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BANGLADESH

COUNTRY REPORT

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EXECUTIVE SUMMARY

Bangladesh is the 39th largest country in the world in terms of nominal gross domestic product (GDP), and it is the 30th largest in terms of purchasing power parity. It is classified among the Next Eleven emerging market middle-income economies and as a frontier market. In 2018, agriculture made up 13.07% of Bangladesh's GDP, industry made up approximately 28.54%, and the services sector made up about 52.96%. Gross national income (GNI) per capita in Bangladesh was reported at US\$1,750 in 2018 which has been calculated in Atlas method (current US\$), a method used by the World Bank since 1993 to estimate the size of economies in terms of gross national income (GNI) in U.S. dollars. The poverty rate in Bangladesh dropped to 20.5% of the population in the fiscal year 2018–19. This same figure was 21.8% at the end of fiscal year 2017–18. The extreme poverty rate also dropped to 10.5% in 2018–19, but was 11.3% in 2017–18. Bangladesh has moved from 136th to 135th place among 189 countries in the Human Development Index (HDI).

Bangladesh is the eighth-most populated country in the world, with almost 2.2% of the global population. The United Nations estimates the population of Bangladesh as of July 1, 2020 at 164,689,383. The massive influx of Rohingya refugees into Bangladesh, fleeing a campaign of terror by the Myanmar military, has had a profound impact on the population of Bangladesh. With less than 0.31% of the world's population, Bangladesh now hosts 4.7% of its refugees. As of March 2019, over 909,000 stateless Rohingya refugees resided in Ukhiya and Teknaf Upazilas.

The Bangladesh government has consistently prioritized urbanization in its national development plans, starting with the first Five Year Plan (FYP). Almost all subsequent FYPs, including the seventh FYP (2016–2020), emphasized its importance. Currently, more than 60% of the urban population is concentrated mainly in four metropolitan cities: Dhaka, Chattogram, Khulna, and Rajshahi. By 2030, this trend in population migration from rural to urban areas will become even more pronounced. Dhaka's population is estimated to double, and Chattogram is expected to grow into Bangladesh's next megacity with a population of 5 to 10 million, a growth driven largely by migration.



Bangladesh advances on achieving Sustainable Development Goals (SDGs) health indicators with important progresses on under-5 mortality that persistently declined from 36 per 1,000 live births in 2015 to 29 in 2018 and the neo-natal mortality rate that decreased to 16 per 1,000 live births in 2018 from 20 in 2015. Both these achievements represent achievements of the 2025 SDG targets.

Life-expectancy in Bangladesh is 73.6 years for both sexes; this number was 65 in 2006. This gives Bangladesh a World Life Expectancy ranking of 97 out of 183 countries. Females have a higher (75.6 years) life expectancy than males (71.8 years). Infant mortality under-5 (per 1,000 live births) has gone down from 136.545 to 33.1 from 1990 to 2017. And infant mortality under-1 has gone from 96.1 to 27.7 from 1990 to 2017. The number of medical colleges has increased from 46 to 111. The total number of registered private hospitals and facilities run by Directorate General of Health Services (DGHS) are 1,43,394.

The health system in Bangladesh is experiencing the manifold burden of disease, low service coverage, and a paucity of effective financial risk protection mechanisms. Bangladesh has a pluralistic healthcare system that is highly unregulated and consists mainly of government, for-profit private sector, not-for-profit private sector (generally nongovernmental organizations), and international development organizations.



One of the largest tobacco-consuming countries in the world, Bangladesh is home to an estimated 46.3 million adults who use of a variety of combustible and/or smokeless tobacco products. Men are the main drivers of tobacco use in the country. Tobacco use prevalence significantly decreased among adults from 43.3% in 2009 to 35.3% in 2017. Bangladesh's tobacco production is ever increasing, and it now constitutes a sizeable portion of the world tobacco supply. The two major tobacco companies in Bangladesh include British American Tobacco (62% of the cigarette market by volume) and Dhaka Tobacco Industries (under Akij Group; 21.3% of the market). Cigarette sales in Bangladesh increased from 72.9 to 88.9 billion sticks from 2011 to 2017. Over the same period, smokeless tobacco sales decreased from 46.5 to 42.6 tons.

Bangladesh has no separate law on tobacco taxation. Rather, tobacco taxation is implemented as part of the 1991 Value Added Tax (VAT) Law. Bangladesh has imposed a VAT on all tobacco products as well as a variety of other taxes — including supplementary duties on cigarettes, bidis, chewing tobacco, and pipe tobacco; duties on imported tobacco products and on both imported and exported tobacco leaf.

Bangladesh ratified the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) in 2004. The primary national law regarding tobacco is the Smoking and Tobacco Products

Usage (Control) Act in 2005; this was amended with the Smoking and Tobacco Products Usage (Control) (Amendment) Act in 2013.

Anti-tobacco laws and regulations, including taxation, have been progressively tightened since Bangladesh signed the WHO FCT in 2004.

In Bangladesh, WHO provides technical support for implementation of the FCTC and tobacco control, especially in the key areas of tobacco taxation, policy development, enforcement of legislation, and surveillance of tobacco use (most recently through technical support for the second round of the Global Adult Tobacco Survey Bangladesh, or GATS).

The heavy burden of tobacco-related health conditions in Bangladesh is rooted in the country's high production and consumption of tobacco products, thus Bangladesh is one of the five focus countries of the Bloomberg Initiative (BI) to Reduce Tobacco Use.



The law of Bangladesh doesn't state that warnings on packages do not remove or diminish the liability of the tobacco industry. There is no law prohibiting tobacco packaging and labels from incorporating figurative or other signs, including colors or numbers, as substitutes for prohibited misleading terms (health care, treatment, safe environmental protection, low harms and other functions of cigarette ingredients) and descriptors. And there is no law prohibiting descriptors of flavors on tobacco packaging and labels. The display of quantitative information on emission yields is permitted on tobacco packaging, including when it is used as part of a brand name or trademark.



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CHAPTER 1

Economic, social, and demographic state of Bangladesh

1.1 Economic trends and outlook

Bangladesh constitutes a developing market economy. It is the 39th largest country in nominal terms, and 30th in terms of purchasing power parity; it is classified among the Next Eleven emerging market middle income economies and as a frontier market. The Bangladesh economy has maintained an average annual growth rate above 6% over the last decade, with 7.9% outturn in fiscal year 2018 (FY2018). However, the real GDP growth of Bangladesh was 2% in 2020 ("Real GDP growth", 2020). In 2018, agriculture represented 13.07% of the Bangladesh GDP, industry approximately 28.54%, and the services sector about 52.96%. The financial sector in Bangladesh is the second largest on the Indian subcontinent. Bangladesh is one of the world's fastest growing economies.

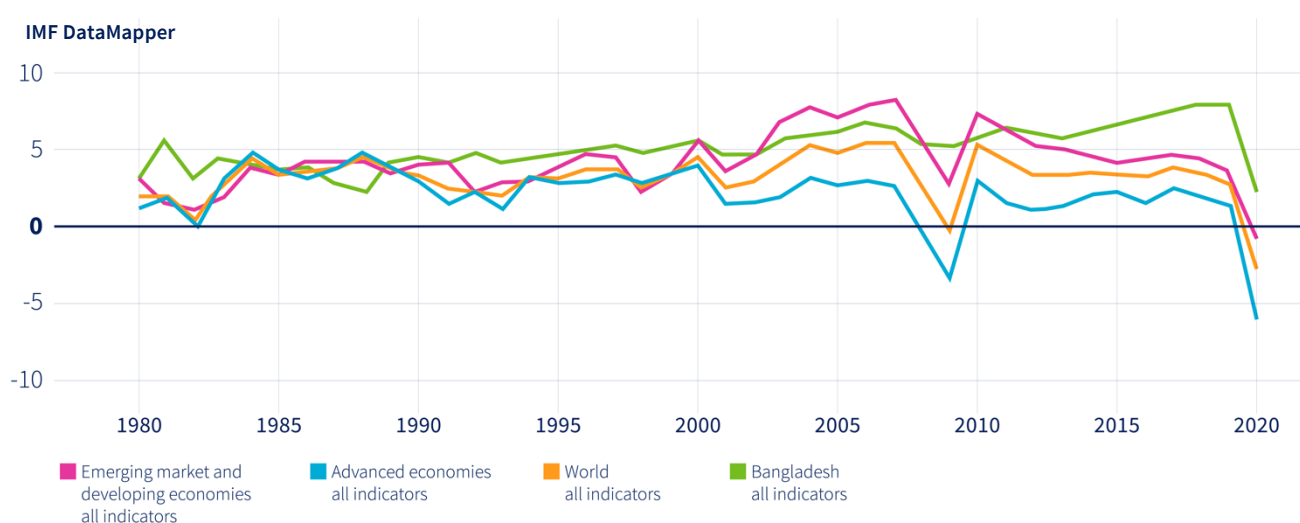


Figure 1: Real GDP growth rate (annual percent change), 1980–2020.¹

CIMF, 2020,
Source: World Economic Outlook (April 2020)

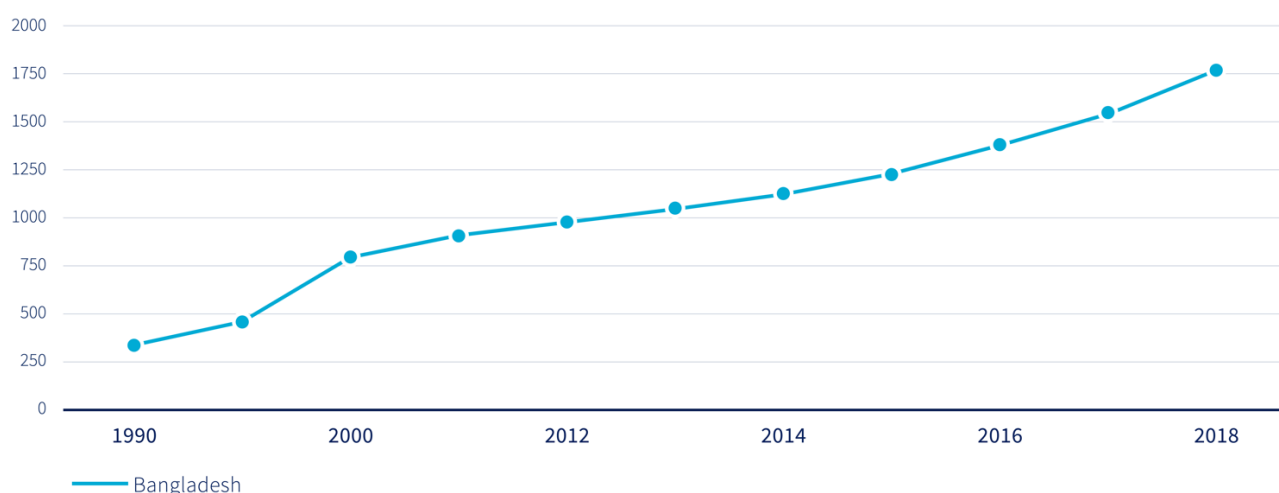


Figure 2: GNI per capita, Atlas method (current USD) in Bangladesh.²

Series: GNI per capita, Atlas method (current US\$)
Source: World Development Indicators
Created on: 05/29/2020

¹ Adapted from IMF DataMapper.

² Source, World Bank

Bangladesh is classified as a lower middle-income country. Since its founding, it has generally matched the percent GDP growth rate in other emerging and developing Asian countries. The real GDP growth of Bangladesh is 2% in 2020.

GNI per capita, determined using the Atlas method (current USD), in Bangladesh was US\$1,750 in 2018, according to the World Bank collection of development indicators, compiled from officially recognized sources. The types of information, used in this chapter, like Bangladeshi GNI (per capita), Atlas method- actual values, historical data, forecasts and projections were sourced from the World Bank on May of 2020 ("Bangladesh - GNI Per Capita, Atlas Method - 1973-2018 Data | 2020 Forecast", 2020).¹

1.2 Socioeconomic status

According to the Bangladesh Bureau of Statistics (BBS), the poverty rate in Bangladesh dropped to 20.5% in FY2018–2019. This same figure was 21.8% at the end of FY2017–2018. The extreme poverty rate also dropped to 10.5% in 2018–2019, from 11.3% in 2017–2018 ("Wage Earners Remittance", 2019).

Poverty and extreme poverty, 2017–2019

	HIES 2000	HIES 2005	HIES 2010	HIES 2016	2016-17 Estimated	2017-18 Estimated	2018-19 Estimated
Poverty	48.9	40	31.5	24.3	23.1	21.8	20.5
Extreme Poverty	34.3	25.1	17.6	12.9	12.1	11.3	10.5

Poverty and extreme poverty position, 2017–2019

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
GDP Growth Rate	5.57	6.46	6.52	6.01	6.06	6.55	7.11	7.28	7.86	8.15
Per Capita real GDP (taka)	41,076	43,190	45,421	47,491	49,701	52,243	55,259	58,603	62,447	66,795
Growth Rate per capita real GDP	4.14	5.15	5.17	4.56	4.65	5.12	5.77	6.05	6.61	6.91
Poverty	31.5						24.3	23.1	21.8	20.5
Extreme Poverty	17.6						12.9	12.1	11.3	10.5

Figure 3: Poverty and extreme poverty, 2017–2019. ³

World Bank data show remarkable progress in the reduction of poverty in Bangladesh since 2000. Extreme poverty rates have halved to 24.3%, while extreme poverty rates have reduced by two-thirds to 12.9%. Measures of poverty using the international extreme poverty line have shown comparable trends. Yet, trends between 2010 and 2016 suggest a deceleration in the rate of poverty reduction in a period of faster economic growth. The poverty level of urban areas has been decreasing day by day. Inequality measured by the [Gini](#)

³ Source: Bangladesh Bureau of Statistics

[index](#) was 32.4 in 2016, with very little change since 2000. inequality increased slightly in rural areas and decreased in urban areas

The COVID-19 pandemic is creating an unprecedented crisis in Bangladesh, and poverty is likely to increase substantially in this short-term. The sharp decline in demand of manufactured goods, particularly from the export-oriented ready-made garments sector, is expected to affect employment creation in urban areas, which has been an important driver of poverty reduction in the past. Large labor income losses are also expected for households engaged in informal services, and for those working in labor-intensive sectors like construction. The growing escalation of poverty rates will likely be highest in urban centers.

There have a large number of international migrants from Chittagong, Sylhet, and Dhaka division. If the remittances come from these migrants slightly, it impact on the poverty rate of Bangladesh badly. A domestic outbreak and the consequent healthcare burden and related disruptions will exacerbate negative impacts in access to services and poverty. High-density slum and urban areas, as well as camps in Cox's Bazar, will be particularly vulnerable. In the absence of mitigating measures, the welfare impacts of the pandemic are likely to be widespread and long lasting — as formal safety nets are limited, households will likely need to reduce consumption and deplete assets and savings to cope with income losses or to finance extraordinary health expenses(Raza, 2020).

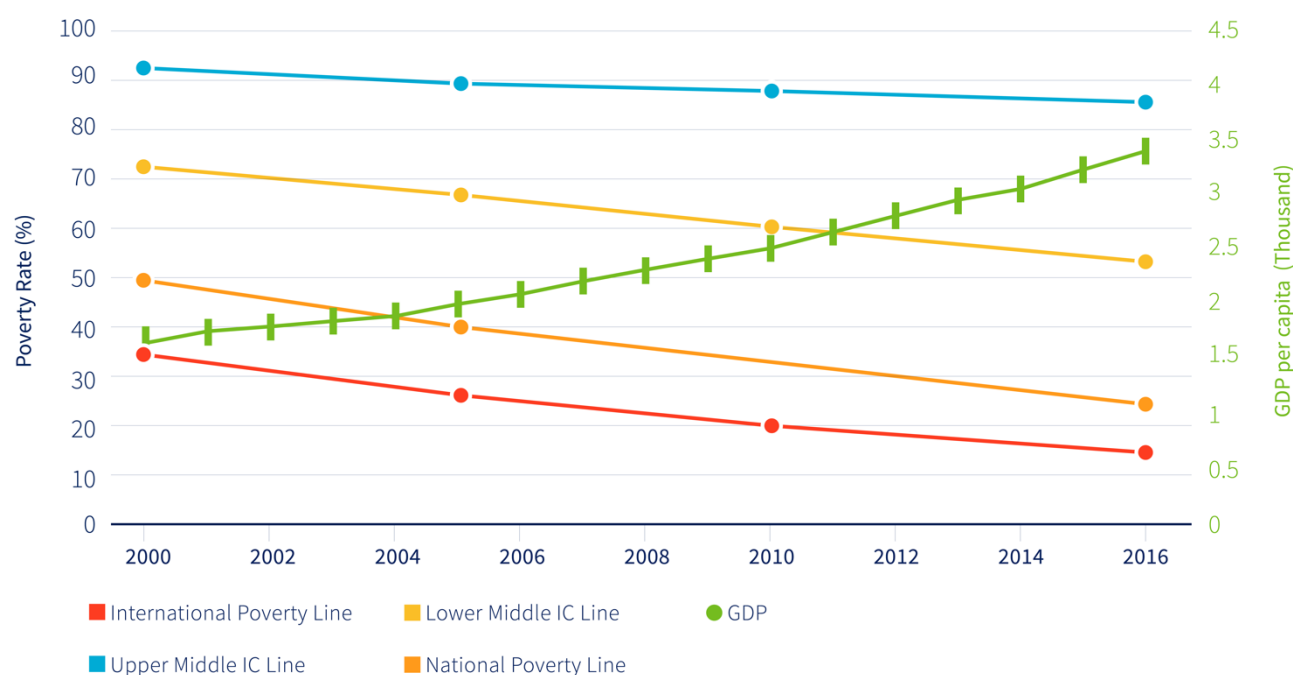


Figure 4: Bangladesh poverty headcount rate, 2001–2016. ⁴

Source: World Bank using HIES/SARMD/GMD

⁴ Adapted from W2010 World Bank Group, Poverty & Equity Brief (2020).

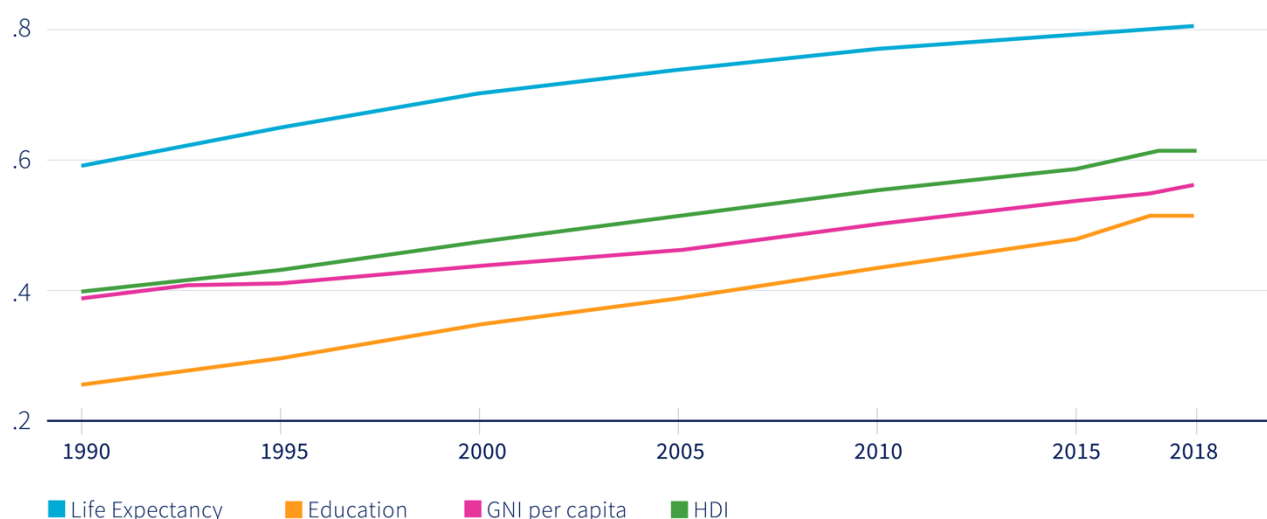


Figure 5: Trends in Bangladesh's HDI component indices, 1990–2018.

According to the UNHDI, Bangladesh has moved from 136 to 135 among 189 countries, per the 2019 Human Development Report (HDR) released by the UN Development Program (UNDP). As stated in the report, Bangladesh is one of the countries that has made the greatest progress in recent decades, with its HDI increasing by 81% in the past 30 years. Even with such impressive relative gains, Bangladesh remains a country in need of continued and coherent development assistance. Bangladesh's HDI value for 2018 is 0.614— which put the country in the medium human development category— ranking 135 out of 189 countries. Between 1990 and 2018, Bangladesh's HDI value increased 58.3%, from 0.388 to 0.614 ("Bangladesh moves up in UNDP Human Development Report", 2019).

Table 1: Bangladesh's HDI trends based on consistent time series data and new goalposts.⁵

	Life Expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP\$)	HDI value
1990	58.2	5.6	2.8	1,358	0.388
1995	62.0	6.6	3.3	1,531	0.427
2000	65.4	7.5	4.1	1,750	0.470
2005	67.8	8.4	4.5	2,802	0.506
2010	69.9	9.2	5.3	2,723	0.549
2015	71.5	10.3	5.8	3,439	0.588
2016	71.8	10.8	5.9	3,620	0.599
2017	72.1	11.2	6.1	3,792	0.609
2018	72.3	11.2	6.1	4,057	0.614

Table 1 reviews Bangladesh's progress in each of the HDI indicators between 1990 and 2018. Bangladesh's life expectancy at birth increased by 14.1 years, mean years of schooling increased by 3.2 years, and expected

⁵ Source: Human Development Report 2019 (Bangladesh), UNDP

years of schooling increased by 5.6 years. Bangladesh's GNI per capita increased by about 198.7% between 1990 and 2018.

Table 2: Bangladesh's relative HDI and component indicators for 2018.⁶

Country or group	HDI value	HDI rank	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP USD)
Pakistan	0.56	152	67.1	8.5	5.2	5.19
Bangladesh	0.614	135	72.3	11.2	6.1	4.057
India	0.647	129	69.4	12.3	6.5	6.829
South Asia	0.642		69.7	11.8	6.5	6.794
Medium HDI	0.634		69.3	11.7	6.4	6.24

Table 3: Socioeconomic indicators of Bangladesh

General Geographical Location/Characteristics					
Location		37,895			
Area (Sq. Km)		1,47,570 Standard Time GMT +6 Hours			
Vital Statistics		Poverty Situation		Labour Force and Employment	
General Vital Statistics		Incidence of Poverty (%)		Labour Force Source, 2016-17	
Population (In Million)		21.8			
Population Census 2001	130.0	Incidence of Extreme Poverty (%)	11.3	Total Labour Force (15+ yrs), (Crore)	6.35
Population Census 2011	151.7	Gross Domestic Product (GDP), 2018-19 (Prov.)		Male	4.35
Estimated 2018	163.7	GDP at Current Price (In Cr. Tk.)	2536177	Female	2.00
Population Growth Rate (percentage) 2017	1.37	GDP at Constant Price (In Cr. Tk.)	1105514	Percentage of Total Labour Force by Broad Sectors	
Male-Female Ratio, 2017	100.2	GDP Growth at Constant Price (%)	8.13	Agriculture Sector	40.6
Population Density/Sq. Km, 2017	1103	Per Capita National Income (In Tk.)	160060	Industry Service	20.4
Basic Vital Statistics		Per Capita National Income (In US\$)	1909	Service	39
Crude Birth Rate (Per 1000 Population), 2017	18.5	Per Capita GDP (In Tk.)	153197	Transportation (Km.), Up to February, 2019	
Crude Death Rate (Per 1000 Population), 2017	5.1	Per Capita GDP (In US\$)	1827	National Highway	3906

⁶ Source: Finance Division, Ministry of Finance

Infant Mortality Rate (Per Thousand Live Birth), (Below 1 Year of Age), 2017	24	Savings and Investment (Percentage of GDP) 2018-19 (Prov.)		Regional Highway	4483
Total Fertility Rate Per Woman (15-49), 2017	2.05	Domestic Savings	23.93	Feeder Road/Zila Road	13207
Life Expectancy (yrs), 2017	62.5	National Savings	28.41	Total Road	21596
Both Sex		Total Investment	31.56	Railway 2017-18	2956
Male	72.0	Public	8.17	Exchange Rate Average (July-February, 2019)	
Female	70.6	Private	23.40	Taka/US\$	83.89
Mean Age (yrs) at First Marriage, 2017	73.5	Balance of Payments, 2018-19 (July-February, 2019) (In Million US\$)		Inflation (%) Average	
Male		Export Earning, fob	27144	2018-19 (July to March, 2019)	5.44
Female	18.4	Import Payments, fob	37839	Financial Statistics Year (Up to February, 2019)	
Health and Social Services		Current Account Balance	(-)4270	Total Number of Commercial Banks	59
Persons Per Registered Physician, 2018	1:1724	Overall Balance	(-)499	State Owned Bank	6
Improved Drinking Water Coverage (%), 2017 (tube-well)	98.0	Workers' Remittances (July-March, 2019)	11869	Specialised Bank	3
Improved Sanitation Facility (%), 2017	76.8	Foreign Exchange Reserves (30.04.2019)	32123	Local Private Bank	41
Literacy Rate of Population 7+ yrs (%), 2017	72.3	Budget 2018-19 (Revised)		Foreign Bank	9
Male	74.3	Total Revenue (In Core Taka)	316599	Non-Bank Financial Institution	34
Female	70.2	Total Expenditure (In Core Taka)	442541	Money Supply (In Billion TK.) End February, 2019	
		Total Revenue (As Percentage of GDP)	12.48	Narrow Money (M ₁)	252374
		Budget Deficit (Excluding Foreign Grants, % GDP)	17.45	Reserve Money	226743
		Budget Deficit (Including Foreign Grants, % GDP)	4.82	Broad Money (M ₂)	1160573
		Budget Deficit (Including Foreign Grants, % GDP)	4.97	Capital Market (Share Price Index, as on 30 April 2019)	
				DSE Broad Index (Base=100)	5203
				Chattogram Stock Exchange (Base=1000)	15913

1.3 Population demographics

Bangladesh has one of the highest population densities in the world. It is the eighth most populated country in the world with almost 2.2% of the world's population. The UN estimates the population of Bangladesh as of July 1, 2020 at 164,689,383 ("Bangladesh Population 2020 (Live)", 2020).

The total fertility rate (TFR) has been reduced by more than two-thirds since the country gained independence in 1971. Current TFR in Bangladesh is 2.1, which means that women have an average of 2.1 children in their lifetime. At this TFR, and without migration, the country's population will eventually be neither growing nor shrinking once the top of its age pyramid fills in.

Table 4: Bangladesh population trends, 1950–2015

Year	Total population (thousands)	Population aged 0–14 (%)	Population aged 15–64 (%)	Population aged 65+ (%)
1950	37,895	41.2	54.8	3.9
1955	43,444	42.4	54.1	3.5
1960	50,102	43.6	53.1	3.3
1965	57,792	44.7	52.0	3.3
1970	66,881	44.7	51.8	3.4
1975	70,582	45.8	50.7	3.5
1980	80,624	45.0	51.4	3.6
1985	92,284	43.9	52.5	3.6
1990	105,256	42.5	53.8	3.7
1995	117,487	40.3	55.9	3.8
2000	129,592	37.3	61.4	4.0
2005	140,588	34.3	61.4	4.3
2010	148,692	31.3	64.1	4.6
2015	160,996	28	65	6

(*"Demographics of Bangladesh", 2016*).

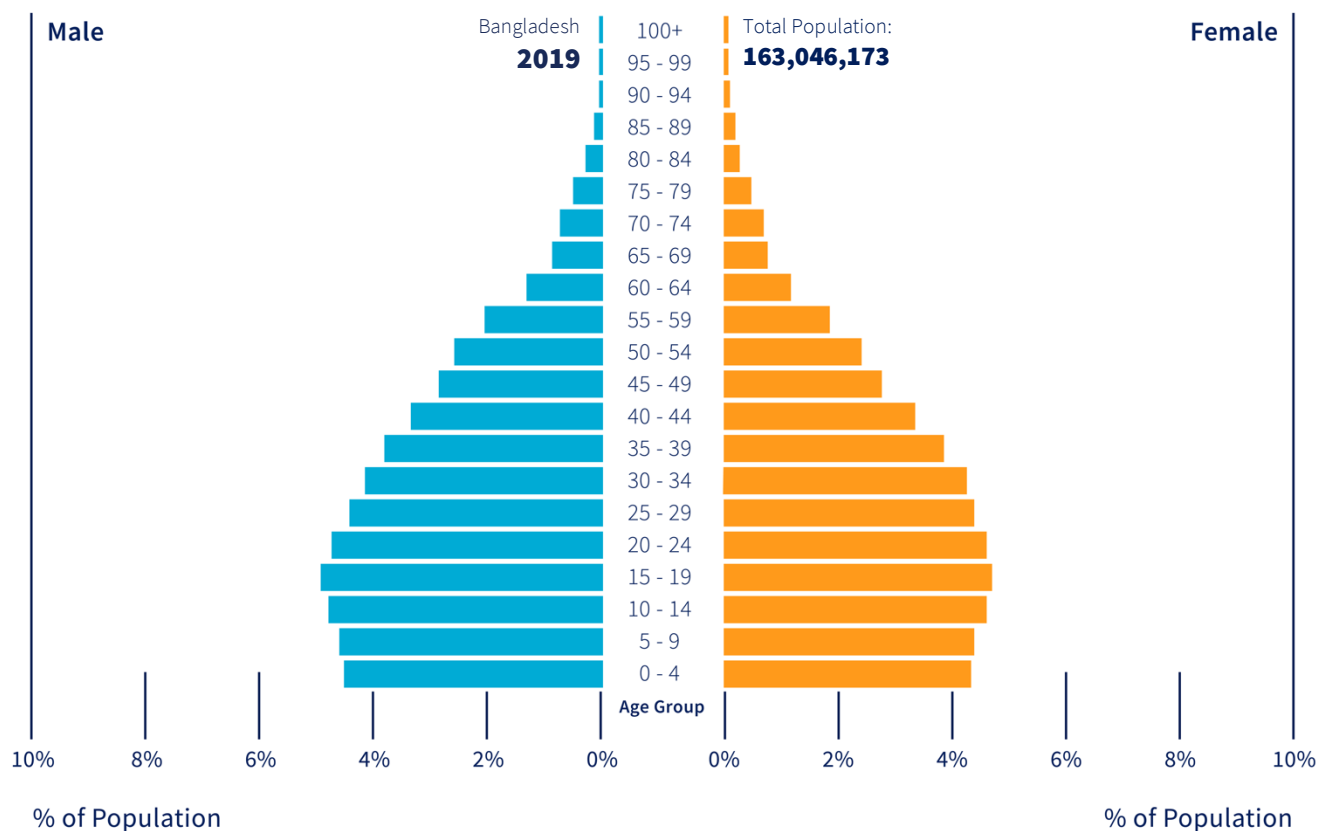


Figure 6: Bangladesh population pyramid, 2019⁷

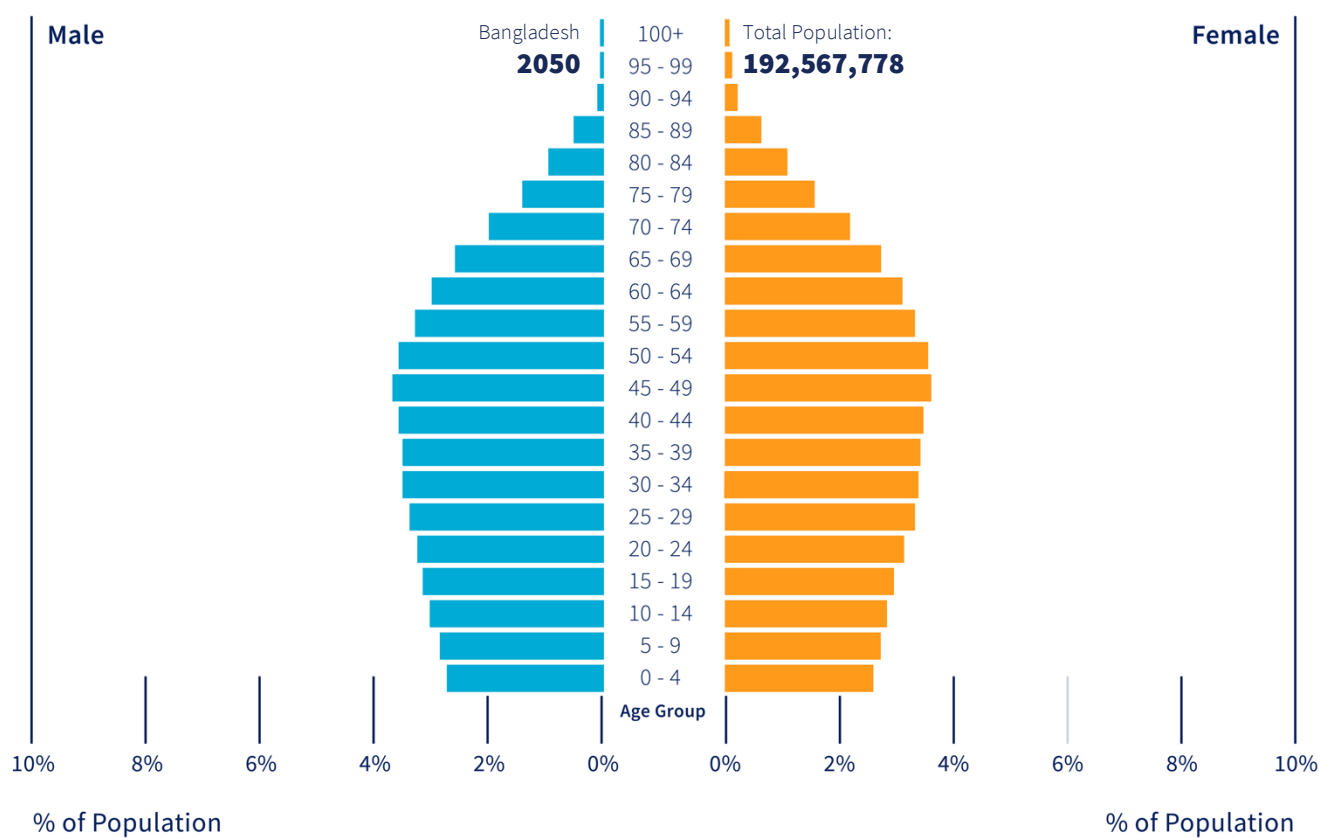


Figure 7: Bangladesh population pyramid, 2050.

⁷ Source: Population Pyramids of the World from 1950 to 2100", 2019

According to current population projections Bangladesh's population will reach its peak in 2050 with a population of 192,567,778. The population growth rate has significantly decreased in Bangladesh over the last 60 years, peaking at 3.23% in 1967, and now as low as 1%. But the population continues to grow, and Bangladesh remains one of the most populated countries in the world. Reasons for Bangladesh's ongoing growth include low contraception use, child marriage, and high total and adolescent fertility rates. Additionally, the birth rate in Bangladesh is 17.88 births per 1,000 people, and the death rate is about 4.8 deaths per 1,000 people.

Through the 1960s and 1970s, the birth rate in Bangladesh was among the highest in the world, but it began to slow considerably in the 1980s. The fertility rate is now at 2.4 children born per woman. Bangladesh has a fairly young population, with 34% aged 15 and younger, and just 5% aged 65 and older. The rate of population growth has been slowing steadily for quite a while, and that trend is expected to continue further into the 21st century. The country is currently growing at an annual rate of around 1%, but experts predict this will be halved by 2040. Bangladesh is expected to reach a population of 186 million by 2030 ("Bangladesh Population 2020 (Live)", 2020).

The country's massive influx of Rohingya refugees, fleeing the Myanmar military's campaign of terror, has had a profound impact on the population of Bangladesh— especially in Cox's Bazar and Bandarban districts in the Chattogram division, where an overwhelming majority of the refugees have settled. With less than 0.31% of the world's population, Bangladesh now hosts 4.7% of global refugees. The two southern Cox's Bazar sub-districts (upazilas)—Teknaf and Ukhiya—have borne the brunt of this crisis. As of March 2019, over 909,000 stateless Rohingya refugees were residing in the Teknaf and Ukhiya Upazilas. Most of these refugees live in 34 extremely congested camps; the largest single site, the Kutupalong-Balukhali Expansion Site, which hosts approximately 626,500 Rohingya refugees ("Rohingya Refugee Crisis", 2019).

1.4 Demographic shifts and urbanization

Bangladesh has a population of about 164,497,521, equivalent to 2.11% of the total world population. Bangladesh is the eighth most populous country in the world, with an annual population growth rate of 1.1%. Males constitute 50.6% of the population; females, 49.4%. Most people live in rural areas (61%). The infant mortality rate is 21.6 per 1,000, and the crude death rate is 5.6 per 1,000 ("Bangladesh Population (2020) - Worldometer", 2019).

Urbanization remains relatively low in Bangladesh— just 28% of the population lived in an urban area in 2011—despite significant urban–rural migration. Past estimates indicate that, in the largest metropolitan area, the urban population growth rate was 3.53% migration was due to increase in natural balance. More crucially, slum populations have been increasing at double the rate of urban areas. In Dhaka 2006⁽⁶⁷⁾, 37% of the city's population was estimated to be living in slums. Although living conditions in urban slums have improved, they remain highly inadequate. According to NIPORT *et al.* (2014), three-quarters of slum households live in one room, and the median living area is less than 40% of that in non-slum areas. Slum dwellers are disproportionately poor, the vast majority belonging to the lowest two wealth quintiles. Access to sanitation and adequate garbage disposal is poor. Recent migrants form the poorest groups in slum areas.

The absence of adequate urban planning, coupled with uncontrolled migration resulting in extremely high urban density in the poorest areas, has contributed to deteriorating environmental conditions, particularly in the largest cities. Air pollution (related to traffic congestion), drainage overflow, flooding and waterlogging, poor sanitation, and inadequate water supply are common in urban areas. Impoverished rural–urban migrants will likely not find their quality of living an improvement on that in the places they have fled (Hayes, 2015).

The Bangladesh government has consistently prioritized urbanization in its national development plans, starting with its first FYP. Almost all subsequent FYPs, including the seventh FYP (2016–2020), have emphasized the importance of urbanization. About half of all Bangladeshis are expected to live in urban areas by 2035. Currently, more than 60% of the urban population is concentrated mainly in four metropolitan cities: Dhaka, Chattogram, Khulna, and Rajshahi. By 2030, this trend in population migration from rural to urban areas will become even more pronounced. Dhaka's population is estimated to double, and Chattogram is expected to grow into Bangladesh's next megacity with a population of 5 to 10 million driven largely by migration. The cabinet approved the draft National Urban Sector Policy in 2015 ("Why a national urban policy should be our top priority | UNDP in Bangladesh", 2019).

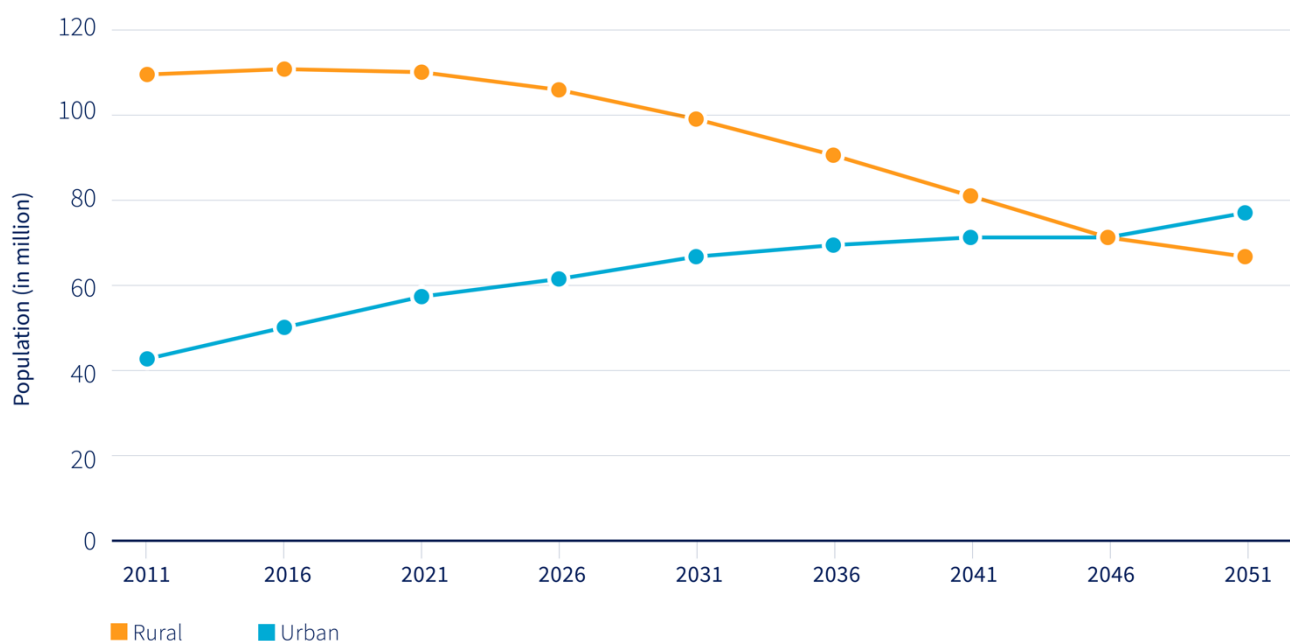


Figure 8: Projected rural and urban population in Bangladesh, 2011–2051⁸

Source: Bangladesh Census, and estimations shown in Islam, 2015.

Urbanization has a positive correlation with a country's GDP. The urban sector contributes much more to GDP than the rural sector in many developing countries like Bangladesh. Before the inception of the country (1971), agriculture has been a critical sector to overall productivity, accounting for more than 50% of GDP during 1960-1979, but it is at just 16% today. The contribution of the urban sector to GDP is increasing each year in Bangladesh, and it is now about 65%. Urbanization also plays a great role in sociocultural and political development ("An Overview of Agriculture in Bangladesh", 2019).

⁸ Rahman, 2013

CHAPTER 2

Health status and health system of Bangladesh

The health of Bangladesh can be contextualized within the country's demographic and epidemiological transition. Against this backdrop, the Bangladeshi health system is experiencing a multifold burden of disease, low service coverage, and a lack of effective financial risk protection mechanisms. These are compounded by several health system challenges.

2.1 Basic health statistics

Bangladesh has taken giant steps in healthcare and made significant improvement in its health sector, making it an example for other developing countries in spite of its resource paucity. In 2010-2020, key health indicators such as life expectancy and immunization coverage have improved. Long before the emergence of contemporary global health initiatives, the government placed strong emphasis on the importance of childhood immunization as a key mechanism for reducing childhood mortality, raising life expectancy, and increasing the healthcare to capital ratio.

Bangladesh advances on achieving Sustainable Development Goal(SDG) health indicators with important progresses on under-five mortality that persistently declined from 36 per 1,000 live births in 2015 to 29 in 2018 and the neo-natal mortality rate that decreased from 20 per 1,000 live births in 2015 to 16 per 1,000 live births in 2018 .. Both these achievements represented achievements of the 2025 SDG targets ("Bangladesh makes consistent progress achieving SDGs health indicators", 2020).

In 2018, a summary measure of essential health services coverage, a composite service coverage index, was used:16 indicators were derived from four main areas of work — (1) reproductive, maternal, newborn and child health; (2) infectious disease; (3) non-communicable disease (NCDs); (4) service capacity, access ,and health security. Healthy life expectancy reflects the overall health of the country's population("2018 Health SDG profile: Bangladesh", 2020).

2.2 Life expectancy

Life expectancy at birth in Bangladesh is 73.6 years; this figure was 65 in 2006. This gives Bangladesh a World Life Expectancy ranking of 97("Worldometer", 2020). Females have a higher (75.6 years) life expectancy at birth than males (71.8 years). The expectations of life at birth for women and men were 54.5 and 55.3 in 1981. These increased to 73.5 and 70.6 years in 2017 over a period of 36 years, which implies an average annual increase of 0.53 years for women and 0.43 years for men. A satisfactory level of progress has also been made in family planning. Population growth rate has been brought down. A huge and thriving network of private physicians has spread across the country to meet the needs of day-to-day medical problems Hossain, 2015).The health sector has also witnessed remarkable progress. Infant mortality under-5 (per 1,000 live births) has gone down from 136.545 to 33.1 from 1990 to 2017. And infant mortality under-1 has gone down from 96.1 to 27.7 from 1990 to 2017. The number of medical colleges has increased from 46 to 111. According to Directorate General of Health Services DGHS, the total number of registered private hospitals and run facilities are 1,43,394 (HEALTH BULLETIN 2018, 2018). Figure 8 shows life expectancy in years and its annual percent change in Bangladesh. Figures 9 and 10 show the expected and observed life expectancy among males and females, as well as mortality trends in the under-5 and under-1 age of Bangladesh (1990–2017).

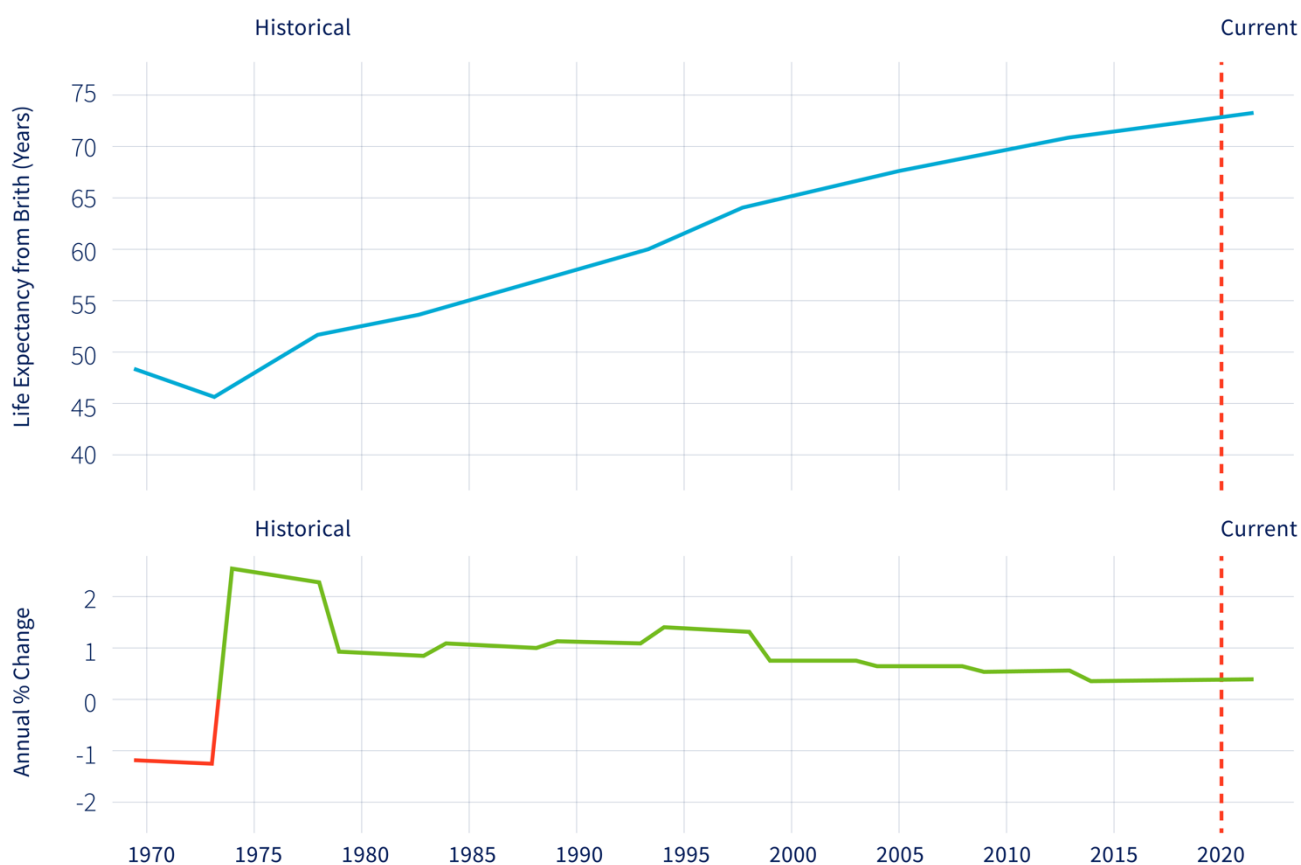


Figure 9: Life expectancy from birth (years) and annual percent change in Bangladesh⁹

How long do people live?

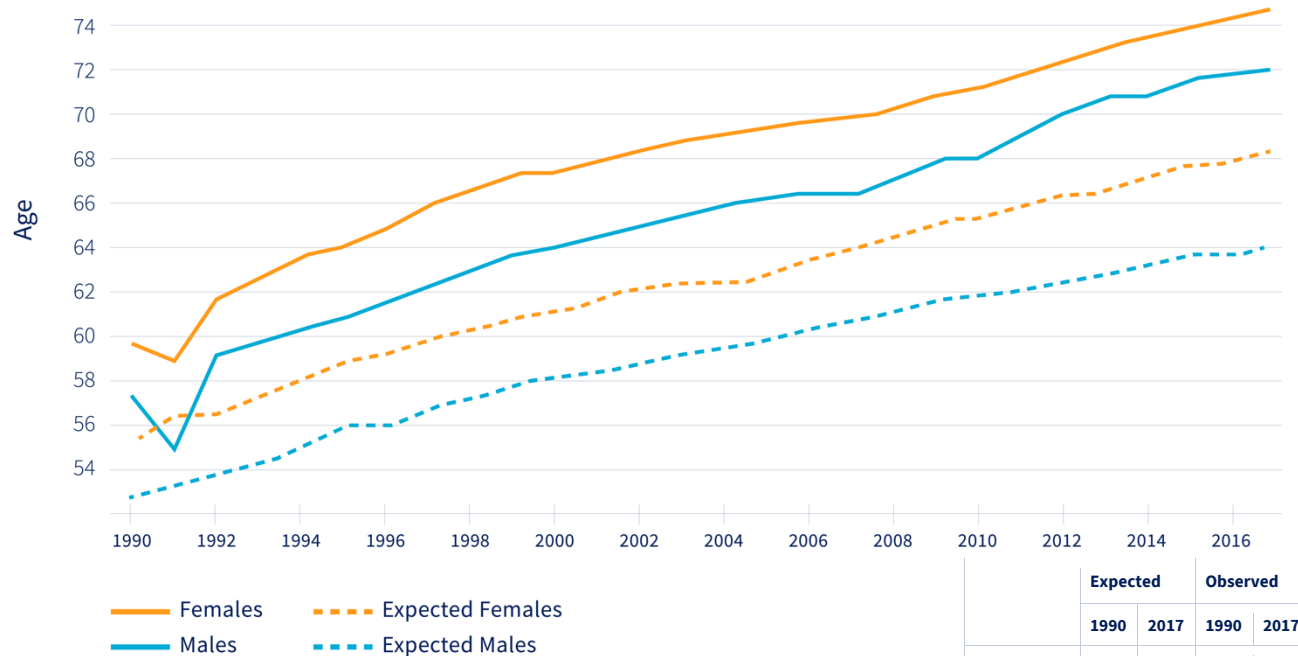


Figure 10: Expected and observed life expectancy in Bangladesh (1990–2017).

Life Expectancy, 1990-2017

⁹ <https://data.worldbank.org/>

What is the mortality trend in the under-5 and under-1 age groups?

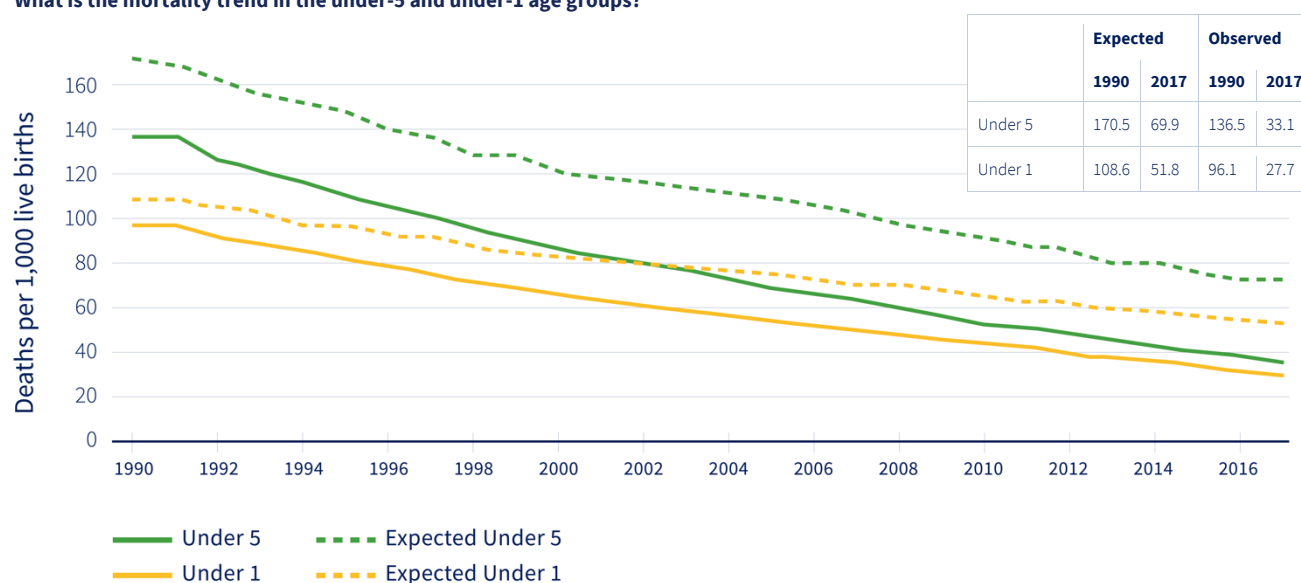


Figure 11: Expected and observed mortality trends in the under-5 and under-1 groups in Bangladesh (1990–2017).

Child mortality, 1990-2017

2.3 Double burden of disease

The term “disease burden” combines mortality and morbidity into a single measurement with Disability Adjusted Life Years (DALYs), the composite indicator. Double burden diseases are a serious global problem that are currently affecting many low- and middle-income countries including Bangladesh. However, proper understanding of the need for a joint intervention against both infectious diseases and NCDs has risen only recently. Excessive caloric intake coupled with poor health hygiene are common factors behind health conditions and risk factors, along with other lifestyle choices and genetic predisposition.

Double burden diseases are effectively controlled by primary prevention that involves promoting healthy lifestyles — necessary during all phases of life. Control strategies should focus on preventing and mitigating risk factors in an integrated manner. Intervention at all levels of society, from communities to governments, private organizations, and non-governmental groups, is essential to prevention because it amplifies healthy lifestyle awareness.

The most recent estimates — made in 2017 and expressed as a percentage of DALYs lost according to causes of diseases — show a double burden attributable to infectious and subsequent risk for NCDs. Projections indicate that the ratio of the most death and disability combined will continue to reflect a progressively shifting burden of NCDs. In Bangladesh, the top three causes of DALYs in 2017 were neonatal disorders, strokes, and ischemic heart disease (“What causes the most deaths?”, 2019).

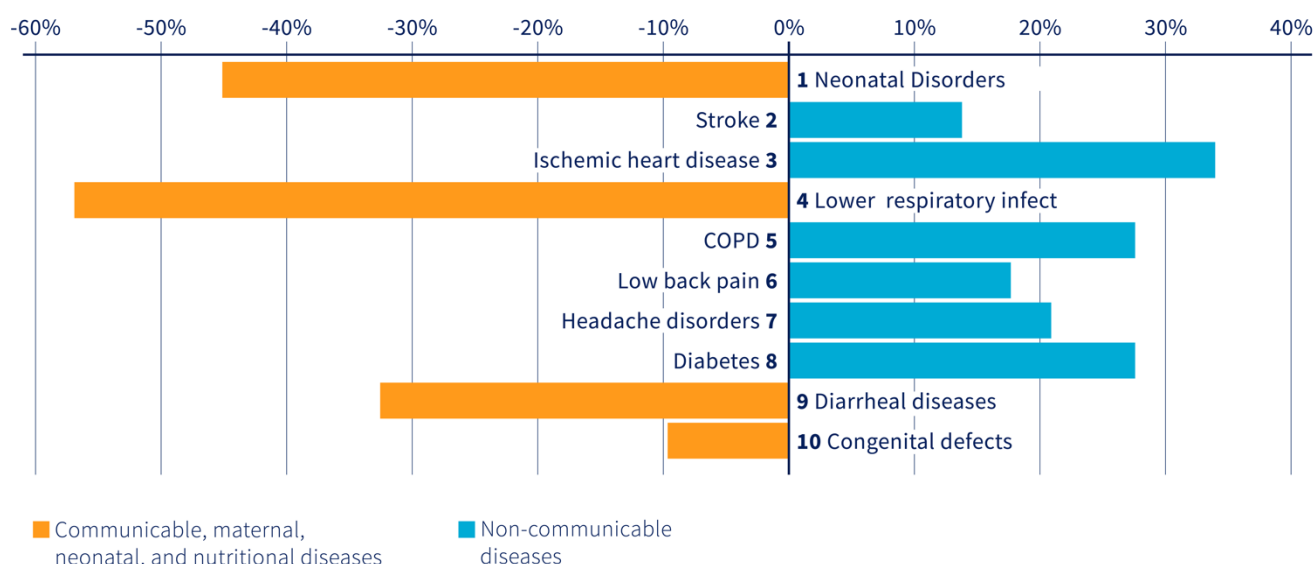


Figure 12: What causes the most death and disability combined?

What causes the most deaths?

● Metabolic risks ● Environmental/occupational risks ● Behavioral risks

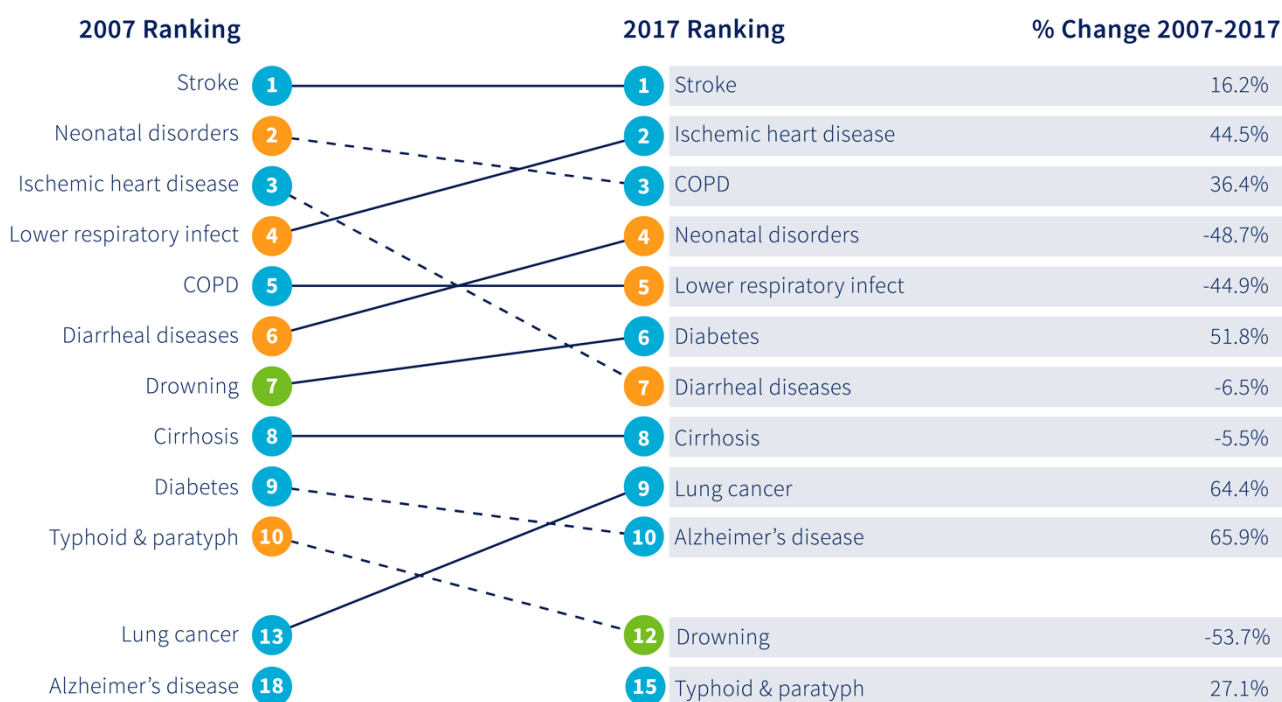


Figure 13: Top ten causes of death and percent change, 2007–2017.

Double burden of disease refers to the dual burden of NCDs and infectious diseases upon Lower Middle-Income Countries (LMICs). In fact, NCDs such as cardiovascular diseases and diabetes are emerging and imposing a new burden to those countries with limited resources, yet they are still struggling to meet the challenges of infectious diseases like tuberculosis and HIV/AIDS. According to the 2017 Global Burden of Disease Study, NCDs and injuries are estimated to account for 58% of all deaths globally. The WHO predicts 169,400 lives could be saved by 2025 through implementing the WHO 'best buys', which include setting

national targets for tobacco use, alcohol consumption, and physical activity("Noncommunicable diseases are the no. 1 killers in the WHO SEA Region", n.d.).

2.4 Health system of Bangladesh

The health system of Bangladesh is experiencing the multifaceted burden of disease, low service coverage, and a lack of effective financial risk protection mechanism. Bangladesh has a pluralistic healthcare system that is highly unregulated and consists of four key actors: government, for-profit private sector, not-for-profit private sector (mainly NGOs), and the international development organizations.

Public healthcare is steered by the Ministry of Health and Family Welfare through its different Directorate Generals: Health Services, Family Planning, Drug Administration, Nursing and Midwifery, Health Economics Unit, etc(Ahmed et al., 2015). Private healthcare encompasses for-profit private, not-for-profit private (mainly NGOs), and informal providers (village doctors and the vast array of unprofessional providers).

The public healthcare services are organized along four levels: community level healthcare (provided by the domiciliary health providers and community clinics), primary level healthcare (provided in rural health centers, union sub-centers, union family welfare centers, and Upazila health complexes (UHCs)), secondary level healthcare (provided in district hospitals, general hospitals, chest disease clinics, tuberculosis clinics, and leprosy hospitals), and tertiary level healthcare (provided in postgraduate medical institutes, specialized healthcare centers, medical college hospitals, and infectious disease hospitals).

The private sector is comprised of health facilities that range from individual doctors' offices to high-end tertiary level international standard hospitals. Public healthcare is highly subsidized by the government with only nominal payments required from patients, especially for outpatient care. By 2018, the total number of hospital beds under DGHS facilities and registered private hospitals reached 143,394. The total number of hospital beds under the DGHS is now 52,807 — in private hospitals registered by the DGHS that number is 90,587.

According to the Bangladesh government health bulletin, 2017,the total number of government facilities under the DGHS was 2,258; primary level facilities (except community clinics),2,004; secondary and tertiary level, 254; registered private hospitals and clinics, 5,054; and registered private diagnostic centers, 9,529.The numbers of registered physicians, doctors, medical technologists, and community and domiciliary health workers working under DGHS are (respectively)6.33, 1.28, 0.32, and 2.13 per 10,000 people. The population per registered physician is 1,581. The number of beds in DGHS-run public hospitals and private hospitals (registered by DGHS) per 10,000 populations is 3.24 and 5.57("Health Bulletin 2017", 2017)

Table 5 presents the total allocation in the operation and development budget in the social sector of Bangladesh from FY2009–2010 to FY2018–2019. The Health and Family Welfare sector is the second in position, following the Education, Science, and ICT sectors(Bangladesh Economic Review 2019, 2019).

Bangladesh still spends only 3.0% of its GDP in the health sector, while government health expenditure in relation to GDP is only 0.69% — placing Bangladesh among the countries that spend the least on health in the Southeast Asia Region (SEAR). It is estimated that 67% of total health expenditure is paid by households out of pocket (OOP), which is the highest in this region, followed by India with 62%, and far from the Maldives' 18%. Out of the OOP in Bangladesh, almost 69.4% was spent on medicines; so out of the total health spending in the country, 46% corresponds to expenditure on medicines and medical products.

The Bangladesh National Health Accounts (BNHA) show that there are considerable regional disparities in health expenditure of Bangladesh. The Dhaka division consumed 46% of the total health expenditure, whereas the Barisal and Sylhet divisions consumed only 4%.

Table 5: Allocation of selected Ministries.

Sector	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Education, Science & IDT	16171	18575	20316	21561	28272	33499	34370	52914	65444	67935
Health and Family Welfare	6833	7617	8869	9130	9955	11537	12695	17486	20652	23383
Youth, Sports and Culture	530	911	924	976	1061	1068	1199	1343	1803	2008
Labour and Employment	69	67	82	134	192	226	302	308	262	227
Social Welfare, Women's Affairs and Liberation War Affairs	2812	3499	3967	4091	4730	5962	7613	9433	11394	13343
Chittagong Hill Tracts Affairs	465	549	560	583	633	684	779	840	1150	1309
TOTAL ALLOCATION (Operating and Development)	26880	31218	34718	36475	44843	52976	56958	82324	100705	108205

Sources: Finance Division, Ministry of Finance *Figures are based on budget

2.5 Demand

Bangladesh has two parallel health care systems — public and private. Under the public sector health services, The Ministry of Health and Family Welfare has an extensive health infrastructure. The service delivery structure follows the country's administrative pattern starting from the national to the district, Upazila, union, and finally to the ward levels. It provides promotional, preventive, and curative services such as outdoor (outpatient), indoor (inpatient), and emergency care at different levels — primary, secondary, and tertiary. In the private sector, providers can be grouped into two main categories. First, the organized private sector (both for profit and nonprofit), which includes qualified practitioners of different systems of medicine. Second, the private informal sector, which consists of providers practicing in rural areas who don't have any formal qualifications (e.g., untrained allopaths, homeopaths, and kobiraj)(HOSSAIN, 2016). According to DGHS, the total number of registered private hospitals and clinics was 5,054 in 2018. The total number of beds provided by the private sector was 90,587(HEALTH BULLETIN 2018, 2018).

The private sector's share in healthcare was initially relatively small, since the great majority doctors began private practices and transformed into hospitals over time. Increasing population, industrialization, resultant high levels of environmental pollution, increased healthcare awareness, and lack of emphasis on a structured public healthcare system has limited the capacity of the existing public healthcare system in Bangladesh. This has led to high demand for private sector healthcare facilities to complement the country's public sector counterpart. Although awareness of environmental issues is rising in health sectors, these issues are not properly addressed in hospitals. Of them, medical waste management (MWM) is considered most significant.

Due to the growing number of patients, and the lack of infrastructural maintenance in the public sector, private hospitals have developed a growing priority over the years and seem to have become more likely to provide better treatment and quality care. However, given the high-quality services they provide, private sector hospitals are much more expensive than public sector care, and they are unaffordable for most of the population.

2.6 Supply

Government health facilities are situated at different administrative levels: national, division, district, Upazila, union, and ward. The Health Sector Support Program (HSPP), through its disbursement linked indicators (DLIs), supports system development at all levels and service delivery results at or below the Upazila level. Services are delivered by both DGHS and the Directorate General Family Planning (DGFP), which operate through parallel systems. The lowest level facility is the community clinic (CC), which serves at the ward level as the first point of contact for primary healthcare services including immunization, family planning, and health education. According to DGHS, the total number of community clinics is 13,507 (HEALTH BULLETIN 2018, 2018).

At the union level there are three kinds of facilities, each of which includes physicians on staff who provide outpatient care. These facilities include: rural health centers, union subcenters, and union health and family welfare centers. At the Upazila level, services are provided by Upazila Health Complexes, which have an inpatient capacity from 30 to 50 beds. Some of these facilities provide first-referral (secondary) care, including comprehensive emergency obstetrical care. At the district level, general hospitals of different sizes (100–250 beds) provide secondary care, and some districts also have government medical colleges that provide tertiary care. In addition, at the district level there are maternal and child welfare centers from 10 to 20 beds that offer family planning as well as maternal care services. The government also runs a number of tertiary and specialized hospitals at the division and national levels.

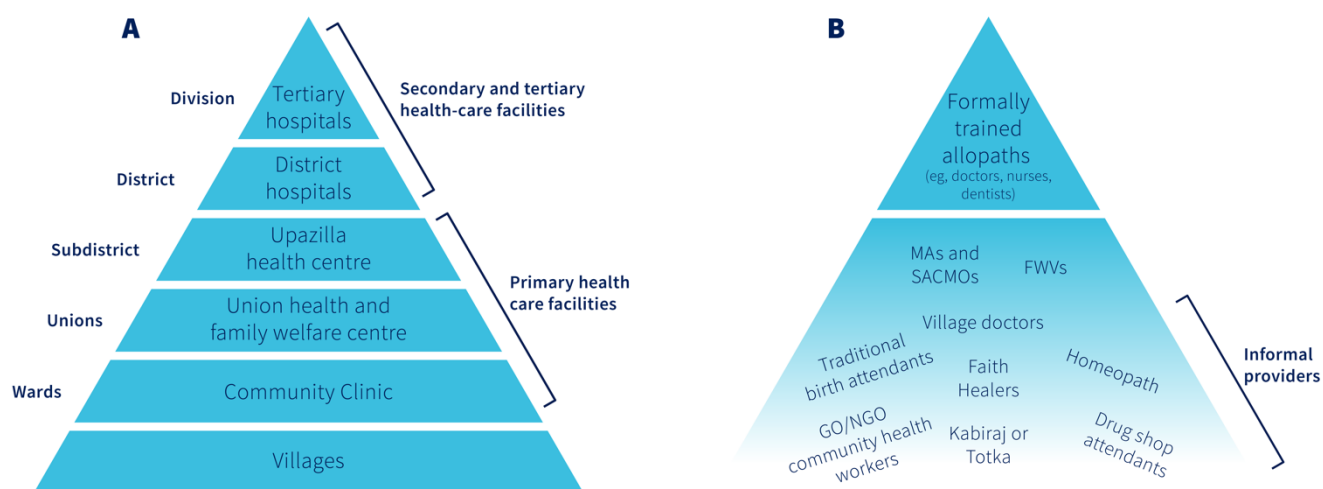
Among countries that provide free medical services to the people at the community level through various public health facilities, Bangladesh has a top-ranking position. The country's primary healthcare is provided through an extensive network of health facilities, which extend to the community level, with upward referral linkage and a set of government-funded permanent community healthcare workers.

The community clinics are the lowest level of static health facilities and are located at the ward level. These have upward referral linkages with health facilities located at the union and Upazila levels. There are 467 government hospitals at the Upazila level which altogether have 18,791 hospital beds. At the Upazila level, there are 436 hospitals with 18,301 beds. At the union level, there are 31 hospitals with 490 beds — as well as 1,362 health facilities that offer only outpatient services. So, at the union level, there are 1,393 health facilities. At the ward level, there are 12,584 community clinics in operation to date, although the baseline scenario and status of medical waste management in these clinics and facilities are currently unknown. An Environmental Management Framework (EMF) has been designed to control the medical waste to implemented health facilities / hospital premises and improve environmental performance. The EMF provides a template for screening these facilities as well as for designing suitable MWM protocols and a format for monitoring and recordkeeping. The Ministry of Health and Family Welfare (MOHFW) prepared a gap analysis of the present MWM system and an action plan for 2017 to 2022 that includes a tentative budget.

Among countries that provide free medical services at the community level through various public health facilities, Bangladesh stands out as exemplary. The nation's primary healthcare is provided through an

extensive network of health facilities that extend to the community level with upward referral linkage and a set of government-funded permanent community healthcare workers.

Box 1: Organizational structure of the health system and scope of the health workforce in Bangladesh



Source: Ahmed SM, Evans TG, Standinh H, Mahmud S. Harnessing pluralism for better health in Bangladesh. *Lancet* 2013;382:1746-55

Health professionals are critical supply side inputs to the health system. From a systems perspective, the interdependence of the health and education sectors is obvious. A balance between these sectors is critical to achieve efficient, effective, and equitable health services for all. In the Global Independent Commission's article, the role of the labor market is well acknowledged which governs the fit and misfit between demand and supply of health professionals. The medical educational institutions determine the current production of health professionals in terms of their types, quantity, and quality. However, in reality there are imbalances among health professionals in the labor market related to undersupply, oversupply, underemployment, and unemployment. These issues affect the whole health workforce planning process. To avoid these imbalances, the educational system must respond to the requirements of the health systems ("Mapping of Health Professional Education Institutions in Bangladesh", 2019).

CHAPTER 3

Tobacco use in Bangladesh

3.1 Product type, prevalence, and use

Bangladesh is one of the largest tobacco-consuming countries in the world, with 37.8 million (35.3 percent) adults consuming a variety of smoked (e.g., cigarettes, bidis) and/or smokeless (e.g., betel quid with tobacco, gul, sadapata, khaini) tobacco products. The prevalence of tobacco usage in Bangladesh differs by gender. Smoking prevalence is far higher among males (36.2%) than among females (0.8%). The use of smokeless tobacco (SLT) is much higher among females (24.8%) than males (16.2%). There is also variation in the prevalence of tobacco products between rural and urban areas. While the prevalence of bidi use declined substantially from 2009 to 2017, the use of cigarettes and SLT products remained almost static over the same period. In 2018, about 126,000 people died of tobacco-attributable diseases, and this constituted 13.5% of all deaths recorded in that year. The overall economic cost of tobacco use was estimated to be 1.4% of GDP in 2018.

3.2 Product use by gender, age, region, and socioeconomic standing

Men are the main drivers of tobacco use in Bangladesh. The prevalence of tobacco uses significantly decreased among adults, from 43.3% in 2009 to 35.3% in 2017 (from 58.0% to 46.0% among males; from 28.7% to 25.2% among females). This represents an 18.5% relative decline of tobacco use prevalence (20.8% decline for males; 12.2% decline for females).

Exposure to secondhand smoke in homes and public places has significantly declined. In homes, exposure declined from 54.9% in 2009 to 39% in 2017. Among adults who have visited various public places in the past 30 days, exposure declined from 79.7% to 49.7% in restaurants; from 62.2% to 42.7% in indoor workspaces; from 53.6% to 44% on public transportation; and from 23.8% to 12.7% in healthcare facilities.

The number of current smokers who were advised to quit by healthcare providers increased significantly, from 52.9% in 2009 to 65.8% in 2017. There was no significant change in the percentage of smokers who made quit attempts in the last 12 months.

The percentage of current smokers or STL product users who considered quitting because of health warnings on tobacco packages increased significantly in 2017. The percentage of adults who noticed anti-cigarette smoking information during the last 30 days increased significantly, from 49.8% in 2009 to 55.9% in 2017.

While the exposure to any cigarette advertisement, promotion, or sponsorship in the past 30 days decreased significantly from 48.7% in 2009 to 39.6% in 2017; it increased significantly for bidis (29.8% to 36.5%) and for STL products (16.5% to 24.4%).

Among current users of manufactured cigarettes, the average cigarette expenditure per month increased significantly, from 662.6 Bangladeshi Taka (BDT) in 2009 (inflation adjusted) to 1,077.8 BDT in 2017. Likewise, the average cost of a pack of 20 manufactured cigarettes increased during the same period (from 56.3 BDT (inflation adjusted) to 85.3 BDT) ("Global Adult Tobacco Survey data", 2017).

3.3 Any smoked tobacco product

Mortality rates associated with smoking tobacco or using STL products constitute the most preventable cause of death in Bangladesh. The prevalence of psychological distress is increasing globally. A recent study shows that 35% of adults are currently using tobacco either in smoked and/or smokeless form. Furthermore, 43%

and 39% of adults are exposed to secondhand smoke at their workplaces and in their homes, respectively. Of youth aged 13 to 15 years, 7% use tobacco.

In another study conducted in the rural Narail district of Bangladesh, data were collected from 2,425 adults aged 18–90 years regarding their smoking status and their association with psychological distress and other factors. The crude (age-standardized) prevalence of those who have ever smoked was 27.1(24.3)% that includes the current smokers 25.6(23.7)% and the past smoker 1.5(0.6)%, and the prevalence of SLT product use was 23.5(13.4)%. The prevalence of ever smoking was the highest in daily laborers (62.9%), and SLT use was the highest in widowed people (47.2%). After adjustment for covariates, individuals with no education (odds ratio (OR): 3.78, 95%; confidence interval (CI): 1.57–9.07 for females. OR: 2.69, 95%; CI: 1.87–3.87 for males) compared to those with at least a secondary level of education and daily labors (OR: 6.66, 95% CI: 1.67–26.6 for females and OR: 5.12, 95% CI: 1.30–20.19 for males) compared to housework were associated with higher prevalence of ever smoking. Any level of psychological distress, such as mild psychological distress, was associated with at least double the prevalence of tobacco smoking in females (OR: 2.12, 95% CI: 1.67–3.83) but not in males (OR: 1.12, 95% CI: 0.80–1.56). Prevalence of both smoking and SLT use was high, particularly in daily laborers, people with no education, and females with psychological distress in rural Bangladesh. For this study, the sample size of 2,425 was 98% powered at a significance level of 0.05 to show a prevalence of current smoking at 23%, with a 95% CI (Islam & Walton, 2019).

3.4 Tobacco use among adults

Smoking prevalence in Bangladesh has been assessed infrequently since the mid-1990s. Surveys suggest that smoking prevalence has been relatively flat (40–45%) among men for a long time, but declining somewhat among women (4–1.5%).

Three annual urban and rural cross-sectional surveys carried out between 2001 and 2003 found that the overall prevalence of smoking, chewing tobacco, and gul usage constituted 20.5%, 20.6%, and 1.8%, respectively. Current smoking and gul usage were significantly higher in males (42.2% and 2.2%, respectively) than in females (2.3% and 1.5%, respectively), whereas chewing tobacco was slightly more common in females (21.6%) than males (19.4%). No significant urban–rural difference was observed in smoking rate after adjusting for socio demographic variables, but chewing tobacco was 1.5 times more likely to be used by rural residents, and gul usage was 3.6 times more likely in urban residents. On average, a smoker consumed 9.3 sticks a day, and males and rural residents smoking more. (World Bank Group, 2019)

The 2004 national survey conducted revealed that 41% of men and 1.8% of women (aged 15+) smoked tobacco products, whereas 14.8% of men and 24.4% of women used smokeless tobacco; 36.8% of adults (aged 15+) used some form of tobacco. The 2006 Urban Health Survey attracted attention to the socioeconomic disparities in tobacco use — the overall smoking prevalence among men was 53.6%, and the study found a significantly higher occurrence of men smoking in slums (59.8%) than outside them (46.4%). Respondents living in slums were significantly more likely to confirm that they smoked cigarettes (53.3%) as compared to those living outside slums (44.6%). A similar pattern was found for bidis (slums, 11.4%; other areas, 3.2%).

Several waves of the Demographics and Health Survey were conducted in Bangladesh, but data on tobacco use were collected only in 2007. Health survey which held on 2007, the report documents a high prevalence of tobacco use among Bangladeshi men — 60% smoked cigarettes, and 20% consumed other forms of tobacco. Tobacco use was more common among older men, those living in rural areas, men with no education, and men in the lowest wealth quintile. Regional variations were also notable. Although rural men were more likely

to smoke cigarettes than urban men, urban smokers tended to smoke more cigarettes per day than their rural counterparts. In this survey, women were not asked about tobacco use.

Table 6: Tobacco use among adults in Bangladesh.

Year	2002	2004	2009	2010	2013	2017
Survey (age groups)	STEPS (25–64)	Health cost study (15+)	GATS (15+)	STEPS (25– 64)	STEPS (25–64)	GATS [23 .24]
Current smoking prevalence	21 .80	20 .90	23 .00	26 .20	20 .30	18.00
(among men)		41.00	44 .70	54 .80	39 .90	36.20
(among women)		01 .8 0	01 .50	01 .30	03 .50	00.80
Smokeless tobacco use		19 .70	27 .20	31 .70	28 .70	20.60
(among men)		14 .80	26 .40	29 .40	28 .50	16.20
(among women)		24 .40	27 .90	33 .60	29 .50	24.80
Use of any tobacco products		36 .80	43 .30	51 .00	45 .80	35.30
(among men)		48 .60	58 .00	70 .00	58 .00	46.00
(among women)		25 .40	28 .70	34 .40	32 .00	25.20

In 2009, the Global Adult Tobacco Survey Bangladesh (GATS Bangladesh) found that 43.3% of adults (aged 15+) used some form of tobacco, with a higher prevalence of tobacco use among males (58.0%) than females (28.7%). Estimates from GATS Bangladesh showed that 23.0% of adults smoked tobacco and 27.2% used smokeless tobacco products. These findings also showed that, although the occurrence of smoking tobacco was much higher among males (44.7%) than females (1.5%), the prevalence of smokeless tobacco use was similar among males (26.4%) and females (27.9%). The overall prevalence of both smoked and smokeless tobacco use was higher in rural areas than in urban areas. The analysis of GATS data found some evidence of education and wealth gradients regarding smokeless tobacco use (Sinha et al., 2011).

Bangladesh was found to differ from other countries of the region in terms of smokeless tobacco use, which is more prevalent among women than men (Giovino et al., 2012). In 2011, a survey that specifically aimed to consider smokeless tobacco use among women (Bandyopadhyay & Irfan, 2019) found that among adult rural women with a history of at least one pregnancy the prevalence of 'current consumption', 'ever consumption but not current', and 'never consumption' were 25%, 44%, and 31%, respectively. Current consumption was associated with being over 25 years of age, having limited access to education, earning an income, identifying as Muslim, and being divorced, separated, or widowed.

Regarding age distribution, the prevalence of tobacco use was lowest in the youngest age groups and increased with age. Among women, this was true regarding both smoking (which increased from 0.4% among those aged 25–34 to 6.2% among women aged 65+) and smokeless tobacco use (which increased from 16.4% among the youngest group to 62.9% among the oldest). Among men, smokeless tobacco use steadily increased with age, from 18.3% to 40.9%. However, the prevalence of smoking among men was over 50% in all age groups between 25 and 64 years old. Only those aged above 65 years had a prevalence of smoking below 40%. This pattern could indicate that the population of Bangladesh is experiencing three tobacco use

epidemics — two traditional (bidi smoking and smokeless tobacco use, which are more widespread among older population groups) and one new epidemic of manufactured cigarettes smoking which predominantly overwhelms young and middle-aged men.

M.M. Zaman from WHO Bangladesh conducted an analysis of tobacco use trends in which he compiled national studies from 2004 to 2013. Although subjects came from a variety of age groups, his analysis was based on the subjects aged 25 years or older. He concluded that the prevalence of tobacco uses slightly increased from 2004 to 2009 and declined from 2009 to 2013. This decline was primarily caused by the declining trend in smoking. However, smokeless tobacco use was on the rise. A similar conclusion was made regarding Bangladeshi men (World Bank Group, 2019)⁽⁶⁵⁾.

However, a different pattern was described using International Tobacco Control data. Over 90,000 individuals from over 30,000 households participated in two waves of the International Tobacco Control (ITC) Bangladesh Project that was conducted in 2009 and 2012. Estimates were obtained for the prevalence of all types of tobacco products used according to socioeconomic standing. Between 2009 and 2012, overall tobacco use dropped from 42.4% to 36.3%. The decline was more pronounced with respect to smokeless tobacco use than smoking. The prevalence of exclusive cigarette smoking went up from 7.2% to 10.6%; whereas smoking both cigarette and bidi went from 4.6% to 1.8%⁽⁶⁹⁾.

It seems that the market for exclusive cigarette use expanded significantly, with 4.15 million additional smokers in 3 years. At the average consumption of 9.3 cigarettes per day (ITC Wave 3 Survey)⁽⁶⁸⁾ (Nargis, Thompson, Fong, & Driezen, 2015), this increase in the number of cigarette smokers means an additional consumption of 4.7 billion cigarettes each year. On the other hand, the number of dual smokers and mixed tobacco users dropped. The average daily consumption of cigarettes by dual smokers (those who also smoke bidis) is lower than it is among exclusive cigarettes smokers (5.7 cigarettes per day). But the average daily consumption of cigarettes among mixed tobacco users (those who also use smokeless tobacco) is the same (9.3 cigarettes per day). Thus, the decline in cigarette consumption from the reduction of 2.7 million dual smokers and 3 million mixed tobacco users is expected to be 5.34 billion pieces, which more than offsets the increase in cigarette consumption from the growth in exclusive cigarette use. In other words, the net cigarette consumption decreased over 2009–2012.

Exclusive bidi smoking, on the other hand, remained around 2%. The total prevalence of bidi smoking (including mixed use) decreased from 6.6% to 3.7%. Exclusive smokeless tobacco use decreased from 20.2% to 16.9%, and both smokeless tobacco use and smoking from 8.4% to 5.1%. This might indicate that the trend has changed compared with the results of previously conducted surveys, which showed an upward change in smokeless tobacco use.

The recent release of the GATS 2017 results showed a decline in most indicators of tobacco use among the adult population in Bangladesh (see Table 6). In general, the prevalence of tobacco use was higher among men, older age groups, individuals with limited economic means, those who live in slum areas, members of indigenous tribal groups, and those occupying border areas— suggesting that the greater burden of tobacco use is carried by disadvantaged groups. The overall decline in the prevalence of tobacco use can therefore be viewed as a structural shift in the tobacco market in Bangladesh from cheap products such as bidi and smokeless tobacco to more expensive cigarettes, which is in line with income growth and purchasing power of the general population.

3.5 Tobacco use among adolescents and young people

According to Hossain et al, One study was designed to determine the prevalence of tobacco smoking and the factors associated with smoking initiation among university students in Dhaka, Bangladesh. This cross-

sectional survey study was conducted with 264 students of Jahangirnagar University, Dhaka, Bangladesh in 2015. The overall prevalence of tobacco smoking was 60.2%, and males smoked at higher rates than females (68.81% versus 19.56%). Peer pressure was the most significantly reported reason for beginning to smoke tobacco. Perceptions surrounding tobacco smoking were reported as significantly related to ongoing tobacco use. Logistic-regression models identified that smoking-related attitudes, potential health problems, and incidence of family members dying from cardiovascular disease and cancer were significantly associated with tobacco smoking. This study concluded that the current prevalence of tobacco smoking among university students in Bangladesh is over 60%, and it especially recommended that university students adopt WHO FCTC policies(Hossain et al., 2017).

The Global Youth Tobacco Survey (GYTS) was conducted in Dhaka, Bangladesh, in 2004, 2007, and 2013. Surveys conducted at the national level found that the use of manufactured cigarettes was low among adolescents, especially among girls. Many more girls them reported using other tobacco products, although this rate did significantly increase among boys between 2004 and 2007 (Table 7).

Table 7: Tobacco use among adolescents

		2004	2007	2013
Percent of adolescents who smoke cigarettes	Total	1.8 (1.2–2.8)	3.0 (1.6–5.4)	2.1 (0.9–4.9)
	Boys	2.3 (1.4–3.9)	4.6 (2.8–7.5)	3.4 (1.5–7.1)
	Girls	0.0	1.1 (0.4–2.9)	0.0
Percent of adolescents who use other tobacco products	Total	4.0 (3.1–5.2)	6.5 (4.9–8.6)	
	Boys	3.6 (2.5–5.0)	7.3 (5.2–10.1)	
	Girls	4.7 (3.4–6.4)	4.7 (2.8–7.8)	

Several waves of the Global Health Professions Students Survey (GHPSS) were conducted as another part of GTSS in Bangladesh. Groups surveyed in separate years did not produce similar responses. The results of these surveys lead us to conclude that manufactured cigarettes are smoked by 35–50% of male students. Among female students this proportion is dramatically smaller, ranging from less than 1% among nursing students in 2008 to about 10% among dental and pharmacy students in 2009.

However, female dental students did exhibit significant increases in their rates of cigarette smoking between 2005 and 2009, from 3% to 8%. Other specialties(Dentist, Nursing and Pharmacy) were either surveyed once or did not reveal significant changes in smoking rates. For usage of other tobacco products, GHPSS offers a mosaic picture reflecting different levels of tobacco use among individuals of various socio demographic standing in Bangladesh society. Among some specialties, the tobacco use does not differ between men and women. For other students (e.g., nursing students), many more men report using other tobacco products than female students. For some groups (e.g., dental students), the prevalence increased dramatically over time; in other groups (e.g., medical students) it remained constant(World Bank Group & Global Tobacco Control Program, 2019).

Table 8: Prevalence of cigarette smoking and other tobacco use among medical students in Bangladesh.

	Indicator	Specialty	2005	2006	2008	2009
Men	Prevalence of those who currently smoke cigarettes	Dental	46.7 (39.0–54.7)	–	–	41.0 (37.7–44.4)
		Medical	–	46.5 (37.6–55.6)	–	37.3 (21.6–56.3)
		Nursing	–	–	49.5 (45.6–53.5)	–
		Pharmacy	–	–	–	36.2 (28.1–45.2)
	Prevalence of individuals who use other tobacco products	Dental	7.8 (4.6–13.1)	–	–	17.9 (15.6–20.5)
		Medical	–	13.3 (3.7–38.2)	–	13.1 (8.5–19.6)
		Nursing	–	–	26.4 (23.1–29.9)	–
		Pharmacy	–	–	–	21.1 (11.9 - 34.8)
Women	Prevalence of those who currently smoke cigarettes	Dental	3.3 (1.6–6.7)	–	–	8.2 (6.9–9.8)
		Medical	–	4.4 (1.2–14.1)	–	1.5 (0.5–5.0)
		Nursing	–	–	0.3 (0.2–0.5)	–
		Pharmacy	–	–	–	9.8 (5.4–17.2)
	Prevalence of individuals who use other tobacco products	Dental	0.9 (0.2–3.8)	–	–	17.8 (15.9–19.9)
		Medical	–	9.9 (4.6–20.0)	–	7.0 (3.2–14.8)
		Nursing	–	–	6.5 (6.0–7.1)	–
		Pharmacy	–	–	–	13.9 (7.3–24.9)

3.6 Integration of tobacco cessation into health services

In 2017, the WHO supported the National Institute of Preventive and Social Medicine (NIPSOM) to pilot tobacco cessation service. Through brief interventions in primary health care settings, NIPSOM set up a training network on tobacco cessation in collaboration with NTCC and DGHS and trained 30 master trainers and 120 primary healthcare physicians on brief interventions. With these master trainers, services can be scaled up.

CHAPTER 4

Tobacco and the economy, employment and trade

4.1 Tobacco production: type and location

4.1.1 Growing tobacco

Since the mid-1960s, tobacco has been introduced into fields where food crops were grown — this introduction was further widespread after the 1971 liberation by the British American Tobacco Company in Teesta silt in Rangpur area. Tobacco is grown throughout the country with the largest tobacco growing areas including Rangpur, Kushtia and Chittagong Hill.

Tobacco cultivation has some negative effects on environment and health though it has some short term positive effects such as more profit. The direct users of tobacco their family members including children and others colleagues in addition tobacco producers, processors, workers and all other peoples around are affected by the adverse impact of tobacco. The production of food crops has been reducing with time due to extension of tobacco production. A huge quantity of fuel wood is needed for curing of tobacco leaves which releases poisonous smoke in the environment. Consequently, trees are logged indiscriminately and the environment is polluted by the poisonous smoke. Finally, it is recommended that a comprehensive policy on tobacco control in general and control tobacco cultivation in particular must be taken up by the government. As a part of global movement against usage of products Bangladesh government as well as the groups working on tobacco control must incorporate the issues of harmful impact of tobacco cultivation on environment food production and human health. It is not only the Ministry of Health that can take decision on controlling tobacco cultivation but the Ministry of Finance, Ministry of Environment and Ministry of Agriculture must act together to regulate tobacco cultivation(Hossain & Rahman, 2013).

The acreage devoted to tobacco growing in Bangladesh has been falling steadily for most of the past three decades before rising sharply in 2010. According to the Statistical Yearbooks in 2000-2009 tobacco acreage area was rather stable (about 75,000 hectares) before rising in 2010. In 2011-2014 the area was around 120,000 hectares but then decreased to 105,000 hectares in 2017-2018. Tobacco leaf production increased from about 40,000 tons in 2000-2009 to about 80-90 thousand tons in 2011-2018.

While widely grown tobacco is a relatively minor crop in overall agriculture in Bangladesh. In 2010 the acreage devoted to tobacco growing accounted for only 0.25% of acreage for all crop production and in 2009 the monetary value of the tobacco grown was only 0.22% of the value of all agricultural production.

4.1.2 Tobacco production by type and location

With Bangladesh's tobacco production ever increasing the commodity contributes a sizeable portion of the world's supplies. The two major tobacco companies in Bangladesh include British American Tobacco which holds 62% of the cigarette market by volume and Dhaka Tobacco Industries (under Akij Group) with 21.3% of the cigarette market. Philip Morris International distributes its products in Bangladesh through Dhaka Tobacco Industries. Smaller domestic companies include Abul Khair Tobacco and Nasir Tobacco. In 2017, 88.9 billion cigarettes were sold in Bangladesh(World Bank Group & Global Tobacco Control Program, 2019).Japan Tobacco Inc. (JT) announces that the JT Group has signed an agreement to acquire the tobacco business of Akij Group¹ (Akij) the second largest tobacco company in Bangladesh further increasing its presence in Asia. The purchase price for the transaction is estimated at around BDT 124.3 billion (USD 1,476 million).

Farmers are generally contracted by the before mentioned companies and auctions play no role to speak of. Although some rogue trading by a handful of small-scale and opportunistic merchants does occur, the tobacco amounts involved are negligible and the produce is most likely to eventually end up with the main players anyway. In terms of their quality. Bangladeshi tobaccos are most commonly used as fillers or blending tobaccos but also find their way into shisha tobaccos.

According to the official Agricultural Statistics (Statistics) three varieties of tobacco-Jati, Motihari and Virginia are grown in different districts of Bangladesh. Jati and Motihari are mostly grown in Rangpur and Bandarban, while Virginia is mostly grown in Kushtia, Rangpur, Jessore and Dhaka. Other varieties such as Burley are also grown in limited quantities. In terms of land area covered by all three kinds of tobacco, Kustia remains highest with 35721 acres during 2018-19 followed by Lalmonirhat 18013 and Nilphamari 10776 acres of land. Table-9 shows the district wise area in acres and production in M.Tons of tobacco cultivation in Bangladesh during FY 2016-17 to 2018-19.

Table 9: District and Division wise tobacco Cultivation in 2016-17, 2017-18 and 2018-19. ¹⁰

Zila/Division	2016-17		2017-18		2018-19	
	Area (acres)	Production (M. Ton)	Area (acres)	Production (M. Ton)	Area (acres)	Production (M. Ton)
1 Bandarban	6486	3145	6569	3196	6621	3215
2 Chattogram	105	32	107	18	99	29
3 Cox's Bazar	366	388	371	389	374	400
4 Khagrachhari	2050	2187	2097	2263	2141	2313
5 Rangamati	1390	905	1770	1258	1709	1259
Chattogram	10397	6657	10914	7124	10944	7216
6 Faridpur	70	55	59	41	0	0
7 Gopalganj	31	18	0	0	0	0
8 Manikganj	5360	3670	5419	3605	0	0
9 Munshiganj	3	2	3	2	0	0
Dhaka	6010	4056	5928	3930	0	0
10 Chuadanga	2395	2333	2392	2378	2499	2468
11 Jhenaidah	4118	3318	4142	3331	4021	3200
12 Kushtia	34936	36118	35451	37437	35721	36869
13 Magura	2	1	2	1	1	1
14 Meherpur	9901	8059	9216	7713	6319	7055
Khulna	51352	49829	51202	50860	48560	49592
15 Jamalpur	12	4	0	0	0	0
Mymensing	12	4	0	0	0	0
16 Natore	76	37	77	36	0	0
Rajshahi	76	37	77	36	0	0

¹⁰ Source: Yearbook of Agricultural Statistics-2019, BBS

17	Dinajpur	12	6	15	6	15	6
18	Gaibandha	88	54	97	64	82	54
19	Kurigram	415	251	245	172	396	243
20	Lalmonirhat	20910	15557	17645	13923	18013	15305
21	Nilphamari	12903	8657	11249	8680	10776	8350
22	Panchagarh	8	2	8	2	8	2
23	Rangpur	11112	6462	7883	4477	5469	1896
24	Thakurgaon	2	1	0	0	0	0
	Rangpur	45450	30990	37142	27324	34759	25856
	BANGLADESH	113297	91573	104914	89013	93998	82399

This quite small clique of industry players is supervised and regulated by the National Tobacco Committee under the Ministry of Agriculture which also sets the annual tobacco production targets. Just like in neighboring India and Pakistan and pretty much anywhere else across Asia tobacco in Bangladesh is almost exclusively planted on smallholder farms each averaging about 93998 acres by the 2018-2019 crop season. The total agricultural area utilized for tobacco cultivation had increased by an additional 4985 acres nationwide.

Nicotiana Tabacum Unmanufactured dry tobacco including refuse that is not stemmed or stripped or is partly or wholly stemmed or stripped. Figures relate to the total domestic production whether inside or outside the agricultural sector i.e. it includes non-commercial production and production from kitchen gardens. Unless otherwise indicated production is reported at the farm level("Tobacco, production quantity (tons) for Bangladesh", n.d.).

4.1.3 Cigarette production

Cigarette manufacturing is highly concentrated in Bangladesh while bidi manufacturing is much more fragmented.

Cigarette markets are dominated by two companies—British American Tobacco Bangladesh (BATB) and the domestic Dhaka Tobacco Industries (DTI) a part of the Akij Group. BATB brands share in retail cigarette volume increased from 44% in 2013 to 62% in 2017. DTI's share of the cigarette market was around 21-24% over recent years. There are several other smaller domestic cigarette companies operating in Bangladesh. Together in 2017 they accounted for 17% of the Bangladeshi cigarette market. Imports account for less than 1% of cigarette consumption in Bangladesh. Similarly, cigarette exports are minimal accounting for less than 1% of production in most years.

Derby (BATB) was the most popular cigarette brand in 2017 with market share 28%. It is followed by Pilot (BATB), Navy (DTI), Hollywood (BATB), Star (BATB) and Sheikh (DTI). Together the top six brands accounted for over 68% of cigarette consumption in 2017. Premium brand cigarettes are typically sold in packs of 20 while discount brands are often sold in 10-cigarette packs so as to keep pack prices more affordable.

4.1.4 Bidi production

Bidi production is much more fragmented than cigarette manufacturing. The top four firms account for a little less than 50% of the market and according to the 2001/03 Economic Census there were a total

of 9,624 bidi manufacturers with over 96% of these being household-based. The 2001/03 Economic Census estimated that 45,272 people were employed in bidi manufacturing. About two-thirds of employment in bidi manufacturing was in the formal sector and one-third was related to household-based establishments. Women are more likely to be employed in producing bidis in the formal sector and about 65% of those employed in household-based bidi manufacturing are women. Wages for bidi workers are very low most bidi workers live in poverty and many children are also involved as unpaid assistants in household bidi production.

A recent study conducted by the Tobacco Industry Watch BD team and widely covered by the media found mismatches in numbers of bidi factories and workers in Bangladesh. According to the study there were 117 bidi factories in Bangladesh employing around 65,000 workers who produced 48.65 billion sticks annually. Some 60 to 65 percent of the bidi workers are children aged between four and 14 years although child labor is banned in the country by law. Most of the children were malnourished (their actual age could not be known) and low paid and could not attend school regularly. Working in the bidi factories stands fourth among the government-listed 38 hazardous jobs prohibited for children.

4.2 Tobacco-related employment

Bangladesh is one of the largest tobacco consuming countries in the world. Employment in tobacco farming accounts for less than 0.5% of agricultural employment in Bangladesh. The Bangladesh Bureau of Statistics estimated that in 2005/06 5,893 persons were employed in cigarette manufacturing and 115,500 persons were employed in tobacco growing, about 0.3% of the agricultural labor force. While the recent rise in tobacco growing in Bangladesh was likely to have increased the number of tobacco farmers in the country, the overall share of agricultural employment in tobacco growing is likely to be less than 0.5%.

A total of 32,180 persons worked (1,517 administrative staff and 30,663 production workers) in the 198 functional bidi factories. Among the production workers, daily labourers accounted for 94%, female employees 33% and child employees 4% of all persons employed on the factory premises. The majority of production workers worked on a temporary (94%) or part-time (75%) basis. They were categorized as skilled (having mastery) in bidi making (91%) by the bidi manufacturers.

Apart from the regular employees working on the factory premises bidi factories contract out bidi rolling and tobacco dust filling to contractors who then commission the work to their family labourers; this segment totaled 134,927 workers. About 10% of these people received contracts for bidi rolling and tobacco dust filling from the factories and the rest worked under their supervision. An overwhelming majority (75%) of these contract workers were women and children (below 18 years of age).

On average, regular production workers on the factory premises worked for 18.6 days a month and 8.9 hours a day: full-time employees worked 20.7 days a month, 10 hours a day while part-time employees worked 16.9 days per month, 8 hours a day. A similar trend was observed when permanent workers, daily labourers/ temporary workers and unpaid family labourers were compared.

Considering 65% utilization rate of the full-time capacity of a regular employee working on the factory premises and 26% utilization rate of the full-time capacity of a contract worker that account for actual production at 33% of potential output the total. The total full-time equivalent (FTE) employment in the bidi equivalent employment industry including regular and contractual in the bidi industry was employment was estimated at 55,682. Among them estimated at 46,916 with FTE employment of only production workers children excluded amounted to 54,694. With children excluded. FTE of production workers decreased to 46,916.

The average monthly salary ranged from the lowest for daily labourers (below Bangladesh Taka (BDT) 2,000) to the second lowest for permanent workers (BDT 2,000–4,000) to the clerk (BDT 4,000–5,000), to the managerial staff (BDT 6,000–9,000) and finally to the much higher-level owner employees (BDT 20,000–30,000). For each category of employees females generally received lower salary than their male counterparts. The average daily wage rate was BDT 146 for the daily labourers in bidi making–BDT 174 for males and BDT 117 for females. Those who worked on a piece rate basis were paid BDT 22 per 1000 sticks on average.

Beside this there are a huge percentage of minor tobacco seller (48%) who sell tobacco to earn money. The influencing factors are categorized into seven sections. Less than half of the sellers (45.5%) sell cigarette for earning more money where taking care of family business (41.9%) is the second highest reason for selling cigarette. Both reasons are much more influential than that of others. 16.8% sellers sell cigarette after being influenced by the agents of Tobacco Company (Al Amin et al., 2018).

4.2.1 Socioeconomic status of bidi worker households

Bidi workers are generally identified with the underemployed, low income and resource poor segment of the population in Bangladesh, living below the poverty line and missed by the mainstream of economic growth. Several aspects of the socioeconomic status of the bidi workers were observed in the study:

- Only 20% of the bidi workers was working full time in bidi making. The remaining workforce was underemployed in terms of the utilization of their time and earning potential.
- The main source of household income for most of the respondents (43.4%) was bidi manufacturing. The second largest source was trade followed by day labour that did not necessarily generate regular income flows. In addition to bidi making and daily labour, about 84% of bidi worker households survived on casual sources of employment and income, which added to the vulnerability of this population to economic and natural shocks.
- The household heads of two-thirds of bidi workers did not have any schooling. The average education level for all members in a household was 2.5 years and the maximum education level was 5.7 years. With extremely low level of education. The potential for transition of bidi workers and their family members out of poverty and to alternative employment opportunities on their own would be very limited.
- About 97% of the bidi workers were landless. Given the negative correlation between land ownership and poverty bidi workers may be susceptible to worsening poverty in the event of unmitigated job loss.

4.2.2 Livelihood options for bidi workers

Bidi making has been the mainstay for most bidi workers for generations. About 58% reported to be working in bidi manufacturing for over 10 years. Several observations were made with regards to livelihood options for bidi workers:

- The parents of 46% workers and the grandparents of 28% workers were employed in the bidi industry. When asked if their children would continue to work in the bidi industry, 70% workers answered in the negative. It appears that even though bidi making had been the source of livelihood for at least three generations, the future generation was unlikely to stay in the same occupation. The intergenerational transition from a decaying bidi industry to more thriving industries seems to be already in place.
- 22.5% workers reported that bidi making was not their only source of income. They supplemented income by undertaking various other economic activities.

- The average income of the bidi worker who is exclusively dependent on the bidi industry was BDT 1,927 per month. In contrast, bidi workers who were involved in other economic activities along with bidi making made BDT 5,457 per month. For this group of workers, income from bidi making constituted 41% of their total income. Apparently, these workers managed to diversify and allocate their work hour to enhance their earnings. They would also be able to recover income faster in the event of job loss from the bidi industry.
- 54% bidi workers reported that his/her other family members were also involved in bidi making. On average, two persons from each family worked in a bidi factory.
- About 93% workers reported that income from bidi making was not sufficient for subsisting. When asked about means to supplement income from other sources in the event of job loss an overwhelming majority (70%) reported that they would live off the income of other family members. This indicates that the income pooling mechanism at the family level cushions against the uncertainty and insufficiency of income flow from bidi making.
- If alternative market opportunities that could generate income equivalent to what they make as bidi workers were available 22% were willing to take their own initiative to switch to the new occupation while others (78%) were not willing to leave their current occupation. Relatively few workers saw the advantage of leaving a decaying industry for an income-equivalent job in other growing sectors and noted the flexibility of work hours independence proximity of the workplace to their homes and casual working conditions that are characteristic of the bidi industry.
- However, if the government launched any redeployment programme for bidi workers 78.4% were willing to give up bidi making and move to other occupations. Their expected income from an alternative job on average was BDT 4,811 which is more than twice of what they currently make in the bidi industry.
- A majority of bidi workers (63%) reported that bidi making was their first occupation. The second major occupation was as unpaid family labour or housewives (19%). When asked about potential occupations where they could be employed if the bidi factory closes most workers (58.3%) who responded expressed that they did not know where to go or cannot do any other work. This category of workers would need support for employment generating opportunities. The remaining said that they would find some kind of nonagricultural self-employment on their own.
- Nearly 62.6% workers believed that they did not have the necessary skills to make a transition to an alternative employment. Most (75%) of those who believed that they did not have the necessary skills were interested in acquiring new skills. When asked about preference for full- or part-time job 63% expressed willingness to do a full-time job.
- The role of NGOs or the microfinance institutions (MFIs) in offering alternative income generating opportunities for bidi workers appeared to be limited. About 48% workers reported that they or a person from their family were members of NGOs/MFIs that offered loan services to engage in income generating activities which could be a potential way out for bidi workers.
- Nearly 38.5% workers mentioned government programmes for poverty alleviation in their locality, which targeted particular poor and vulnerable population groups but that bidi workers may not necessarily be eligible for receiving the benefits. Only 26% workers reported that they benefitted from one of these programmes.

4.2.3 Bangladesh exports of tobacco and manufacture of tobacco substitutes

Bangladesh Exports of Tobacco and manufactures tobacco substitutes was US\$48.84 million during 2015, according to the United Nations COMTRADE database on international trade. Bangladesh Exports of Tobacco and manufactures tobacco substitutes – data, historical chart and statistics - was last updated on May of 2020("Bangladesh - Economic Indicators", 2020).

4.3 Illicit trade

According to a World Bank report titled Confronting Illicit Tobacco Trade: A Global review of Country Experiences published in February 2019 the increase in tobacco taxes has barely any relation with illicit trade of cigarettes and the percentage of illicit trade of tobacco in Bangladesh stands at merely 1.8 percent the lowest in 27 countries. The report also states that illicit tobacco trade constitutes 17 percent of tobacco trade in the neighboring country India, 38 percent in Pakistan, 36 percent in Malaysia and the highest 50 percent in Latvia. The World Bank report also suggests that there is no relation between increasing tobacco tax and influx of illicit cigarettes because the latter is completely related to the efficiency of administration. Illicit tobacco trade is solely a result of gross administrative mismanagement in the country. So relating these two unlikely factors based on tobacco companies' relentless propaganda is utterly undesirable.

1. Prices of tobacco products is very cheap in Bangladesh which makes illicit tobacco trade even more unlikely. A 2016 World Health Organization (WHO) report analyzed the average price of a cigarette pack containing 20 cigarettes in different countries and found out that average price of cheapest cigarettes is more than twice in India than it is in Bangladesh. So, the common logic of Economics dictates that there is no scope for Bangladesh to experience the influx of smuggled cigarettes. Thus, the National Revenue Board should ignore the tobacco industry propaganda and to take effective tobacco price and tax measures for increasing the prices of all tobacco products in the upcoming budget("Tobacco Watch Detail", 2014).

Although the government has not banned cigarette imports it imposes high taxes on imported cigarettes. Tobacco imports in all forms are heavily taxed but the tax rates are particularly high for imported cigarettes, ranging from 220 percent to 476 percent. Such high import taxes effectively function as an import ban on foreign cigarettes. So cigarette consumption is almost equal to cigarette production.

The country FCTC reports informed that 80 billion cigarettes and 50 billion bidis were produced in 2012, whereas in 2014 the production decreased to 71 billion cigarettes and 43 billion bidis.

Data on cigarette and bidi production in Bangladesh in 2007-2017 are presented in Table 6. The data demonstrate that in 2007-2012 cigarette production increased more than 3-fold: from 23.5 billion to 82.1 billion cigarettes slightly declined in 2012-2013 FY but then average annual production exceeded 80 billion cigarettes. Bidi production also substantially increased in 2007-2012: from 35.3 billion to 72.8 billion but then decreased to about 45 billion sticks a year.

Table 10: Cigarette and bidi production. Billion sticks¹¹

Financial Year	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Premium cigarettes	2.9	3.3	4.1	4.4	5.2	4.2	3.8	4.1	4.0	4.4
High cigarettes	7.5	6.8	9.2	7.0	8.1	8.1	8.8	8.0	4.6	4.5
Medium cigarettes	11.7	18.8	19.2	19.9	19.4	14.6	16.8	12.5	9.4	8.8
Low cigarettes	1.4	13.7	33.6	41.5	49.4	39.7	50.3	58.1	65.9	66.8
Total Cigarette	23.5	42.6	66.1	72.8	82.1	66.6	79.7	82.7	83.9	84.5
Bidi	35.3	46.3	63.4	67.2	72.8	44.4	46.8	44.5	43.2	43.5
Total cigarettes and Bidi	58.8	89.0	129.4	140.0	154.9	111.0	126.5	127.2	127.0	128.0

Euro Monitor International reports that cigarette sales in Bangladesh increased from 72.9 billion stick in 2011 to 88.9 billion sticks in 2017. Over the same period of time smokeless tobacco sales decreased from 46.5 tons to 42.6 tons.

However, according to UN database in 2008-2010 annual cigarette production in Bangladesh was rather stable– about 24 billion cigarettes each year. Statistical Yearbook also reported that in 2004-2011 annual availability for consumption was about 24 billion cigarettes a year and then this quantity increased to 32 billion cigarettes in 2011-2012 FY. Unfortunately, data are not available for later years("Bangladesh: Tobacco Use, Tobacco Control Legislation, and Taxation", 2019).

According to the BAT Directors reports, the cigarette industry had marginal volume growth in 2015 (January-December) and 2016 (but not in 2014) as the consumers were shifting from bidi to cigarettes while total tobacco industry was in decline. The growth dynamics of the industry varied across the price slabs of cigarettes. The low segment experienced growth (its share increased from 67% in 2014 to 80% in 2016) while high and medium segments declined. The situation changed in 2017-2018 the cigarette production in the country declined by 4.4% in 2017 and 9% in 2018 (January-December) mainly due to the decline in low segment cigarettes by 9% and 26% respectively. Low segment cigarette share decreased to 60% in 2018 as sales of the 3 top cigarette segments increased. BAT reported that the decline of low segment production in 2018 was mainly caused by their price increase by 30%(World Bank Group & Global Tobacco Control Program, 2019).

4.4 Tobacco taxation

Bangladesh has no separate law on tobacco taxation. Rather tobacco taxation is implemented as part of the Value-Added Tax (VAT) Law of 1991. Bangladesh imposes a variety of taxes on tobacco products including supplementary duties on cigarettes, bidis, chewing tobacco and pipe tobacco, duties on imported tobacco products and on both imported and exported tobacco leaf and a value-added tax on all tobacco products. Table 11 shows the tobacco tax structure in Bangladesh in the recent financial year (FY 2019-20).

¹¹ Source: National Board of Revenue

Table 3: Tobacco tax structure in Bangladesh, FY 2019-20.¹²

Tobacco products	Category	Tax base	Price (BDT)	VAT (percent)	SD (percent)	HDS (percent)	TTI (percent)
Cigarette (10 sticks)	Low	MRP	37+	15	55	1	71
	Medium		63+	15	65	1	81
	High		93+	15	65	1	81
	Premium		123+	15	65	1	81
Bidi (sticks)	Without filter (25 sticks)	MRP	14	15	35	1	51
	With filter (20 sticks)		17	15	40	1	56
Smokeless (Pouch of 10 grams)	<i>Zarda</i>	MRP	30	15	50	1	66
	<i>Gul</i>		15	15	50	1	66

Notes: In case of cigarettes, bidis and SLT products, MRP is inclusive of all taxes.

Anti-tobacco laws and regulations including taxation have been progressively tightened since Bangladesh signed the WHO Framework Convention on Tobacco Control (FCTC) in 2003. Bangladesh has the distinction of being the first country to sign the FCTC and was among the first to ratify the treaty in May 2004. The country's tobacco control laws, regulations and policies now encompass all four major areas of anti-smoking strategy: smoke-free places; advertising, promotion and sponsorships; packaging and labeling; and taxation aimed at increasing prices and lowering the affordability of tobacco products. Despite the progress noted above results regarding the changing composition of tobacco products are mixed. Smoked tobacco in Bangladesh comprises two major products: cigarettes and bidis. Bidi is a crude hand-rolled tobacco product that creates more health damage than cigarettes on average. It is also very cheap incurs low tax rates and yields very little revenue compared with cigarettes. Over time, the share of bidi in total production has declined from 72 percent in 2001/02 to 34 percent in 2016/17. This is a positive development in terms both of health outcomes and government revenues. Within the cigarette market there are four lines of products for pricing and taxation purposes in Bangladesh: Premium, High, Medium and Low. Much of the country's cigarette production is concentrated around the low grade and its relative share has risen substantially over time. Low-grade cigarettes have a relatively higher health hazard compared with higher grades and yield lower revenues owing to lower tax rates (Ahmed et al., n.d.).

4.4.1 Cigarette taxation

In Bangladesh the prices of each brand of cigarettes were determined by the National Board of Revenue and these prices were used as the tax base for calculating the tax liability of cigarette manufacturers. Based on these administered prices by brands, cigarettes are categorized into four brand tiers which are called "slabs" in Bangladesh. The ad valorem excise tax rate (known as Supplementary Duty- SD) which is based on the administered retail price varies by these price categories (see Table 12) with the current rate varying (from July 2017) between 52%-65%. In addition, there is value added tax (VAT) at 15% of retail price levied at the point of

¹² Source: National Board of Revenue (2019)

sale. The tax rate for the low-priced category is significantly lower than that for the top tiers. This was designed to protect domestic low-priced brands and low-income smokers consuming these brands.

Table 4: Ad valorem excise rates for cigarettes of different price categories (prices are for 10 sticks per pack)

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Low	6.6-.99	6.5-7.5	7.25-8.75	8.4-9.15	11-11.3	12.1-12.3	13.69-13.91	15-16.5	18	23	27 L 35 I	32
Tax rate, %	32	32	32	33	36	39	39	43	48	50	52 L 55 I	55
Medium	12.5-13.49	13.25-14.25	16.25-17.25	18.4-19	22.5-23	24.75-25.25	28-30	32.5-35	42-44	45-69	45-69	48-74
Tax, %	52	52	52	53	55	56	56	60	61	62	63	65
High	19-26.9	21-28	23.25-29.25	27-32	32-36	35.2-39.5	42-45	50-54	70-100	70-100	70-100	75-100
Tax rate, %	55	55	55	56	58	59	59	61	63	64	65	65
Premium	35+	41+	46.25	52+	60+	66+	80+	90+	101+	101+	101+	101+
Tax rate, %	57	57	57	58	60	61	61	61	63	64	65	65

Key: L - Local; I - international

The price slabs that define the tiered tax structure were not continuous. No brands are supposed to be priced below the minimum price in the slab for lowest price cigarettes. Brands sold at prices between the slabs were taxed at the maximum rate. Most cigarette smokers in Bangladesh surveyed in the ITC Bangladesh surveys of 2009 and 2010 reported paying prices between the price slabs in effect paying lower taxes (Barkat et al., 2012).

The significant price gaps between brands of cigarettes in different price categories created greater incentives for smokers to switch to cheaper brands in response to price and tax increases. These gaps also created greater incentives for manufacturers to engage in tax avoidance and evasion (e.g. by positioning brands in the gaps between price slabs) ("Tobacco Price and Taxation Policies in Bangladesh: Evidence of Effectiveness and Implications for Action | May 2014 | English - ITC Project", 2014).

In November 2013 the National Board of Revenue (NBR) issued a demand notice to British American Tobacco Bangladesh (BATB) for paying 19 billion BDT as value-added tax and supplementary duty which the company evaded by selling medium-slab cigarettes declaring them as low-slab ones. According to the NBR the BATB evaded the taxes from August 19, 2009 to January 31, 2013 by selling its Pilot and Bristol brand cigarettes at lower prices declaring the two brands in lower slab though they belong to the medium slab. BATB filed petitions before the high court challenging retrospective tax demanded by the revenue board. However, BATB has won an appeal in the Supreme Court against a High Court order. With the apex court order delivered on July 25, 2018 the BATB need not pay the amount to NBR.

From July 2015, continuous tier structure was introduced and every brand can be set to a defined tier. Since July 2017, the lower slab has been divided into two new slabs titled 'local brands' and 'international brands'.

In 2007-2009 ad valorem rates did not change, but from July 2010 the rates for all tiers were changed almost annually. The rates for lowest tier were increased much faster: from 32% to 52% or by 62% while the high-priced cigarettes rate was increased from 57% to 65% or by 14%.

The minimum price of the lowest tier cigarettes increased from 6 BDT per pack of 10 cigarettes in 2007 to 27 BDT in 2017. Prices of other tiers also increased while the increase of tier prices could move some brands to a tier with a lower rate and vice versa.

In 2018-2019 FY actually only two ad valorem excise rates were used: 55% for the low segment (with price Tk. 32-47 per 10 cigarettes) and 65% for medium and high segments cigarettes with price Tk. 48-101 per 10 cigarettes). In general, the tier structure was gradually moving towards unified rates in 2018 the difference between lowest and highest rates was 10 percentage points while in 2010 it was 25 percentage points.

4.4.2 Bidi taxation

The prices of bidis are determined by the bidi manufacturers themselves and their tax liability was calculated based on a pre-determined tariff value per pack of bidis. The VAT was imposed on the tariff value plus the excise tax. The excise tax rate differentiates between non-filter and filter bidis.

Table 5: Bidi excise taxes and prices

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Bidi non-filter (price BDT per pack of 20 sticks)	4.36	5.354	6.14	7.06	10.61	12.5	12.5
Tariff value (in BDT)	3.1579	3.88	4.27	4.91	7.1		
tax rate (%)	20	20	25	25	30	30	30
Actual specific tax (BDT per pack)	0.63	0.78	0.85	0.98	1.42	3.75	3.75
Bidi filter (price BDT per pack of 20 sticks)	4.93	6.052	6.92	7.98	12.03	12.5	15
Tariff value (in BDT)	3.43	4.22	4.64	5.34	7.75		
tax rate (%)	25	25	30	30	35	35	35
Actual specific tax (BDT per pack)	0.69	0.84	0.93	1.07	1.55	4.375	5.25

For example, in 2011, bidi was sold at an average retail price of BDT 6.00 per pack of 25 sticks while the retail price was not the tax base. Supplementary Duty (SD) and VAT were rather applied to a tariff value of BDT 3.1579 and BDT 3.43 per pack of 25 non-filter and filter bidi respectively. Therefore, this tariff value-driven tax base reduced the effective rate of SD and VAT to 10.5% and 9% respectively (National Board of Revenue Government of Bangladesh, 2012).

According to the law, the excise for bidi is calculated as established tariff value multiplied by the SD (ad valorem) rate which actually makes this excise a specific one. The calculated specific rates are presented in Table 8. In 2012-2016 such specific excise increased by 125% in four years.

In June 2017, the Minister of Finance Abul Maal Abdul Muhith proposed to abolish the existing bidi tariff system and to fix the tax inclusive prices of both a pack of 25 sticks of non-filter bidi and a pack of 20 sticks of filter bidi at the level of BDT 15. However, the parliament reduced these prices to BDT 12.5. Anyway, this measure is expected to increase the actual excise tax for bidi by 170%. In the 2018-19 FY, fixed price of filter bidi was increased to BDT 15

4.4.3 Smokeless tobacco taxation

The excise tax rate on the most widely used smokeless tobacco products (Zarda and Gul) is set as a percentage of the ex-factory price. The excise rate of smokeless tobacco products was 10% in 2009, 20% (from July 2011); 30% (from July 2012), 60% (from July 2014) and 100% (from July 2016). For tax collection purposes, administrative prices (which are used as a base for ad valorem rate) of Zarda and Gul were fixed at Taka 25 per 10 grams from July 2018. So, over the last six years, the smokeless tobacco excise rate was increased 10-fold. An analysis of fiscal policies results concluded that taxation had significantly reduced smokeless tobacco use among adults in both India and Bangladesh (John et al., 2018).

4.4.4 Electronic cigarettes

In early 2017, a 10% duty was applied to e-cigarettes and to their refill packs. In June 2017, the Minister of Finance proposed to introduce two separate Harmonized System Codes for these two items and to impose 25 percent customs duty on both items. At the same time, he also proposed to impose 100 percent Supplementary Duty on these products.

4.4.5 Additional tobacco taxes

The tobacco companies pay corporate tax calculated as 45% of the profit.

In 2017, the government has proposed to impose a surcharge of 2.5% on incomes from tobacco products including cigarettes, bidi, zarda and gul. Supplementary duty at the rate of 20% is levied on the domestic production of the cigarette and bidi paper. In 2015, customs duty on Artificial Filament Tow used to produce filter tips for cigarettes was increased from 5% to 25%.

The government imposed the 'health development surcharge' as 1% tax from tobacco companies in the budget for the fiscal year 2014-15. The VAT authority collects the surcharge on the basis of the same value on which they claim VAT. The surcharge is levied for supply of locally produced tobacco products at the production stage. The National Board of Revenue (NBR) collected the revenue during the last three financial years 2014-15, 2015-16 and 2016-17; however, the health development surcharge worth BDT 9.0 billion remained unutilized during the last three fiscal years due to the lack of a specific guideline to spend the amount. The draft of the policy got approval in an inter-ministerial meeting on February 15, 2017. The policy was scheduled to be placed before the cabinet in August 2017. The National Tobacco Control Cell under the Ministry of Health could use the surcharge revenue to execute a national tobacco control program which assumes conducting research and awareness campaigns, rehabilitating tobacco users, creating alternative jobs for tobacco farmers and ensuring overall health development.

4.4.6 Tobacco revenue

According to the WHO reports on the global tobacco epidemic, tobacco revenue in Bangladesh increased in 2012-2016 by 72%. In 2016-2017 FY tobacco tax revenue increased to 193 billion BDT growing by 16 percent per year (9 percent in real terms) in 2014-2017.

Table 6: Tobacco tax revenue in billion BDT

	2011-2012	2013-2014	2014-2015	2015-2016	2016-2017
Excise	74.5	97		130	
VAT	20	26		33	
Total Revenue	94.5	123	145	163	193

According to the British American Tobacco annual reports, this company's total payments (Value added tax (VAT), Supplementary Duty (SD), Health Development Surcharge (HDSC), Income Tax & Customs duty) increased from 46 billion BDT in 2010 to 191 billion BDT in 2018. The annual reports also provide data on BAT contribution and percentage to the total VAT, SDC and HDSC from cigarette industry. Calculations based on this data revealed that this revenue from 140 billion BDT in 2014 to 243 billion BDT in 2018 or by 73% in nominal terms or by 38% in real (inflation-adjusted) terms.

The main part of tobacco revenue comes from cigarette taxes. Bidi consumption was estimated to be 35-40% of the total tobacco consumption, but its tax earning as a fraction of the total tobacco revenue was less than 2% in 2016 and 3% in 2017.

In 2013-14, the government revenue from smokeless tobacco (Zarda and Gul) was only 15 million BDT. In 2014-15, total expenditure on consumption of smokeless tobacco products was BDT 16.50 billion. But the government earned only BDT 143.6 million tax from the sector, which is less than 1.0 percent of the total expenditure, according to NBR data.

4.4.7 Tobacco prices

According to the WHO reports, prices of the most sold brand and the cheapest brand increased 3-fold over six years (2010-2016) and the price of the premium brand increased 2-fold (Table 15).

Table 7: Cigarette prices (BDT per pack of 20 cigarettes)

WHO reports					
	2008	2010	2012	2014	2016
Most sold brand	25.9	33	50	70	100
Premium brand		104		190	220
Cheapest brand		14.6	28	30	50
ITC reports					
	2009	2010	2011-12	2014-15	
Nominal average price	31.2	39.4	55.4		
Real (inflation-adjusted) average price	40.6	47.0	57.8		
Low-priced cigarette brand	20	20	24	31	
Medium-priced cigarette brand	40	43	53	53	
High-priced cigarette brand	89	90	100	119	
Premium cigarette brand	153	156	185	205	

The ITC survey results also demonstrated the increases in average cigarette prices both in nominal and real terms. ITC also presents self-reported prices (Table 15) on cigarettes of different price tiers while the pace of increase is slower than the average price increase.

According to the data published in the Annual Statistical Yearbooks cigarettes and bidi had different price trends. In 2007-2013 cigarette price increase was above the inflation while bidi price- below inflation. However, from 2014 bidi price increase much exceeded the inflation. Cigarette price declined in 2014-2015 but then highly increased.

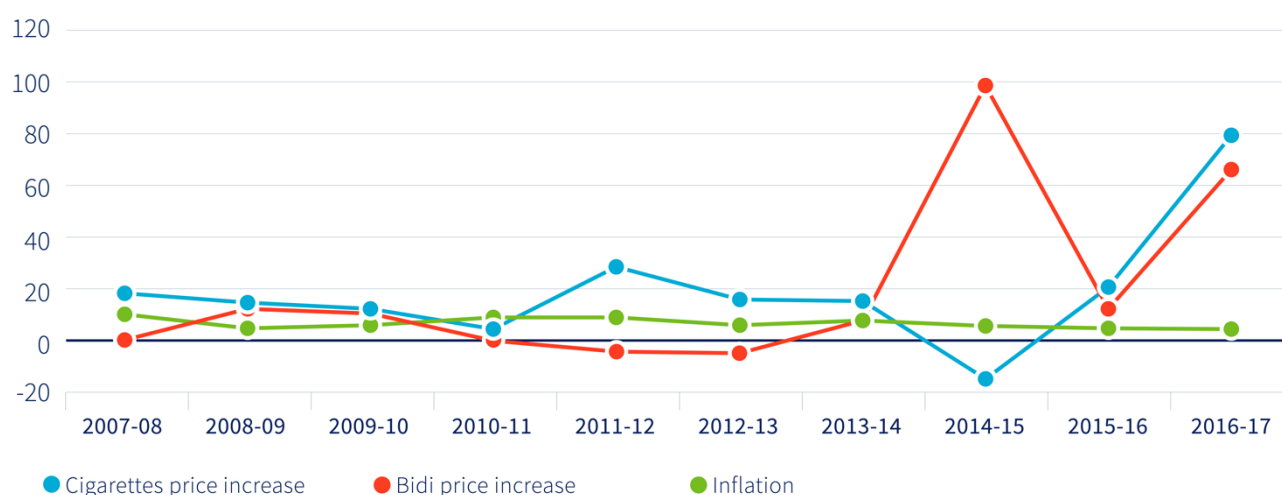


Figure 14: Changes in prices of tobacco products, comparison with inflation¹³

4.4.8 Comparison of cigarette prices and taxes in Bangladesh and neighboring countries

1. The WHO Global Tobacco Report 2017 shows information on cigarette prices and taxes in Bangladesh and other countries of the WHO South-East Asia Region (SEARO) in 2016(WHO report on the global tobacco epidemic, 2017, 2017)(Table 16).

Table 8: Cigarette prices and taxes in Bangladesh and other SEARO countries¹⁴

Country	Price of a 20-cigarette pack of the most sold brand			Taxes as a % of price of the most sold brand						
	In reported currency	Reported currency	In USD	Specific excise (%)	Ad valorem excise (%)	Total Excise (%)	VAT/ Sales tax (%)	Other taxes and duties (%)	TOTAL TAX	Net-of-tax part of the price in USD
Bangladesh	100	BDT	1.28	0.00	62.00	62.00	15.00	0.00	77.00	0.29
India	158	INR	2.36	26.46	0.00	26.46	16.67	0.00	43.12	1.34
Indonesia	21667	IDR	1.65	44.31	4.43	48.74	8.70	0.00	57.44	0.70
Maldives	47	MVR	3.05	0.00	0.00	0.00	0.00	53.19	53.19	1.43

¹³ Data source: Statistical Yearbooks

¹⁴ WHO report on the global tobacco epidemic, 2017

Myanmar	850	MMK	0.72	35.29	0.00	35.29	0.00	0.00	35.29	0.47
Nepal	80	NPR	1.68	14.84	0.00	14.84	11.50	0.00	26.35	1.24
Sri Lanka	1000	LKR	6.86	47.50	3.93	51.43	10.71	0.00	62.15	2.60
Thailand	86	THB	2.47	2.16	64.77	66.93	6.54	0.00	73.48	0.66
Timor-Leste	1.50	USD	1.50	25.33	0.00	25.33	2.44	0.23	28.01	1.08

The net-of-tax price of the most popular cigarette brand have been calculated as follows:

Price in USD * (1 – Total tax share). Cigarettes in Bangladesh had the second lowest price in the Region (after Myanmar) but paradoxically the highest tax share percentage: Bangladesh is the only country in the Region where tax share exceeds 75%. It was caused by the lowest net-of-tax cigarette price in Bangladesh and this proves that the tax share indicator can be misleading in comparing countries tobacco taxation policies.

4.4.9 Comparison of prices of various tobacco products

In 2011-2012 the price of one stick of bidi was less than one-fourth of one stick of the cheapest cigarette brand(Nargis et al., 2014). There were two distinct varieties of zarda available in the market—the cheaper variety that sells for less than 0.60 BDT per gram and the higher-priced variety that sells for 0.60 to 1.00 BDT per gram. The average price of the cheaper variety of zarda is comparable to the bidi price per stick while the price of higher-priced variety zarda is higher than bidi price. On average, the price of zarda per gram is less than half of the price per stick of the cheapest brand of cigarette. The price of gul was around 0.10 BDT per gram and it was comparable to the cheaper price variety of zarda.

In early 2016 excise taxes on the most sold brands of cigarettes were approximately 61% of their retail price. 'Bidi' taxes account for approximately 11% of retail prices and taxes on smokeless tobacco products are approximately 19% of retail prices.

CHAPTER 5

Key players and Stakeholders

5.1 Key players in tobacco industry

1. The two major tobacco companies in Bangladesh include British American Tobacco which holds 62% of the cigarette market by volume and Dhaka Tobacco Industries (under Akij Group) with 21.3% of the cigarette market. Philip Morris International distributes its products in Bangladesh through Dhaka Tobacco Industries. Smaller domestic companies include Abul Khair Tobacco and Nasir Tobacco. In 2017 88.9 billion cigarettes were sold in Bangladesh ("The Toll of Tobacco in Bangladesh", 2019).
2. Japan Tobacco Inc. (JT) announces that the JT Group has signed an agreement to acquire the tobacco business of Akij Group (Akij), the second largest tobacco company in Bangladesh further increasing its presence in Asia. The purchase price for the transaction is estimated at around BDT 124.3 billion (USD 1.476 million) ("JT Group Agrees to Acquire Tobacco Business of Akij Group in Bangladesh", 2020).
3. Founded only in 2014, Virgo Tobacco currently has 250 employees and thus considers itself a "medium-sized company". It has its tobaccos processed at the facilities of Dhaka Tobacco Industries and intends to set up their own GLT plant soon (Schmid, 2018).

Jomar Tobacco Co. Ltd. occupies a rather intriguing position within the exclusive club of tobacco merchants operating in the country. It is neither the local subsidiary of a multinational firm like BAT nor a local outfit firmly based in Bangladesh and Bangladesh only, for it sits somewhere in between. Jomar Tobacco was founded 13 years ago as a joint venture between a group of European and a group of Bangladeshi private investors, each party holding an equal 50% share in the company. The company maintains offices in Rangpur as well as in Madrid, being registered as a tobacco trading firm both in Bangladesh and the European Union (EU).

National Tobacco Control Cell (NTCC) is the functional arm of the Health Services Division, Ministry of Health and Family Welfare for tobacco control activities in Bangladesh. It has become the central hub of national coordination, referral and support center for all tobacco control stakeholders including NGOs & INGO's in Bangladesh.

5.2 Current programs funded by the Bloomberg Initiative to Reduce Tobacco Use

Project	Grants	Focus
Introduce, implement and monitor National and Sub national licensing policy for tobacco sales through advocacy, capacity building and multi-stakeholder engagement.	AID Foundation (Sep 2017- Aug 2019)	Tobacco Control Policy (general)
Sustainable Implementation of Tobacco Control Law in Rajshahi and Rangpur Division	Association for community development-ACD (Jan 2019- Dec 2020)	To ensure sustainable enforcement of tobacco control laws locally and build Rajshahi and Rangpur into Tobacco Free Cities
Support for Institutionalization of Enforcement of Tobacco Control Law in Rajshahi and Rangpur Division	Association for Community Development-ACD (Aug 2017-Nov 2018)	The project aims to institutionalize tobacco control within the Rajshahi and Rangpur division and build public and political support to strengthen tobacco control nationally

Project	Grants	Focus
People's Jubilant Engagement for Tobacco Free Chittagong City	Bangladesh Institute of Theatre Arts (BITA) (Aug 2018-Jan 2020)	To create a Tobacco Free Chittagong through effective implementation of the tobacco control law with an emphasis on comprehensive TAPS ban provisions.
Developing tax proposals, support in drafting tobacco tax policy ,capacity building of stakeholders and policy advocacy to increase tobacco taxes in Bangladesh	Bureau of Economic Research (Feb 2018-Jul 2019)	Tax/Price
Discredit tobacco industries regarding their mal-governance, ill-tactics, interferences in policymaking and its implementation involving CSOs and citizen groups.	Campaign for Good Governance (SUPRO) (Nov 2018-Jan 2020)	This project aims to investigate the relationship between the Government of Bangladesh and British American Tobacco and advocate for the government's divestment in BAT
Advocacy for mainstreaming and sustainable implementation of Tobacco Control Law and campaign against TI tactics targeting students and youths.	Dhaka Ahsania Mission (Feb 2017-Jul 2018)	The purpose of this project is to advocate for the sustainable implementation of the tobacco control law through capacity building and policy advocacy and to monitor and counter industry efforts to undermine tobacco control in Bangladesh.
Advocacy for mainstreaming, sustainable implementation of Tobacco Control Law & increasing tobacco tax and campaign against TI tactics.	Dhaka Ahsania Mission (Aug 2018-Jul 2019)	The purpose of this project is to advocate for the sustainable implementation and enforcement of the tobacco control law through capacity building and policy advocacy and to counter tobacco industry interference.
Mainstreaming the Tobacco Control Law for Sustainable Implementation and Countering TI tactics & Advocacy for Tobacco Tax Policy Reform.	Dhaka Ahsania Mission (Aug 2019-Jul 2020)	The project will focus on establishing city level smoke-free environments and support a national level advocacy campaign to increase the tobacco tax
Implementation of Bans on Tobacco Advertising, Promotion and Sponsorship of Tobacco Control Laws of Bangladesh in Barisal Division	GrambanglaUnnayan Committee (Oct 2018-Sep 2020)	Ad Bans
Implementation of TAPS ban in Bangladesh through capacity building, effective enforcement and strengthening reporting and monitoring system	National Anti-Tuberculosis Association of Bangladesh (NATAB) (Mar 2018-Mar 2020)	Ad Bans
Engaging physicians and civil society for tobacco control policy advocacy and law implementation	National Heart Foundation of Bangladesh (Sep 2017-Nov 2018)	This project aims to mobilize physician coalitions to strengthen and institutionalize tobacco control at the national level in Bangladesh.
Deepening engagement of physicians and civil society networks for adoption of favorable tobacco control policies and programs by government	National Heart Foundation of Bangladesh (Jan 2019-Dec 2020)	The project will continue to support the adoption, enforcement and sustainability of tobacco control policies at the national and local level.
Advancing Tobacco Control in Bangladesh through strengthening MPOWER, developing a sustainable National Tobacco Control Program and stopping Tobacco Industry Interference	National Tobacco Control Cell (NTCC) ,Ministry of Health and Family Welfare (Jan 2018-Dec 2019)	Tobacco Control Policy (general)

Project	Grants	Focus
Earned media for tobacco control in Bangladesh through enhanced capacity of journalists	PROGGA (Jan 2017-Dec 2017)	This project aims to mobilize earned media coverage to support and strengthen the implementation and enforcement of the amended tobacco control law and the rules in Bangladesh.
Earned Media for supporting implementation of TAPS Law, advocating for stronger tobacco price and tax measures and exposing tobacco industry ill tactics in Bangladesh	PROGGA (Jan 2018-Mar 2019)	use earned media to build public and political support for tobacco control
Strengthen implementation of Graphic Health Warnings and increase the size of GHW on tobacco products in Bangladesh through advocacy, capacity building and monitoring.	Tobacco Control & Research Cell (TCRC), Dhaka International University (Sep 2017-Aug 2019)	Pack Warnings
Advocacy for Adoption of Smokeless Tobacco Strategy and amendment of the TC Law more compliant with FCTC	UBINIG (PVT) Ltd. (Oct 2018-Sep 2019)	This project aims to reduce smokeless tobacco use in Bangladesh through policy advocacy focused on a comprehensive regulation and amendment of the current tobacco control law to address gaps in FCTC compliance.
Evidence-based policy advocacy on standardized SLT packaging and bringing SLT producers under regulation and tax net	UBINIG (PVT) LTD. (Feb 2020-Jan 2021)	This project aims to reduce smokeless tobacco use in Bangladesh through policy advocacy focused on standardized packaging and increased taxation of smokeless tobacco products.
Advancing Tobacco Control in Chittagong Division through institutionalization of effective enforcement of Tobacco Control Law	YPSA (Young Power in Social Action) (Jan 2017-Nov 2018)	This project aims to institutionalize tobacco control within the Chittagong division and build public and political support to strengthen tobacco control nationally
Institutionalize the Tobacco Control Initiative in Chittagong Division	Young Power in Social Action (YPSA) (Jan 2019-Dec 2020)	To institutionalize TC law implementation and build Chattogram Division and Cox's Bazar into model Tobacco Free Cities
Advancing tobacco control in Bangladesh through raising tobacco taxes, strengthening TAPS ban, stopping TII and developing a National Tobacco Control Program.	Work for a Better Bangladesh (WBB) Trust (Oct 2017- Mar 2019)	Tobacco Control Policy (general)

5.3 Status of media awareness and overage of tobacco-related issues

Study result documented that Mass media was found to play a strong role in support of the tobacco control law and its implication that could be created public support against tobacco farming, exposing to companies' tactics and other tobacco control activities. The study results also revealed that in controlling tobacco supply and demand effectively media has been assisting the government and anti-tobacco activities productively. Study shows evidence that mass media coverage of tobacco control issues is influencing the context of comprehensive tobacco control programs. To reduce tobacco consumption along with strict enforcement efforts media should be used to assist with the implementation of the tobacco control law. A sustained nationwide campaign to educate the masses against the dangers of smoking and smokeless tobacco is needed and media can play an important role in creating further awareness about the dangers associated with tobacco consumption (Sadeque & Ahmed, 2017).

According to Smoking and using of Tobacco products (Control) act 2005 which was amended in 2013 the domestic TV and radio (including all broadcast media such as satellite and cable), domestic newspapers and magazines, other domestic print media such as pamphlets, leaflet, flyers, posters, internet communications, outdoor advertising (e.g. billboards, posters), Vending machines, Telephone and cellular phone, Conventional mail, Brand marking on physical structures, Point of sale product display are banned for promoting tobacco. The law does not explicitly ban advertising and promotion via International TV and radio (including all broadcast media such as satellite and cable). International newspapers and magazines, Direct person to person targeting of individuals so the regulatory status Uncertain is given. The law allowed Internet tobacco product sales, reverse brand stretching or brand sharing. But there is some restrictions of Brand stretching/trademark diversification, tobacco industry sponsorship of events, activities, individuals, organizations or governments and Promotion by any means that are false, misleading or deceptive("Bangladesh Details | Tobacco Control Laws", 2019).

CHAPTER 6

Regulation of tobacco: status, benefits, and gaps

6.1 Tobacco policy landscape

Bangladesh ratified the WHO Framework Convention on Tobacco Control (FCTC) in 2004. The primary national law regarding tobacco is The Smoking and Tobacco Products Usage (Control) Act, 2005 as amended by the Smoking and Tobacco Products Usage (Control) (Amendment) Act, 2013. The Act:

- Prohibits smoking in many public places and work places but allows smoking areas in some spaces such as restaurants and hotels. Many outdoor areas (e.g. children's parks, fairs and bus stops) are also smoke-free with some smoking areas allowed in these locations.
- Prohibits all tobacco advertising, promotion and sponsorship including point of sale.
- Requires Graphic Health Warnings covering at least 50% of the front and back of packaging for smoking and smokeless tobacco. Text must be in Bengali.
- Allows sub-national regulations that are stricter than the national law ("Bangladesh; The Tobacco Epidemic", 2015).

The Smoking and Using of Tobacco Products (Control) Act, 2005 (Act No. XI of 2005) is one of the principal laws governing tobacco control in Bangladesh. The law is comprehensive and provides for: restrictions on smoking in public places; restrictions on tobacco advertising, promotion and sponsorship; health warnings on packaging and labeling; and loans for the cultivation of other cash crops as alternatives to tobacco, among others. The provisions of the Act were deemed to be in addition to and not in derogation of tobacco control provisions of existing laws to the extent that there were no contradictory provisions. Chronology of Tobacco-related legislation in Bangladesh is given below:

Ministry of Health & Family Welfare, National Tobacco Control Cell, Public Notice

Legislations	Description
Article 110 of The Railways Act, 1890 (Act No. IX 1890) May 1, 1890	Article 110 of the Railways Act, 1890 prohibits any passenger from smoking in any compartment of a train other than a compartment specifically designated for smoking. Article 110 also establishes the penalties for those who violate this provision. The date of enactment is March 21, 1890. The law came into force on May 1, 1890. An excerpted portion - Article 110 - is available here .
The Juvenile Smoking Act, 1919 (as amended) February 1, 1919	The Juvenile Smoking Act, 1919 has been repealed.
Smoking and Using of Tobacco Products (Control) Act, 2005 March 15, 2005	The Smoking and Using of Tobacco Products (Control) Act, 2005 (Act No. XI of 2005) is one of the principal laws governing tobacco control in Bangladesh. The law is comprehensive and provides for: restrictions on smoking in public places; restrictions on tobacco advertising, promotion and sponsorship; health warnings on packaging and labeling; and loans for the cultivation of other cash crops as alternatives to tobacco among others. The provisions of the Act were deemed to be in addition to and not in derogation of tobacco control provisions of existing laws to the extent that there were no contradictory provisions. The list of existing laws specifically included the Railways Act, 1890 and the Juvenile Smoking Act, 1919.
Smoking and Using of Tobacco Products (Control) Rules, 2006 May 19, 2006	The Smoking and Using of Tobacco Products (Control) Rules, 2006 have been repealed.

Legislations	Description
Smoking and Tobacco Products Usage (Control) (Amendment) Act, 2013 (Act No. 16 of 2013) May 2, 2013	The Smoking and Using of Tobacco Products (Control) (Amendment) Act, 2013 contains amendments to the 2005 Act of the same name. The amended act is the principal law governing tobacco control in Bangladesh. The law is comprehensive and provides for: restrictions on smoking in public places; restrictions on tobacco advertising promotion and sponsorship; graphic health warnings on packaging and labeling; and loans for the cultivation of other cash crops as alternatives to tobacco among others. This document contains the amendments to the Act only and should be read with the 2005 Act.
Ministry of Health & Family Welfare Pictorial Health Warnings (Issued pursuant to Smoking and Tobacco Products Usage (Control) (Amendment) Act . 2013 and Smoking and Tobacco Products Usage (Control) Rule) March 12, 2015	The Ministry of Health & Family Welfare issued nine pictorial health warnings which are required to appear on 50% of principal display areas on tobacco product packaging (seven warnings apply to smoked tobacco products . and two warnings apply to smokeless tobacco products). The images were issued pursuant to Smoking and Tobacco Products Usage (Control) (Amendment) Act, 2013 and Smoking and Tobacco Products Usage (Control) Rule.
Smoking and Tobacco Products Usage (Control) Rule ,2015 (S.R.O. No. 58) March 12, 2015	The Smoking and Tobacco Products Usage (Control) Rule, 2015 elaborates upon many of the provisions of the Smoking and Tobacco Products Usage (Control) Act 2005, as amended by Act No. 16 of 2013. Areas covered include: location and conditions of smoking areas; the use of tobacco products in films; duties of public place and public transport owners and managers; signage in smoke free environments; and requirements of pack warnings.
Ministry of Health & Family Welfare, National Tobacco Control Cell, Public Notice July 4, 2017	The Public Notice issued by the National Tobacco Control Cell of the Ministry of Health & Family Welfare clarifies that pictorial health warning labels must be placed on the upper part of the principal display areas. The previous public notice (dated March 16, 2016) permitting bottom placement as an interim measure has been rescinded.

6.2 Efforts for tobacco control and smoking cessation in Bangladesh

The WHO Framework Convention on Tobacco Control (WHO FCTC) is an evidence-based treaty that asserts the importance of both demand and supply reduction strategies. The WHO FCTC is the first global public health treaty negotiated under the auspices of WHO in response to the globalization of the tobacco pandemic. Bangladesh ratified the WHO FCTC in 2004, and in 2005, enacted the Smoking and Using of Tobacco Products (Control) Act. The law was amended in 2013 to make it more compliant with the WHO FCTC.

In Bangladesh, WHO provides technical support for implementation of the FCTC and tobacco control, especially in the key areas of tobacco taxation, policy development, enforcement of legislation and surveillance of tobacco use, most recently through technical support for the second round of the GATS. (Islam & Walton, 2019)

Under FCTC, Bangladesh has taken measures for smoke free environment and completely banned smoking at health care facilities, schools, universities, governmental facilities, private offices etc. Bangladesh also banned tobacco advertising, promotion, and sponsorship along with health warnings on smoking tobacco products. The summary of tobacco and smoking control efforts are given in Table below.

Table 9: Status of tobacco control policies in Bangladesh, Pakistan, India and Sri Lanka.

	Bangladesh	Pakistan	India	Sri Lanka
Smoke-free environments - complete smoking ban				
Healthcare facilities	Yes	Yes	Yes	Yes
Primary and secondary schools	Yes	Yes	Yes	Yes
Universities	Yes	Yes	Yes	Yes
Governmental facilities	Yes	Yes	Yes	Yes
Private offices	Yes	Yes	Yes	Yes
Public transport	No	Yes	No	Yes
Restaurants	No	Yes	No	No
Bans on tobacco advertising, promotion, and sponsorship				
Domestic TV and radio	Yes	Yes	Yes	Yes
Domestic magazines and newspapers	Yes	Yes	Yes	Yes
Outdoor advertising	Yes	Yes	Yes	Yes
Point-of-sale advertising	Yes	No	Yes	Yes
Retail product display	Yes	No	Yes	Yes
Internet advertising	Yes	No	Yes	Yes
Free distribution	Yes	Yes	Yes	Yes
Promotional discounts	Yes	Yes	Yes	Yes
Non-tobacco products or services with tobacco brand names	No	No	Yes	Yes
Tobacco products with non-tobacco brand names	No	No	Yes	No
Paid placement in media	Yes	Yes	Yes	Yes
Financial sponsorship, including corporate social responsibility	No	No	No	No
Publicity of sponsorships	Yes	No	No	No
Health warnings on smoking tobacco products				
Text warnings describe health impact	Yes	Yes	Yes	Yes
Warnings include a picture or graphic	Yes	Yes	Yes	Yes
Health warnings on smokeless tobacco products	Yes	Yes	Yes	Yes
Warnings are written in the principal language(s)	Yes	No	Yes	No
Ban on misleading packaging and labelling	No	No	Yes	No

Bangladesh was the first country to sign the WHO Framework Convention on Tobacco Control (FCTC) in 2003 which is the world's first health treaty against the global tobacco epidemic and was among the first countries to ratify the treaty in May 2004, Bangladesh was also among the first countries to ratify it in 2004. Through

amending the tobacco control law in 2013 smokeless tobacco is brought under purview of law; penalty for violation of various sections of the law has been increased; ban on advertisement of tobacco products made comprehensive; sale of tobacco to and by minors has been banned and printing of Graphic Health Warning on packs of tobacco products made mandatory. WHO supported the publication of Graphic Health Warning (GHW)-based anti-tobacco advertisements in national daily newspapers in late 2015 and mid 2016. The Government of Bangladesh (GOB) is committed to a “tobacco-free Bangladesh” by 2040

Tobacco control in Bangladesh

Taxation

- Both imported and domestically produced tobacco products are taxed in Bangladesh.
- The tax system is tiered ad-valorem.
- Value added tax (VAT), supplementary duty (SD) and health development surcharge are imposed on all kinds of domestically produced tobacco products including cigarettes, bidi and smokeless tobacco products (SLT).
- WHO along with partners is working closely with the National Board of Revenue (NBR) to strengthen the tobacco tax system in Bangladesh, developed and presented to the Government a tobacco tax proposal for FY 2018 – 19
- Tobacco taxation raises revenue and improves population health.

Enforcement

- The law prohibits smoking in selected public places and on public transport.
- The law also imposes a ban on advertisement and promotion of tobacco products, and sponsorship of events by the tobacco industry.
- As part of the legislation, tobacco sale to and by minors is banned.
- With technical support from WHO, printing of pictorial health warnings on 50% on both the front and back of tobacco packaging came into effect in 2016.
- WHO works closely with the National Tobacco Control Cell (NTCC) of MOHFW to train authorized officers to enforce tobacco control legislation, and to organize mobile courts.
- In 2017, WHO supported NTCC to train 128 Sanitary Inspectors (SI) working at Upazila level, on enforcement of tobacco control law and authorized to prosecute and play an important role to enforce the tobacco control law, especially through ‘mobile courts’.
- Moreover, the law empowers authorized officers to enforce some sections of the tobacco control law themselves.
- In 2018, NTCC provided refresher training to trained SIs.
- WHO provided technical assistance to the Directorate General of Health Services to include indicators to report tobacco control activities by SIs online through DHIS2
- Civil administration regularly operates mobile court to enforce the law.
- In October 2017, WHO also supported NTCC to facilitate the operation of mobile courts, one in each of the 64 districts. The courts fined violators of the tobacco control law and confiscated and destroyed illicit tobacco products worth BDT 1,500,000.
- The initiative engaged government officials, tobacco control taskforce committee members, the community, and NGOs, and received wide coverage in the media.

Policy Development

WHO is providing technical support to NTCC to develop several policies in accordance with the obligations under the FCTC including-

- the National Tobacco Control Policy; and
- the Policy to Curb Tobacco Cultivation.

Integration of Tobacco Cessation into Health Services

Tobacco control in Bangladesh

- In 2017, WHO supported the National Institute of Preventive and Social Medicine (NIPSOM) to pilot tobacco cessation service through brief intervention in primary health care settings.
- NIPSOM set up a training network on tobacco cessation in collaboration with NTCC
- DGHS, trained 30 master trainers and 120 primary health care physicians on brief interventions for the purposes. With these master trainers, services can be scaled up.

Tobacco-free Bangladesh by 2040

- Through implementation of the legislation and comprehensive efforts for tobacco control, there has been an 18.5% relative reduction in tobacco use in Bangladesh from 2009 to 2017.
- The absolute number of tobacco users among adults has also decreased from 41.3 million to 37.8 million.
- Tobacco control is one of the most important prevention strategies to avert death and reduce the risk of developing non-communicable diseases worldwide.
- Tobacco control can also contribute to breaking the cycle of poverty and promoting sustainable development of national economies of a country. It is therefore recognized as an essential component of the Sustainable Development Goals (Target 3.a).
- WHO will continue to provide support to the Government to achieve the vision of a tobacco free Bangladesh by 2040.

WHO FCTC articles

The core demand reduction provisions in the WHO FCTC are:

- Article 6: Price and tax measures to increase the price of tobacco products
- Article 8: Protection of non-smokers from exposure to second hand tobacco smoke
- Article 11: Packaging and labelling of tobacco products
- Article 12: Creation of public awareness on detrimental effects of tobacco use and tobacco control law
- Article 13: Banning tobacco advertising, promotion and sponsorship (TAPS)
- Article 14: Support for tobacco cessation

The core supply reduction provisions in the WHO FCTC are contained in articles 15-17

- Preventing illicit trade in tobacco products;
- Banning sales to and by minors; and,
- Making provisions to support economically viable alternative activities for tobacco farmers, workers and individual sellers.

Monitoring

- WHO encourages the use of standards and scientific and evidence-based protocols for tobacco surveys.
- WHO supports the Government of Bangladesh to identify specific strategies for use of evidence in tobacco control policies and programmes and to implement effective MPOWER policies to protect health and combat the tobacco epidemics.
- The country also completed the WHO STEP wise Approach to Surveillance in 2003

Cigarette (Printing of Warning) Ordinance (World Bank)

- According to the Smoking and Tobacco Products Usage Act 2013 and Rules 2015 printing of graphic health warnings on all tobacco packets was made mandatory from March 19 . 2016.
- According to Section 10 of the law, the graphic health warnings were supposed to be printed covering 50 percent upper part of the tobacco packets' surface but due the interference of the tobacco companies the Ministry of Law, Justice and Parliamentary Affairs issued a temporary permission to print the graphic health warnings covering 50 percent lower part of tobacco packets and the National Tobacco Control Cell issued a public circular about the issue on March 16 . 2016.
- The National Tobacco Control Cell issued another public circular on July 04, 2017 prescribing to print graphic health warnings on 50 percent upper part of tobacco products packages mandatorily from September 19, 2017.

6.3 Gaps and Challenges for Smoking Cessation

Tobacco, a leading risk factor for several non-communicable diseases, is a global public health concern. Every year, tobacco use kills more than 7 million people worldwide. This includes almost 900,000 deaths of non-smokers exposed to secondhand smoke. In Bangladesh, the burden from tobacco is alarming: 35% of adults are currently using tobacco either in smoked and/or in smokeless form. Furthermore, 43% and 39% of adults are exposed to secondhand smoke at their workplaces and in their homes, respectively. Seven percent of youth aged 13 to 15 years use tobacco. 66.2% of current smokers and 51.3% of current smokeless tobacco users planned to or were thinking quitting. 65.8% of smokers and 57.2% of smokeless tobacco users who visited a healthcare provider in the past 12 months were advised to quit smoking ("GLOBAL ADULT TOBACCO SURVEY", 2017).

The heavy burden of tobacco-related ill health in Bangladesh is rooted in the country's high production and consumption of tobacco products, thus Bangladesh is one of the five focus countries of the Bloomberg Initiative (BI) to Reduce Tobacco Use ("Tobacco control in Bangladesh", 2015)

The WHO report on the global tobacco epidemic, 2019 ("WHO report on the global tobacco epidemic, 2019; Country profile Bangladesh", 2019) indicates the Gaps and Challenges for Smoking Cessation in Bangladesh. According to the report regarding health warnings on tobacco packages the law doesn't state that warnings on packages do not remove or diminish the liability of the tobacco industry. There is no law requiring that tobacco packaging and labelling do not use figurative or other signs, including colours or numbers, as substitutes for prohibited misleading terms and descriptors. Also there is no law requiring that tobacco packaging and labelling do not use descriptors depicting flavours. Law doesn't ban the display of quantitative information on emission yields (such as tar, nicotine and carbon monoxide) on tobacco packaging, including when used as part of a brand name or trademark.

Law doesn't mandate the display of qualitative information on relevant constituents and emissions of tobacco products on tobacco packaging and plain packaging. Even the law doesn't prevent the display of expiry dates on tobacco packaging. It is also not mandatory for the quit line number to appear on packaging or labelling.

Tobacco companies are not funding or making contributions (including in-kind contributions) to smoking prevention media campaigns, including those directed at youth. Law doesn't explicitly ban tobacco products display at point of sale and internet sales of tobacco products.

Subnational jurisdictions do not have the authority to adopt laws that ban tobacco smoking in any or all of the places mentioned above. Subnational jurisdictions also do not have the authority to adopt laws that ban some or all types of tobacco advertising, promotion and sponsorship mentioned above.

Considering the anti-tobacco mass media campaigns between 1 July 2016 and 30 June 2018 it has been found that, before the campaign, any research about the target audience was not conducted or used to develop the campaign messages/materials. Even the campaign materials were not tested with the target audience before the campaign was run. And also any evaluation was not done to assess the impact of the campaign.

References

1. *Bangladesh - GNI Per Capita, Atlas Method - 1973-2018 Data | 2020 Forecast*. Tradingeconomics.com. (2020). Retrieved 15 July 2020, from <https://tradingeconomics.com/bangladesh/gni-per-capita-atlas-method-us-dollar-wb-data.html>.
2. *GDP growth (annual %) - Bangladesh | Data*. Data.worldbank.org. (2020). Retrieved 15 July 2020, from https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=BD&name_desc=false&view=chart.
3. *Real GDP growth Annual percent change*. imf.org. (2020). Retrieved 15 July 2020, from https://www.imf.org/external/datamapper/NGDP_RPCH@WEO/OEMDC/ADVEC/WEOWORLD/AUS/BGD.
4. Raza, W. (2020). *Poverty & Equity Brief South Asia Bangladesh*. Databank.worldbank.org. Retrieved 17 July 2020, from https://databank.worldbank.org/data/download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global_POVEQ_BGD.pdf?fbclid=IwAR04muyBpuV4vI4e4DRP6Yy65byXcDwbfsmkUS2xFlTmVE8PoQ-KxE-1A.
5. *Wage Earners Remittance*. Bbs.portal.gov.bd. (2019). Retrieved 10 July 2020, from http://bbs.portal.gov.bd/sites/default/files/files/bbs.portal.gov.bd/page/5695ab85_1403_483a_afb4_26dfd767df18/2019-12-17-16-30-614e10bcb101bc1df5938723cc141c5d.pdf.
6. *Bangladesh moves up in UNDP Human Development Report*. UNDP. (2019). Retrieved 10 July 2020, from https://www.bd.undp.org/content/bangladesh/en/home/presscenter/pressreleases/2019/12/11/HDR_2019_Launching.html.
7. *Bangladesh Population 2020 (Live)*. World Population Review. (2020). Retrieved 8 July 2020, from <https://worldpopulationreview.com/countries/bangladesh-population/>.
8. *Demographics of Bangladesh*. En.m.wikipedia.org. (2016). Retrieved 13 July 2020, from https://en.m.wikipedia.org/wiki/Demographics_of_Bangladesh.
9. *Population Pyramids of the World from 1950 to 2100*. Population Pyramid. (2019). Retrieved 14 July 2020, from <https://www.populationpyramid.net/bangladesh/2019/>.
10. *Bangladesh Population 2020 (Live)*. World Population Review. (2020). Retrieved 8 July 2020, from <https://worldpopulationreview.com/countries/bangladesh-population/>.
11. *Rohingya Refugee Crisis*. OCHA. (2019). Retrieved 17 July 2020, from <https://www.unocha.org/rohingya-refugee-crisis/>.
12. *Bangladesh Population (2020) - Worldometer*. Worldometers.info. (2019). Retrieved 4 July 2020, from <https://www.worldometers.info/world-population/bangladesh-population/>.
13. Hayes, G. (2015). *The impact of demographic transition on socio-economic development in Bangladesh*. United Nations Population Fund Bangladesh.
14. *Why a national urban policy should be our top priority | UNDP in Bangladesh*. UNDP. (2019). Retrieved 12 July 2020, from <https://www.bd.undp.org/content/bangladesh/en/home/blog/2019/october/31/why-a-national-urban-policy-should-be-our-top-priority.html>.

15. Rahman, M. (2013). STRATEGY FOR URBAN SECTOR DEVELOPMENT IN BANGLADESH. Theigc.org. Retrieved 13 July 2020, from <https://www.theigc.org/wp-content/uploads/2015/05/1SouthAsiaRahman.pdf>.
16. *Bangladesh makes consistent progress achieving SDGs health indicators*. Who.int. (2020). Retrieved 6 July 2020, from <https://www.who.int/bangladesh/news/detail/05-03-2020-bangladesh-makes-consistent-progress-achieving-sdgs-health-indicators>.
17. 2018 Health SDG profile: Bangladesh. Apps.who.int. (2020). Retrieved 3 July 2020, from <https://apps.who.int/iris/handle/10665/276833?show=full>.
18. Worldometer. (2020). Population. <https://www.worldometers.info/population>.
19. Hossain, R. (2015). Current status of health sector in Bangladesh. Banglajol.info. Retrieved 6 July 2020, from <https://www.banglajol.info/index.php/BMJ/article/view/26356/17685>.
20. Ministry of Health and Family Welfare Government of the People's Republic of Bangladesh. (2018). HEALTH BULLETIN 2018 [Ebook]. Retrieved 6 July 2020, from <https://dghs.gov.bd/images/docs/Publicaations/HB%202018%20final.pdf>.
21. What causes the most deaths?. Institute for Health Metrics and Evaluation. (2019). Retrieved 12 July 2020, from <http://www.healthdata.org/bangladesh>.
22. Noncommunicable diseases are the no. 1 killers in the WHO SEA Region. Who.int. Retrieved 13 July 2020, from <https://www.who.int/southeastasia/activities/noncommunicable-diseases-are-the-no.-1-killers-in-the-who-sear>.
23. Ahmed, S., Naheed, A., BinteAlam, B., Anwar, I., Begum, T., &Huque, R. et al. (2015). Bangladesh health system review. World Health Organization.
24. Health Bulletin 2017. Dghs.gov.bd. (2017). Retrieved 4 July 2020, from <https://dghs.gov.bd/index.php/en/home/4364-health-bulletin-2017>.
25. Health Bulletin 2017. Dghs.gov.bd. (2017). Retrieved 4 July 2020, from <https://dghs.gov.bd/index.php/en/home/4364-health-bulletin-2017>.
26. Finance Division, Ministry of Finance, Bangladesh Government. (2019). Bangladesh Economic Review 2019 [Ebook]. Retrieved 3 July 2020, from https://mof.portal.gov.bd/sites/default/files/files/mof.portal.gov.bd/page/f2d8fabb_29c1_423a_9d37_cd_b500260002/Ch-12%20%28english-2019%29.pdf.
27. HOSSAIN, S. (2016). Bangladesh Healthcare Industry: Growing Faster than Country's GDP. LightCastle Partners. Retrieved 13 July 2020, from <https://www.lightcastlebd.com/insights/2016/04/11/bangladesh-healthcare-industry-the-thriving-industry-that-is-growing-faster-than-the-gdp>.
28. Ministry of Health and Family Welfare, Bangladesh. (2018). HEALTH BULLETIN 2018 [Ebook]. Retrieved 14 July 2020, from <https://dghs.gov.bd/images/docs/Publicaations/HB%202018%20final.pdf>.
29. Ministry of Health and Family Welfare, Bangladesh. (2018). HEALTH BULLETIN 2018 [Ebook]. Retrieved 14 July 2020, from <https://dghs.gov.bd/images/docs/Publicaations/HB%202018%20final.pdf>.
30. Mapping of Health Professional Education Institutions in Bangladesh. Who.int. (2019). Retrieved 10 July 2020, from <https://www.who.int/docs/default-source/searo/bangladesh/pdf-reports/year-2016->

[2018/mapping-of-health-professional-education-institutions-in-bangladesh-2019.pdf?sfvrsn=8c8bbb63_2](https://www.who.int/tobacco/surveillance/survey/gats/bgd/en/).

31. Global Adult Tobacco Survey data. World Health Organization. (2017). Retrieved 4 July 2020, from <https://www.who.int/tobacco/surveillance/survey/gats/bgd/en/>.
32. Islam, F., & Walton, A. (2019). Tobacco Smoking and Use of Smokeless Tobacco and Their Association with Psychological Distress and Other Factors in a Rural District in Bangladesh: A Cross-Sectional Study. *Journal Of Environmental And Public Health*, 2019, 1-11. <https://doi.org/10.1155/2019/1424592>
33. Sinha, D., Rolle, I., Rinchen, S., Palipudi, K., & Asma, S. (2011). Tobacco use among youth and adults in member countries of South-East Asia region: Review of findings from surveys under the global tobacco surveillance system. *Indian Journal Of Public Health*, 55(3), 169. <https://doi.org/10.4103/0019-557x.89946>
34. Giovino, G., Mirza, S., Samet, J., Gupta, P., Jarvis, M., & Bhala, N. et al. (2012). Tobacco use in 3 billion individuals from 16 countries: an analysis of nationally representative cross-sectional household surveys. *The Lancet*, 380(9842), 668-679. [https://doi.org/10.1016/s0140-6736\(12\)61085-x](https://doi.org/10.1016/s0140-6736(12)61085-x)
35. Bandyopadhyay, A., & Irfan, M. (2019). Educational and Wealth Inequalities in Smokeless Tobacco Use: An Analysis of Rural-Urban Areas of Bangladesh and India. *Substance Abuse: Research And Treatment*, 13(117822181882507). <https://doi.org/10.1177/1178221818825074>
36. Hossain, S., Hossain, S., Ahmed, F., Islam, R., Sikder, T., & Rahman, A. (2017). Prevalence Tobacco Smoking and Factors Associated with the Initiation of Smoking among University Students in Dhaka, Bangladesh. *Central Asian Journal Of Global Health*, 6(1). <https://doi.org/10.5195/cajgh.2017.244>
37. World Bank Group, & Global Tobacco Control Program. (2019). Bangladesh Overview of Tobacco Use, Tobacco Control Legislation, and Taxation. *worldbank.org*. Retrieved 7 July 2020, from <http://documents1.worldbank.org/curated/en/230701560806135545/pdf/Bangladesh-Overview-of-Tobacco-Use-Tobacco-Control-Legislation-and-Taxation.pdf>.
38. Hossain, M., & Rahman, M. (2013). A Socioeconomic Analysis on Tobacco Cultivation in Kushtia District of Bangladesh. *Social Sciences*, 2(3), 128. <https://doi.org/10.11648/j.ss.20130203.14>
39. The Toll of Tobacco in Bangladesh. Campaign for Tobacco-Free Kids. (2019). Retrieved 5 July 2020, from <https://www.tobaccofreekids.org/problem/toll-global/asia/bangladesh>.
40. Tobacco, production quantity (tons) for Bangladesh. *Tilasto.com*. Retrieved 13 July 2020, from <https://www.tilasto.com/en/country/bangladesh/geography-and-agriculture/tobacco-production-quantity>.
41. Al Amin, M., Islam Sarker, M., Hossin, M., Nasrin, M., & Huda, N. (2018). Cigarette Selling and Buying by the Minor and Adolescents in Bangladesh: Prevalence, Perceptions and Awareness. *The Journal Of Social Sciences Research*, (12), 556-570. <https://doi.org/10.32861/jssr.412.556.570>
42. Bangladesh - Economic Indicators. *Tradingeconomics.com*. (2020). Retrieved 12 July 2020, from <https://tradingeconomics.com/bangladesh/indicators>.
43. Tobacco Watch Detail. *Tobaccoindustrywatchbd.org*. (2014). Retrieved 10 July 2020, from <http://www.tobaccoindustrywatchbd.org/article/articledetail/TobaccoWatch/438>.
44. Bangladesh: Tobacco Use, Tobacco Control Legislation, and Taxation. *Documents.worldbank.org*. (2019). Retrieved 15 July 2020, from

<http://documents.worldbank.org/curated/en/230701560806135545/text/Bangladesh-Overview-of-Tobacco-Use-Tobacco-Control-Legislation-and-Taxation.txt>.

45. World Bank Group, & Global Tobacco Control Program. (2019). Bangladesh Overview of Tobacco Use, Tobacco Control Legislation, and Taxation. worldbank.org. Retrieved 7 July 2020, from <http://documents1.worldbank.org/curated/en/230701560806135545/pdf/Bangladesh-Overview-of-Tobacco-Use-Tobacco-Control-Legislation-and-Taxation.pdf>.
46. Ahmed, S., Sattar, Z., & Alam, K. A GLOBAL REVIEW OF COUNTRY EXPERIENCES, BANGLADESH: ILLICIT TOBACCO TRADE [Ebook] (pp. 407-437). World Bank Group. Retrieved 16 July 2020, from <http://pubdocs.worldbank.org/en/455291548434730684/WBG-Tobacco-IllicitTrade-Bangladesh.pdf>.
47. World Bank Group, & Global Tobacco Control Program. (2019). Bangladesh Overview of Tobacco Use, Tobacco Control Legislation, and Taxation. worldbank.org. Retrieved 7 July 2020, from <http://documents1.worldbank.org/curated/en/230701560806135545/pdf/Bangladesh-Overview-of-Tobacco-Use-Tobacco-Control-Legislation-and-Taxation.pdf>.
48. Barkat, A., Chowdhury, A., Nargis, N., Rahman, M., Khan, M., & Pk., A. et al. (2012). The Economics of Tobacco and Tobacco Taxation in Bangladesh. International Union Against Tuberculosis and Lung Disease.
49. Tobacco Price and Taxation Policies in Bangladesh: Evidence of Effectiveness and Implications for Action | May 2014 | English - ITC Project. Itcproject.org. (2014). Retrieved 7 July 2020, from <https://itcproject.org/findings/reports/tobacco-price-and-taxation-policies-in-bangladesh-may-2014/>.
50. National Board of Revenue Government of Bangladesh. (2012). Tobacco Taxation in Bangladesh: Administrative and Political Constraints. Singapore. Retrieved from https://www.who.int/tobacco/economics/meetings/wctoh_2012_tob_tax_bangladesh.pdf.
51. John, R., Yadav, A., & Sinha, D. (2018). Smokeless tobacco taxation: Lessons from Southeast Asia. Indian Journal Of Medical Research, 148(1), 46. https://doi.org/10.4103/ijmr.ijmr_1822_17
52. World Health Organization. (2017). WHO report on the global tobacco epidemic, 2017.
53. Nargis, N., Hussain, A., & Fong, G. (2014). Smokeless tobacco product prices and taxation in Bangladesh: findings from the International Tobacco Control Survey. Indian Journal Of Cancer. <https://doi.org/10.4103/0019-509X.147452>.
54. Smokeless tobacco product prices and taxation in Bangladesh: Findings from the ITC survey. (2014), 51(5), 33-38. <https://doi.org/10.4103/0019-509X.147452>
55. The Toll of Tobacco in Bangladesh. Campaign for Tobacco-Free Kids. (2019). Retrieved 9 July 2020, from <https://www.tobaccofreekids.org/problem/toll-global/asia/bangladesh>.
56. JT Group Agrees to Acquire Tobacco Business of Akij Group in Bangladesh. Japan Tobacco International – a global tobacco company. (2020). Retrieved 10 July 2020, from <https://www.jti.com/jt-group-agrees-acquire-tobacco-business-akij-group-bangladesh>.
57. Schmid, T. (2018). Bangladesh Tobacco: Higher Global Visibility. Tobacco Asia. Retrieved 7 July 2020, from <https://www.tobaccoasia.com/features/bangladesh-tobacco-higher-global-visibility/>.

58. Sadeque, T., & Ahmed, K. (2017). P1.01-025 Mass Media and Tobacco in Bangladesh: An Investigation on the Role of Mass Media in the Light of Tobacco Control. *Journal Of Thoracic Oncology*, 12(1), S463-S464. <https://doi.org/10.1016/j.jtho.2016.11.549>
59. Bangladesh Details | Tobacco Control Laws. *Tobaccocontrolaws.org*. (2019). Retrieved 12 July 2020, from <https://www.tobaccocontrolaws.org/legislation/country/bangladesh/aps-regulated-forms>.
60. Bangladesh; The Tobacco Epidemic. *Tobaccofreeunion.org*. (2015). Retrieved 14 July 2020, from <https://www.tobaccofreeunion.org/index.php/where-we-work/priority-countries/bangladesh>.
61. Islam, F., & Walton, A. (2019). Tobacco Smoking and Use of Smokeless Tobacco and Their Association with Psychological Distress and Other Factors in a Rural District in Bangladesh: A Cross-Sectional Study. *Journal Of Environmental And Public Health*, 2019, 1-11. <https://doi.org/10.1155/2019/1424592>
62. GLOBAL ADULT TOBACCO SURVEY. *Who.int*. (2017). Retrieved 15 July 2020, from <https://www.who.int/tobacco/surveillance/survey/gats/fact-sheet-gats-bangladesh-2017.pdf?ua=1>.
63. Tobacco control in Bangladesh. *World Health Organization*. (2015). Retrieved 10 July 2020, from <https://www.who.int/tobacco/about/partners/bloomberg/bgd/en/>.
64. WHO report on the global tobacco epidemic, 2019; Country profile Bangladesh. *Who.int*. (2019). Retrieved 16 July 2020, from https://www.who.int/tobacco/surveillance/policy/country_profile/bgd.pdf.
65. World Bank Group. (2019). Bangladesh Overview of Tobacco Use Tobacco Control Legislation and Taxation [Ebook] (p. 11). Retrieved from <http://documents1.worldbank.org/curated/en/230701560806135545/pdf/Bangladesh-Overview-of-Tobacco-Use-Tobacco-Control-Legislation-and-Taxation.pdf>
66. An Overview of Agriculture in Bangladesh. (2019). Retrieved 28 October 2020, from <https://databd.co/stories/an-overview-of-agriculture-in-bangladesh-4185>
67. Bayes, A. (2018). Slums and poverty. Retrieved 28 October 2020, from <https://www.thefinancialexpress.com.bd/views/slums-and-poverty-1516640099>
68. Nargis, N., Thompson, M., Fong, G., Driezen, P., Hussain, A., & Ruthbah, U. et al. (2015). Prevalence and Patterns of Tobacco Use in Bangladesh from 2009 to 2012: Evidence from International Tobacco Control (ITC) Study. *PLOS ONE*, 10(11), e0141135. doi: 10.1371/journal.pone.0141135
69. World Bank Group. (2019). Bangladesh Overview of Tobacco Use Tobacco Control Legislation and Taxation [Ebook] (p. 11). Retrieved from <http://documents1.worldbank.org/curated/en/230701560806135545/pdf/Bangladesh-Overview-of-Tobacco-Use-Tobacco-Control-Legislation-and-Taxation.pdf>
70. NIPOORT et al. (2014). Bangladesh Urban Health Survey 2013. Dhaka. Retrieved from https://www.researchgate.net/publication/268277899_Bangladesh_Urban_Health_Survey_2013_Preliminary_Results