Programmes by the Institute	Gaps and Suggestions	Remarks
				• young people would not bother much about the health effects of smoking, they will adhere to their group norms. Price/ taxation is an effective way of controlling young smokers as their disposable income is comparatively low. Further, educating them on the way they have been 'made to smoke' and how they have been manipulated by the industry to keep them hooked on cigarettes, for older groups focussing on health effect and economic effect of smoking is more useful) • All of our current prevention programmes are designed for persons who can read and write and use traditional methods. But this won't capture the out of school children, informal sector workers (e.g. construction workers, workers in the fishery sector) and illiterate people.	• been done by the pharmaceutical industry. • The efficacy of pharmacological treatments like nicotine therapy is not proven in a real-world setting such as ours. • In Sri Lanka, community-level intervention spontaneous quitting is more effective • When doing prevention programmes for school children, young people the programmes should be carefully designed not to convey wrong messages • Prepared the 'National Strategy for Smoking Cessation 2020-2025'
5	**Ms. Sachintha Fernando - Verite**	• Verité Research is an independent think tank engaging in substantial research in the fields of economics, politics, law and media. The institute has been conducting and continues to research tobacco policy-making and	• Conducting research in the field of tobacco cessation and advocating the government bodies and sharing their stance on tobacco with the public through media. • Active involvement in addressing tobacco-related policy gaps and publishing research findings in print media and social media is important. Their research studies include tobacco policy,	• Government has failed to gazette the stated indexation to the lowest priced/taxed cigarette • The government needs to calibrate the taxes on cigarettes with a lower market share in a manner that does not exacerbate the risk of consumers switching to cigarettes that have a lower tax • Sri Lanka is much in need of more professional management regarding its cigarette taxation. Currently, it is done in an impromptu way, and there is inconsistency in the regularity and extent of cigarette tax increases	

	Interviewee	Institution's Role	Programmes by the Institute	Gaps and Suggestions	Remarks
		advocating on addressing the gaps in tobacco policies in the country.	cigarette tax indexation and transparency in tobacco policy-making.	• There is no definite information on who is responsible for the spate of falsehoods in the media on tobacco taxation	
6	**Public Health Inspector, Ministry of Health Sri Lanka** ***(Name of the interviewee is not disclosed owing to confidentiality reasons upon his request)***	• PHI is the first person to make contact with the community in all field-based programmes focussing on promoting health among the country's people. • PHI is an important member of the health team functioning under the present 'Health Unit' system in the country. • PHI is responsible for understanding the behavior of communities and putting efforts at changing unhealthy behavior in persons who have undesirable habits such as tobacco.	• Conducting educative sessions and training programmes on tobacco cessation • Conducting awareness campaigns and special campaigns on specific dates (e.g. 'World No Tobacco Day'). • Referring identified victims of continuous tobacco smoking to the cancer Hospital/OPD of Public Hospitals	• There should be more firm supervision on the tasks assigned to PHIs in terms of tobacco cessation (for instance, most of the people at the superior level are concerned in controlling dengue and other diseases which is commendable but, the same attention should be given to controlling tobacco smoking). • There should be a proper system to prevent youngsters from initiating tobacco smoking. For instance, their skills should be developed by paying more attention to subjects like 'Life Skills' in schools (e.g. people who have done scouting during their school are less likely to engage in tobacco smoking). It is observed that people who have improved their life skills have self-control and determination to overcome tobacco smoking • There is no systematic link and coordination between the ground level medical officers and the ones who are in the top hierarchy. • A dominant concern that requires urgent attention is that a majority of people who currently addicted to smoking owing to factors that are rooted upon pressing issues in life, such as being disabled, unemployment and stress. Those	• There should be a mechanism to stop former smokers from restarting smoking • The older group of smokers are not ready to learn new things and as such educative sessions and training programmes will be useless, in tackling them • In most of the international channels and movies/ teledramas, tobacco advertising can be seen • There have been many occasions where CTC has held parties and awarded PHI officers in order to make sure they take the industry's side • There should be follow-up programmes on former smokers to make sure they do not restart (post-counselling) • In order to prevent the spreading of tobacco smoking in the upcoming generations the best way is to come up with 'de-glamorization programmes' which focusses on three things: bad smell, adverse health effects and cost) • Having a till near the washroom and inserting the amount spent on cigarettes to that till whenever the

	Interviewee	Institution's Role	Programmes by the Institute	Gaps and Suggestions	Remarks
				problems which provoke them to smoke need to be identified first, and then addressed subsequently, to lower the rate of addiction towards smoking. • Most of the smokers who have visited the Cancer hospital are more likely to quit smoking after seeing the patients there • There should be more collaborative community-based involvement by welfare organizations such as 'Samurdhi,' 'Youth Organizations', in tackling the tobacco issue in the rural sector. • Involvement of religious leaders is needed in provoking people to stop smoking especially in villages • There is an urgency to have a proper Action Plan for PHI officers in terms of controlling tobacco smoking in their respective areas	smoker gets a craving to have a cigarette and asking him to count the money saved at the end of the month will encourage them to stop spending on cigarettes and save money • In tackling the Last Mile in the urban areas, educative programmes, counselling programmes are more effective • Testimonials given by celebrities will be effective in terms of initiation of tobacco smoking among youngsters who believe that 'smoking is cool.' • All PHI officers are expected to lodge a complaint and fight a court case against the people who violate the current law related to tobacco. But PHIs are doing these legal matters and appear before courts without proper knowledge, practice and legal help. And this is a very cumbersome process. Because of these reasons, in some cases, PHIs avoid lodging complaints on tobacco law violations about such activities.

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