YANGON UNIVERSITY OF ECONOMICS
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A STUDY ON KNOWLEDGE, ATTITUDE AND PRACTICE OF SMOKING HABITS IN MYANMAR (CASE STUDY: SHWE PYI THAR TOWNSHIP)

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A thesis submitted in partial fulfillment towards the requirements for the degree of Master of Public Administration (MPA)

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This is to certify that this thesis entitled **"A Study on Knowledge Attitude and Practice of Smoking Habits in Myanmar (Case Study: Shwe Pyi Thar Township)"**, submitted as a partial fulfillment towards the requirements for the degree of Master of Public Administration has been accepted by the Board of Examiners.

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ABSTRACT

Smoking is the leading cause of preventable diseases and deaths in the world. Smoking kills more than five million people every year. Smoking is one of the public health problems in Myanmar. The objective of the study is to identify the knowledge level concerning with smoking related diseases and measure the attitude and practice of smoking habits in Shwe Pyi Thar Township. This thesis used descriptive method and face to face interview with the respondents. The respondent's knowledge had normal level and current smokers had poor level of practice. Both of the knowledge and practice are related with respondent of their background education and weakness of health knowledge. Also influencing factors of smoking were advertising and promotion of cigarette selling in loose form and easily accessible to cigarette. r Stress, tension, pressure, family factors and weak law enforcement attributed to smoking.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMD	Age-related Macular Degeneration (AMD
ASEAN	Association of Southeast Asian Nations
BAT	British American Tobacco
CDC	Centers for Disease Control and Prevention
CIF	Cost, Insurance and Freight
CSR	Co-operate Social Responsibility
DDT	Dichlorodiphenyltrichloroethane
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration
GDP	Gross Domestic Product
MSR	Myanmar Survey Research
TIRC	Tobacco Industry Research Council
WHO	World Health Organization

CHAPTER I
INTRODUCTION

1.1 Rationale of the Study

Smoking is the leading cause of preventable deaths and is estimated to kill more than five million people each year worldwide. If current trends persist, smoking will kill more than eight million people worldwide each year by the year 2030 with 80% of these premature deaths in low and middle-income countries. By the end of this century, tobacco may kill a billion people or more unless urgent action is taken.

Since one third of the world population is smokers, there are about 1100 million smokers over the world. Among then, 900 million are male and 200 million are female. Eight hundred million smokers are from developing countries and three million are from developed countries. Therefore, death related to cigarette smoking will be increased about 50% in developed countries and 70% in developing countries in next thirty years. According to world health organization, out of 2000 million children of today, 800 million will become adult cigarette smokers in the future. It is also estimated that one third of these smokers will die prematurely due to the risk smoking. (Pan American Health Organization , 1992)

Morbidity and mortality due to the risk of smoking reduce the number of healthy, workable people. Smokers will suffer many kinds of medical diseases. Smoking harms nearly every organ of the human body and diminishes the general health of the smokers. Smoking causes coronary heart diseases, blood vessel constriction and the nicotine stimulates adrenal epinephrine secretion, which increases blood pressure and heart rate. In addition, smoking is a leading cause of respiratory such as emphysema, bronchitis, pneumonia and chronic airway obstruction by damaging the airways and alveoli of the lungs. (Latif, Jamshed & Khan, 2017)

Habit of cigarette smoking is still wide spread among our young generation. Cigarette companies have flooded the hemisphere with advertising, expanding their markets and imposing the consumption of tobacco in every corner. Furthermore, to varying degree throughout the region, the population is ageing and migrating to urban

area, women are increasingly becoming part of the work forces and their life styles are changing. Within this context, tobacco consumption is growing, particularly among urban women and young people. The long-term toll of this trend in term of disease, disability and death may become apparent in the next few decades. But there is room for optimism. There are certain classes of people especially educated persons, who have decreased tobacco consumption and it is expected that the ratio of cigarette smokers may decrease among that class in future. It is demonstration that the prevention and control of smoking are attainable goals. Not only is there greater awareness of the problem, but government departments and non-government' organization also have gathered an increased constructive cooperation, public opinion is informed and broad inter sectoral and multidisciplinary programs for the control of smoking have been set in the motion. Myanmar is fully engaged in this struggle, so that tobacco free future generation in long term can expected. (World Health Organization , 2002)

Smokeless forms of tobacco use include chewing of raw tobacco. Among smokeless tobacco users most of them chewed tobacco with betel and only a few percentages chewed raw tobacco.

Since a majority of the adult men smokes or chews betel quid or uses both, it is no wonder that Myanmar children that towards smoking and betel chewing as a normal adult behavior. Most families have a least one of the household members smoking or chewing betel quid. A very important determinant factor that initiates smoking Myanmar children to light cheroots for them. Cheroots are usually lit by using the burnt charcoal from the kitchen. Children are asked to go to the kitchen to like cheroots with the red hot charcoal and asked to take the cheroots are keep lit on the way back from the kitchen. The children take care by smoking the cheroots on the way to their mothers or grandmothers and by doing so learn how to smoke at a very early age. (Nyo Nyo Khaing, 2001)

At tea shops, cigarettes as well as cheroots are usually sold. Still vending machines are not in common use, cigarettes can be brought loose either single or in two or three depending on the price. Lack of the legal enforcement on the 'age to buy or sell cigarettes', tea shops sell cigarettes, cheroots and betel quid freely to all ages. Young teenage boys love to meet friends at tea shops, which is the ideal place for teenagers to start learning to smoke.

Shwe Pyi Thar Township is one of the populated in Yangon because this township has many factory and more daily worker and factory worker. They live together in the hired hostel. Therefore, one people is made on smoking and another people effect on second-hand smoke. Most of the found adolescence and young-adult are smoker. People feel many diseases from smoking, tobacco used in Myanmar. This study will find out the knowledge level concerning with smoking related diseases, smoking attitude and smoking practice of habits in Shwe Pyi Thar Township.

1.2 Objectives of the Study

The objective of this study is to identify the knowledge level concerning with smoking related diseases and measure the attitude and practice of smoking habit in Shwe Pyi Thar Township.

1.3 Method of Study

This thesis used descriptive method based on primary data and secondary data. Relevant data were collected using a face-to-face interview of a random sample of 200 respondents above 15 years. Other relevant facts and figures were downloaded from a few internet websites and read on the master thesis books.

1.4 Scope and Limitation of the Study

This thesis studies on knowledge, attitude and practice of smoking habits. In this thesis the target population was adolescence and adult who live in the Shwe Pyi Thar Township. The survey was conducted in January 2019. This survey was not representing in Yangon Region.

1.5 Organization of the Study

This paper is organized into five chapters. Chapter I is introductory chapter and consist of the rationale of the study, objective of the study, scope and limitation of the study, method of the study and organization of the study. Chapter II is the literature review. Chapter III describes the tobacco usage and tobacco control in Myanmar. Chapter IV describes data analysis and finding. This thesis finally concludes with Chapter V which presents finding and recommendations.

CHAPTER II
LITERATURE REVIEW

2.1 History of Smoking

The history of smoking dates back to as early as 5000 BC in the Americas in shamanistic rituals. With the arrival of the Europeans in the 16th century, the consumption, cultivation, and trading of tobacco quickly spread. The modernization of farming equipment and manufacturing increased the availability of cigarettes following the reconstruction era in the United States. Mass production quickly expanded the scope of consumption, which grew until the scientific controversies of the 1960s, and condemnation in the 1980s. (Rebecca, Joao & Sara, 2015)

Cannabis was common in Eurasia before the arrival of tobacco, and is known to have been used since at least 5000 BC. Cannabis was not commonly smoked directly until the advent of tobacco in the 16th century. Before this cannabis and numerous other plants were vaporized on hot rocks or charcoal, burned as incense or in vessels and censers and inhaled indirectly. (Rebecca, Joao & Sara, 2015)

Evidence of direct smoking before the 16th century is contentious, with pipes thought to have been used to smoke cannabis dated to the 10th to 12th centuries found in Southeastern Africa. Previously eaten for its medicinal properties, opium smoking became widespread during the 19th century from British trade with China. This spawned the many infamous Opium dens. In the latter half of the century, opium smoking became popular in the artistic communities of Europe. While Opium dens continued to exist throughout the world, the trend among the Europeans abated during the First World War, and among the Chinese during the cultural revolution. More widespread cigarette usage as well as increased life expectancy during the 1920s made adverse health effects more noticeable. (Rebecca, Joao & Sara, 2015)

Smoking has been practiced in one form or another since ancient times. Tobacco and various hallucinogenic drugs were smoked all over the Americas as early as 5000 BC in shamanistic rituals and originated in the Peruvian and Ecuadorian Andes. (Rebecca, Joao & Sara, 2015)

A Frenchman named Jean Nicot introduced tobacco to France in 1560 from Spain. Continuing it spread to England. Waterpipes were introduced into Persia and the Middle East in the 16th century from China. At first these pipes were used to smoke tobacco but very quickly cannabis flowers and hashish were mixed in. As tobacco use exploded across the Middle East and Northern Africa the hashish trade blossomed within a few decades. Throughout the 18th century the technique of gathering and drying cannabis plants to make hashish became increasingly widespread as mass production became necessary to satisfy the rapidly increasing Eurasian hashish trade. (Rebecca, Joao & Sara, 2015)

As today, the pipes often had several tubes to accommodate multiple smokers, or smokers would pass the nozzle around in the many smoking houses that functioned as social hubs in major centers of Muslim culture like Istanbul, Baghdad, and Cairo. Smoking, especially after the introduction of tobacco, was an essential component of Muslim society and culture and became integrated with important traditions like weddings, funerals and was expressed in architecture, clothing, literature and poetry.

The water-pipe called Argila (or hookah) was created in Persia. The pipes of the rich were made of finely crafted glass and precious metals while common people used coconuts with bamboo tubing and these were used to smoke cannabis before the arrival of tobacco. (Rebecca, Joao & Sara, 2015)

The two substances in combination became very popular and were also smoked in normal "dry" pipes. The water-pipe, however, remained the most common smoking tool until the introduction of the cigarette in the 20th century. Foreign visitors to the region often remarked that smoking was immensely popular among Persians. On Ramadan, the Muslim period of fasting when no food is eaten while the sun is up, among the first thing many Persians did after sunset was light their pipes. Both sexes smoked, but for women it was a private affair enjoyed in the seclusion of private homes. In the 19th century Iran was one of the world's largest tobacco exporters, and the habit had by then become a national Iranian trait. (Rebecca, Joao & Sara, 2015)

Since the 1990s, smoking defense groups have reacted against legislation in some countries with increased taxes, restrictions on where to smoke, and anti-smoking campaigns. These groups feel that new regulations and the general atmosphere are oppressive, and stigmatization placed on them is excessive. Some

smoking defense groups are independent, while others are funded by tobacco companies. (Rebecca, Joao & Sara, 2015)

In the 21st century, smoking has become stigmatized throughout Western societies, but it is still a frequent practice among individuals, mostly from a lower socioeconomic background. Research implies that the act of smoking generates intimidating impressions, and it has been suggested that individuals of a low socioeconomic status are motivated to smoke by a desire to appear intimidating and forceful. (Graham & Hilary, 2012)

The main threat to the tobacco industry is the rise in popularity of e-cigarettes. Some people praise them for helping people quit smoking, but others remain skeptical about vaping. Though safer than cigarettes by a wide margin; the full health risks are still not yet fully understood. (Graham & Hilary, 2012)

In the United Kingdom, it was estimated in September 2018 that there are now 3,000,000 people who vape, 40% of whom are smokers trying to quit smoking. There is an ongoing debate in the country about whether e-cigarettes should be treated the same under the law, as regular cigarettes would. For example, many businesses have put up signs saying "no vaping" next to their no smoking signs. (Graham & Hilary, 2012)

2.2 Background Information on Tobacco and Health

Smoking is a leading cause of preventable morbidity and mortality worldwide. The relationship between smoking and many diseases such as coronary artery disease, lung cancer, bladder cancer, oral cancer, pulmonary emphysema and chronic bronchiolitis. Smoking is very harmful to pregnant women and to their babies whether as an active, or as a second-hand (passive) smoking, leading to stillbirth, low birth weight, congenital anomalies and contribute significantly to respiratory tract infections in infants.

The World Health Organization (WHO) has estimated that five million deaths occur annually due to tobacco use. This number of deaths is expected to reach more than eight million by the year 2030, with most of the tobacco-related morbidity and mortality occurring disproportionately in low- and middle-income countries. In Saudi Arabia, the prevalence of smoking has been reported to be as high as 52.3%, and among school and university students, it has reached an alarming rate of 30% and 50%, respectively. Furthermore, tobacco consumption rates in Saudi Arabia have

risen from 21.9% of males and 0.6% of females in 1996 to 37% of males and 6% of females in 2012. More recent study, though it gave a lower rate of smoking among medical students, it still alarming rates, and more seriously, a hidden problem in such a conservative culture. (World Health Organization, 2012)

Among young people, the short-term health consequences of smoking include respiratory and non-respiratory effects, addiction to nicotine, and the associated risk of another drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood. Cigarette smokers have a lower level of lung function than those persons who have never smoked. Smoking reduces the rate of lung growth.

In adults, cigarette smoking causes heart disease and stroke. Studies have shown that early signs of these diseases can be found in adolescents who smoke. Smoking hurts young people's physical fitness in terms of both performance and endurance - even among young people trained in competitive running. On average, someone who smokes a pack or more of cigarettes each day lives 7 years less than someone who never smoked.

The resting heart rates of young adult smokers are two to three beats per minute faster than nonsmokers. Smoking at an early age increases the risk of lung cancer. For most smoking-related cancers, the risk rises as the individual continues to smoke. (Elders, 1994)

Teenage smokers suffer from shortness of breath almost three times as often as teens who don't smoke, and produce phlegm more than twice as often as teens who don't smoke. Teenage smokers are more likely to have seen a doctor or other health professionals for an emotional or psychological complaint. (Arday, Giovino, Schulman, Nelson, Mowery & Samet, 1995)

2.3 Magnitude of the Smoking Problem

Smoking remains the most common preventable cause of death. Smoking claims 450,000 lives annually, as many as are caused by alcohol, cocaine, heroin, suicide, homicide, motor vehicle accidents, fire and AIDS combined. Smoking doubles the overall mortality rate and is responsible for 30% of all deaths in the United States in 2006, including 90% of deaths due to lung cancer, 35% of all cancer deaths, 21% of deaths due to coronary heart disease, and 90% of deaths due to chronic obstructive lung disease. Smoking and the use of smokeless tobacco are also the

major cause of cancer of the oral cavity and cancer of the esophagus and contribute to the mortality from cancer of the pancreas, cancer of the urinary tract, peripheral vascular disease, and cerebrovascular disease. Smoking also plays a significant role in the development of peptic ulcer disease and infectious respiratory disease and compounds the complications associated with diabetes.

Because women started smoking in large numbers more recently than men, their death rate from smoking has in the past been lower, but they are catching up: whereas the age-adjusted mortality from smoking rose 18% for men from 1973 to 1989. Smoking exposes women to the same risks as men and also increases their risk of cancer of the cervix and osteoporosis. Smoking advance the age of menopause, causes premature ageing of the skin, and increases the frequency of complication of stoke associated with the use of oral contraceptives. Smoking in pregnancy leads to premature births, miscarriages, stillbirths, and low-birth-weight babies. Smoking causes death, disease and disability not only in smokers but also in those exposed to environmental tobacco smoke. Parental smoking, for example, causes pneumonia, bronchitis, and middle ear effusions in children, reduces their lung function, and places them at increased risk of developing asthma. Smoking by a spouse increases the incidence of lung cancer in the non-smoking partner. Environmental tobacco smoke has been estimated to cause 50,000 deaths due to cancer and coronary heart disease annually in the United States.

The direct medical costs associated with smoking have been estimated conservatively at $53 billion annually. The total cost of smoking probably exceeds $100 billion annually. In 1965, 42.4% of the population smoked and 50% of all adults who have ever smoked have quit, a success unparalleled in the annals of public health. Despite a massive campaign to inform the public of the hazards of smoking, and despite increasing restrictions on smoking in the workplace and in public places, 48 million Americans, or 27.7% of males and 22.5% of females, were still smoking in 1993. Furthermore, 70% of smokers responding to a 1993 survey of the Centers for Diseases Control and Prevention expressed a desire to quit and 34% actually made an attempt in the prior year. Unfortunately, the addictive nature of nicotine, the strength of a habit reinforced by a million puffs taken over the career of a smoker, intense marketing by the tobacco industry and the ready availability of tobacco products conspire so that only 2.5% of smokers succeed in quitting in any given year. (Munzer, 2010)

2.4 Threat to Health of Tobacco Use

The increased use of tobacco is one of the greatest public health threats for the 21st century. The tobacco epidemic is spreading across international borders by a variety of means, including advertising, promotion and smuggling. Tobacco poses a major challenge not only to health, but also to social and economic development and to environmental sustainability. Tobacco use is a major drain on financial resources. The magnitude of the harm that tobacco causes is such a powerful and widespread agent of disease. Deaths due to tobacco use happen more than 20 years after the initiation of smoking. If current smoking patterns continue, it will cause some 10 million deaths each year by 2005.

In addition to the high public health costs of treating tobacco caused diseases, tobacco kills people at the height of their productivity, depriving families of breadwinners and nations of a healthy workforce. Tobacco users are also less productive while they are alive due to increased sickness.

The spread of the tobacco epidemic has serious consequences for public health. The increase in consumption and production of cigarettes and other tobacco products places a heavy burden on families, on the poor and on national health system. Scientific evidence has shown that tobacco consumption and exposure to tobacco smoke cause death, disease and disability. A time lag exists between exposure to smoking including the use of tobacco products and the onset of tobacco-related diseases.

The poor waste a substantial amount of income on tobacco products. Tobacco cultivation has led to significant deforestation. Rapid demographic and socioeconomic changes along with longevity, industrialization, urbanization. Higher incomes and globalization had negative impact on life styles, which in turn led to unhealthy dietary patterns, reduced physical activity and tobacco use. Controlling non-communicable diseases demands an integrated approach which focuses on appropriate diet, physical activity and reduction in tobacco use. National policies and strategies are required to deal effectively with these, risk factors. (Kyi Lwin, 2012)

2.5 Factors Associated with Smoking Cessation

The devastating impact of smoking on health, determining the smoking status should be as routine a part of every patient contact as measuring vital signs. A more detailed evaluation to prescribe a specific smoking-cessation method should be

include measurement of the duration and severity of the smoking habit, identification of any symptoms or illnesses exhibited by the smoker that may be attributable to smoking, assessment of the smoker's readiness to quit, a history of previous attempts to quit, and identification of personality variables and other inter or external factors that may facilitate or hinder quitting and staying quit. (Munzer, 2010)

2.5.1 Duration and Severity of Smoking Habit

The longer and the more packs of cigarettes per day a smoker has smoked and the greater impact on health. This time need for smoking cessation. In this smoking cessation smoker are the more likely resistance to quitting and stay quit and the need for incentive support during cessation. An urgent need to smoke within 30 minutes of waking up appears to the most important indicator of severe physical dependence. (Myat Thura Khaing, 2005)

2.5.2 Symptoms and Illnesses Attributable to Smoking

Evidence of heart disease and evidence of other diseases attributable to smoking are among the most potent motivators for smoking cessation. Smoking can make it harder for a woman to become pregnant. It can also affect her baby's health before and after birth. Smoking can also affect men's sperm, which can reduce fertility and also increase risks for birth defects and miscarriage. Smoking can affect bone health. Women past childbearing years who smoke have weaker bones than women who never smoked. They are also at greater risk for broken bones. (Rockville, 2017)

Smoking affects the health of your teeth and gums and can cause tooth loss. Smoking can increase your risk for cataracts (clouding of the eye's lens that makes it hard for you to see). It can also cause age-related macular degeneration (AMD). AMD is damage to a small spot near the center of the retina, the part of the eye needed for central vision. (Rockville, 2017)

Smoking is a cause of type 2 diabetes mellitus and can make it harder to control. The risk of developing diabetes is 30–40% higher for active smokers than nonsmokers. Smoking causes general adverse effects on the body, including inflammation and decreased immune function. (Rockville, 2017)

2.5.3 Readiness to Quit

All smokers should be advised to stop smoking, all smokers should clearly be told of any adverse effects that smoking has had on their health. Otherwise, it is best to tailor advice to the specific stage smoker is in. Those in the pre-contemplation stage, for example, should be given information about the effects of smoking on health, which may motivate them to move to the next stage. They should be asked to read materials carefully and should be questioned about them at a follow-up visit. Smoker in the contemplation stage should be given information about specific cessation methods and should be encouraged to set a "quit date." Smokers in the action stage should be given maximal support in the form of behavioral techniques or pharmacologic agents to help them withstand the urge to smoke.

2.5.4 Personality Variables, Internal Factors and External Factors

Rebelliousness, impulsiveness, and "identity assertion" in adolescence and adulthood have traditionally been viewed as major determinants of smoking. They are now seen as modifiers of other forces that favor change. Self-confidence and a sense of self-efficacy or the attribution of success to oneself rather to others are important predictors of success in smoking cessation that should be nurtured. A negative effect or depression may be an obstacle to permanent abstinence from smoking, particularly if the euphoriant properties of nicotine were used to combat depression.

Fear of weight gain is an important obstacle to smoking cessation and continued abstinence for many smokers. Appetite and hunger are common withdrawal symptoms after smoking cessation. Six months after cessation, men will typically have gained 9 lb and women 10 lb; greater weight gains are occasionally encountered. It is important to anticipate changes in weight and to develop appropriate strategies to prevent relapse of smoking. It should be stressed to the patient that the health benefits of smoking cessation far outweigh the risks associated with the usual weight again.

The presence of a non-smoking environment, beginning in the physician's office and also at home and work and during leisure activities is an important contributor to success in smoking cessation. Conversely, continued smoking by family and peers can be major obstacles that require specific, predetermined coping strategies.

2.5.5 Smoking-Cessation Methods

Most smokers who have quit have done so without any obvious outside intervention. As the number of smokers in the population declines, however, an increasing number will be highly addicted to nicotine; these are the ones most in need of more intensive support and more specific cessation methods. Smoking-cessation methods can be classified on the basis of the intensity of the intervention and whether pharmacologic agents are used. Every smoker should be individually evaluated to determine the most appropriate smoking-cessation method. The patient's preference and his or her experience of previous attempts at quitting play a key role in choosing a specific cessation method. (Munzer, 2010)

2.6 Stages in Tobacco Use and Smoking Cessation

Tobacco use is often through of as a career that typically spans decades and runs a circuitous route from experimentation to quitting. No single factor governs the career of tobacco use: it is determined by the complex interaction of the psychopharmacological properties of nicotine, the psychological makeup of the smoker, and perhaps most importantly, the cultural, social and economic setting surrounding him or her.

Several stages have been described in the smoker career: experimentation, initiation, and regular or habitual.

Smoking initiation typically occurs during childhood or adolescence. Regular or habitual smoking typically begins during the transition from adolescence to adulthood. Of those who experiment, one third to one half goes on to smoke habitually. Contrary to the popular belief that early experimentation is merely a rite of passage, it is more likely to lead to habitual smoking than later experimentation.

Habitual smoking is more common among persons who are more impulsive, more extroverted, and more subject to depression. Smoking is also more common among those who have a low level of academic achievement and among those whose parents and peers smoke. A higher degree of concordance for smoking status among monozygotic than among heterozygotic twins suggests that there may also be genetic factors involved in establishing the smoking habit. Tobacco marketing may also be a major influence on smoking initiation and habitual use.

The tobacco industry spends an estimated $3.25 billion yearly on advertising and marketing, generally targeted to specific groups. For example, is readily

recognized by children. Marlboro cigarettes are the choice of adolescent males and females. On the other hand, Virginia Slims are targeted to young women. Many of these young women smoke as a means of avoiding weight gain. Much advertising also appears to be directed at those who have quit smoking emphasizing prior triggers of smoking. Smoking behavior is further complicated by social factors that enhance or deter smoking.

Recent rises in the excise tax on tobacco have shown that the cost of tobacco may be an important deterrent in the use of tobacco, particularly by children and teenagers.

It is useful to think of smoking cessation not just as a single event but as a cyclic process with five stages: pre-contemplation, contemplation, action, maintenance, and relapse.

In pre-contemplation, the smoker is not yet thinking of quitting; he or she may be unwilling, unaware, or discouraged from consideration smoking cessation and may be defensive about smoking.

Contemplation occurs as the smoker actively considers smoking cessation. In this stage, he or she seeks information and is typically concerned about smoking.

Action occurs when the smoker takes steps to stop smoking. The smoker typically develops various strategies to prevent or overcome the temptation to smoke.

Maintenance involves ongoing efforts to refrain from smoking after the smoker has achieved abstinence for about 6 months.

Relapse**,** unfortunately the norm in smoking cessation, occurs when the smoker fails to maintain abstinence after quitting. Because smokers typically make many attempts at cessation before succeeding, permanently, they may find themselves in various parts of the cycle several times during their smoking career. Identifying the stages is useful because each requires a different intervention by the health-care provider. (Munzer, 2010)

2.7 Effects of Quitting Smoking on the Body

Smoking can create several negative effects on people health such as an increased risk of developing serious diseases like cancer and heart diseases. It can also lead to an earlier death. While these risks are good incentives to quit, quitting can be hard for some people because of withdrawal symptoms. These can include irritability,

headaches and intense nicotine cravings. Quitting can be a challenge the benefits on people physical and mental health are worth it.

The Benefit of Quitting Smoking are broken addiction cycle, better circulation, more energy, cleaner teeth and mouth, lower risk of cancer.

Broken addition cycle: within one month of quitting are the many nicotine receptors in their brain will return to normal, breaking the cycle of addiction.

Better circulation. Their blood circulation improves within 2 to 12 weeks of stopping smoking. This makes physical activity a lot easier and lowers their risk of a heart attack.

Improved taste and smell: Smoking damages nerve endings in people nose and mouth, dulling their senses of taste and smell. Within just 48 hours of quitting the nerve endings begin to grow and people have more sense of taste and smell begin to improve.

More energy: Along with improves circulation increases oxygen in their body will also give people more energy.

Cleaner teeth and mouth: Smoking creates yellow teeth causes bad breath, and increases the risk of oral infections. During a week of quitting.

Lower risk of cancer**:** After quitting, it may take a few years but people lower the risk of cancers such as; lung cancer, esophageal cancer, kidney cancer, bladder cancer, pancreatic cancers.

The Side Effects of Quitting Smoking are - Smoking releases thousands of chemicals into the body. The result is not only damage to the lungs, but also heart and many other body structures. The side effects of quitting smoking can be extreme for some people. Many people feel like have the flu when they are going through withdrawal. This is because smoking affects every system in their body. When people quit, their body needs to adjust to not having nicotine. It is important to remember that these side effects are only temporary.

CHAPTER III
TOBACCO USAGE AND TOBACCO CONTROL IN MYANMAR

3.1 Tobacco Usage in Myanmar

Tobacco has been identified as one of Myanmar's top 20 key industries. Its market size is worth an estimated US $450 million – up there with dairy products and dried processed foods. The compound annual growth rate from 2013-18 for tobacco is 16 %.

With market liberalization, British American Tobacco (BAT) re-entered in Myanmar 2013 a decade after it exited the country. When re-establishing itself in the country, it announced that it will invest $50 million in a tobacco manufacturing factory. BAT already has a significant 22 % market share in the growing cigarette market.

Myanmar currently has over six million smokers. Like other Asian countries, a high percentage 44% of adult men smoke. This number is set to increase given the growing adolescent smoking population.

In 2010 cigarette sales in Myanmar were about 13 billion sticks, but these sales are projected to almost double to 25 billion sticks in 2018. (Assunta, 2017) Myanmar's projection is the highest increase among all ASEAN countries. This is bad news for the public health system given that Myanmar already has more than 70,000 tobacco-related deaths annually. Myanmar also has the lowest Human Development Index among Asian countries with a global ranking of 148 out of 188 and public health expenditure is a low 1.8% of GDP. (Assunta, 2017)

Myanmar is a typical developing country in that the bulk of smokers are from the lower-income category. Cigarettes are also extremely cheap in Myanmar and within easy reach for the poor. The most popular pack of cigarettes costs only Kyat 889. A survey on smoking indicates that about 40% of Myanmar's youths can purchase cigarettes from a store. Even more worrying is that 15% of non-smoking youths have indicated that they intend to start smoking next year again the highest percentage in the ASEAN region. (Assunta, 2017)

Myanmar has some basic tobacco control measures in place to address the problem. Since ratifying the global tobacco treaty in 2004 - the WHO Framework Convention on Tobacco Control (FCTC) - the country has passed legislation banning all tobacco advertising and making public places smoke-free, but there is still plenty of room for improvement.

Myanmar needs to further increase taxes on tobacco products and put it out of reach for the poor and youths. While tobacco advertising and promotions are banned, there are loop holes that can be exploited. Myanmar faces sleek marketing tactics from transnational tobacco companies who take advantage of government officials' inexperience. (Assunta, 2017)

Where civil society groups come into play, they should play a more prominent role in exposing the unethical and exploitative practices of transnational tobacco companies operating in Myanmar. It is important for Myanmar to keep abreast of ASEAN countries' achievements on tobacco control measures. Most countries have already banned advertising at points of sale. Brunei, Thailand and Singapore have banned pack displays at retail outlets.

These are the next steps for tobacco control in Myanmar. But Myanmar lacks the resources needed for enforcement particularly staff. It is the only country in the ASEAN region that has not committed national funds for tobacco control efforts. Strengthening tobacco control measures and allocating more resources to enforcement will send a strong message to the public and private sector that the government is serious about protecting public health from the ravages of tobacco. (Assunta, 2017)

3.2 Myanmar Tobacco and Smoking Control Law

Myanmar Tobacco and Smoking Control Law is also called the Control of Smoking and Consumption of Tobacco Product Law. This law aimed to promote the public awareness for adverse effects of smoking and consumption of tobacco product to create tobacco smoke free environment, to obtain the healthy living style of public including child and youth by preventing the habit of smoking and consumption of tobacco product, to uplift the health , economy and social standard of the public, and to implement the measure in conformity with the international convention ratified by Myanmar to control smoking and consumption of tobacco product.

The Central Board of the control of smoking and consumption of tobacco product was formed to implement the objectives of this law. It also carries out measure to create tobacco smoke free environment, and giving guidance for tobacco cessation programmes, public awareness environment programmes such as exhibitions, seminar, workshop, and health talk, and research works. It cooperates and coordinates with the relevant Government department, international organizations, regional organizations, local and international non-governmental organizations for carrying out effectively the control of smoking and consumption of tobacco product. It is also responsible for formation of the supervisory bodies at the State, Region and Township levels and other necessary committees. (The New Light of Myanmar, 2006)

Non-smoking areas are mentioned in this law. Those areas are hospital building and office compounds, medical treatment centers and clinics, stadium and indoor playing fields, children drill sheds and playgrounds, teaching buildings, classrooms, offices and compounds, teaching building of universities, colleges and institutes, opera houses, cinema halls, video halls and other building of entertainment, marts department stores, stores and market sheds, museums, archives, public libraries and reading rooms, elevators and escalators, motor vehicles and aircrafts for passenger transport, air-conditioned public rooms, public auditoriums, teaching buildings and classrooms of private tuition classes and training schools, and other public compounds, buildings and places prescribed through notification by the Ministry of Health. However, specific places where smoking is allowed, shall be arranged in such areas: building of offices and departments, buildings of factories and workshops, buildings of hotels, motels, guest houses and lodging houses, buildings of railway stations, airports, ports and highway bus terminals, restaurants, trains and vessels for passenger transport and other public buildings, rooms and places prescribed through notification by the Ministry of Health. (The New Light of Myanmar, 2006)

The person-in-charge of any university, college, institute, school, private tuition class and training school may pass orders on a person who smokes or holds lighted cigar at the places of mention in non-smoking areas. For the first offence, educating, warning and informing the parents or guarding shall be taken. For subsequent offences, action be taken in accordance with the rules and regulations

prescribed by the relevant ministry in coordination with the Central Board. (The New Light of Myanmar, 2006)

Any mean of advertisement including distributing free of charge, giving as a present and sponsorship is prohibited in this law. The caption of warning in Myanmar language that smoking can seriously affect health and other necessary warnings in accordance with the stipulations must be mentioned on the package. The toxic chemical potency must be less than the amount prescribed by the Central Board. Showing the label of any cigar and tobacco product on any other goods and production, distribution and sales of toys, edibles or wares made in the form of cigar are prohibited. (The New Light of Myanmar, 2006)

Selling the cigar by vending machine and within the compound and 100 yards from the compound of a school is also prohibited. Employing a person who has not attained the age of eighteen in distributing or selling cigar, and selling or giving cigar and exchanging the cigar with any goods from a person who has not attained the age of eighteen are prohibited. Sale of cigarette singly or in a package containing less than 20 is not allowed to protect easy purchase and smoking. Government commits the acts such as obstruction, disturbance, prohibition or commission of assault to any member of Supervisory Body who comes and inspects under this law or the person-in-charge who supervise to prevent smoking at the non-smoking areas shall be punished with imprisonment for a term which may extend to two years or with fine or with both. (The New Light of Myanmar, 2006)

3.3 Tobacco Control in Myanmar

The Southeast Asia Tobacco Control Alliance (SEATCA) study measures each of the ASEAN countries' implementation of the World Health Organization (WHO) framework for tobacco control. Myanmar scored 45.7 out of 100, falling just behind the Philippines and Laos. Singapore topped the list with a score of 80.5. (Simpson, 2016)

Myanmar adopted the Control of Smoking and Consumption of Tobacco Product Law on May 4, 2006, to reduce the number of people using tobacco and tobacco-related products. The law contains rules on non-smoking areas and regulations to control the sale, production and advertising of tobacco products. (Simpson, 2016)

However, according to the SEATCA survey, Myanmar lags behind other countries in its banning of smoking in indoor workspaces, including bars and restaurants, and indoor public places. It is the only country that has not regularly updated its tobacco control policy and strategy, according to the study. (Simpson, 2016)

While it falls in the middle of the pack for taxation of tobacco products, Myanmar stands alone as the only country in the region that does not spend any public money on tobacco control, according to the study. And, despite the taxation, cigarettes are still fairly cheap: K2000 for a pack of Regular Marl-boros and K800 for a pack of Red Ruby, the most popular brand in the country. Red Ruby's are the cheapest cigarettes in the region. (Simpson, 2016)

The country is also middling in its ability to provide education or cessation programs. According to the report, the government does not allow tobacco industry officials to sit on government committees or advisory groups that are deciding health policy. However, the government does give preferential treatment to the tobacco industry, according to the report. (Simpson, 2016)

Like many of the other countries in the region, regulation of tobacco advertising and sponsorship goes unenforced in many mediums. Tobacco ads are banned in television, movies, print media, and billboards but there is no enforcement of tobacco advertising bans on the internet. Regulations on the packaging of tobacco products, on the other hand, are fairly strong when compared with other countries in the region. A majority of the packaging is dedicated to raising awareness about the dangers of using tobacco. (Simpson, 2016)

The government announced that new regulations would go into effect on September, requiring that health warnings and graphic photos illustrating the dangers of tobacco use must appear on all brands of cigarette and other tobacco products manufactured in Myanmar. (Simpson, 2016)

However, the tobacco companies asked for a six-month reprieve. The Department of Public Health told The Myanmar Times that following appeals from the companies – which cited a lack of awareness among retailers that they could face punishment if they sell incorrectly packaged products – the rules would not go into effect until February 2017. (Simpson, 2016)

Once the new law is in full effect, anyone involved in the production, distribution or sale of tobacco products that do not contain a graphic warning label

could be subject to a fine of between K10,000 (US$7.95) and K30,000 for a first offence. According to a 2014 survey, the rate of tobacco use in Myanmar is 26.1 percent of the population, including 43.8% of men and 8.4% of women. (Simpson, 2016)

Myanmar has made progress on tobacco control in recent years. (World Health Organization, 2012). However, people continue to die and become sick needlessly and the costs to society from tobacco use continue to mount. Myanmar can still do more to make the proven tobacco control tools work for its citizens' well-being. (Global New Light of Myanmar, 2018)

Myanmar to reduce tobacco use with control policies in cooperation with international organizations. Myanmar is looking to cut the number of smokers in the country by passing laws to curb consumption. Myanmar is set to scale up efforts to reduce tobacco related deaths and other products in cooperation with international organizations. There has been an increase in smoking and tobacco consumption in Myanmar. The World Health Organization (WHO) has conducted training courses to control cigarettes and tobacco products in Myanmar. (Global New Light of Myanmar, 2018)

Attendees to the five-day workshop are set to meet with parliamentarians on the final day of the meeting to hold discussions on national tobacco program. According to WHO, tobacco kills approximately 6million people annually and secondhand smoke kill more than 600,000 people worldwide. Recent estimates show that there are about 246m smokers and 290m smokeless users in the region. (Global New Light of Myanmar, 2018)

Myanmar became the 11th signatory to the International Convention on Tobacco Control in 2003. The Union Government Office released a statement on 19 May this year calling for necessary measures to be taken to reduce chewing of betel quid and recklessly spitting betel juice in Myanmar. (Global New Light of Myanmar, 2018)

Myanmar became a member to the WHO Framework Convention on Tobacco Control on February 2015.

(a) Smoke Free Places

Smoking is prohibited in most indoor public places, indoor workplaces, and on public transportation. However, smoking is allowed in private rooms and offices in

office buildings, factories, places of loading, public transportation terminals, trains and vessels, and restaurants. In places where smoking is allowed in private rooms and offices, smoking is also permitted in designated smoking areas, but these areas must be outside and the least ten meters away from the building entrance.

(b) Tobacco Advertising, Promotion and Sponsorship

Most forms of tobacco advertising and promotion are prohibited, especially through the mass the media and other means of wide distribution, including outdoor advertising. There are some restrictions on tobacco sponsorship and the publicity of such sponsorship.

(c) Tobacco Packaging and Labeling

Rotating health warnings comprised of text and images are required to cover at least 75 percent of the main surfaces of the unit and outside packaging and labeling. Misleading terms such as "light" and "low" are prohibited on tobacco product packaging.

(d) Roadmap Tobacco Control Legislation

The Control of Smoking and Consumption of Tobacco Product Law was enacted in 2006, repealing the Law of the Prohibition of Smoking at the Entertainment Building Act, 1959. Two notifications have been issued by the Ministry of Health specifying requirements of smoke free places. These notifications are: (1) Ministry of Health Notification No.5/2014, Order Stipulating the Caption, Sign and Marks Referring to the "No-Smoking Area" and (2) Ministry of Health Notification No.6/2014, Order Stipulating the Requirements to be Managed at the Specific Area where Smoking is Allowed. In addition, the President's Office issued a letter with instructions on tobacco use in government offices. Ministry of Health Proclamation No.11/2016, Order of Printing Warning Messages and Texts on the Packaging of Tobacco Products prescribes the requirements of the graphic health warnings that must appear on product packaging. (tobacco control law, 2017)

3.4 Enforce Ban on Tobacco Advertising, Promotion and Sponsorship

The law does not explicitly address cross-border advertising. However, given that advertising is banned on all TV and radio, all magazines and newspapers, it is interpreted that both domestic and international levels are covered by the ban.

Subnational jurisdictions do not have the authority to adopt laws that ban some or all types of tobacco advertising, promotion and sponsorship mention below.

Bans on direct tobacco advertising are –

(1) National TV and radio
(2) International TV and radio
(3) Local magazines and newspapers
(4) Billboards and outdoor advertising
(5) Advertising on internet
(6) Law requires fines for violations of direct advertising bans (World Health Organization, 2017)

Bans on tobacco promotion and sponsorship are –

(1) Free distribution
(2) Non-tobacco products identified with tobacco brand name
(3) Appearance of tobacco brands in TV and films
(4) Appearance of tobacco products in TV and films (World Health Organization, 2017)

Bans on Corporate Social Responsibility activities (CSR) –

(1) Tobacco companies/ the tobacco industry publicizing their CSR activities
(2) Entities other bans tobacco companies/ tobacco industry publicizing the CSR activities of the tobacco companies
(3) Tobacco companies funding or making contributions (including in-kind contribution) to smoking prevention media campaigns, including those at youth
(4) Laws requires fines for violations of indirect advertising bans (World Health Organization, 2017)

3.5 The Tobacco Industry in Myanmar

The tobacco industry in Myanmar comprises factories and cottage industries that produce cheroots. Two state-owned factories produce cigarettes, one in Yangon, the other in Pakokku, in the central plains. Production of cigarettes by these factories has fluctuated considerably, declining from 1985-86 to 1993-94 (with the exception of 1990-91) and increasing from 1994-95 onwards. With the introduction of foreign brands at cheaper prices, cigarettes produced by the state-owned factories are

becoming less popular. Cheroot production also declined between 1988 and 1995 and is thought to have continued to decline, although no data are available for years since 1995. Imports of cigarettes and raw tobacco products are increasing. There are no exports of cigarettes, cheroots, cigars or any other tobacco products from Myanmar. Tobacco advertisements have been banned on radio and television from 1999, and recently were prohibited in all forms of electronic and print media, and on billboards. Sports sponsorship by tobacco companies has been restricted recently also. A draft law on control of tobacco products seeks to prohibit all forms of tobacco advertisement.

3.6 Cigarette Market in Myanmar

Myanmar's tobacco market is set for a shakeup following the return this year of the world's second largest cigarette manufacturer, British American Tobacco, which entered into a joint partnership to locally manufacture its once ubiquitous London brand of cigarettes. However, British American Tobacco (BAT) faces an uneasy coexistence among a thriving black market of duty-free cigarettes and renewed efforts by the Ministry of Health to enforce existing anti-tobacco laws and bring new ones into effect.

Smoking rates in Myanmar are relatively high, among men at least. According to 2012 data from Myanmar Survey Research (MSR), 30 percent of males in the two largest cities, Yangon and Mandalay, are occasional or regular smokers. An additional 15 percent of urban males smoke the traditional, hand-rolled cigars, known as cheroots. MSR said that the chewing of betel nut is far more prevalent in rural areas where 70 percent of Myanmar's population of an estimated 60 million resides than any other form of tobacco because of its low cost. Yet the study found that only 1 to 2 percent of urban women smoke either form of tobacco on a regular basis however this may be starting to change.

According to a Yangon tobacco retailer with 30 years of experience in the trade and who spoke on condition of anonymity, 10 percent of his customers are now young Myanmar women. A big increase in the numbers of women buying cigarettes lately, which may be due to the emergence of a nightclub scene in Yangon. (Muddit. J, 2013).

The retailer stocks more than 100 brands of cigarettes, which he buys from pilots and cabin crew flying in from countries such as Thailand, The Philippines,

Vietnam, Singapore and Indonesia. He sells major brands such as Marlboro and Benson and Hedges for less than $2 because each carton was purchased duty-free. (Muddit. J, 2013).

Supermarkets are also involved in the black-market trade of duty-free cigarettes. Whether cigarettes are smuggled across Myanmar's porous borders or flown in on duty-free allowances, the likes of BAT are well aware of how illicit trade damages their chances of success among price conscious consumers in Myanmar. (Muddit. J, 2013).

Cigarettes are meant to be sold through the travel trade channel but they are sold in the domestic market through illicit channels. BAT is willing to work closely with government and industry stakeholders such as law enforcement agencies, customs officials and international organizations, such as the World Customs Organization, to counter illicit trade. (Muddit, 2013)

Cigarettes from Singapore are by far the most popular because the packets don't contain graphic warnings about the effects of smoking. It seems BAT has done its homework well: London cigarettes, which are already being manufactured in Yangon, contain a small written warning in Myanmar along the side of its packets, which also states that a person must be over 18 to buy cigarettes. (Muddit, 2013)

Myanmar's Ministry of Health is starting to get tough on the blasé attitude towards the dangers of smoking. Anti-smoking seminars are currently being planned to take place in schools and a new by-law about tobacco is being drafted. There is even talk that a ban on smoking in public areas, such as bars and restaurants, is on the cards. (Muddit, 2013).

3.7 Price and Taxes of Tobacco

Unlike the trend shown in nominal prices, the real prices of all tobacco products have fallen dramatically since 1987/1988. This is especially the case for cigarettes. Cheroot and cigar prices fell by half in real terms in the late 1980s, and have fluctuated around that real level since 1990. All domestically made tobacco products are exempt from all commercial taxes up to an annual threshold of kyats 240000. Cheroots, which are the most popular form of smoked tobacco, cost around 12.36 kyats in 1991 but dropped to around 7.4 kyats in 2000. The price of 1 package of Marlboro cigarettes in Yangon is 2,607 Kyat in 2019.

The local results of the Global Youth Tobacco Survey which was conducted among school students in 2016, 13.6 percent of young adolescents in Myanmar, aged 13 to 15 years, smoke or use smokeless tobacco products, while 33.2 percent are exposed to tobacco smoke at home and 28.4 percent are exposed inside enclosed public places.

Sales above this threshold are taxed at a rate of 75% of the tax-inclusive retail sales price for cigarettes, 10% for cheroots, 20% for cigars and pipes, and 25% for betel preparations and pipe tobacco. No tax is charged on Virginia tobacco and cured tobacco produced locally. (Tax summaries, 2017)

Tobacco products may only be imported for sale in duty free shops and hotels. Customs imposes a tariff of 30% on the CIF value of imported cigarettes (reduced from 300% in 1997). (Commercial Tax Law, 1990) .Customs duty is also charged on raw material under the heading of cut tobacco, which includes tobacco leaf, paper, filter and packaging, and even ink. Imported cigarette sales exceeding kyats 240000 attract a tax of 7.5% of the landed cost, which includes the customs tariff plus the CIF value of the imported cigarettes (Worldwide Tax Summaries Corporate Taxes, 2017). Profit and income taxes are applied only to locally manufactured tobacco products. There are no additional taxes such as a health tax levied on the tobacco industry. (Tax summaries, 2017)

Tobacco revenue only accounts for 1.4% of total government revenue. Household expenditure on tobacco averaged over all households (including those who purchase no tobacco products at all) was 2.7% of total household expenditure, and considerably higher among lower income groups (4%) than higher income groups (less than 2%) (Worldwide Tax Summaries Corporate Taxes, 2017).

It was higher in urban areas than in rural areas. These percentages are approximately double this level for households that have non-zero tobacco product expenditures. The estimated price elasticity of demand, using the data from the 2001 survey, was very high and significant; indicating that for each 10% increase in prices of tobacco products, consumption would decrease by about 16%. The analysis suggests that increases in tobacco product prices would have a stronger effect on the decision to quit smoking than in reducing the quantity of tobacco consumed by smokers. Individuals from the highest income group reacted less to increases in price than individuals from lower income groups. Younger people were also more price-

sensitive Health consequences of tobacco control. (Worldwide Tax Summaries Corporate Taxes, 2017).

Although data are incomplete (since they exclude the growing private sector), there appears to be an increasing trend in admissions for cancers of the stomach, lungs and larynx and also an increase in admissions due to tuberculosis of the respiratory system and stroke. The smoking attributable disease burden and direct medical costs borne by patients were estimated. Direct medical costs (average cost of treatment) due to key tobacco - attributable diseases was estimated to be kyats 85.3 million for admissions and kyats 37.9 million for outpatient cases in 1999. (Tax summaries, 2017)

Cigarette Prices of tobacco products in Myanmar have become relatively cheaper over the past two decades. (Nyo Nyo Khaing, Perucic & Rahman, 2005)

While the sentinel prevalence studies of tobacco use conducted in Myanmar show that smoking prevalence is gradually declining, there is also a significant and steadily growing prevalence of smokeless tobacco use, such as chewing of betel quid with tobacco, with most recent estimates at 20.8% (31.8% of men and 12% of women). Examining the various types of tobacco available and their affordability may explain these prevalence trends. (Nyo Nyo Khaing, Perucic & Rahman, 2005)

Table (3.1) Tobacco Tax Rates for Locally Produced Tobacco in Myanmar 2012

Locally Produced Tobacco Products	Excise Tax Rate
Cigarettes	100%
Cheroots	50%
Cigars and Pipes	50%
Tobacco	50%
Virginia tobacco, cured	50%
Pipe tobacco	50%

Sources: ASEAN Tobacco Tax in Myanmar 2012

The recent tobacco tax increases show the commitment of the Myanmar government to reducing tobacco consumption and tobacco harms, but whether they will actually help discourage tobacco consumption remains to be seen. In addition, when differential tax rates are applied to different types of tobacco products, including imported versus domestic, users may shift to cheaper forms. (Nyo Nyo Khaing, Perucic & Rahman, 2005)

The industry is dominated by local cheroots factories and cottage industries. The country has two state-owned factories that produce cigarettes. The market is also believed to be growing with the government opening up to imports through its laxer import duties. (Nyo Nyo Khaing, Perucic & Rahman, 2005)

3.8 Smoking Prevalence of Tobacco Use

Several surveys with limited coverage provide smoking prevalence data, but there is no nationally representative survey. Surveys in 1999 and 2000 found male prevalence of 60% and more. The 2001 survey done for this study recorded much lower male of 31%. Survey findings on female prevalence differ even more widely, finding rates from 7% to over 50%. The most common form of tobacco in Myanmar is cheroots, in both urban and rural areas. Cigarettes are smoked more in urban areas and by adolescents and young people. The median consumption of tobacco (sticks) per day is 4 for males and 3 for females. There is a wide variety of tobacco products available in Myanmar. Betel quid with tobacco is the most popular form of tobacco use (45%) closely followed by cheroots (43%). Other forms include hand-rolled cheroots, chewing tobacco, cigars, and cigarettes, though these take up much smaller portions of the tobacco market. The smoking population is believed to be concentrated in the central plains mainly because of the presence of the local cheroot cottage industries in the area. Popular cigarette brands include London, Vegas, Duya, and Golden Triangle. (Southeast Asia Tobacco Control Alliance: Tobacco Tax Program, 2013)

Sentinel prevalence studies of tobacco use in Myanmar were conducted in the years 2001, 2004 and 2007 with the objective to build a database on prevalence of tobacco use for planning and evaluation of tobacco control interventions in Myanmar. Study results showed that although prevalence of smoking is gradually declining, prevalence of smokeless tobacco use such as chewing of betel quid with tobacco is rising steadily. Misconceptions that smokeless tobacco use are less dangerous than smoking tobacco products is a big challenge to the tobacco control measures, along with the very low prices of smokeless tobacco products. (Kyaw Myint, 2009)

Table (3.2) Tobacco Usage in Myanmar

	Youth tobacco use		Adult tobacco use	
	Current Tobacco use	**Current Cigarette Smoking**	**Current Tobacco use**	**Current Cigarette Smoking**
Male	9.5	6.8	27	26.9
Female	4.8	3	10.3	10.1
Total	14.3	9.8	37.3	37

Source: WHO report on the global tobacco epidemic, 2017

CHAPTER IV
SURVEY ANALYSIS

4.1 Survey Profile

Current total population of Shwe Pyi Thar Township is 282193. This township was found basic human level and middle human level. Many of the employees are factory and daily worker. Most of the factory located in the Shwe Pyi Thar Township. The respondents hired hostel and at least five people live together with in the hostel.

Shwe Pyi Thar township is located in the northwestern part of Yangon Myanmar. The township comprises fifteen wards and five village tracts, and shares borders with Htantabin Township to the north, Mingaladon Township to the east, the Yangon river to the west, and Insein Township to the south. Incorporated into the city of Yangon in 1986, Shwe Pyi Thar is now developing and has basic municipal services. Improvements include tidy and broad main roads and many streets form a grid. Hlaing River separates Shwe Pyi Thar and Hlaingtharyar. Shwe Pyi Thar Bridge which is one of the most useful and busiest bridge in Yangon was built in 1996, which is also the starting point of Pathein-Chaungthar Highway.

The township has 46 primary schools, 15 middle schools and 4 high schools. The most famous high school is B.E.H.S No.1 and B.E.H.S No.3. There are 30 middle (branch) schools and 10 high (branch) schools. Private schools include Kaung Su San, Aung Thukha, New Life, Education Palace, etc. The University of Computer (Yangon) and Institute of Technology (Shwe Pyi Thar) are located there, too.

4.2 Survey Design

This Study was a study of knowledge attitude and practice of smoking habits in Myanmar (case study: Shwe Pyi Thar Township). Total population is 132283 of male and 149910 of female in Shwe Pyi Thar Township. Sample size is 200 respondents in the Shwe Pyi Thar Township.

The survey design is based on the 200 respondent’s data was collected in Shwe Pyi Thar Township. This study was collected by using questionnaire with face-

to-face interview method of data collection. These data were derived from the participants (age 16 years and above).

The questionnaire is divided into five main parts. They are –

- Personal Profile
- Question for Smoking
- Educational Question of Smoking
- Observation Question of Smoking Attitude
- Observation Question of Smoking Practice.

First, the personal profile included five questions. In this question include the respondents of age, gender, marital status, education and family income. Second part of question divided into three main questions. They are –non-smoker, quitting smoker and smoker. If you are smoker you fill the following questions. The third question was knowledge of respondents with smoking related diseases. The knowledge level based on 21 questions and respondents were filled correct answer and then give score or mark. The fourth question is measured the attitude level of respondents. The practice questions have nine questions. Respondents were filled accept or don't accept. The last questions were practice of respondents. Practice level of respondents is measured on the basic of fifteen questions.

4.3 Survey Analysis

4.3.1 Characteristics of the Respondents

Table (4.1) Characteristics of the Respondents

Biography of the Respondents	Frequency	Percentage (%)
Male	134	67
Female	66	33
Total	200	100
Marital Status		
Single	75	37.5
Married	125	62.5
Total	200	100
Age		
15-24	53	26.5
25-34	65	32.5
35-44	46	23
45-54	24	12
55-64	5	2.5
65-74	7	3.5
Total	200	100
Education		
Primary	4	2
Middle	23	11.5
Hight	90	45
University	27	13.5
Graduate	56	28
Total	200	100
Occupation		
Factory	88	44
Students	18	9
Government Service	12	6
Company Staff	15	7.5
Seller	13	6.5
Driver	17	8.5
Dependents	12	6
Retired person	10	5
Motorcycle Carry	8	4
Construction	7	3.5
Total	200	100

Source: Survey data (2019)

Table (4.1) shows the characteristic of the respondents. Among 200 respondents 134 respondents were male and 66 respondents were female.

According to the Table (4.1), the number of single respondents 37.5% and married respondents 62.5%% in the sample. The age distribution of respondents in Shwe Pyi Thar Township is presented in Table. The respondents' age ranges from 16 years to 75 years. Most of the respondents are 25 to 34 years old.

Most of the smoker and tried one time are youth (15-24) and middle-aged (25-34) and ex-smoker were found in the age of 45 and above. Most of the ex-smokers were felt unhealthy and financial problem and they have basic knowledge about diseases which are caused by smoking.

Among the respondents, all are literate ranges from primary level to graduates level. It can be clearly seen that most of the respondents were high school level shown in Table (4.1). And then 28 % respondents were graduates. According to the table (4.1), this data is difference between the level of the respondent's education. Two percentage of the respondents are primary level found the survey data and they have not knowledge for these smoking related diseases. Eighty-five percentage of the respondents well known concerning with smoking related diseases. About 15% of the respondents are weakness of their education level and have not knowledge on smoking related diseases.

Table shows the distribution of respondents by occupation. All of the respondents except 12 dependents and 18 students were earner in the sample. Most of the earners employed in factory. And then, it can be said that the people in Shwe Pyi Thar Township worked in the various fields; factory, government service, company staff, driver, carry and construction based on sample data. Most of the smokers are found occupation in factory, motorcycle carry, and driver.

4.3.2 Prevalence of Smoking among the Respondents

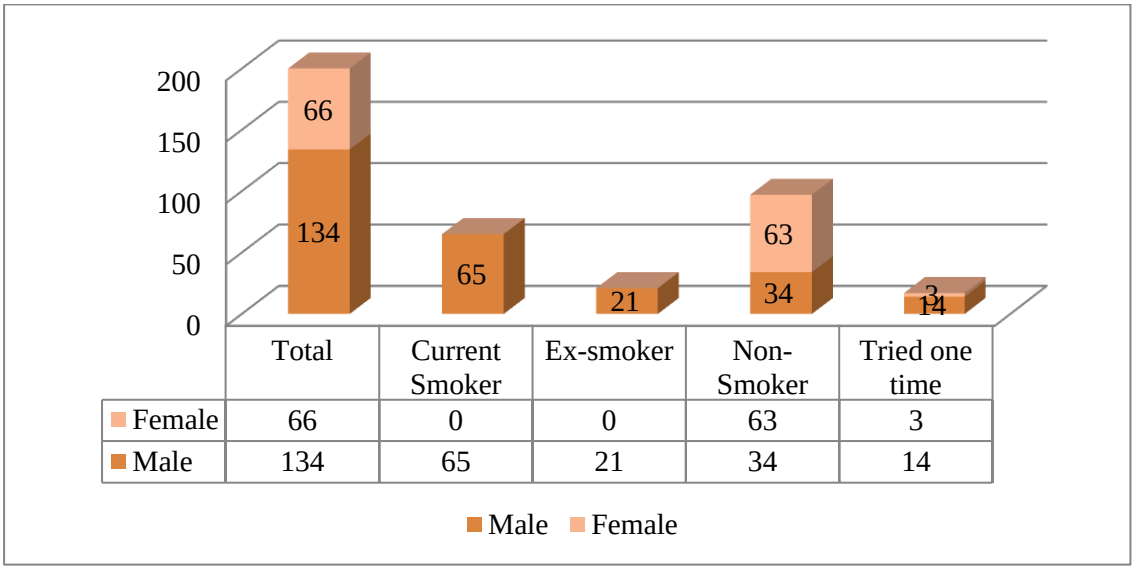
Prevalence of smoking among all sample people was mentioned in Table (4.2). It was divided into four groups – current smoker, ex-smoker, non-smoker and non-smoker who tried smoking just one time.

Table (4.2) Prevalence of Smoking among Respondents

Respondents	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Current Smoker	65	48.5	0	0	65	32.5
Ex-smoker	21	15.7	0	0	21	10.5
Non-Smoker	34	25.4	63	95.5	97	48.5
Tried one Time	14	10.4	3	4.5	17	8.5
Total	134	100	66	100	200	100

Source: Survey data (2019)

Figure (4.1) Prevalence of Smoking among Respondents



Source: Survey data (2019)

Regarding to the survey data, all of the male are current smokers in this data and female have not current smokers. Because this is the related to culture in this nation. Female have only 3 just tried smoking one time. All current smokers and ex-smokers were male as shown in Figure (4.1).

About 49% of male were current smokers and about 16% were ex-smokers. 35% were non-smokers including tried one-time smoke.

4.3.3 Causes of Quitting Smoking

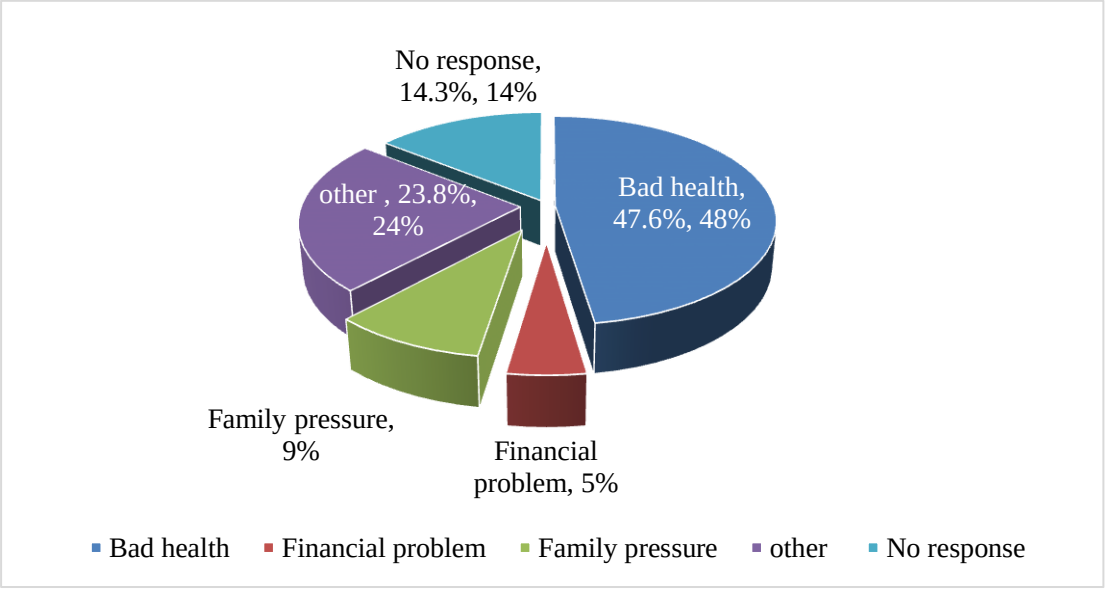
Causes of quitting smoking among ex-smoker were mentioned in Table (4.3) and Figure (4.2).

Table (4.3) Causes of Quitting Smoking

	No. of Ex-smoker	Percent
Bad health	10	47.6%
Financial Problem	1	4.8%
Family pressure	2	9.5%
Other	5	23.8%
No response	3	14.3%
Total	21	100

Source: Survey data (2019)

Figure (4.2) Causes of Quitting Smoking



Source: Survey data (2019)

There were 21 ex-smokers in Sample data. Among those, only 1 ex-smoker had quitted smoking for financial problem which was accounted for 5%. 50% of ex-smokers had quitted smoking due to bad health and they feel unhealthy and they well known smoking or tobacco were used related with diseases. Other respondents had financial problem. They increase the number of family and increase in the of commodity prices. The other reasons are family pressure 5% and others 25%. Parent told their son or wife told their husband to stop smoking or tobacco use.

4.3.4 Age at Initiated to Smoking and Types of Cigarette Use

The following table (4.4) shows the age distribution of the respondents who started smoking, each respondent was initiated to smoking and the respondents are what types of cigarette use.

Table (4.4) Respondents by Age Initiated to Smoking, Types of Cigarette Use Reasons for Smoking

Initiation Age	**Initiation Age**	
	Number	**Percent**
Between 15 and 18 years	36	42%
Between 18 and 21 years	34	35%
Between 21 and 24 years	20	23%
Total	86	100
Types of Cigarette use	**Respondents**	
	Number	**Percent**
Cigarette	55	64%
Cheroot	21	24%
Cigar	10	12%
Total	86	100%
Reasons to Start Smoking	**Respondents**	
	Number	**Percent**
Propose by other people	19	22%
Trying myself to smoke	57	66%
I think smart	10	12%
Total	86	100%
Reasons for Smoking	**Respondents**	
	Number	**Percent**
For being free	10	11.6
For relaxation	18	20.9
For enjoyment	25	29.1
For bring idle	28	32.6
For style	5	5.8
Total	86	100%

Source: Survey data (2019)

About 42% of respondents were initiated to smoking when they were between 15 and 18 years of age. Children in households in which smoking is allowed by household-members were more likely to test smoking at very young age. Sometimes adults-members themselves might ask children to light cigarette for them. Lighting cigarettes for other would eventually lead children to experiment with smoking. Among those people who have had ever started smoking, began by experimenting with different types of tobacco use.

Table (4.4) shows that 64% of the respondents started smoking cigarettes and about 24% with cheroots. Most of people are used cigarette in urban and rural area and also this cigarette is cheap price in Myanmar like as Red Ruby. Young people were using cigarette they get easy from tea shop, mini mart, betel shot, etc… The cheroot was using Myanmar have many types of cigarette.

Table (4.4) shows that 66% started smoking simply experimenting with smoking and 22% of the respondents were proposed by other people. The number of respondents by the reasons given by those current smoker, ex-smoker. About the 12% of respondents was found to smoke in order to pass time during their free time, about 21% for relaxation purposes, around 27% for enjoyment, about 35% for being idle and about 6% for their style. A majority of 50% of the respondents was smoking because they have ample free time and was feeling lazy or idle.

4.3.5 Knowledge Concerning Smoking Related Diseases

Distributions of the respondents by their knowledge and their practice on various questions concerning smoking and smoking related diseases are presented in Appendix A. It was designed to access the knowledge level of respondents in Shwe Pyi Thar Township, to find out the prevalence of smoking in Shwe Pyi Thar and influencing factors of smoking.

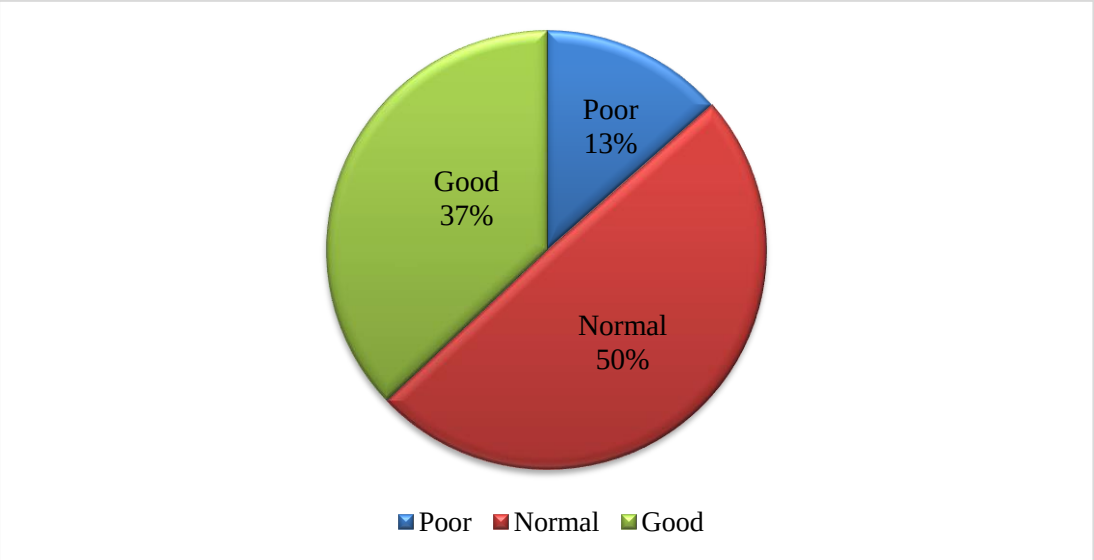
Respondents' knowledge concerning smoking related diseases is examined on the basis 21 question presented in Appendix. Knowledge test included twenty-one questions and 21 scores were given the correct response for each question is given by score 1. These 21 questions made divided into three portions, they are 0 to 7 is poor level of knowledge, 8-14 is middle level of knowledge and the last 15 to 21 is good level of knowledge on smoking related diseases. Total scores for sample respondents are computed and the distribution of total scores is presented in Table (4.5).

Table (4.5) Distribution of Total Scores on Knowledge

Knowledge Level	Scores	Male		Female		Total	
		No.	Percent	No.	Percent	No.	Percent
Poor	0 - 7	17	12.7	10	15.1	27	13.5
Normal	8 - 14	68	50.7	31	47	99	49.5
Good	15 - 21	49	36.6	25	37.9	74	37
Total		134	100	66	100	200	100

Source: Survey data (2019)

Figure (4.3) Total Knowledge Levels of the Respondents



Source: Survey data (2019)

As above expressed, table (4.5) show that round about 15% of people had poor knowledge and nearly 50% of people had enough knowledge concerning with related smoking diseases. This was no obvious difference among gender even smoking is not advance in female**.** Those data are most of the people have normal knowledge on smoking related with diseases. Other people are unknown effect on the smoking. Government should provide the knowledge health care, how to prevent and practice and education for this people.

4.3.6 Attitude toward Smoking

The attitude on smoking depends on the neighborhood in which individual was born and brought up. Socio-economic environment also exerts a great influence on the attitude, behavior, and moral person. Respondents' attitude concerning smoking is examined on the basis nine questions presented in Appendix. Total scores for sample respondents are computed and the distribution of total scores is presented in Table (4.6).

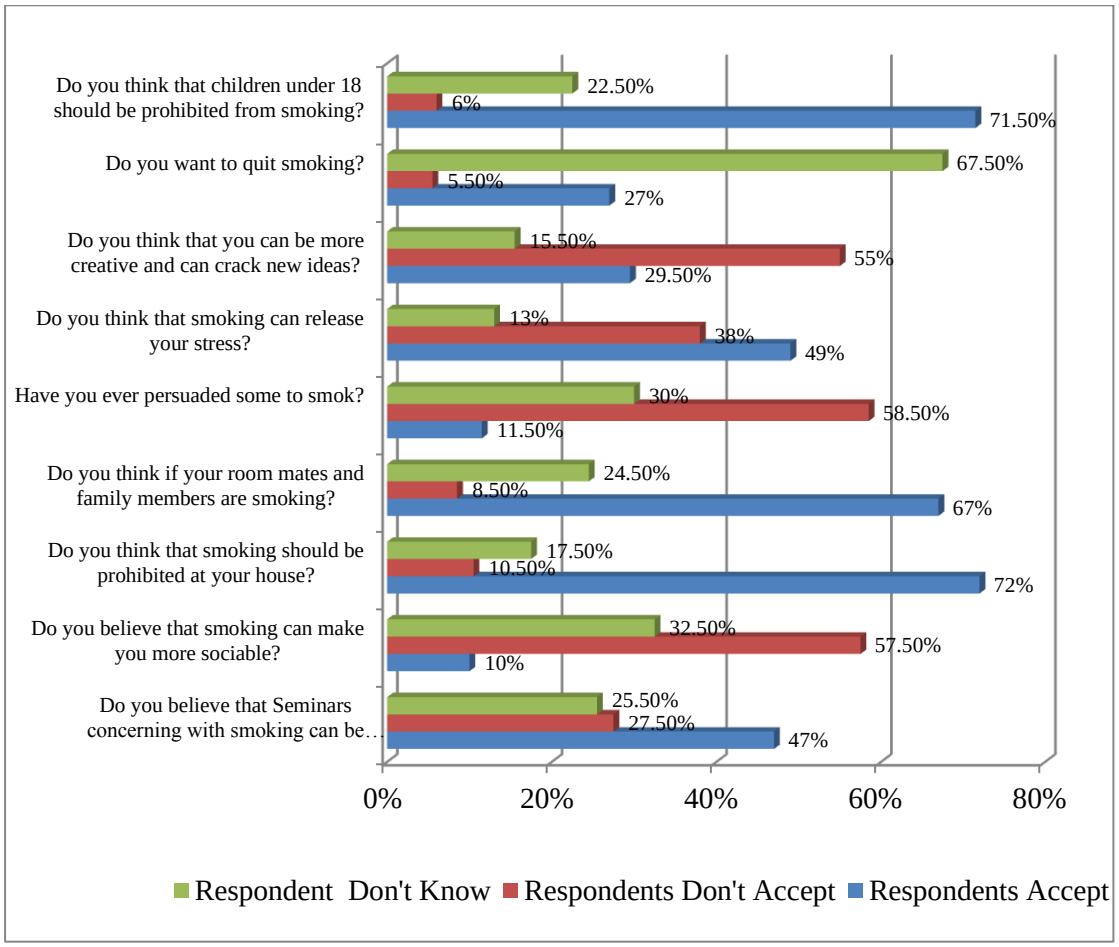
All of the respondents were believed that health seminars concerning with smoking can be effective. They have knowledge, about how to quit smoking and tobacco use from health seminar. Governments provide education message, documentaries, etc… The respondents were doing not accept this smoking can make more sociable. 114% of the respondents were accepting smoking should be prohibited at their house because some of the respondents had their child, wife, parents or old age they live together with their family. They well had known related smoking diseases and smoking effect on their health. The respondents think that smoking can make they reduce their stress and pressure. When they feel had a stressful and then they started cigarette smoking. Most of the smoker cannot decide quit to smoke.

Table (4.6) Respondent's Attitude by toward Smoking

No.	Attitude Questions	Respondents Accept		Respondents Don't Accept		Respondent Don't Know		Total	
		No	%	No	%	No	%	No	%
1	Do you believe that Seminars concerning with smoking can be effective?	94	47	55	27.5	51	25.5	200	100
2	Do you believe that smoking can make you more sociable?	20	10	115	57.5	65	32.5	200	100
3	Do you think that smoking should be prohibited at your house?	144	72	21	10.5	35	17.5	200	100
4	Do you think if your room mates and family members are smoking?	134	67	17	8.5	49	24.5	200	100
5	Have you ever persuaded some to smoke?	23	11.5	117	58.5	60	30	200	100
6	Do you think that smoking can release your stress?	98	49	76	38	26	13	200	100
7	Do you think that you can be more creative and can crack new ideas?	59	29.5	110	55	31	15.5	200	100
8	Do you want to quit smoking?	54	27	11	5.5	135	67.5	200	100
9	Do you think that children under 18 should be prohibited from smoking?	143	71.5	12	6	45	22.5	200	100

Source: Survey data (2019)

Figure (4.4) Respondent's Attitude by toward Smoking



Source: Survey data (2019)

4.3.7 Practice of Respondents Smoking

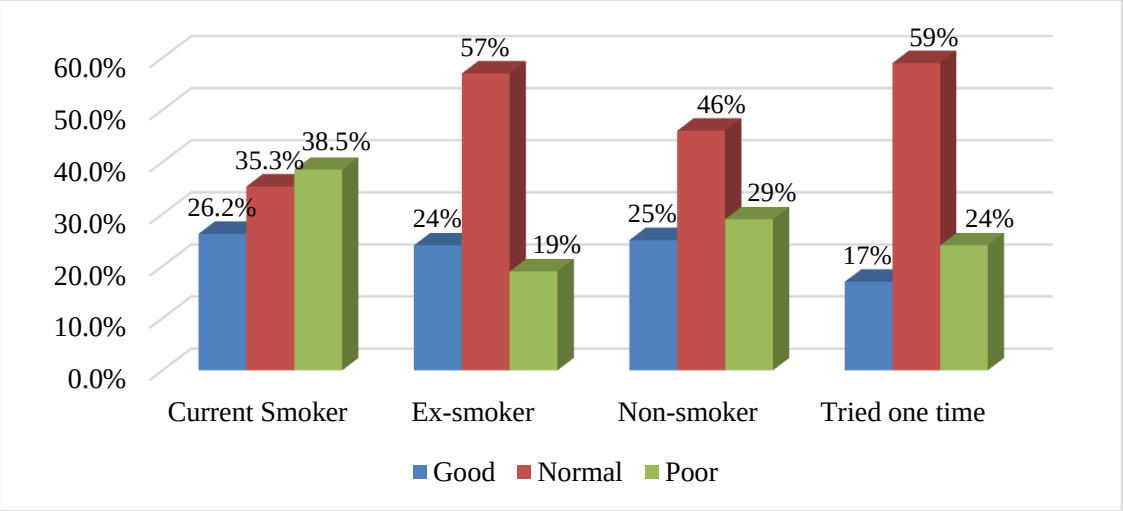
Practice test included fifteen questions and 15 scores were given the accept response for each question is given by score 1. These 15 questions made divided into three part, they are 0 to 5 is poor level of practice, 6 to 10 is normal level of practice and 11 to 15 is good practice level of related with smoking. Total scores for sample respondents are computed and the distribution of total scores is presented in Table (4.7) and Figure (4.4).

Table (4.7) Total Scores on Practice of Respondents

Practice Level	Scores	Current Smoker		Ex-smoker		Non-smoker		Tried one Time	
		No	%	No	%	No	%	No	%
Good	11-15	17	26.2	5	24	24	25	3	17
Normal	6-10	23	35.3	12	57	45	46	10	59
Poor	0-5	25	38.5	4	19	28	29	4	24
Total		65	100	21	100	97	100	17	100

Source: Survey data (2019)

Figure (4.5) Total Scores on Practice of Respondents



Source: Survey data (2019)

According to above figure (4.4), current smoker have good practice level about 26.2% than ex-smoker and non-smokers have good practice level about 25% than tried one time smoke. Current smoker has highest poor level of practice more than other respondents.

CHAPTER V
CONCLUSION

5.1 Finding

This study was aimed to assess the public awareness, attitude, and practice of smoking habit in Shwe Pyi Thar Township. A total of 200 sample respondents were interviewed using structured questionnaires in randomly selected in the Township.

This survey is focus to the adolescence and young-adult. Because smoking initiation typically occurs during the transition from adolescence to adulthood. In this survey data, most of the respondents are male. According to the basic characteristics of sample respondents, were 67% males and were 33% of females. Among these 43.5% were single and 56.5% were married. So, it can be said that sex and marital status of the respondents were fairly distributed in this sample.

The minimum age was 16 years and maximum age was 75 years. Regarding educational level, most represents 48% had high school level, 1% had primary level and 28% were graduates.

Current smokers well known about the related smoking diseases but they cannot willingness quit to smoke because of their like on cigarette. The respondents of education were found weakness and they have no observation on knowledge. So, they have not practice on smoking. Non-smokers feel the bad health on their body, so they quit the smoking. They well known disadvantage of the smoking.

It can conclude that the people in Shwe Pyi Thar Township had the most normal-level of knowledge and then it can also be concluded that people in Shwe Pyi Thar Township found the most normal-level of practice concerning on smoking habit.

5.2 Recommendation

The risk of developing cancer can be significantly reduced through simple measures such as stopping tobacco use and smoking, avoiding exposure to passive smoke, limiting alcohol consumption, avoiding excessive sun exposure, regular

physical activity, eating healthily, maintaining a healthy weight and protecting against cancer causing infection.

Weakness of law enforcement was an important role of smoking among smoker. Myanmar tobacco and smoking control law prohibited selling the cigarette to a person below the age of 18. Different kinds of advertising and selling cigarette in loose were also prohibited in this law.

According to this study, 42% of smokers started smoking the age between 15 and 18 years, and 35% of smokers started smoking the age of between 18 and 21. According the survey data, most of the smoker started were youth. Government give the information related with smoking diseases and Health Knowledge for citizen. And then government always issue laws and regulation (barriers smoking). If you people's knowledge has increased, the delivery for treatment may be strong.

Health education should be intensified especially directed to young people. Information and education message were also raised through mass media such as TV sports, short messages and documentaries, health seminar, movies and songs and through printed media such as daily newspaper, pamphlets, poster and billboards. The effective communication channel should be developed between Ministry of Health and local and international social organizations that are actively participation in prevention and control activities. As the incensement of rules and regulations on the tobacco and the restriction on the smoking of the public areas and the effective knowledge sharing programs may results as the decrease unhealthy condition in our country. Thus, health education programmes concerning Cancer should be provided to public through media and health assistants.

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Appendix

Public Education, Attitude and Practical Observation of Smoking (No need to mention name and address)

(1) Personal Information

1. Age
2. Gender
3. Marital Status
4. Education
5. Family's income

(2) Questions for Smoking

1. You are

(a) Non-smoker

(b) Used to smoke

(c) Smoker

If you are not smoker,

2. Have you tried to smoke?
3. (If you had), At which age did you try?
4. Is there any smoker in your family members?
5. If there is place mention the quantity of family member.
6. Is there any smoker in your friends?
7. If there is please mention the quantity.

If you quitted smoking.

8. When did start smoking?
9. What type of cigarette did you smoke?
10. How many cigarette did you smoke a day?
11. The reason why you quit smoking.
    - because of your health
    - because of your income
    - other
12. Is there any smoker in your family?
13. If there is please mention the quantity of family number.
14. Is there is any smoker in your friends?
15. If there is please mention the quantity of friends number.

Appendix Continue

If you are smoker,

16. When did you start smoking?
17. What type of cigarette did you smoke?
18. How many cigarette did you smoke a day?
19. Smoking can cause
    - fertility problem
    - declining stamina
    - cough
    - respiration system
    - reducing memory
20. Please mention when do you smoke
    - after meal
    - when you meet friends
    - feeling down
21. The reasons you started smoking is lighting other's cigarette.

(a) Yes (b) No

22. What type of cigarette do you smoke?
    - cigarette
    - cheroot
    - cigar
    - others
23. Where do you buy cigarette?
    - supermarket
    - betel shop
    - tea shop
    - restaurant
    - canteen
    - store
    - others
24. How many cigarettes do buy a week?

    ---

25. How often do you smoke?
    - sometime
    - everyday
    - never
26. How many cigarettes do you smoke a day?
    - feeling down
    - you like to smoke
    - addicted to smoke
    - when you meet friends
    - when you are bored
    - you think it look smart

(3) Educational Questions of Smoking

1. Do you think smoking can affect your health and life?
   (a) Yes (b) No (c) No idea
2. Smoking has impacts on the surrounding?
   (a) Yes (b) No (c) No idea
3. Smoking can affect heart blood vessels.
   (a) Yes (b) No (c) No idea
4. Smoking can cause throat problems.
   (a) Yes (b) No (c) No idea
5. Smoking leads to legs and arms amputation.
   (a) Yes (b) No (c) No idea
6. Smoking can cause lung cancer
   (a) Yes (b) No (c) No idea
7. Smoking can occur tuberculosis.
   (a) Yes (b) No (c) No idea
8. Smoking can arise hypertension.
   (a) Yes (b) No (c) No idea
9. Cigarette consist of nicotine and tax.
   (a) True (b) False (c) No idea
10. Smoking can affect low birth weight and premature birth.
    (a) Yes (b) No (c) No idea

11. Smoking can happen abortion.
    (a) Yes (b) No (c) No idea

12. Smoking can cause fetal brain problems
    (a) Yes (b) No (c) No idea

13. Second hand smoke can be affected health problem as smokers?
    (a) Yes (b) No (c) No idea

14. Do you agree you should stop smoking if there are children beside you?
    (a) Yes (b) No (c) No idea

15. You shouldn't smoke in crowded places?
    (a) Yes (b) No (c) No idea

16. You should go with mask in every crowded places.
    (a) Yes (b) No (c) No idea

17. When someone is smoking beside you, you should cover your nose with handkerchief or tissues.
    (a) Yes (b) No (c) No idea

18. You should do your normal medical check.
    (a) Yes (b) No (c) No idea

19. You should do some sport or exercise daily.
    (a) Yes (b) No (c) No idea

20. You should eat nutritious food.
    (a) Yes (b) No (c) No idea

21. You should explain about the impact of smoking to children.
    (a) Yes (b) No (c) No idea

(4) Observation Question Smoking Attitude

1. Do you believe that seminars concerning with smoking can be effective?
    (a) Yes (b) No (c) No idea

2. Do you believe that smoking can make you more sociable?
   (a) Yes (b) No (c) No idea
3. Do you think that smoking should be prohibited at your house?
   (a) Yes (b) No (c) No idea
4. If your room mates and family members been smoking you should
   (a) Do prohibit (b) Envied (c) Others
5. Have you ever persuaded some to smoke?
   (a) Do persuaded (b) Don't persuaded (c) No idea
6. Do you think that smoking can make you release your stress?
   (a) Yes (b) No (c) No idea
7. Do you think that you can be more creative and can crack new ideas?
   (a) Yes (b) No (c) No idea
8. Do you want to quit smoking?
   (a) Yes (b) No (c) No idea
9. Do you think that children under 18 should be prohibited from smoking?
   (a) Do prohibited (b) Don't prohibited (c) Others

(5) Questions of Smoking Practice

1. You will reduce daily smoking ----------
2. You will quit smoking ----------
3. You will eat nutritous meals ----------
4. You will do exercise everyday ----------
5. You will stay at the fresh air place ----------
6. You will go medical check in every six months or once a year ----------
7. Do you ever stop smoking when there are children beside you? Or not?
   ----
8. Do you ever stop smoking in crowded places? Or not? ----------

If you are non-smoker, do you stay following practices?

9. Do you ever go out with mask in public crowded places ? or not?----------
10. Do you ever cover your handkerchief or tissue? Or not?----------
11. Do you ever stay in fresh air places? Or not?----------
12. Do you ever do medical check ? or not?----------
13. Do you ever do sports or exercise? Or not?----------
14. Do you ever have nutritious meals? Or not?----------
15. Do you ever explain to smokers about the upcoming health problems of smoking?
