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# 1 Overview

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Countries around the world are grappling with difficult public health challenges and policy decisions. Disease and death caused by tobacco use, once a problem mainly in high-income countries, have become a large and increasing part of the burden of disease in developing countries.

According to the most recent estimate by the World Health Organization (WHO), 4.9 million people worldwide died in 2000 as a result of their addiction to nicotine, about half of them prematurely (WHO 2002). This huge death toll is rising rapidly, especially in low- and middle-income countries, where most of the world's 1.2 billion tobacco users live. As shown in figure 1.1, developing countries already account for half of all deaths attributable to tobacco. The proportion will rise to 7 out of 10 by 2025 because smoking prevalence has been increasing in many low- and middle-income countries even as it is falling in richer countries, especially among men. Developing countries also account for about half of the world disease burden related to tobacco (figure 1.2). And tobacco use has far-reaching indirect effects on human health and the economy, in addition to the direct harm it causes.<sup>1</sup>

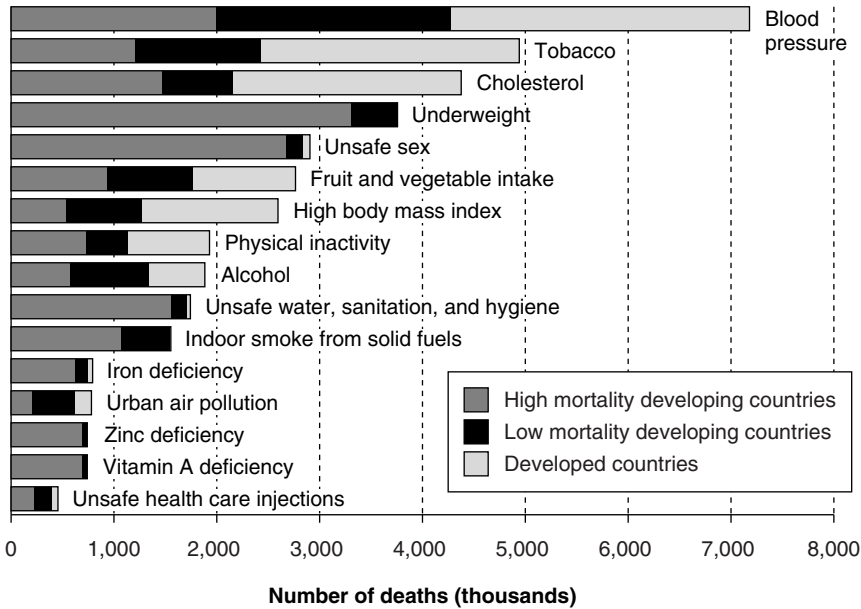
But the course and pattern of this epidemic can be changed. The policies that are effective in encouraging tobacco users to quit and dissuading young people from starting are well known and proven. Many countries have managed to change behavior, reduce the prevalence of tobacco use, and ease the burden of tobacco-related disease and death. This book describes recent struggles, successes, and setbacks in six countries on six continents, where the efforts of public health practitioners, researchers, activists, policymakers, politicians, and the press have achieved sound tobacco control policies even in the face of enormous opposition from those who profit from these deadly products.

Reducing the devastating health damage caused by tobacco use is especially difficult because of nicotine's powerful addictive properties,

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1. For studies on the prevalence of tobacco use and on the associated health and economic effects, see, for example, Murray and Lopez (1996); WHO (1997); World Bank (1999); Corrao and others (2000); Jha and Chaloupka (2000); and Mackay and Eriksen (2002).

**Figure 1.1. Deaths Attributable to Selected Leading Risk Factors, Worldwide, 2000**



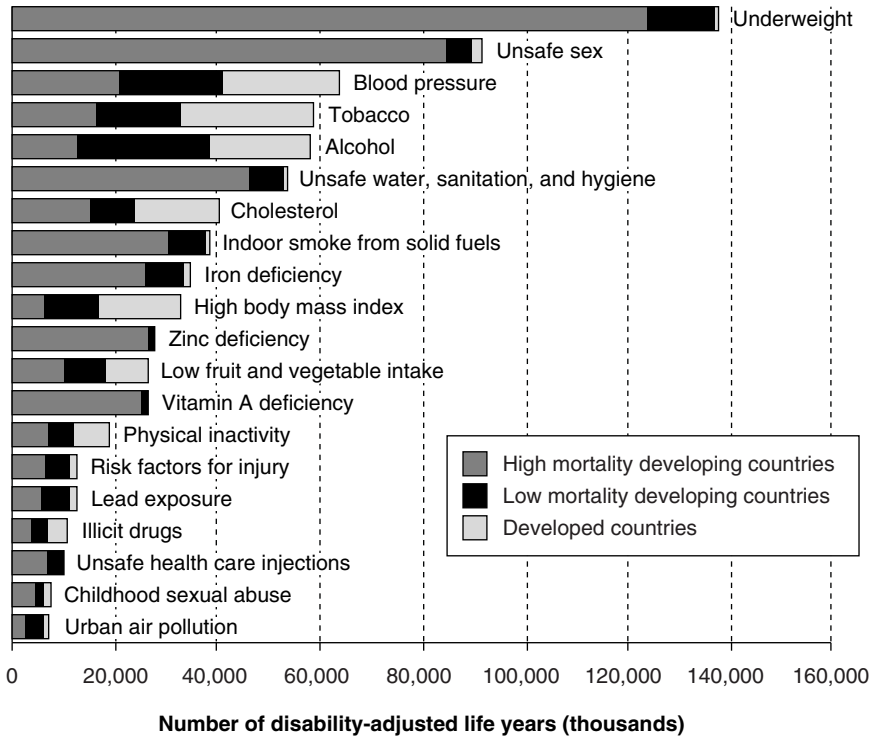
Source: WHO 2002.

low prices for tobacco products, well-established social norms, and constant inducements to smoke, fueled by billions of dollars worth of tobacco industry advertising and promotion. Low prices and advertising can be countered by policies that raise taxes on tobacco products and outlaw all advertising and promotion of these products. Such policies are likely to have an even stronger effect in reducing tobacco use if complemented by good public information on the associated health risks (for instance, through strong, large warnings on cigarette packs), by bans on smoking in public spaces, and by advice and help to people who want to quit.

### Why These Six Countries?

The six countries whose stories are told in this book—Bangladesh, Brazil, Canada, Poland, South Africa, and Thailand—are at very different stages of development and of the tobacco epidemic (see table 1.1). Brazil and Bangladesh are two to six times more populous than any of the other four countries. With regard to wealth and social indicators such as child malnutrition and illiteracy rates, Canada, a developed country, is at one extreme and Bangladesh at the other. Life expectancy at birth is consider-

**Figure 1.2. Disease Burden Attributable to Selected Leading Risk Factors, Worldwide, 2000**



Source: WHO 2002.

ably higher in Canada than in any of the other countries; it is lowest in South Africa, as a result of the ravages of AIDS.

The six countries also differ in the strength and history of their tobacco control policies and in the extent to which they are succeeding in reducing tobacco use. The share of adult men who regularly use tobacco is around 40 percent in five of the countries. In Canada it is substantially lower, 27 percent, down from a peak of 60 percent in 1960 (Smoking and Health Action Foundation 2000). Male smoking prevalence has fallen significantly in three of the other countries: in South Africa, from well over 50 percent in the early 1990s to 42 percent in 1998 (Corrao and others 2000; van Walbeek 2002); in Thailand, from 49 percent in 1986 to 38 percent in 1999 (Vateesatokit et al 2000); and in the most dramatic case, that of Poland, from peak levels of 65–75 percent in the mid-1970s to 39 percent in 1998 (Corrao and others 2000). It is no coincidence that, as table 1.1 shows, compared to the other middle- and high-income countries, cigarettes are (relatively) the

**Table 1.1. Indicators of Development, Tobacco Use, Health Impact, and Cigarette Prices in Six Countries**

<i>Indicator</i>	<i>Bangladesh</i>	<i>Brazil</i>	<i>Canada</i>	<i>Poland</i>	<i>South Africa</i>	<i>Thailand</i>
<b>General</b>						
GDP per capita, 2001 (U.S. dollars)	370	3,060	21,340	4,240	2,900	1,970
Population, 2001 (millions)	133.4	172.5	31.0	38.6	43.2	61.2
Life expectancy at birth, 2000	61	68	79	73	48	69
Percentage of children under 5 malnourished <sup>a</sup>	48	6	0	0	9	19
<b>Illiteracy (percent)</b>						
Adult women	69	14	0	0	15	6
Adult men	47	15	0	0	14	3
<b>Tobacco use by adults</b>						
<i>Percentage of adults who are regular users<sup>b</sup></i>						
Men	40	38	27	39	42	38
Women <sup>c</sup>	10–(50?)	29	23	19	11	2
Per capita annual cigarette consumption <sup>d</sup>	245	1,802	1,976	3,291	1,516	1,067
<b>Health impact</b>						
<i>Lung cancer rate per 100,000 population<sup>e</sup></i>						
Male	79	45	79	162/510	100	21
Female	12	14	34/77	43	24	7

Table 1.1. continued

Indicator	Bangladesh	Brazil	Canada	Poland	South Africa	Thailand
<i>Lip, mouth, and pharynx cancer rate per 100,000 population</i>						
Male	65	15	9	19/26	47	3
Female	49	3	3/6	4	9	2
<i>Cigarette prices, March 2001</i>						
Local brand (U.S. dollars)	0.83	0.80	2.88	1.13	1.34	0.69
Imported brand (U.S. dollars)	1.26	0.85	3.40	1.51	1.34	1.26
Minutes of labor to buy pack of local brand of cigarettes	106	17-18 <sup>f</sup>	16-17 <sup>g</sup>	40	20	23
Minutes of labor to buy 1 kilogram of rice	76-89 <sup>h</sup>	11-13	9-11	23	9	14
Minutes of labor to buy a Big Mac hamburger	435 <sup>i</sup>	36-45	13-14	54	19	43

a. Less than 2 standard deviations below international reference median weight for age.

b. For Bangladesh, Poland, and South Africa, data are for 1998; for Brazil, 1995; for Canada and Thailand, 1999.

c. About 10 percent of adult Bangladeshi women smoke cigarettes, but many more chew tobacco. There is no national statistic on chewing prevalence, but one nongovernmental organization, Navipokho, estimates it at about 50 percent among adult women, which would be similar to India's rate.

d. For Bangladesh, Canada, Poland, and Thailand, data are for 1995; for Brazil, 1990; for South Africa, 1997.

e. Cancers of trachea, lung, and bronchus. Data are for adults age 35 and older (Brazil and Thailand) or 45 and older (Bangladesh and South Africa), and 45-64/65 and older (Poland). For Canada, oral cancers include cancers of the tongue, gum, mouth, and pharynx, and are for all ages, 1999. Lung cancer data for Canada are also for all ages.

f. Data are for Rio de Janeiro and São Paulo.

g. Data are for Montreal and Toronto.

h. Range is 76 for coarse rice, 89 for medium rice.

i. Big Macs are not sold in Bangladesh; this is for a comparable "Wimpy" Hamburger.

Source: World Bank 2002; Corrao and others 2000; Guindon, Tobin, and Yach 2002; Health Canada; Cancer Institute and Center (Warsaw); Bangladesh Bureau of Statistics.

least affordable in Poland, where a person earning the average wage must work for about 40 minutes to earn the price of a pack of cigarettes—roughly twice as long as in the other four countries in the same or high income category (Guindon, Tobin, and Yach 2002). In Bangladesh, very low wage rates make cigarettes least affordable of all the countries, even though the prices (of local brands) are among the lowest.

This is a very heterogeneous group of countries. But there is a common thread: all six have achieved notable successes in tobacco control policymaking by building advocacy on sound research and evidence. Their stories exemplify important features of policymaking, particularly the significant role that can be played by determined individuals and by civil society groups.

The stories make it clear that there is no magic formula. Instead, they tell of policy entrepreneurs (Kingdon 1995)—both individuals and groups—willing to champion the issue; of politicians committed to public health and to placing tobacco control on the policy agenda; of researchers who have published and publicized compelling national or international data; and of national, regional, and international political, social, economic, and policy environments that supported action on this important issue.

Many other countries, or states and provinces within countries, have achieved admirable successes in tobacco control policymaking and could have been included in this book, were it not for the limitations of space. We hope that the inspiring experiences of other countries will be related elsewhere.

Each country included in this book has some extraordinary accomplishments in tobacco control policy and its own particular strengths. In Bangladesh systematic, concerted, and methodical efforts by nongovernmental organizations (NGOs) provide a model of very low-budget but effective advocacy against what seemed to be impossible odds. In Brazil, by contrast, persistent action led from within the government resulted in strong legislation and a nationwide, decentralized program, with training and support cascading down the levels of government.

Canada has long been a world leader in tobacco control legislation, taxation, and health warnings, backed by strong citizen and political support. It provides a model of coalition building among civil society groups that resulted in well-planned, systematic advocacy initiatives.

In Poland and South Africa dramatic political and social change created new environments and policy windows that public health advocates were able to turn to their advantage. In the 1990s these countries enacted, relatively quickly, strong, comprehensive legislation—in both cases, in two legislative steps, with a second law strengthening the first. Both countries began with policies to better inform consumers and to restrict smok-

ing and advertising. At a later stage, tax increases were put in place and helped reduce consumption. Each country had strong, charismatic champions who helped drive the issue, through undaunted, persistent efforts over many years. And in both countries the availability of strong local research evidence, especially on the economic implications of tax increases, was enormously important.

In Thailand, as in Bangladesh, an NGO played a pivotal role. Tobacco control policy has been significantly influenced by strong advocates in the health sector with direct access to government officials, some of whom showed great political courage, integrity, and commitment to serving the best interests of the Thai people.

Although all of the stories describe setbacks and disappointments, none of them dwells on mistakes made or opportunities missed, or on what could have been done better. There are lessons to be learned from both the successes and the setbacks in each country. The stories describe how advocates and policymakers changed their strategies in certain countries as they learned from their mistakes and built on their achievements.

### **What Factors Made the Difference?**

Although each country's situation and story is unique, there are commonalities across the six countries—lessons and experiences that are also applicable in other contexts.

- In each case, legislative successes were won in the face of vigorous opposition from a tobacco industry striving to defend its profits and market. Sometimes the legislation was weakened or delayed or its implementation was inhibited. Compromises had to be made, but these sometimes paved the way for stronger follow-up laws a few years later.
- Time and again, a key role was played by NGOs and by individuals—often very charismatic people—who showed extraordinary commitment and dedication. Through their knowledge and perseverance, they became credible spokespersons for their cause and won the ear of policymakers.
- Coalitions of individuals and organizations brought new skills and perspectives to bear on the issue. Broad-based groups such as consumers' rights groups, development agencies, women's rights activists, lawyers, and religious organizations made important contributions. Personal and institutional objectives and prestige were sometimes set aside for the sake of achieving common goals. Groups had to grapple with the organizational and relationship issues that are part of maintaining a smoothly functioning coalition. Not all coalitions survived.

- Effective advocacy has to be learned. Tobacco control advocates found that change is a slow, evolutionary process; they learned to expect setbacks and make use of them to turn defeats into victories; to take advantage of favorable opportunities as they arose, developing rapid-response, short-term strategies as well as long-term goals; and to be creative in seeking allies. Not least, they learned about the need for optimism and for a continuous, sustained effort.
- While much can be done with little money if funds are used wisely, lack of an organizational home and a minimal level of financial resources can make it hard to operate effectively. Working collaboratively with national and international agencies can help provide access to sustained, if limited, resources.
- Strong political support and political champions are absolutely crucial to success. At times, political champions have had to persuade and win over (or prevail over) their own colleagues. Public opinion polls have been influential in some countries, demonstrating to politicians clear popular support for strong policies to protect children and adults from the harm caused by tobacco use.
- Amazing transformations in social norms can occur, spurred by changes in legislation, shifts in the socioeconomic context, and better public information. This is starkly evident to anyone who choked through meetings in smoke-filled rooms in Poland in the late 1980s and has had the pleasure of visiting Poland again in recent years and enjoying smoke-free meetings and meals. The media can have a powerful effect in influencing popular opinion and paving the way for legislation. Legislation both reflects and reinforces—or institutionalizes—changing social norms.
- An understanding of the political framework and the legislative timetable of the country contributes to effective advocacy. That understanding might involve knowing when to intervene and whom to target; cultivating legislators who are favorably disposed to an issue; or recognizing when an idea's time has come and responding swiftly with information and advocacy.
- Legislation must be coupled with strong attention to implementation and enforcement. This can be an even greater challenge than getting the legislation through with its teeth intact. Often, legislation is only a first step, and regulations or further actions are required before provisions can be implemented and take effect.
- Sound research and evidence are extremely important as a basis for good policy decisions. Evidence and research findings from other countries can be compelling, but there is also likely to be a need for strategic, selective local studies and data, presented concisely and graphically. Building, publishing, and widely publicizing a solid infor-

mation base proved enormously useful to policymakers and advocates and helped promote changes in public attitudes and awareness that gradually led to changes in social norms in several countries.

- Tobacco control policies and strategies must be comprehensive. It is now well recognized that single initiatives are not enough; real impact comes from a combination of education and information, legislation, taxation, community action, professional involvement, prevention and cessation programs in various settings, prohibitions on smoking in public places, and complete bans on advertising and promotion of tobacco and tobacco brands.
- Strong, effective tobacco control policy that includes tax increases and complementary health promotion efforts relies on success in bringing together diverse interest groups and finding common ground. This is especially important with regard to the ministries of health and finance, whose objectives of sound fiscal management and better public health outcomes can both be furthered by tobacco tax increases.
- Not all policymakers were won over by data on tobacco-related morbidity and mortality. In Bangladesh reframing the issue to focus on the contribution of tobacco use to malnutrition was what captured the attention of policymakers. Donor agencies may be more interested in and willing to support tobacco control to the extent that it contributes to and relates to broader development issues.
- Not long ago, in some countries, the situation seemed hopeless. Efforts by poorly funded public health groups were opposed by tobacco companies with powerful political connections and deep pockets. Social norms favored smoking, and many people were skeptical about or even hostile to tobacco control efforts. But, as in Canada, public health proponents discovered that “seemingly irresistible forces within the tobacco industry could be successfully challenged by effective advocacy” (Sweanor and Kyle, ch. 4 in this volume).
- Persistence is essential. Never give up.

## The Big Picture

Each country profiled in this book has recorded great progress and substantial achievements in tobacco control policy. But in none of them is victory assured, and in none has the war against misinformation, ignorance, addiction, preventable disease, and premature death been won. Smoking still claims too many lives, and too many teenagers are enticed into trying “just one” and then another, starting what will become a deadly addiction that most will regret ever taking up and will later struggle to break.

This is an important time—perhaps a watershed—in the history of tobacco control policy and of efforts to curb the epidemic caused by

tobacco use. The negotiations for an international Framework Convention on Tobacco Control (FCTC) have provided an important forum and process, enabling each of the 165 participating countries to weigh competing national interests carefully and decide how strongly committed they are to measures that can improve health outcomes by reducing tobacco use. The challenge that lies ahead for countries is to ratify the FCTC and to strengthen national legislation, policies, and programs and international cooperation to reduce tobacco use.

Sometimes the discussion about tobacco control is framed as health versus economics, with people conceding the harm that tobacco does to health but emphasizing the economic contributions of the tobacco industry in the form of jobs, incomes, exports, and tax revenues. The relative economic importance of the tobacco industry, however, is often exaggerated, and the economic costs of tobacco should also be considered. These costs include the direct and indirect costs of medical care; the loss of productivity and earnings as a result of tobacco-related illnesses and deaths; environmental degradation caused by pesticides and the use of firewood for curing tobacco; and fires caused by lit cigarettes and matches.

Perhaps most insidious is the harm done to poor smokers and their families by the diversion of scarce family income to buy tobacco products. The chapter on Bangladesh presents detailed data on the opportunity cost of tobacco purchases, comparing the cost of cigarettes with the costs of food staples that the money spent on cigarettes might have bought—this in a country where perhaps half of all adults smoke or chew tobacco while nearly half of all children under five are malnourished. As Efroymsen and others (2001) have shown, “Each tobacco user represents one or more people—whether the smoker or his or her spouse or child—who is needlessly going hungry.” Although this situation is not well documented in many other countries, it is certainly not unique to Bangladesh; for example, women in a poor village in Sri Lanka said that cigarettes were the leading cause of poverty in their village (Skolnik 2003). National surveys of household expenditure find that in Egypt and India 2 to 3 percent of all household expenditures go for tobacco products; in South Africa, families that include at least one smoker and that are in the lowest income quartile spent 4.7 percent of their income on cigarettes in 1995 (Basheer 1993; van Walbeek 2000; Sayginsoy 2002). For families living on the edge of poverty, even small amounts can make an enormous difference to family well-being.

It is thus misleading to frame the tobacco control debate as “health versus economics.” Tobacco generates income for some but entails large costs for others. Tobacco control is clearly key to promoting health and preventing unnecessary deaths, and it can be achieved in the context of

sound economic and social policies, without harming economies. Brazil's discussions with tobacco farmers and its initiatives to work with them are a case in point.

Tobacco is clearly much more than a health issue; it has significant economic implications and can have an impact on economic development. Improvements in health can contribute to sustained and substantial improvements in social and economic well-being, as the WHO Commission on Macroeconomics and Health (2001) recently emphasized. Conversely, poor health can undermine social and economic development. The broader development issues relating to tobacco and its control have been much discussed in the FCTC deliberations. The FCTC has the potential to provide a common framework allowing countries to move ahead together to reduce tobacco use, mindful both of those—particularly among the poor—who will benefit and of those whose livelihoods may be jeopardized if national and global markets for tobacco decline.

Global partnerships, both explicit and implicit, can work to the common good of citizens in all countries. There is great value in comparing notes with other countries, learning from their successes and mistakes, and borrowing their data. Governments often hesitate to step out ahead of the pack but can be emboldened by the actions of others, as shown by the domino effect of changes in tax policy, advertising bans, and the recently introduced large pictorial health warnings on cigarette packs.

We hope that this book will help inspire and inform tobacco control activists, public health practitioners, policymakers, and citizens who care about their health and the futures of their children, so that more can be done to reduce the harm that tobacco does to health and lives around the world.

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