

# *Executive Summary*

## *Global Adult Tobacco Survey: 2011 GATS, Thailand*

*Bureau of Tobacco Control  
Department of Disease Control, Ministry of Public Health*

*28 May 2012*





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# Executive Summary

## Overview of the survey characteristics

Thailand implemented the Global Adult Tobacco Survey (GATS) in 2009 and 2011, using a standard global protocol. Findings from GATS assist countries in the formulation, tracking and implementation of effective tobacco control interventions. The findings allow for strong exchange of information following the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) Article 20 – research and surveillance and exchange of information, and Article 21 – reporting and exchange of information. Thailand ratified the WHO FCTC on 8 November 2004. The GATS findings also inform the implementation of the WHO MPOWER, a package of six evidence-based demand reduction measures contained in the WHO FCTC include: monitor tobacco use and prevention policies, protect people from tobacco smoke, offer help to quit tobacco use, warn about the dangers of tobacco, enforce bans on tobacco advertising, promotion, and sponsorship and raise taxes on tobacco.

GATS is a nationally representative household survey of all non-institutionalized persons aged 15 years and above. The survey used three-stage stratified cluster sampling and was designed to produce key indicators for the whole country stratified by gender, urban and rural residence, and each of the five regions of the country – Bangkok metropolis, Central, North, Northeast and South – stratified by gender. Data were collected from one selected person in each household using an adapted questionnaire administered using an electronic data collection device.

Primary sampling units (PSUs) in the repeat 2011 GATS were from the same enumeration areas as in the 2009 GATS. In the 2011 GATS, new households were selected from previously sampled PSUs. The 2011 GATS provides information on tobacco use, cessation, second-hand smoke (SHS), economics of manufactured cigarettes and shredded tobacco products, media, knowledge, attitudes and perceptions, and pictorial health warnings. In the 2011 GATS, 21 488 households were screened and 20 606 individuals aged 15 years and above were interviewed; the overall response rate was 96.3%. Field implementation took three months, from 1 October to 30 December 2011. The average time for each interview was 21.9 minutes per respondent.

Implementing organizations conducting the 2011 GATS were the Bureau of Tobacco Control (BTC), Department of Disease Control, Ministry of Public Health, National Statistical Office (NSO), and Faculty of Public Health, Mahidol University (PH-MU). Technical assistance was provided by WHO and the United States Centers for Disease Control and Prevention (CDC).

This report provides key findings from the 2011 GATS and also provides a comparative summary between the two survey rounds.

## Key findings

### **T**obacco use

Overall, 24.0% of adults (13.0 million people) currently smoked tobacco in 2011. More men smoked than women (46.6% vs. 2.6%). Current smoking was reported more often in rural than in urban areas (25.9% vs. 20.3%). The commonly smoked tobacco products were manufactured cigarettes (15.2%, 8.2 million) and hand-rolled

cigarettes (14.4%, 7.8 million). The prevalence of manufactured cigarette smoking was high among persons aged 15–24 years (20.1%), those in urban areas (17.0%), and people in the high socioeconomic status (SES, 19.6%). In contrast, the prevalence of current hand-rolled cigarette smoking was high in rural areas (18.9%), among poor people (17.8% of those with low SES1 (4th quintile of personal monthly income)) and less educated people (22.5% of those with a primary level of education).

Overall, 3.2% (1.7 million people) currently used smokeless tobacco products. Current smokeless tobacco use is more prevalent among women (5.2% for women vs. 1.1% for men), those who were aged 60 years and above (13.6%) and those who lived in rural areas (4.2%). The majority of smokeless tobacco users (1.8%) used betel quid with tobacco, followed by oral snuff (1.3%).

Current tobacco use in any form among Thai people aged 15 years and above was 26.9% (14.6 million people), being 47.2% among men and 7.6% among women. Among current tobacco users, 97.7% of men smoked tobacco products only, while almost two out of three women used smokeless tobacco only (65.8%).

Among daily smokers, 57.7% had their first cigarette of the day within 30 minutes of waking up.

**Comparison:** The prevalence of current tobacco smoking did not show a statistically significant change between 2009 and 2011 among men (45.6% vs. 46.6%, respectively), women (3.1% vs. 2.6%, respectively), and overall (23.7% vs. 24.0%, respectively).

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<sup>1</sup>Socioeconomic status (SES) is defined by personal monthly income quintiles

The main products used were manufactured cigarettes and hand-rolled cigarettes. The prevalence of current manufactured cigarette smoking did not show a statistically significant change between 2009 and 2011 among men (29.6% vs. 30.1%, respectively), women (1.1% vs. 1.1%, respectively), and overall (15.0% vs. 15.2%, respectively). The prevalence of current hand-rolled cigarette smoking also remained at the same level between 2009 and 2011 among men (27.0% vs. 28.1%, respectively), women (1.8% vs. 1.4%, respectively), and overall (14.1% vs. 14.4%, respectively).

Overall, the distribution of the age at initiation of smoking by age remained the same from 2009 to 2011. There were no statistically significant changes in the quit ratio between 2009 and 2011 (28.8% vs. 27.2%, respectively).

### **C**essation

Among current smokers and recent quitters within 12 months, 36.7% made a quit attempt in the past 12 months. The percentage of those who made a quit attempt declined with increasing age, and with decreasing educational and SES level. The percentage of smokers who made a quit attempt did not show a statistically significant difference between men and women (36.5% and 39.4%, respectively) but the percentage of smokers living in urban areas who made a quit attempt was higher than that for smokers living in rural areas (41.3% and 34.7%, respectively). Among current smokers and those who quit within the past 12 months who visited any health-care facility, 65.3% were asked about their smoking behaviour by the health-care provider (HCP) and 55.8% were advised to quit by the HCP. Most smokers (90.7%) who tried to quit did so without any assistance during the past 12 months.

The percentage of those who quit without using any assistance during the past 12 months showed no differences by gender, residence and region.

Among smokeless tobacco users, 16.4% made a quit attempt in the past 12 months. Among current smokeless tobacco users and those who quit within the past 12 months who visited any health-care facility in the past 12 months, 25.1% were asked about their use of smokeless tobacco products and 16.3% were advised to quit smokeless tobacco use by the HCP.

**Comparison:** A statistically significant decline in percentage of smokers making quit attempts during the past 12 months was reported between 2009 and 2011 (49.8% vs. 36.7%, respectively). The decline was found across all age groups, and by all demographic variables including residence, education level and SES.

Among current smokers and those who quit within 12 months who visited any health-care facility in the past 12 months, the percentage of smokers who were asked about their smoking status by the HCP increased from 2009 to 2011 (60.2% in 2009 and 65.3% in 2011). The same trend was found in urban areas (59.2% to 68.4%). However, there was no statistically significant change in advice to quit by HCPs between 2009 and 2011 (51.9% vs. 55.8%, respectively).

## **S**econd-hand smoke

Regarding exposure to second-hand smoke (SHS) in the 30 days preceding the survey, it was found that among workers who usually worked indoors or both indoors and outdoors, 30.5% (4.2 million) were exposed to SHS at their workplaces. Men workers were more likely to be exposed to SHS than women workers (37.1% vs. 22.8%, respectively).

The prevalence of exposure to SHS among workers in rural areas was statistically higher than among those in urban areas (35.2% vs. 25.4%, respectively).

In the last 30 days preceding the survey, the three most common public places of exposure to SHS were markets (68.8%), bars or night clubs (68.4%), and restaurants (46.9%).

About 36.0% (19.5 million people) were exposed to SHS at home at least monthly during the 30 days preceding the survey. A higher prevalence of exposure to SHS at home at least monthly was found among those living in rural areas, among those who had secondary school education or less, and those with a low and middle level of socio economic status (SES).

**Comparison:** The prevalence of exposure to SHS at home at least monthly showed a statistically significant increase from 2009 to 2011 (33.2% to 36.0%, respectively). The prevalence of exposure to SHS at indoor workplaces did not show a statistically significant change between 2009 and 2011 (27.2% vs. 30.5%, respectively). Public places where the prevalence of exposure to SHS showed a statistically significant increase from 2009 to 2011 were health-care facilities (4.8% vs. 7.3%, respectively) and public transportation (21.6% vs. 25.6%, respectively). The prevalence of exposure to SHS in markets did not show a statistically significant change (69.3% vs. 68.8%, respectively) during this period.

## **E**conomics

Among current smokers of manufactured cigarettes, 47.3% purchased their last cigarettes as individual sticks. Of the top five cigarette brands, two were inexpensive brands (approximately 30–45 Thai Baht [THB]/pack) of Thailand Tobacco Monopoly (TTM), accounting for 35.3% of purchased brands.

The median amount spent on 20 manufactured cigarettes was THB 58, while the median monthly cigarette expenditure was THB 585.5, accounting for 9.7% of monthly personal income. Expenditure on shredded tobacco products (THB 37.5 per month) was considerably lower than expenditure on manufactured cigarettes. Most cigarette smokers (88.3%) bought cigarettes from grocery stores. Among current manufactured cigarette smokers, 4.8% reported that the last cigarette pack they purchased did not exhibit pictorial health warnings (PHWs). This percentage was highest in the Southern region (18.5%), suggesting increased occurrence of tax avoidance in that region.

**Comparison:** The median price paid per 20 manufactured cigarettes increased from THB 45.0 in 2009 to THB 58.0 in 2011. The affordability decreased slightly since the relative income price (price paid per 2000 cigarettes as a fraction of annual per capita gross domestic product [GDP]) slightly increased from 3.4% to 3.6%. The percentage of youth aged 15–17 years buying manufactured cigarettes as individual sticks remained high (84.3% in 2009 vs. 88.3% in 2011).

TTM responded to the 2009 increase in cigarette excise taxes by introducing a new inexpensive cigarette brand (approximately 30 THB/per pack) after 2009. Consequently, the percentage of smokers who purchased inexpensive TTM cigarette brands increased from 20.0% in 2009 to 35.3% in 2011 among the top five most popular brands. Furthermore, it was found that the percentage of cigarette packs purchased without PHWs statistically significantly increased from 2.6% to 4.8%. This suggests that tax avoidance may have intensified after the 2009 tax increase.

## **Media**

Anti-smoking information was noticed by 81.2% of people in the past 30 days, mostly on television (68.1%), and 25.7% of people noticed any tobacco advertisement, promotion and sponsorship (TAPS). Differences were observed by gender (28.5% of men and 23.1% of women), residence (29.4% of urban areas and 23.7% of rural areas), and age group (34.2% of those 15–24 years old and 23.7% of those aged 25 years and above). Advertisements noticed were mainly in stores where cigarettes are sold (18.2%), and were mostly displays of cigarette brands and cigarette packages.

Among current smokers, 94.6% noticed coloured pictorial health warnings (PHWs) on cigarette packages, and 62.6% of those who noticed PHWs thought about quitting smoking because of the PHWs. Among shredded tobacco users, 75.2% noticed black and white PHWs on shredded tobacco packages and 49.5% of those who noticed the PHWs thought about quitting smoking because of the PHWs.

**Comparison:** Current smokers who were exposed to anti-smoking information in any location statistically significantly decreased from 86.9% in 2009 to 81.2% in 2011. In contrast, those who were exposed to any TAPS statistically significantly increased from 17.8% to 25.7%. There was also a statistically significant increase in those who noticed advertisements in stores where cigarettes are sold (from 6.7% in 2009 to 18.2% in 2011).

The percentage of current smokers who noticed health warnings on cigarette packets did not show a change (93.0% in 2009 and 94.6% in 2011). However, those who thought about quitting smoking because of the PHWs statistically significantly decreased from 67.0% in 2009 to 62.6% in 2011.

### **K**nowledge, attitudes and perceptions

Of all people, 97.0% believed that smoking causes serious illnesses. For each specific disease, the percentage of people who believed that smoking causes lung cancer was the highest (97.8%) and bladder cancer was the lowest (48.1%). In addition, 94.2% of people believed that exposure to SHS causes serious illness; the percentage of people who believed that SHS causes lung cancer was highest (91.2%) and premature birth was the lowest (58.6%). About one third (34.3%) believed that smoking hand-rolled cigarettes was less harmful than smoking manufactured cigarettes.

**Comparison:** The percentage of people who believed smoking causes serious illness decreased slightly (98.6% in 2009 and 97.0% in 2011). The percentage of people who believed that exposure to SHS causes serious illness also remained high (94.9% and 94.2%, respectively). Those who thought that smoking hand-rolled cigarettes

was less harmful than smoking manufactured cigarettes statistically significantly decreased from 2009 to 2011 (38.1% to 34.3%, respectively).

### Policy implications

The findings of the 2011 GATS and the comparisons between the two surveys (2009 and 2011) have provided critical information on key indicators of tobacco control by selected demographic characteristics. This creates an opportunity for policy-makers and the public health community to modify interventions, scale up and accelerate implementation of tobacco control programs and policies at the national, regional and local levels. Following are a set of recommendations based on WHO MPOWER strategies:

**M:** Monitor tobacco use and preventive and protective policies. The policy goal is to decrease the prevalence of tobacco use by the following means:

- a. Seek and intensify cooperation and commitment of all offices and organizations working for children and youth in the community to limit their accessibility to tobacco;
- b. Systematically develop the process of monitoring violation of the tobacco control legislation and acts and interference by the tobacco industry at the national and local levels through active participation of civil society.
- c. Launch campaigns to create awareness consistently and continuously through social and community networking.
- d. Continue systematic monitoring of tobacco use and key tobacco control measures through national surveys and also integrate standard tobacco questions into ongoing surveys.

**P:** Protect people from tobacco smoke. The policy goal is to decrease exposure to SHS in workplaces and public places, which shall be smoke free by law:

- a. Strengthen the existing policy and its compliance through amendments in the Non-Smoker's Health Protection Act, 1992, especially with regard to enforcement such as clear demarcation of the roles and responsibilities of law enforcers and penalty adjustments for effective law enforcement (e.g., business, entertainment complex, etc).
- b. Strengthen the education, training and communication programme to raise public awareness of exposure to tobacco smoke and compliance with smoke-free laws, especially among rural populations, disadvantaged groups, owners/managers of public places and workplaces.

**O:** Offer help to quit tobacco use. The policy goal is to increase the number of quitters through the following:

- a. Improve the systematic tobacco use cessation service:
  - Regularly build the capacity of HCPs at different levels of the health-care facilities to provide cessation services.
  - Integrate effective cessation approaches with routine work in primary health-care services, particularly 100% use of at least 2As (ask and advise).

- Increase the outreach capacity of the national “Quitline 1600” to serve the maximum number of people who desire to quit.
  - Set up an effective referral system for smoking cessation.
- b. Increase media campaigns to make people realize the value of a smoke-free life, especially for younger smokers.

**W:** Warn about the dangers of tobacco. The policy goal is to increase the effectiveness of PHWs by doing the following:

- a. Revise the Tobacco Control Product Act, 1992 to conform to the following requirements for PHWs:
- Extend colour PHWs to all forms of tobacco products, especially shredded tobacco used for hand-rolled cigarettes and smokeless tobacco.
  - Update and refresh the PHWs every two years with the aim of sustaining the impact of the health warning message.
  - Use clear, simple, direct warnings and well-defined pictures. These need to be recognizable and easily identifiable.
  - Use simple language in the text to influence readability, help understanding and lessen confusion.

- Increase the size of the PHWs to promote visibility and noticeability, and consider adopting plain packaging instead of the PHWs to restrict or prohibit the use of logos, colours and brand images on packaging.
- b. Integrate pack imagery for use in other media (e.g. TV and social media). It would reinforce the warnings and heighten the impact in general.

**E:** Enforce bans on tobacco advertising, promotion and sponsorship. The policy goal is to decrease exposure to TAPs by the following means:

- a. Amend the Tobacco Control Product Act, 1992 according to the international guideline of the WHO FCTC 13 and ensure comprehensive tobacco control legislation.
- b. Develop systematic monitoring on interference by the tobacco industry to determine the magnitude of interference.
- c. Ensure effective and vigorous law enforcement to eliminate advertising by the tobacco industry.

**R:** Raise taxes on tobacco. The policy goal is to decrease the accessibility of tobacco products, especially among minors, by the following methods:

- a. Advocate to authorized organizations and the Ministry of Finance to effectively implement tobacco taxes on all kinds of tobacco products.
- b. Formulate effective strategies to prohibit the sale of cigarettes in loose form nationwide. For example, increase the level of public concern about selling cigarettes in loose form to minors and strictly enforce the law on any store that sells cigarettes in loose form. Strengthen and generate awareness among the community to monitor stores where cigarettes are sold to ensure that minors cannot access tobacco products.
- c. Strengthen public policy and advocacy among political leaders and decision-makers to obtain strong commitment to supporting tobacco control policies such as tax measures for increasing the price of tobacco products and eliminating the sale of illicit cigarettes.
- d. Increase the tax on all kinds of tobacco products, especially shredded tobacco products.





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