Nearly 20% of the world’s population smokes cigarettes, including about 400 million men and 200 million women. An estimated 600,000 individuals die annually from secondhand smoke, and 75% of these deaths are among women and children. More than half the countries of the world have a female smoking prevalence rate of less than 10%. Smoking rates between boys and girls differ by less than five percentage points in almost half of the world’s countries. Smokers consumed nearly 5.9 trillion cigarettes in 2009. Tobacco is grown in 124 countries, occupying 3.8 million hectares of agricultural land. China grows 43% of the world’s tobacco, which is more tobacco than the other top nine tobacco-producing countries combined. Annual revenues from the global tobacco industry are approaching half a trillion dollars. Cigarettes account for 92% of the value of all tobacco products sold globally. The amount of smokeless tobacco sold globally increased by 59% between 2000 and 2010. If illicit trade were eliminated, governments worldwide would gain at least $31.3 billion a year in tax revenue. Governments collect nearly $133 billion in tobacco tax revenues each year, but spend less than $1 billion on tobacco control. WHO recommends that at least 70% of the retail price of tobacco products come from excise taxes. At least 86% of WHO Member States imposed a tobacco excise tax, and at least 14% use a portion of tobacco tax revenue for health purposes. Some countries are now envisioning an end game for tobacco, with prevalence targets of under 5%. The WHO FCTC covers 87.4% of the world population. Approximately 2.8 billion people are covered by at least one MPOWER measure at the highest level of achievement. The number of people protected by comprehensive smoke-free laws has doubled from 2008 to 2010. A comprehensive ban on all tobacco advertising, promotion, and sponsorship could decrease tobacco consumption by about 7%.

TOPICS INCLUDE
- The harm caused by tobacco
- Global smoking prevalence
- Electronic and other emerging nicotine delivery systems
- Affordability of cigarettes
- Global smuggling of tobacco use
- Cross-border trade
- Illicit trade and the black market
- Public health strategies to reduce tobacco use

Since the first publication of The Tobacco Atlas a decade ago, almost 50 million additional people have been killed as a result of using tobacco, and more than 43 trillion cigarettes have been smoked. If trends continue, 1 billion people will die from tobacco use in the 21st century. Mere lists of statistics cannot fully express the immensity of the tobacco epidemic. To understand its complexity and global reach requires an all-encompassing view that is compelling and easily comprehensible, such as that presented here in The Tobacco Atlas, Fourth Edition.

Ten years ago, the groundbreaking first edition of The Tobacco Atlas appeared as the world prepared to take united action against tobacco. Since then, clean air laws, advertising bans, tobacco taxes, and the WHO Framework Convention on Tobacco Control have altered the landscape, proving it was possible to defy the industry and reduce tobacco use if strategies were properly applied.

This all-new fourth edition expands upon the qualities that made the original an essential tool for understanding the tobacco epidemic. Full-color maps and striking graphics present carefully researched and sourced data in a clear, accessible format. Produced by a global collaboration of scientists and researchers, this easy-to-understand compendium of facts provides a compelling survey of the tobacco trade and its financial and human costs—and what can be done to avert a global health catastrophe.

Michael Eriksen
Judith Mackay
Hana Ross
The first and pioneering edition of *The Tobacco Atlas* was published by the World Health Organization in 2002. The words of previous WHO Director-General Dr. Gro Harlem Brundtland still resonate today: “Let us all speak out: Tobacco is a killer. It should not be advertised, subsidized or glamorized.” Her foreword in the first edition was a clarion call to develop the WHO Framework Convention on Tobacco Control (WHO FCTC), which at the time was several years in the future, and to build a “vibrant alliance with other UN agencies, NGOs, the private sector, academic/research institutions, and donors.”

Many of these ambitions have been achieved, for example:

- **2005:** The WHO FCTC entered into force.
- **Today the WHO FCTC has 174 Parties.**
- **2011:** The United Nations High-Level Meeting on noncommunicable diseases (NCDs) prevention and control recognized tobacco control as a key factor in reducing the rise of NCDs. WHO provides the secretariat for taking the meeting’s Political Declaration forward, liaising with other UN agencies to develop voluntary targets for 2025.

To help countries fulfill some of their WHO FCTC obligations, WHO has highlighted the good and best buys for reducing tobacco use—the MPOWER package of six cost-effective measures that reduce the demand for tobacco. As a result of decisive action taken by many countries around the world, 1.1 billion people have become covered over the past two years by at least one of these measures newly applied at the highest level.

All four editions of *The Tobacco Atlas* have utilized published data from WHO sources, especially from the WHO *Report on the Global Tobacco Epidemic*, and the newly available tobacco attributable mortality data. In addition, the atlases contain data from the Global Tobacco Surveillance System (GTSS), the Global Youth Tobacco Survey (GYS), Global School Personnel Survey (GSPS), Global Health Professions Student Survey (GHPSS), and Global Adult Tobacco Survey (GATS), a joint venture between WHO and the United States Centers for Disease Control and Prevention (CDC)—an example of a successful partnership in monitoring the tobacco epidemic.

The battle is far from being over. Unless the prevalence of smoking is reduced substantially, the number of smokers will increase in the world in the next several decades, mostly due to population expansion in low- and middle-income countries. Measures to tackle the epidemic remain seriously under-funded. As the subtle promotion of their lethal products under the appearance of “socially responsible causes or business practices” is becoming exposed, the tobacco industry has adopted newer and bolder tactics to undermine and counteract tobacco control measures by means of legal challenges to tobacco control legislation, as well as using bilateral trade agreements to challenge strong laws. Big tobacco can afford to hire the best lawyers and PR firms that money can buy. Big money tries to speak louder than any moral, ethical, or public health argument and wants to trample even the most damning scientific evidence. I urge all countries to stand firm together and not to bow to pressure. We must never allow the tobacco industry to get the upper hand.

I would like to see a united world that no longer accepts the detrimental health and economic effects of tobacco, recognizing that tobacco control and the full implementation of the WHO FCTC are good for the health and wealth of nations.

Margaret Chan, Director-General, WHO, 2012

Margaret Chan
Director-General, World Health Organization
Every six seconds, someone somewhere in the world dies because of tobacco use. Unless concerted global action is taken, that rate of death will accelerate. At the recent United Nations High-Level Meeting on noncommunicable diseases (NCDs) in New York City, government leaders acknowledged tobacco use to be the single most preventable cause of death in the modern world, yet no firm targets were set to help tackle this global pandemic.

We must act now. If we don’t, tobacco will claim 1 billion lives during this century. But the good news that solutions exist to combat this deadly pandemic. The MPOWER package of proven measures outlines six effective steps over the past several years. The policies have been increasingly implemented by governments around the world. In the global fight against tobacco, information is one of our most powerful weapons. The Tobacco Atlas is an invaluable resource for collating our current knowledge about tobacco and demonstrating the true nature of this global pandemic. For example, The Tobacco Atlas notes that more than 80 percent of the world’s population remains unprotected from comprehensive smoke-free laws. We can use the Atlas to educate consumers and health-care professionals about the risks of tobacco use, to unveil misinformation, to share successful tobacco control strategies, and to push for legislation that optimally protects the world’s citizens from the harms of tobacco use.

I encourage advocates, policymakers, health-care professionals, journalists, and commentators to carefully review the contents of The Tobacco Atlas and use the information to push for action.

Michael Bloomberg
Philanthropist and Mayor of New York City, US

With the tenth anniversary of The Tobacco Atlas, it’s a good time to reflect on the accomplishments we’ve made in this fight and to hone in on ways we can continue to make progress.

John R. Seffrin and Peter Baldini
US

Tobacco is the only legal product that when used as directed, is lethal. Its influence extends into all corners of the globe, threatening lives and livelihoods and endangering the health and prosperity of developed and developing nations alike. Left unchecked, tobacco is projected to kill more than 8 million people globally each year by 2020—and to take a staggering 1 billion lives in this century.

The good news is we know how to stop this deadly epidemic—and we have proven successes doing so. We simply must educate, raise awareness, and implement these strategies worldwide. With the tenth anniversary of The Tobacco Atlas, it’s a good time to reflect on the accomplishments we’ve made in this fight and to hone in on ways we can continue to make progress. We have seen many tobacco control milestones in the past decade, but there is still much to do, particularly in low- and middle-income countries, home to 85 percent of the world’s population. A substantial victory came in 2010 with the World Health Organization’s unanimous adoption of the Framework Convention on Tobacco Control (WHO FCTC). Since then, the majority of eligible countries have taken a stand against tobacco, ratifying this first global public health treaty. Building on this work, WHO in 2018 introduced its MPOWER model, offering strategies to implement and manage tobacco control, and providing a proven roadmap for policymakers, advocates, and public health practitioners.

In September 2011, the tobacco fight took on new prominence as global leaders came together in New York for the first-ever United Nations High-Level Meeting on noncommunicable diseases (NCDs). At this historic gathering, world leaders unanimously approved an action plan for fighting NCDs that has the potential to meaningfully impact the tobacco battle. This plan calls for greater international collaboration and for putting in place laws that can help combat tobacco, such as tobacco-free workplaces.

These milestones are impressive, yet so are the challenges and opportunities ahead. While smoking rates have been slowly declining in the United States and many other high-income nations during the past 25 years, they have been increasing in low- and middle-income nations, which are also the least prepared to deal with the effects of tobacco-related disease. In 2011, tobacco use killed approximately 6 million people worldwide, with 80 percent of those deaths occurring in low- and middle-income nations. Now is the time for concerted action to save lives and stop this growing plague—we simply cannot wait.

With cross-sector commitment and collaboration, emerging economies can flourish rather than falter, and millions upon millions of lives can be saved, not lost to tobacco-related deaths. This all-new fourth edition of The Tobacco Atlas will, we believe, be an essential tool as people worldwide seek to understand—and to help turn back—the tide of suffering and death caused by tobacco. In the future, we hope you will be telling the story of our greatest victory—a world free of tobacco-related disease.

John R. Seffrin
CEO, American Cancer Society, US

Peter Baldini
Executive Director, World Lung Foundation, US

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John R. Seffrin
CEO, American Cancer Society, US

Peter Baldini
Executive Director, World Lung Foundation, US
Since the release of the first Tobacco Atlas in 2002, much progress has been made in global efforts to advance tobacco control. But far too much remains to be done. In fact, the 10 years since 2002 have likely been the most productive period in tobacco control history.

During the past 10 years, there have been significant multinational, philanthropic, governmental, and civil society successes. For example, in 2002, the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) was still being discussed by the Intergovernmental Negotiating Body and not yet approved by the World Health Assembly. With the support of civil society and especially low- and middle-income countries, a strong WHO FCTC was approved. Today, the WHO FCTC is one of the most widely adopted treaties in United Nations history, with 174 Parties to the Convention covering over 95 percent of the world’s population.

In September 2011, the UN held an unprecedented high-level meeting on the prevention and control of noncommunicable diseases, with a clear recognition that combating tobacco use is central to success. Countries agreed that the battle against noncommunicable diseases cannot ever be won unless we succeed in reducing tobacco use—the only risk factor that is common to all four of the major chronic diseases—cancer, heart disease, chronic lung disease, and diabetes. The resultant political declaration from the high-level meeting calls on the World Health Organization, WHO, to assess the tobacco-use behaviors of over 2 million children in over 150 countries. The GHTVs has now been conducted multiple times in the same countries, so we are now able to monitor important trends in youth tobacco use—something that had previously been lacking.

In addition to these global success stories, there are scores of examples throughout the world in which individual countries have stepped up to implement the provisions of the WHO FCTC, and have, in many instances, surpassed their obligations. Marketing bans, clean indoor-air laws, graphic warning labels, tax increases, and legislation have made the tobacco industry accountable for the harm it has caused and are becoming the norm rather than the exception. Perhaps the most notable recent effort has been the Australian government requiring the plain packaging of cigarettes. While this law is being challenged by the tobacco industry, Australia’s bold step has integrated global tobacco control efforts and will likely result in similar plain packaging efforts throughout the world.

While much has been accomplished, much still needs to be done. Tobacco use continues to kill millions of people a year, and the tobacco industry continues to operate in a relatively unregulated manner. Moreover, the success that has been achieved in tobacco control is somewhat uneven among countries, and sustained progress is never guaranteed. The tobacco industry is shrewd and effective in its ability to influence public policy—including legal, economic, and trade tactics—in a manner that serves its interests. And the health and public policy communities must be equally vigilant in our efforts to advance tobacco control, and to the extent possible, confine tobacco use to a market associated with the 20th century.
MANY PEOPLE HAVE HELPED IN THE PREPARATION OF THIS ATLAS.

We would especially like to thank our principal researchers: Carra Whitney, Georgia State University; Kimberly Sekol, World Lung Foundation (WLF), and Michael Shkolnik, American Cancer Society (ACS). Other researchers include Eunis Bleicher and Aixs Luber, International Tobacco Control Research, American Cancer Society; and Harley Dong, Tiffany Joseph, and Ichiluya Pant, Georgia State University.

Sincere thanks to the American Cancer Society and the World Lung Foundation for their generous financial and overall support of the fourth edition of The Tobacco Atlas. We would like to especially thank Debta Daughtrey, ACS, and Stephen Hamill, WLF, for their extensive involvement in and organization of this project, as well as Nathaniel Eay, ACS, and Janine Shillue, WLF, for their leadership. Additionally, we would like to thank Len Brown, Otto W. Brearley, Bob Chopman, John M. Daniel, Jacqui Drop, Jay Exness, Thomas Glynn, Soumya Hombaiah, Verena Jordan, L. Lawrence Lichtenfeld, Ann McNeill, Gail Richman, and Brenda Wilson, ACS. We would also like to acknowledge Georgia State University and the Georgia Cancer Coalition for their professional and financial support. We are also grateful to Elsevier, Philanthropies for their tremendous support of the Atlas.

The World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) worked extensively to provide global data in an effort to make the Atlas as up-to-date and complete as possible. Many thanks to WHO for the early release of the WHO Report on the Global Tobacco Epidemic, 2017 Report and data, and to the CDC for the release of the Global Youth Tobacco Survey and Global Health Professionals Student data.

Additional thanks to WHO and CDC for reviewing the full manuscript of the Atlas in order to provide feedback and comments during the editing process. We are especially grateful to Douglas Bettcher, Alison Cornwell, Anne-Mate Pernice, Armando Peruga, Sonam Rai, Kerstin Scholte, Edouard Turenne d’Espaignet, and Ayla Yurdakul with the Tobacco Free Initiative, World Health Organization, as well as to Sammi Asma, Linda Anton, Eugene Lam, Kyung Ah Lee, Nicolai Leonov, Krunalin Patel, Italia Rolle, Raydel Valdez Salgado, and Mykong Shin of the Global Tobacco Control, Office on Smoking and Health, Centers for Disease Control and Prevention.

We are also grateful to Bloomberg Lichtenfeld, Ann McMikel, Gail Richman, and Brenda Wilson, ACS, for their leadership. Additionally, Stephen Hamill, WLF, for their extensive involvement in and data, and to the CDC for the release of Global WHO Report on the Global Tobacco Epidemic Atlas.

ACKNOWLEDGMENTS

Many people have helped in the preparation of this atlas.
RESEARCH SAYS:

"...when you strip it down to what matters, there is really only one thing anyone needs to know about tobacco: It kills people."

Arlene King, Chief Medical Officer of Health, Canada, 2010

SINCE THE FIRST EDITION
OF THE TOBACCO ATLAS A DECADE AGO,

50 Million

ADDITIONAL PEOPLE HAVE BEEN KILLED AS A RESULT OF USING TOBACCO.

From December 2002 to November 2011

1 FACE = 500,000 LIVES
Tobacco use is the number-one killer in China and is responsible for 2.1 million deaths annually. This number is expected to rise to 3.5 million deaths annually by the year 2030.

Globally, tobacco is responsible for 26% of deaths among men and 7% of deaths among women.

By cause, 2015 baseline scenario

Tobacco-Caused Deaths

Projected Global Tobacco-Caused Deaths

By cause, 2015 baseline scenario

Tobacco use in any form is dangerous and is the single most preventable cause of death. Up to half of all lifetime smokers will ultimately die of a disease caused by smoking, and men and women with comparable smoking patterns exhibit similar patterns of death.

Male Deaths

Female Deaths

Canada: Male Lung Cancer Mortality 2004

Poland: Male Lung Cancer Mortality 2004

600,000 nonsmokers died in 2011 from involuntary exposure to secondhand smoke. Exposure to secondhand smoke most commonly occurs in the home, workplace, and public areas and is especially risky for children, pregnant women, and infants.

Tobacco is the leading cause of preventable death worldwide, and if current trends continue, the estimated number of deaths attributable to smoking will increase to nearly 8 million people per year by the year 2020.

Deaths caused by tobacco use are entirely preventable, and measures must be taken worldwide to prevent one person from dying every six seconds because of tobacco use and exposure.

Smokers are often the victims of secondhand smoke. Exposure to secondhand smoke can lead to lung cancer, heart disease, stroke, asthma, and other serious illnesses.

Every one in 8.6 Thais died in [2009] of a smoking-related cause. We have to deal with the tobacco industry, as this can't go on.”

Prakit Vathesatogkit, Action on Smoking and Health Foundation in Thailand, 2011

In Poland, cancers caused by smoking were responsible for more deaths in middle-aged men than all other cancers combined.

Russian Federation

Belarus

Kazakhstan

Armenia

Maldives—

29%

28%

28%

28%

28%
In recent years, tobacco companies have introduced products marketed in a manner that implies they are "safe." But research indicates that there is no completely safe form of tobacco. Smoking, including cigarettes with low tar as measured by a machine, has been scientifically proven to cause harm nearly every organ in the body and increase mortality and morbidity. Smoking tobacco products increase the risk of oral cancer, and smokers of cigar, pipe, water pipes, kreteks, and bidis also experience harm nearly every organ in the body and possibly death of the fetus. Smoking can cause growth retardation, low birth weight, and possible death of the fetus.

We recognize that cigarettes are an addictive product. That doesn’t mean you can’t stop smoking. But nicotine is not the issue. It’s the other compounds that are created— they’re called volatile compounds—that are created in smoke. They are the ones who create the harm, and they’re the ones we’re working on in terms of reduced risk products.

Louis Camilleri, CEO, Philip Morris International, 2011

How Tobacco Harms You

 Heads

Blindness (macular degeneration)
Cataracts
Stripping, excessive tearing and blinking

Ears

Hearing loss
Ear infection

Nose

Cancer of nasal cavities and paranasal sinuses
Impaired sense of smell

Heart

Coronary thrombosis (heart attack)
Atherosclerotic damage and occlusion of coronary vasculature

Chest & Abdomen

Possible increased risk of breast cancer
Epidermal cancer
Gastro, colon, and pancreatic cancer
Abdominal aortic aneurysm
PEEP (positive end expiratory pressure, lung failure)

Male Reproduction

Infertility; sperm count/quality reduced
Male infertility

Skeletal System

Osteoporosis
Fracture
Stem cell to back problems
Bone marrow cancer

Circulatory System

Rheumatic disease (inflammation of arteries, veins, and nerves in the leg)
Acute myocardial ischemia

Brain & Psyche

Stroke (cerebrovascular accident)
Addiction/withdrawal
Altered brain chemistry
Addiction about tobacco’s health affects

Hair

Growth and thinning

Mouth & Throat

Cancers of lips, mouth, throat, larynx, and pharynx
Sores in mouth
Impaired sense of taste
Smell (bad breath)

Lungs

Lung, bronchus, and tracheal cancer
Chronic obstructive pulmonary disease (COPD)
Tobacco smoke contains more than 7,000 chemicals and compounds. Hundreds of these are toxic, and at least 60 are cancer-causing.

To date, no tobacco products have been scientifically proven to reduce the risk of tobacco-related disease. Improve safety, or cause less harm than other tobacco products.

Food and Drug Administration, US, 2014

Smoking increases the risk of tuberculosis and is responsible for approximately 20% of global TB incidence.

Smokers with HIV are nearly twice as likely to develop respiratory infections resulting in poorer health outcomes.

Smoking 25 or more cigarettes a day was found to double the risk of type 2 diabetes in males in the US.

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Health Risks of Smoking During Pregnancy

Chronic Respiratory

Asthma

Susceptibility to back problems

Wounds & Surgery

Impaired wound healing
 Poor postpartum recovery
Burns from cigarette and from fires caused by cigarette

Immune System

Impaired resistance to infection

Legs & Feet

Peripheral vascular disease; cold feet; leg pain; gangrene
Deep vein thrombosis (DVT)

Risk Factors

CHRONIC RESPIRATORY

Smoking increases the risk of tuberculosis and is responsible for approximately 20% of global TB incidence.

Smokers with HIV are nearly twice as likely to develop respiratory infections resulting in poorer health outcomes.

Smoking 25 or more cigarettes a day was found to double the risk of type 2 diabetes in males in the US.
Harm Caused by Secondhand Smoke

**SUFFICIENT EVIDENCE**
- Coronary artery disease, Lung cancer
- Stroke, Head and neck cancer, Breast cancer, Cervical, Prostate, Bladder, Urethral, Bladder, Kidney, Uterine, Thyroid, Hematologic
- Asthma, Chronic obstructive pulmonary disease, Pre-term delivery

**RESEARCH SAYS:**
- Secondhand smoke, or “forced smoking,” kills even those people who have consciously chosen not to smoke. Secondhand smoke, also known as environmental tobacco smoke, is a mixture of sidestream smoke from the burning tip of a cigarette, cigar, or pipe, and mainstream smoke, which smokers exhale. Sidestream smoke is the major component of secondhand smoke, and it contains higher concentrations of carcinogens than mainstream smoke.
- There is no safe level of exposure to secondhand smoke. Globally, about 40% of children and a third of non-smoking adults are exposed to secondhand smoke.

Exposure to secondhand smoke remains one of the world’s most critical environmental health hazards, and is more harmful than all other indoor-air contaminants. The fact that non-smokers have been forced to inhale other people’s smoke has led to unprecedented citizen mobilization and the demand for tobacco control measures, including clean indoor-air laws, tax increases, restrictions on sales to minors, and advertising, promotion, and sponsorship bans.

**THE INDUSTRY WAS TOLD:**
- What the smoker does to himself may be his business, but what the smoker does to the nonsmoker is quite a different matter [...] This we see as the most dangerous development to the viability of the tobacco industry that has yet occurred.

**Roper Organization, US, 1978**

**AN ESTIMATED 500,000 INDIVIDUALS DIE ANNUALLY FROM EXPOSURE TO SECONDHAND SMOKE, AND THE MAJORITY OF SECONDHAND SMOKE DEATHS ARE AMONG WOMEN AND CHILDREN.**

**Percent of Youth Who Live in Homes Where Others Smoke in Their Presence**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of Youth</th>
<th>Number of Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americas</td>
<td>38.3%</td>
<td>52,900 deaths</td>
</tr>
<tr>
<td>Asia</td>
<td>26.6%</td>
<td>162,300 deaths</td>
</tr>
<tr>
<td>Europe</td>
<td>22.6%</td>
<td>172,300 deaths</td>
</tr>
<tr>
<td>Oceania</td>
<td>6.9%</td>
<td>8,810 deaths</td>
</tr>
</tbody>
</table>

**Distribution of Global Deaths From Exposure to Secondhand Smoke**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of Deaths</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Oceania</td>
<td>4.7%</td>
<td>8,810 deaths</td>
</tr>
</tbody>
</table>

**Number of Global Deaths Caused by Secondhand Smoke in Nonsmokers 2014**

<table>
<thead>
<tr>
<th>Region</th>
<th>Males</th>
<th>Females</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americas</td>
<td>26%</td>
<td>47%</td>
<td>28%</td>
</tr>
<tr>
<td>Asia</td>
<td>26%</td>
<td>47%</td>
<td>28%</td>
</tr>
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</table>

**75% of secondhand smoke deaths occur among women and children.**

**SUFFICIENT EVIDENCE**
- Midfoot disease, Respiratory symptoms (bouts, wheezing, phlegm, breathlessness), Impaired lung function; Sudden Infant Death Syndrome (SIDS); Lower respiratory illness (including infections); Low birth weight

**RESEARCH SAYS:**
- Secondhand smoke can even cause lung cancer.

**THE INDUSTRY WAS TOLD:**
- The industry was told: ‘‘...even limited secondhand smoke exposure delivers enough nicotine to the brain to alter its function.’’

Nora Volkow, Director, National Institute on Drug Abuse, US, 2011
Since the first edition of The Tobacco Atlas a decade ago, more than 43 trillion cigarettes have been smoked.

Research says:

“Nobody should cry because of lower consumption of a product that kills half the people who use it.”


1 butt = 10 billion cigarettes
Tobacco use is in many different ways around the world, but the global predominance is the use of MANUFACTURED CIGARETTES, WHICH ACCOUNT FOR 96% OF TOTAL WORLDWIDE SALES, and involves big business rather than small, local, rural enterprises.

The next largest components are the smoking of bidis in South-East Asia, the chewing of tobacco in India, the smoking of krejeks in Indonesia, and the use of moist snuff, which originated in Sweden and is in now becoming global.

New forms of tobacco (and of its component nicotine) are constantly being invented, while older forms historically localized to specific regions of the world (such as the hookah and bidis) are becoming global. For instance, krejeks and moist snuff are currently being marketed to youth in many countries. These regional forms of tobacco sometimes gain footholds in new countries based on their exotic cachet, but to date have not displaced manufactured cigarettes for a significant market share. Instead, they frequently serve as a gateway to addiction, luring dependence on nicotine.

New forms of tobacco may not be covered by existing tobacco control legislation and are thus a challenge to countries seeking to reduce the epidemic (especially to reduce youth uptake). A jihad is needed against tobacco in all its forms, whether inhaled, sniffed, sucked, or chewed. Whether any of the harmful ingredients are reduced; whether some of the harmful ingredients are reduced; whether inhaled, sniffed, sucked, or chewed.

Tobacco smoking is the act of burning dried or cured leaves of the tobacco plant and inhaling the smoke. Combustion warms heat to create new chemical that are not found in unburned tobacco, such as tobacco-specific nitrosamines (TSNAs) and benzo[α]pyrene, and allows them to be absorbed through the lungs.

Manufactured cigarettes are the most commonly consumed tobacco products worldwide. They consist of shredded or reconstituted tobacco, processed with hundreds of chemicals and various flavors such as menthol, and rolled into a paper-wrapped cylinder. Usually tipped with a decorative or private filter, they are lit at one end and inhale through the other.

Most prevalent: Worldwide

Krejeks are close-knit cigarettes. They may also contain a wide range of exotic flavors and spices, which has an aesthetic effect, allowing for deeper and more hazardous smoke inhalation.

Most prevalent: Indonesia

Roll-your-own (RYO) cigarettes are hand-filled by the smoker fromINAUTIVEO leaves and a cigarette paper. RYO cigarette smokers are exposed to high concentrations of tobacco particularate, tar, nicotine, and TSNAs, and see at increased risk for developing cancers of the mouth, pharynx, larynx, lungs, and esophagus.

Most prevalent: Europe and New Zealand

Bidis consist of a small amount of crushed tobacco, hand-wrapped in dried leaves, and tied with string. Despite their small size, bidis tend to deliver more tar and carbon monoxide than manufactured cigarettes because users must puff harder to keep them lit.

Most prevalent: South Asia (and are the most heavily consumed snuffed tobacco products in India)

Cigars are made of unrolled and fermented tobacco rolled in tobacco leaf wrappers. The long aging and fermentation process produces high concentrations of carcinogenic compounds that are released upon combustion. The concentrations of toxins and irritants in cigars are higher than in cigarettes. Cigars are made of many shapes and sizes, from cigarette-like cigarillos to double corona cigars, sheekh shaps, double corona, and divinites. In reverse chuties and divinites smoking, the signed end is placed inside the mouth.

Most prevalent: Worldwide

Water pipes, also known as hookahs, hookah, shisha, or chicha, are made of tobacco and numerous added constituents. The smoke is cooled by filtration through a basin of water and consumed through a hose and mouthpiece. Most prevalent: Middle East, Mediterranean region, and parts of Asia.

Dissolvable smokeless tobacco products dissolve in the mouth without expectation; they contain tobacco and numerous added constituents whose purpose is to deliver nicotine to the user via oral mucosal absorption. They are often elaborations of well-known cigarette brands, such as Copenhagen, Skoal, and Brave. Smokeless tobacco products are developed for use by smokers in any situation where they choose or choose not to smoke.

Most prevalent: High-income nations

Dry snuff is processed tobacco that is inhaled through the nose or taken orally. Dry snuff is widespread, particularly in Europe, the use of dry snuff is in decline.

Most prevalent: Europe

Dry snuff is processed tobacco that is inhaled through the nose or taken orally. Dry snuff is widespread, particularly in Europe, the use of dry snuff is in decline.

Most prevalent: Europe

Chewing tobacco is an oral smokeless tobacco product that is placed in the mouth, cheek, or inner lip and sucked or chewed. It is sometimes referred to as “spit tobacco” because of the tendency by users to spit out the building tobacco juice and slobber.

Most prevalent: Worldwide

There are many varieties of chewing tobacco, including plug, loose-leaf, chum, tobacc, clove, and nicot. Pau, maiz, or bebi, quid consist of tobacco, senza Norfolk, or chupeta, shaved lime (citrus aurantifolia), sugar, and flavored agents wrapped in a leaf leaf (Piper betle). These are many varieties of gn masala, including khadupali, hopaapgo, gundi, budguri, kurta, panna, korean, and mishi.

Most prevalent: India

Moist snuff consists of ground tobacco held in the mouth between the cheek and the gum. Manufacturers are increasingly packaging moist snuff in small paper or cloth packets to make the product more consumer. Moist snuff products are known as moist, khaini, shammaah, nass, or nause. Tobacco pastes or powders are similarly used, placed on the gums or teeth. Five tobacco powder substances are usually inhaled and absorbed through the nasal passages.

Most prevalent: Scandinavia and US but becoming worldwide, found in several countries.

Smokeless tobacco is usually consumed orally or nasally without burning or combustion. Smokeless tobacco increases the risk of cancer and leads to nicotine addiction similar to that produced by cigarette smoking. There are different types of smokeless tobacco: chewing tobacco, snuff, and dissolvable.

Most prevalent: Europe
Nicotine is a highly addictive drug, and to make it look like a piece of candy is recklessly playing with the health of children.”

Gregory Connolly, Harvard University, 10/2016

One of the US Department of Justice’s Cigarette Companies, 2011

The importance of nicotine and want to continue to be the providers of choice for nicotine products, but they also understand the dangers created by the combination of tobacco products, most notably that customers routinely die from their use. Therefore, tobacco companies are creating new products to keep individuals addicted to nicotine while reducing toxic exposures caused by combustion. Such products include non-combustible cigarettes (e.g., Eclipse, Premier) and oral tobacco (e.g., lozenges, strips, snus, orbs), some of which are dissolvable. There is an urgent need for research and regulation of these products. Beginning in the 1970s, pharmaceutical companies began providing nicotine replacement therapy (NRT) to ease nicotine withdrawal symptoms.

For years, tobacco companies were the only providers of nicotine delivery products, such as nicotine patches, gum, lozenges, and inhalers. These products provide nicotine in an innovative yet unregulated manner, and the potential risks are largely unknown. The arrival of novel nicotine delivery products in the mass market creates a new avenue for individuals to initiate or maintain nicotine addiction, which could result in increased addiction, lower cessation attempts, increased use of multiple products, and addiction to higher levels of nicotine. However, these products could also potentially play a role in the cessation of combusted tobacco products.

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EARLY 20% OF THE WORLD’S ADULT POPULATION SMOKES CIGARETTES: Smokers consumed nearly 5.9 trillion cigarettes in 2009, representing a 13% increase in cigarette consumption in the past decade. Cigarette consumption historically has been highest in high-income countries, but because of targeted marketing, increased social acceptability, continued economic development, and population increases, consumption is expected to increase in low- and middle-income countries. Cigarette consumption in Western Europe dropped by 26% between 1990 and 2009 but increased in the Middle East and Africa by 13% during the same period. This change has occurred as people in high-income countries increasingly understand the dangers of smoking and governments continue to implement tobacco control policy and legislation. Globally, the increase in cigarette consumption in low- and middle-income countries is significant enough to offset the decrease in high-income countries.

Cigarette consumption is responsible for a significant disease burden. As consumption rates continue to increase in low- and middle-income countries, these countries will experience a disproportionate amount of tobacco-related illness and death—particularly China, as Chinese men smoke a third of the world’s cigarettes. If the smoking prevalence among Chinese women increases, global consumption of cigarettes will skyrocket, and the country’s economy and healthcare systems will be overwhelmed.

While global smoking prevalence is flat or decreasing, the total number of smokers worldwide continues to increase simply due to population growth. While almost 6 trillion cigarettes are consumed annually, the pattern of nicotine consumption may shift in the future as people seek alternative nicotine delivery systems (see Chapter 5 – Nicotine Delivery Systems). TOBACCO AND NICOTINE ADDICTION MUST BE TREATED CONSERVATIVELY WITH THE ARM’S LENGTH CAUSÉ. The World Health Organization’s Framework Convention on Tobacco Control (WHO FCTC) has outlined how least to reduce tobacco use, and the time has come to act on this information.

THE INDUSTRY SAYS: “We believe we can increase the consumption of kretek elsewhere…. We assured ourselves that they are not more or less dangerous than conventional cigarettes.” Louis Camilleri, CEO, Altra, US, 2005
**THE PUBLIC SAYS:**

> When I began smoking, about 80 percent of men were smokers. The advertising phrase was, ‘You’re healthy when a cigarette tastes so good.’

> Masanobu Mizuno, plaintiff in a suit against Japan Tobacco, Japan, 2009

A bout 80 million adult men worldwide smoke cigarettes. ALMOST 20% OF THE WORLD’S ADULT MALE SMOKERS LIVE IN HIGH-INCOME COUNTRIES, WHILE OVER 80% ARE IN LOW AND MIDDLE-INCOME COUNTRIES.

The global tobacco epidemic can be segmented into four stages in which men typically precede women. Stage 1 represents the very beginning of the epidemic; when the prevalence of smoking has begun to rise but there is as yet no appreciable smoking attributed mortality. In Stage 2 smoking prevalence increases rapidly but smoking attributed deaths still account for a small proportion (less than 5%) of all deaths. In Stage 3 smoking prevalence is stable or decreasing but smoking attributed mortality increases to a maximum of 20–30% of all deaths in middle age (35–44 years). In Stage 4 smoking prevalence (and eventually smoking attributed mortality) decrease towards lower limits that are not yet defined.

While countries may have similar prevalence rates, each country’s location on the curve is important. Countries on the upslope of the epidemic are in the early stages of the epidemic and experience different challenges than those countries on the downslope.

Tobacco marketing associates male smoking with masculinity, happiness, wealth, virility, and power. In reality, smoking kills nearly 8 million men annually and leads to inferiority, health disparities, illness, and premature death. Overall, smoking prevalence rates are declining, but the number of smokers is increasing due to general population growth. Even the most successful tobacco control programs can only desire to cap the number of new tobacco users. People are increasingly using innovative and alternative products, such as oral tobaccos, electronic cigarettes, and nicotine replacement therapy, to obtain nicotine. As we continue to monitor smoking rates throughout the world, we must become increasingly cognizant of these alternative manners of maintaining nicotine addiction (see Chapter 5 – ‘Nicotine Delivery Systems’).

**THE INDUSTRY SAYS:**

> I’m no cowboy and I don’t ride horseback, but I like to think I have the freedom the Marlboro man exemplifies. He’s the man who doesn’t punch a clock. He’s not computerized. He’s a free sparrow.

> George Wexner, Former President and CEO, Philip Morris USA, 1978

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**Male Smoking Prevalence and Deaths Over a Century**

*Weighted average of smoking prevalence, 2020*

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**Tobacco Epidemic Continuum**

- **Stage I:** Smoking as a status symbol
- **Stage II:** Smoking as an addiction
- **Stage III:** Smoking as a health hazard
- **Stage IV:** Smoking as a public health problem

---

**Prevalence and Deaths**

<table>
<thead>
<tr>
<th>Male Smoking</th>
<th>Smoking Prevalence</th>
<th>Deaths</th>
<th>Prevalence</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Low</td>
<td>1%</td>
<td>0.1%</td>
<td>0.01%</td>
</tr>
<tr>
<td>Stage II</td>
<td>Middle</td>
<td>10%</td>
<td>1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Stage III</td>
<td>High</td>
<td>30%</td>
<td>3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Pertinent</td>
<td>50%</td>
<td>5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

---

**Low DAILY Smoking Rates**

<table>
<thead>
<tr>
<th>Country</th>
<th>Smoking Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hong Kong</td>
<td>11.1%</td>
</tr>
<tr>
<td>Canada</td>
<td>13.0%</td>
</tr>
<tr>
<td>Iceland</td>
<td>14.3%</td>
</tr>
<tr>
<td>Singapore</td>
<td>14.3%</td>
</tr>
<tr>
<td>Sweden</td>
<td>14.3%</td>
</tr>
<tr>
<td>Australia</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

---

**Smoking Trends Adult Male Current Smoking Prevalence**

<table>
<thead>
<tr>
<th>Country</th>
<th>Smoking Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>8%</td>
</tr>
<tr>
<td>UK</td>
<td>22%</td>
</tr>
<tr>
<td>US</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

---

**No Data**

**Countries where at least TEN TIMES MORE MEN THAN WOMEN smoke**

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**2010 or latest available**

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**Per Cent of Males Who Smoke Cigarettes**

- Below 10%
- 10–19.9%
- 20–29.9%
- 30–39.9%
- 40–49.9%
- 50–59.9%
- 60% and Above
Women are the target of marketing campaigns, specifically ones promoting “light” or “low-tar” cigarettes. Women often choose these cigarettes because of a false assumption that the products are less harmful than full-flavor cigarettes. In reality, all cigarettes contain approximately the same amount of tar and nicotine, but smokers of “light” and “low-tar” cigarettes compensate (e.g., covering ventilation holes, sucking harder, etc.) to more efficiently extract nicotine from the cigarettes. This has resulted in no net benefit for women who continue to smoke and use these “lighter” products.

Smoking decreases fertility in women, combines with oral contraceptives to increase the risk of heart attack and stroke, and results in poor health outcomes for fetuses and newborns. If women begin smoking at rates equivalent to men, the world will face a public health disaster of enormous proportions.

Over a Century
Prevalence and Deaths
Female Smoking
More than half of all countries have a female smoking prevalence rate of less than 20%
While there are large differences in smoking rates among adults by gender, smoking rates among boys and girls (ages 13–15) vary minimally in many regions of the world. Smoking rates between boys and girls differ by less than five percentage points in almost half of the world’s countries. Tobacco companies view youth smoking as an opportunity to secure new smokers at a young age. The majority of smokers begin smoking in their youth. For example, 83% of smokers in the US begin smoking before the age of 18. Even the tobacco industry understands the importance of youth smoking, and a 1984 R.J. Reynolds document stated that “younger adults are the only source of replacement smokers.”

Boys begin smoking during their youth in response to peer pressure, misconceptions that smoking is cool or enhances popularity, easy access to tobacco products, cigarette pricing, and tobacco marketing. Both marketing and pricing of cigarettes are proven to encourage youth initiation of smoking, because marketing makes smoking appealing to youth, and low pricing makes smoking affordable.

Smoking has an immediate harmful impact on boys’ health, such as a reduction in stamina, and an increase in respiratory symptoms, mental health visits, and school absenteeism. Smoking endangers health, and the longer an individual smokes, the more severe the repercussions. Youth smokers are entering into an addiction that shortens their life span and increases the likelihood they will die early from diseases caused by smoking.

Youth smokers are entering into an addiction that shortens their life span and increases the likelihood they will die early from diseases caused by smoking.

The smoking patterns of teenagers are particularly important to Philip Morris.

Philip Morris USA, 1981

Kids who see others smoking are more likely to take up the habit because they don’t perceive cigarettes as unhealthy.

Simon Racicot, Concordia University, US, 2011
Their use

As with boys, most female smokers initiate their habit before reaching adulthood. Girls begin smoking during their youth in response to peer pressure, misconceptions that smoking is cool or enhances popularity, easy access to tobacco products, and tobacco marketing. Both marketing and pricing of cigarettes encourage youth initiation of smoking. Marketing makes smoking appealing to youth, and low pricing makes smoking affordable.

Some girls initiate smoking or continue to smoke due to the belief that smoking will assist with weight loss. This is especially common in cultures where women are subjected to unrealistic bodyimage goals. The tobacco industry has promoted the adoption of this belief, and a 1982 R.J. Reynolds document stated that “a brand which contains a natural appetite suppressant (in tobacco or tipping) will be perceived as controlling weight.”

Among today’s adults, more men consistently smoke than women. In fact, there are at least 45 countries in which ten times more men than women smoke. The same is not the case for today’s teenagers. In most of the world, the difference in smoking rates between girls and boys is small. In fact, more girls smoke than boys in at least 25 countries.

The similarity of today’s boys’ and girls’ smoking rates suggests that, in the future, today’s teenage girls may be more likely to smoke than today’s adult women. If this pattern continues in the future, the consequences will be deadly.

Research says:

“If you’re not allowed it, but you really want it, then you can have it.”
—Advertisement slogan for Kiss Cigarettes

There is an important public-health message here that we need to get to teenage girls: Smoking is not going to help you lose weight.”
—Loane Pierce, McGill University, Canada, 2006

There are at least 25 countries where girls smoke more than boys. In fact, there are at least 25 countries where girls smoke more than boys.

Research says:

“If the movie stars smoke, especially in romance films, they are effectively encouraging young girls to smoke.”
—John Pierce et al., University of California, San Diego, U.S. 2005

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Places Where Substantially More Girls Than Boys Smoke Cigarettes

Ages 13-15, 2010 or latest available

Common Reasons Young Women Start Smoking

• Association with others (parents and friends) who smoke.
• Concern with weight, body image, or social acceptance.
• Interest in rebelling or stating individuality.
• Exposure to positive images of smoking in magazines, movies, and youth culture.
• Influence from cigarette marketing campaigns targeting women.

Girls Who Have Never Smoked but Are Susceptible to Smoking in the Next Year

Percentage of girls ages 13-15 who have never smoked but are susceptible to smoking in the next year.

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent of Susceptible Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>25.6%</td>
</tr>
<tr>
<td>Asia</td>
<td>33.0%</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>17.4%</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>10.7%</td>
</tr>
<tr>
<td>Below 7%</td>
<td></td>
</tr>
<tr>
<td>7-15.9%</td>
<td></td>
</tr>
<tr>
<td>16-29.9%</td>
<td></td>
</tr>
<tr>
<td>30% and Above</td>
<td></td>
</tr>
</tbody>
</table>

Percent of Female Students Ages 13-15 Who Smoke Cigarettes

2005 or latest available

40.7% of girls in Madagascar think that girls who smoke have more friends.
Smokeless tobacco accounts for a significant and growing portion of global tobacco use, especially in South Asia. Over 25 distinct types of smokeless tobacco products are used worldwide, including both commercialized and local or homegrown products, used orally and nasally. Some products contain tobacco with substantial amounts of chemical additives and other plant material that may confer additional risk to the user. Moreover, smokeless tobacco products contain many of the toxins and carcinogens found in cigarettes, and thus result in many of the same diseases caused by smoking. In addition, smokeless tobacco use increases periodontal disease, tooth loss, and precancerous mouth lesions. Despite the harm from smokeless tobacco use to both individuals and society at large, these products are not sufficiently regulated in many countries. The landscape of smokeless tobacco manufacturing and marketing is rapidly evolving.

### The Industry Says

“We adopted our core strategy for growth and that was to expand the smokeless tobacco product category by converting adult smokers to smokeless tobacco.”

-Daniel Butler, President, U.S. Smokeless Tobacco Company, 2004

Global patterns of smokeless tobacco use vary widely. The import and sale of smokeless tobacco products are banned in 49 countries and areas. In some countries, like Finland and Egypt, men use smokeless tobacco products in much greater numbers than women because such products are perceived as masculine. In countries like South Africa, Thailand, and Bangladesh, women use smokeless tobacco products more than men because they are seen as a discreet way to consume tobacco. Research addressing smokeless tobacco is limited. Monitoring and surveillance systems are scarce, and significant research gaps exist in identifying ingredients, additives, and injuries of smokeless tobacco products. Little is known about product pricing, substitution of smokeless tobacco for smoked tobacco, and youth susceptibility to smokeless tobacco use. Policies to control smokeless tobacco are underdeveloped. The integration of smokeless tobacco control measures into the wider framework of tobacco control can help to curb its use.

### Consumer Says:

“Bena ek guito bhane ka itna shaajit ho to ek kaam na. Ek dost aur hamaa.”

“Son, if you are so fond of eating gutka [chewing tobacco], make sure you make a friend so that you have someone to help carry your coffin.”

Title track from Bollywood movie, Wanted, India, 2009

Global patterns of smokeless tobacco use vary widely. The import and sale of smokeless tobacco products are banned in 49 countries and areas. In some countries, like Finland and Egypt, men use smokeless tobacco products in much greater numbers than women because such products are perceived as masculine. In countries like South Africa, Thailand, and Bangladesh, women use smokeless tobacco products more than men because they are seen as a discreet way to consume tobacco. Research addressing smokeless tobacco is limited. Monitoring and surveillance systems are scarce, and significant research gaps exist in identifying ingredients, additives, and injuries of smokeless tobacco products. Little is known about product pricing, substitution of smokeless tobacco for smoked tobacco, and youth susceptibility to smokeless tobacco use. Policies to control smokeless tobacco are underdeveloped. The integration of smokeless tobacco control measures into the wider framework of tobacco control can help to curb its use.

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THE MEDICAL STUDENTS OF TODAY ARE THE DOCTORS OF TOMORROW, AND IT IS IMPORTANT THAT THESE STUDENTS RECEIVE FORMAL SMOKING CESSATION TRAINING AS PART OF THEIR MEDICAL CURRICULUM. Unfortunately, this formal training does not always occur, and in many parts of the world, medical students smoke at rates equal to or higher than those of the general population. In addition to educating health professionals about tobacco cessation, health facilities, such as hospitals, clinics, and doctors’ offices, must adopt smoke-free policies to protect against secondhand smoke exposure. Smoke-free policies should also be adopted in medical schools. In some countries, smoking rates among medical students increase during their schooling, a circumstance that proper policies can help prevent.

All health professionals should screen patients about tobacco use and interest in quitting. Even brief tobacco cessation counseling can double quit rates. The doctors in 60 countries have quit smoking. The doctors in 60 countries have quit smoking.

No data for 3.6% of countries

No Data

Below 10%

10–19.9%

20–29.9%

30–39.9%

40% and Above


data not available
RESEARCH SAYS:

"Smokers often do not realize that they pay twice for cigarettes. First with cash out of pocket, then later with their health or [their] lives."
AydaYurekli, World Bank, 2003

BETWEEN 2000 AND 2008, TOTAL COSTS IN China ATTRIBUTABLE TO TOBACCO USE MORE THAN Quadrupled

2000 $7.2 BILLION
2008 $28.9 BILLION

Values include direct and indirect costs. Direct costs include all health-care expenditures for treating smoking-related illnesses. Indirect costs largely include the value of lost productivity and cost of premature deaths caused by smoking-related illnesses. Measured in US dollars.
The Opportunity Costs of Smoking

Every society gives up the opportunity to buy something important when valuable resources are spent treating smoking-related illnesses. The enormous resource drain that the use of tobacco products has on society as a whole.

Tobacco companies insist that their business is only a portion of the total cost of tobacco to society. Indirect costs such as losses in labor productivity, cigarette butt littering, fire damage, and so will the need to evaluate these costs.

Tobacco Is a Drain on Health-Care Systems
Percentage of total health-care expenditure used to treat tobacco-related illness, 2003–2008

The direct cost of tobacco-related illnesses is estimated $96 billion per year, while smoking was responsible for an average of $71 billion per year, while smoking was responsible for an estimated $193 billion in annual health-related economic losses.

The direct cost of tobacco use in USD

<table>
<thead>
<tr>
<th>Country</th>
<th>Direct Cost of Tobacco Use</th>
<th>Indirect Cost of Tobacco Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$9,584 million</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$3,584 million</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>$1,66 million</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>$922 million</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>$244 million</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>$166 million</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>$9,600 million</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$2,805 million</td>
<td></td>
</tr>
</tbody>
</table>

Direct Costs of Smoking as a Percentage of Gross Domestic Product

From 2000 to 2004, the value of cigarettes sold in the US averaged $73 billion per year while cigarette smoking was responsible for an estimated $21 billion in annual health-related economic losses. From 2000 to 2004, the value of cigarettes sold in the US averaged $73 billion per year while cigarette smoking was responsible for an estimated $21 billion in annual health-related economic losses.

The monetary value of the health damage from a single pack of cigarettes is $35 to an American smoker. Tobacco-Related Costs

<table>
<thead>
<tr>
<th>Country</th>
<th>Tobacco-Related Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$96,000m</td>
</tr>
<tr>
<td>China</td>
<td>$6,200m</td>
</tr>
<tr>
<td>Canada</td>
<td>$96,000m</td>
</tr>
<tr>
<td>Sweden</td>
<td>$309m</td>
</tr>
<tr>
<td>France</td>
<td>$8,490m</td>
</tr>
<tr>
<td>Japan</td>
<td>$1,390m</td>
</tr>
<tr>
<td>Italy</td>
<td>$127m</td>
</tr>
<tr>
<td>Germany</td>
<td>$1,445m</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$8,860m</td>
</tr>
<tr>
<td>France</td>
<td>$8,490m</td>
</tr>
<tr>
<td>Japan</td>
<td>$1,390m</td>
</tr>
<tr>
<td>Italy</td>
<td>$127m</td>
</tr>
<tr>
<td>Germany</td>
<td>$1,445m</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$8,860m</td>
</tr>
</tbody>
</table>

The ratio depends on the country’s health-care system and income level.

<table>
<thead>
<tr>
<th>Country</th>
<th>Tobacco-Related Costs as a Percentage of Gross Domestic Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>11.3%</td>
</tr>
<tr>
<td>Mexico</td>
<td>10.5%</td>
</tr>
<tr>
<td>US</td>
<td>37.5%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>37.2%</td>
</tr>
<tr>
<td>Sweden</td>
<td>37.5%</td>
</tr>
<tr>
<td>France</td>
<td>49.8%</td>
</tr>
<tr>
<td>Germany</td>
<td>50.2%</td>
</tr>
<tr>
<td>China</td>
<td>50.2%</td>
</tr>
<tr>
<td>Japan</td>
<td>50.2%</td>
</tr>
<tr>
<td>Italy</td>
<td>50.2%</td>
</tr>
<tr>
<td>Germany</td>
<td>50.2%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>50.2%</td>
</tr>
</tbody>
</table>
Money spent on tobacco often reduces resources available for basic necessities, such as nutrition, health care, and education. These opportunity costs impose a significant burden on tobacco users and their families, burying many of them in a vicious cycle of poverty that can span generations. Spending on tobacco products diverts resources from essential goods on to tobacco products, diverting many of them in a vicious cycle of burden on tobacco users and their families. These opportunity costs impose a significant such as nutrition, health care, and education.

In striving for greater profits, the big tobacco firms have pushed the average price of cigarettes up in rich countries, such as Britain — where 20 cigarettes now cost as much as an airline ticket — or in poorer countries, such as India and Malawi.

In Vietnam, smokers spend 2.5 times more on tobacco than on education, 2.5 times more on clothes, and 2.5 times more on health care in 2003.

Tobacco consumption impoverished roughly 1 million people in India in 2004. Students in Nigeria spent 40% of their income on cigarettes in 2003.

In Cambodia in 2004, the money spent on one pack of premium cigarettes could buy as much as 2,500 food calories, comprising a typical Cambodian daily diet.

How Many Servings of Rice Can a Pack of Marlboros Buy?
1 serving = 28.21 g of rice, dry weight, 2010

Price of Local Brand as a Percent of Marlboro Prices
The greater the difference in cigarette prices, the harder it is for the smoker to switch to a cheaper brand or eliminate.
“If real cigarette prices do not rise faster than consumer purchasing power, tobacco becomes relatively more affordable and consumption increases.”


In recent decades, many low- and middle-income countries have achieved unprecedented economic growth. The economies of many countries in Asia, Eastern Europe, and South America have grown at annual rates of 6% or more. Rapid growth increases consumers’ purchasing power, and people discover that many things, including cigarettes, become more affordable. Therefore, fast-growing countries face greater tobacco control challenges.

Consumers’ decisions to buy cigarettes are influenced by their available income and the price of cigarettes. Economists call this combination “affordability,” expressed as the percentage of a worker’s income or duration of work time required to buy a product. The more income required to purchase cigarettes or the more one must work to earn enough money for cigarettes, the less affordable cigarettes are.

Despite cigarette prices being much higher in high-income countries, cigarettes are on average more affordable in those countries. For example, in 2000 the median employed person in Japan had to work almost an hour to buy a pack of cigarettes. However, in many middle-income countries, cigarettes are generally becoming more affordable as economies develop, with the highest increase in affordability within the last decade being observed in China, Libya, and the Russian Federation.

The growth in average income significantly affects the affordability of cigarettes, and in that sense is bad for public health efforts to reduce consumption by making tobacco products less affordable. But tobacco control policymakers cannot argue against economic growth. The best way to make cigarettes less affordable is to increase tobacco taxes and prices (see Chapter 25—Tobacco Taxes). To the extent that tobacco control is a priority for governments and policymakers, tobacco taxes and prices should be adjusted to reduce affordability.

Minutes of Labor Required to Purchase a Pack of Cigarettes

All median wage in 2009

In 2000 nearly 14% of the average annual per capita income was needed to buy 100 packs of the cheapest cigarettes. In 2010 this number dropped to less than 3%.

Cigarette Affordability

Relative Income Price* (RIP), 2009

<table>
<thead>
<tr>
<th>Countries where cigarettes became at least TWICE AS AFFORDABLE</th>
<th>Between 2000 and 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% and Above</td>
<td>Under 2.5%</td>
</tr>
<tr>
<td>7.5–9.99%</td>
<td>2.5–4.99%</td>
</tr>
<tr>
<td>5–7.49%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Under 2.5%</td>
<td>= 21.7%</td>
</tr>
<tr>
<td>By Country Income</td>
<td>By WHO Region</td>
</tr>
<tr>
<td>10.1% <strong>Least Affordable</strong> Countries</td>
<td>9.2% Mediterranean</td>
</tr>
<tr>
<td>Cigarettes Became MORE AFFORDABLE</td>
<td>-4.6% Asian</td>
</tr>
<tr>
<td>Cigarettes Became LESS AFFORDABLE</td>
<td>-47.5% Pacific</td>
</tr>
<tr>
<td>-21.7% Least and Middle Income Countries</td>
<td>-18.3% Asia</td>
</tr>
</tbody>
</table>

*Relative Income Price (RIP) = Percentage of annual per capita income, measured by per capita GNI minus to purchase 100 packs of cheapest cigarettes.

In China, cigarette prices became much more affordable over the last 10 years. In 2000 nearly 14% of the average annual per capita income was needed to buy 100 packs of the cheapest cigarettes. In 2010 this number dropped to less than 3%.
Between 2000 and 2010, world cigarette production increased by 12%.

Today, cigarette companies produce nearly 6 Trillion cigarettes per year.

Research says:
“Tobacco use is unlike other threats to global health. Infectious diseases do not employ multinational public relations firms. There are no front groups to promote the spread of cholera. Mosquitoes have no lobbyists.”

WHO Zeltner Report, 2000
Tobacco is known to be grown in at least 124 countries, occupying 5.8 million hectares of agricultural land. There are only 5 countries in which tobacco is not grown, and it is unknown whether or not tobacco is grown in the remaining countries of the world. World tobacco production peaked in 1997 at over 14.6 tonnes in the same year.

Tobacco farming negatively affects the environment. Deforestation results from wood being needed for the curing process and for hanging leaves to dry. Each year, 20,000 hectares of forests are cleared to cure tobacco. Tobacco leaves the soil of many nutrients, so fertilizers and pesticides are heavily used in tobacco production. These chemicals endanger workers and create runoff that pollutes the environment.

No matter where tobacco farmers work, these individuals experience illnesses through their exposure to pesticides (which cause neurological damage) and nicotine (which results in green damage) and nicotine (which results in green tobacco sickness). In addition to health impacts, many tobacco farmers are trapped in a cycle of poverty, as they are required to purchase high-cost equipment and infrastructure with little profit remaining. In 2001, tobacco farmers in the US received less than 1% of consumer spending on tobacco.

The WHO FCTC calls for financial and technical assistance to tobacco growers in countries dependent on tobacco agriculture. Although shifting from growing tobacco to growing economically and environmentally stable alternatives, such as fruit, addresses the issue of malnutrition, few countries have implemented such measures.

Advocates say: …they cheated the farmers. Tobacco farmers have families, they run businesses, they work real hard on the land… I think they are the innocent people in this.”

Harvey Strosberg, Lawyer, Canada, 2010

Research says:
“…you can’t just tell people not to smoke; just like you can’t tell farmers to stop planting. You need to show them a different way.”

Zhao Yaqiao, Yunnan Agricultural University, China, 2011

No Tobacco Grown
Less than 1,000
1,000–4,999
5,000–9,999
10,000–99,999
100,000 or More

No Data

Land Devoted to Growing Tobacco
Area in Hectares, 2009
One hectare = 2.47 acres

Brazil produces 32% more tobacco than the entire African Region.
“Cigarettes are being extruded — and therefore smoked — at a rate of more than 300 million miles per year, which is about 34,000 miles per hour, 24 hours a day.”

Robert Proctor, Stanford University, US, 2011

There are well over 500 cigarette factories spread around the globe, each responsible for thousands of premature deaths and massive, avoidable costs to society. These factories collectively produce nearly 6 trillion cigarettes every year, roughly 12% more than a decade ago. In 2010, cigarettes were produced in the majority of countries worldwide, and about a million cigarettes were manufactured every five seconds. That year, 41% of the world’s cigarettes were produced in China, followed by Indonesia (3%), Russia (7%), the US (6%), Germany (4%), and Indonesia (3%).

Where are these cigarettes manufactured, and how are they being produced? Most of these factories are highly visible and prominently featured in their communities. With advances in satellite imaging technology, projects such as Stanford University’s Cigarette Clouds now make it possible to locate hundreds of these factories online. For instance, Internet users can view one of the world’s largest cigarette factories in Bergen op Zoom, near the Hague, Netherlands. This facility, built by Philip Morris in the 1980s, currently manufactures about 96 billion cigarettes annually, with most exported to other European countries and Japan. About 50,000 people could die prematurely every year as a result of consuming cigarettes manufactured in this single facility.

Who Is Getting the Money Spent on a Cigarette?

Distribution of value of a premium cigarette, 2009–2010

Cigarettes Dominate, but Are Not the Only Tobacco Product of the Tobacco Industry

Value of global tobacco industry production measured at retail asking price (all taxes included) in 2020, in billion USD

Top 5 Cigarette-Exporting Countries

Number of cigarettes produced in the country that were exported in 2010, in billion

Global Cigarette Production

In billions of cigarettes between 2000 and 2010; cigarette production notably declined from the western to the eastern part of Europe.

Cigarette Production

In billion pieces, 2010 or latest available

0 (No Production)

Under 1

1–4.99

5–19.99

20–49.99

50–1,999.99

2,000 and Above

No Data

Locations of cigarette factories

*http://tobaccoresearch.stanford.edu

In China, the largest cigarette-producing country in the world, only about 25% of every 100,000 workers are employed in the tobacco manufacturing sector. In Korea, the second-largest cigarette producer, the ratio is even lower: 18 out of every 100,000 workers are employed in tobacco manufacturing.
In recent years, publicly traded tobacco companies have consolidated through privatization and mergers. Today there are more major private tobacco companies: British American Tobacco International, Altria/Philip Morris USA, Japan Tobacco International, British American Tobacco, and Imperial Tobacco. In addition to these corporations, there are sixteen state-owned tobacco companies that are the leading cigarette manufacturers in specific countries. CHINA NATURAL TOBACCO CORPORATION is the largest state-owned tobacco company, producing more cigarettes than any other company in the world. In 2008 CNCT manufactured 2.1 billion of the 5.9 trillion cigarettes produced worldwide.

As the tobacco market has consolidated under a few major companies, the direction of these corporations is beginning to change. Traditionally, company buyouts took place in order to consolidate and expand market share. New tobacco companies are branching out into other areas of tobacco products and technology. In recent years, the major tobacco companies have purchased corporations that produce non-tobacco products, such as Snus. In 2011 Philip Morris International purchased a company that produces oral tobacco products, such as snus.

In recent years, the major tobacco companies have pursued mergers that offer the same experience expected from cigarettes without some of the risks of smoking. Estimates of revenues from the global tobacco industry vary wildly but are likely approaching half a trillion dollars annually. Although tobacco is ultimately a financial burden on the governments and health-care systems of countries, it is also a source of government revenue, through tobacco taxes and additional profit for those countries with state-owned tobacco companies. Each year the tobacco industry in China contributes over 7% of the central government’s total revenue. If Big Tobacco were a country, it would have a gross domestic product (GDP) similar to that of Poland and Sweden.

THE INDUSTRY SAYS:

"AMR Group has outperformed the S&P 500 every year since 2000 and has increased its dividend 44 times in the last 12 years. Its scale, balance sheet strength and improved operational focus make the company a compelling consumer products investment opportunity and enable the company to have large-scale economic impact."

Altria website, US, 2011
Cigarette Prices and Illicit Cigarette Trade in the UK

Contrary to tobacco industry claims, the increase in retail price has not led to any corresponding increase in illicit trade.

Tobacco smuggling can also lead to higher levels of corruption. Illicit cigarette trade is highly profitable, allowing crime networks to survive and may increase the general level of corruption in a country.

The TOBACCO INDUSTRY has consistently argued that TOBACCO TAX INCREASES CREATE MORE ILICIT TRADE. HOWEVER, NO RESEARCH EVIDENCE SUPPORTS THIS CLAIM. On the contrary, evidence shows that factors other than tax and price are more important determinants of illicit tobacco trade, and that illicit trade is generally lesser where cigarette prices are higher. Policies that can decrease the penetration of illicit cigarettes within their markets (e.g., UK), on average, this percentage is significantly higher in low- and middle-income countries than in high-income countries.

Circumventing tobacco taxes undermines tax and price policies, which are among the most effective mechanisms to control tobacco use, as well as other tobacco control measures, such as youth access laws or mandatory health-warning labels. Tobacco smuggling can also lead to higher levels of corruption. Illicit cigarette trade is highly profitable for the transnational tobacco companies, allowing them to circumvent tobacco taxation. In Canada, the industry was found guilty of organizing illicit trade and paid billions of dollars in penalties. In Canada, the industry was found guilty of organizing illicit trade.

The Industry Tends to Exaggerate the Scope of Illicit Trade as a Counterargument Against Tobacco Control Measures

Estimates of illicit cigarette trade from the tobacco industry on the estimates from academic studies As a percent of total consumption

### Illicit Cigarette Market Share

- **2021 or latest available**
- **Less than 10%**
- **10–19.9%**
- **20–29.9%**
- **30–39.9%**
- **40% and Above**

**Top Ten Departure Countries of Seized Cigarettes (by volume)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Illicit Cigarette Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>10–19.9%</td>
</tr>
<tr>
<td>Canada</td>
<td>20–29.9%</td>
</tr>
<tr>
<td>Mexico</td>
<td>30–39.9%</td>
</tr>
<tr>
<td>Russia</td>
<td>40% and Above</td>
</tr>
<tr>
<td>Brazil</td>
<td>40% and Above</td>
</tr>
<tr>
<td>China</td>
<td>40% and Above</td>
</tr>
<tr>
<td>India</td>
<td>40% and Above</td>
</tr>
<tr>
<td>Pakistan</td>
<td>40% and Above</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>40% and Above</td>
</tr>
<tr>
<td>Uganda</td>
<td>40% and Above</td>
</tr>
</tbody>
</table>

**NOTABLE SEIZURES exceeding 20 million cigarettes (more common in areas with greater law enforcement), 2009 and 2010**

- **Trinidad and Tobago**
- **Jamaica**
- **Barbados**
- **Dominican Republic**
- **Guyana**
- **Guatemala**
- **Nicaragua**
- **El Salvador**
- **Costa Rica**
- **Belize**

**Additional Information**

- **Illicit cigarette market share**

**Image:** Map of the world showing the illicit cigarette market share for different countries. The map highlights countries with significant illicit cigarette trade, with color coding indicating the percentage of the illicit cigarette market. The map includes major countries such as the United States, Canada, Mexico, Russia, Brazil, China, India, Pakistan, Bangladesh, and Uganda, among others, with varying percentages of illicit cigarette trade.
The tobacco industry claims that it does not market to children and that the purpose of its advertising is only to encourage adult smokers to switch brands. US Federal Judge Gladys Kessler found this argument baseless, and concluded that tobacco advertising contributes to youth smoking.

Despite increasing restrictions on marketing and advertising, tobacco companies continue to spend billions of dollars annually to maintain brand loyalty among current smokers, to influence young people to use tobacco, and to keep smokers addicted.

In 2008, $15 billion was spent on cigarette advertising and promotion in the US alone, and an additional $14 billion was spent on smokeless tobacco marketing. This equaled to more than $34 being spent on tobacco marketing for every dollar incurred when they pay cigarette retailers and whole-salers to reduce the overall price of cigarettes. In the US in 2008, price discounts, coupons, and retail-value-added promotions accounted for 83% of all tobacco marketing expenditures.

In addition to these techniques, tobacco companies are actively engaged in brand-stretching and other strategies to avoid regulation and marketing bans. They also utilize the Internet and other new media. The Internet allows participation and engagement unlike any other form of media, and has great potential for tobacco advertising. Additional attention must be paid to the use of the Internet in cigarette marketing, particularly social media sites.

Continued implementation of the WHO-FCTC and its provisions will increase comprehensive tobacco advertising, marketing, promotion, and sponsorship bans throughout the world.

### Cigarette Marketing Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Expenditures</th>
<th>Price Discounts, Coupons, and Promotional Allocations</th>
<th>Speciality Item Distribution</th>
<th>Retail-Value-Added Promotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$8,263.7m</td>
<td>23%</td>
<td>4.9%</td>
<td>8%</td>
</tr>
<tr>
<td>2011</td>
<td>$9,941 million</td>
<td>19%</td>
<td>3.6%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Tobacco Marketing...

#### In Print

In 2010, 97% of all advertising was noticed in the 30 days prior to the survey. According to the Campaign for Tobacco-Free Kids, US, 2011

#### In Films

“Smoking in films encourages children to take up smoking. And that’s no surprise. That’s why tobacco advertising was banned, because showing images of people, particularly glamorous young people, smoking encourages children to smoke.” Deborah Arnott, Action on Smoking and Health, UK, 2011

#### Online

“Is the Internet good for you? Tobacco marketing on the Internet is the next frontier in tobacco company advertising strategy.” Deborah Arnott, Action on Smoking and Health, UK, 2011

### Tobacco Advertising Seen by Adults in Low- and Middle-Income Countries

- **Philippines:** 53.7%
- **Pakistan:** 43.6%
- **Bulgaria:** 36.5%
- **Bangladesh:** 33.2%
- **Brunei:** 30.6%
- **Jordan:** 20.9%
- **Morocco:** 20.5%
- **Kazakhstan:** 13.9%

Percent of adults who noticed cigarette marketing in a store where cigarettes are sold.

### Percent of Youth Who Have Something With a Tobacco Logo on It

- Under 10%: 10.7%
- 10-14.9%: 20.5%
- 15-19.9%: 24.9%
- Above 25%: 10.7%
**TOBACCO UNDUE INFLUENCE**

**Election Contributions**

<table>
<thead>
<tr>
<th>Total Federal Contributions From Big Tobacco</th>
<th>From Republican Party to Democratic Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990–2010</td>
<td>Bill Clinton</td>
</tr>
<tr>
<td></td>
<td>George W. Bush</td>
</tr>
<tr>
<td></td>
<td>Al Gore</td>
</tr>
<tr>
<td></td>
<td>John Kerry</td>
</tr>
<tr>
<td></td>
<td>Dick Durbin</td>
</tr>
<tr>
<td></td>
<td>$3.6m</td>
</tr>
<tr>
<td></td>
<td>$3.6m</td>
</tr>
<tr>
<td></td>
<td>$8.6m</td>
</tr>
<tr>
<td></td>
<td>$6.6m</td>
</tr>
<tr>
<td></td>
<td>$6.9m</td>
</tr>
<tr>
<td></td>
<td>$7.2m</td>
</tr>
<tr>
<td></td>
<td>$6.9m</td>
</tr>
<tr>
<td></td>
<td>$7.2m</td>
</tr>
<tr>
<td></td>
<td>$8.6m</td>
</tr>
</tbody>
</table>

**United States of America**

In 2011, Leibnitz, the largest producer of toothpaste in the US, hired a former Tobacco Tobacco Administration employee who was a science and regulations expert. At the time of the hire, the FDA was considering restricting methyl alcohol use.

**THE INDUSTRY SAYS:**

“Potray the debate as one between the antismoking lobby and the smoker, instead of pro-health and public citizens versus the tobacco industry.”

**Philip Morris USA, 1952**

**ADVOCATES SAY:**

“We need to be alert and firm in protecting our tobacco control policies from the commercial and vested interests of the tobacco industry.”

**Estina Risubza, lawyer with HealthJustice, Philippines, 2011**

**RESEARCH SAYS:**

“Recent attempts by large tobacco companies to represent themselves as socially responsible have been widely dismissed as image management.”

**Gary Roddy et al., University of Bath, UK, 2013**

**Indonesia**

Sampoerna/Philip Morris International, Indonesia’s largest tobacco company sponsored a rescue camp on the slopes of Mount Merapi, a volcano that erupted in Central Java in 2010. Staff members at the camp were dressed in company-designed uniforms and drove company-branded vehicles and trucks with the same logos.

**Philippines**

Raguso said the tobacco industry must have smoke-free festivals in 2011. Philip Morris International, according to the World Health Organization, hired a former tobacco farm owner to direct a nutrition program.

**China**

China National Tobacco Corporation has sponsored at least 19 elementary schools, and thousands of students are exposed daily to pro-tobacco propaganda, names, and messages. School当局lor reads: “Smoking means hard work/ Tobacco helps you to be successful.”

**Australia**

Australia passed legislation to package all tobacco products in plain, unbranded packages by July 2012. Several members of the World Trade Organization voiced concern that plain packages would restrict the trade of tobacco.

“Ninety-seven percent of British American Tobacco’s money is spent here on two parties: the Liberal Party and the National Party. And they are asking us to [believe] this has no influence on their decision or whether they are going to support plain packaging or not.”

Nicole Atkins, Former Minister of Health and Ageing, Australia, 2011

**Total Federal Election Contributions From Big Tobacco (1990–2011)**

<table>
<thead>
<tr>
<th>Total Federal Election Contributions</th>
<th>From Republican Party to Democratic Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1.2m</td>
<td>Bill Clinton</td>
</tr>
<tr>
<td>$1.8m</td>
<td>George W. Bush</td>
</tr>
<tr>
<td>$2.0m</td>
<td>Al Gore</td>
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<tr>
<td>$2.3m</td>
<td>John Kerry</td>
</tr>
<tr>
<td>$2.0m</td>
<td>Dick Durbin</td>
</tr>
<tr>
<td>$1.4m</td>
<td>$3.4m</td>
</tr>
<tr>
<td>$1.1m</td>
<td>$3.4m</td>
</tr>
<tr>
<td>$1.0m</td>
<td>$2.7m</td>
</tr>
<tr>
<td>$0.1m</td>
<td>$2.6m</td>
</tr>
<tr>
<td>$1.0m</td>
<td>$1.6m</td>
</tr>
<tr>
<td>$1.4m</td>
<td>$1.8m</td>
</tr>
</tbody>
</table>
RESEARCH SAYS:

“We hold in our hands the solution to the global tobacco epidemic... The cure for this devastating epidemic is dependent not on medicines or vaccines, but on the concerted actions of government and civil society.”

Margaret Chan, Director-General, World Health Organization, 2008.

SOLUTIONS

THE NUMBER OF PEOPLE COVERED BY AT LEAST ONE MPOWER MEASURE AT THE HIGHEST LEVEL OF ACHIEVEMENT INCREASED BY 1.1 BILLION PEOPLE TO 3.8 BILLION BETWEEN 2008 AND 2010. THIS MEANS THAT

More Than Half of the world’s population is covered by at least one MPOWER measure.

See Glossary for details on MPOWER
RIGHTS AND TREATIES

WISDOM SAYS:
“Salus populi suprema est lex.”

The welfare of the people is the ultimate law.”

Oxford, Italy, 164-48 BCE

Most World Health Organization Member States have ratified the main treaty on tobacco, the WHO Framework Convention on Tobacco Control (WHO FCTC), making it one of the most rapidly embraced international treaties of ALL TIME. The Conference of Parties’ secretariat has been established and is currently developing protocols and guidelines.

Not surprisingly, the tobacco industry was and is against a strong, legally binding treaty. The industry prefers voluntary agreements and self-regulating market mechanisms, which are essentially ineffective in reducing tobacco use.

Contrary to tobacco industry arguments, implementing tobacco control measures will not harm national economies. The WHO FCTC has mobilized resources, rallied hundreds of nongovernmental organizations (NGOs), encouraged government action, led to the political maturation of health ministries, and raised tobacco control awareness in other government ministries and departments.

A human-rights-based approach to tobacco control helps to expand the discussion of the harm caused by tobacco use.

International Treaties, Conventions, and Agreements That Directly or Indirectly Address Tobacco Issues

1948 • UN UNIVERSAL DECLARATION ON HUMAN RIGHTS

1949 • TREATY OF ROME

1959 • UN CONVENTION ON THE RIGHTS OF THE CHILD

1976 • INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS

1979 • CONVENTION TO ELIMINATE DISCRIMINATION AGAINST WOMEN (CEDAW)

1995 • WORLD TRADE ORGANIZATION (WTO) Agreement on Tobacco and Trade (GATT)

UN High-Level Meeting on Noncommunicable Diseases (NCDs)

2021

• Only 28 such special sessions since 1948, and just one previously on health (AIDS)

• 34 world leaders attended the meeting

• An agreement to tackle the world’s major NCDs was approved by all member nations.

• The IETS Alliance formed of four federations uniting more than 2000 organizations

Notable:

WTO: as Secretariat, to prepare next steps (including recommendations for global targets, plans to issue laws to other 201 agencies, etc.) by the end of 2012

Countries to develop NCD policy by 2013

Civil society to support in myriad ways

The WHO FCTC, which came into effect in 2015, now covers 87.4% of the world’s population. Efforts are needed to enforce and implement all the WHO FCTC provisions.

WHO FCTC Parties

2003 • THE UN BUMS ON THE RESPONSIBILITIES OF TRANSNATIONAL CORPORATION AND OTHER BUSINESS ENTITIES WITH REGARD TO HUMAN RIGHTS

2005 • WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Address subsidies for raw tobacco and other tobacco, and addresses market access, domestic support, and export subsidies.

WHO AGREEMENT ON THE TRADE-RELATED ASPECTS OF INTELLECTUAL PROPERTY RIGHTS (TRIPS)

Recognizes that WTO Members may adopt measures necessary to protect human, animal, or plant life or health.

WHO AGREEMENT ON AGRICULTURE

Covers all agricultural products including tobacco and tobacco-derived products.

WHO AGREEMENT ON NONTARIFF BARRIERS TO TRADE (NTR AGREEMENT)

Requires WTO Members to ensure that all technical regulations are not more trade restrictive than necessary to achieve a level of public health at the border.

WHO AGREEMENT ON SERVICES

Covers tobacco advertising and promotion.

WHO AGREEMENT ON SUBSIDIES

Covers all tobacco subsidies.

WHO AGREEMENT ON TRADE AND SERVICES (GATS)

States that nothing shall be construed to prevent the adoption or enforcement of measures necessary to protect human, animal, or plant life or health.

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WHO AGREEMENT ON SUBSIDIES

Covers all tobacco subsidies.
PUBLIC HEALTH STRATEGIES

Chapter 23

SOLUTIONS

"Measure the distances. Estimate the expenses. Evaluate the forces. Assess the possibilities. Plan for victory."

HISTORY SAYS:

Tobacco control has evolved over the last 30 years from sporadic acts by activists and isolated action by some governments to a mainstream public health issue with known, proven, cost-effective measures. Needed now is a coherent public health strategy designed to reduce tobacco consumption, involving international, regional, national, and local actors involved in strategic planning, policy-oriented research, capacity building, funding, enforcement, and evaluation.

Surveillance is essential to support sound policy. Almost half of all countries have monitoring systems enhanced by research initiatives such as GATS, GATS, and STEPS. Yet research on tobacco continues to be underfunded throughout the world.

Core funding for the development and implementation of public health policy must come from governments themselves. In addition to academic research, various philanthropic organizations have funded policy-oriented research and tobacco control projects. As of 2010, Bloomberg Philanthropies has funded many projects in more than 60 countries. Philanthropist Michael Bloomberg and the Bill and Melinda Gates Foundation’s commitment of $500 million over seven years (2006–2013) more than triples the available resources to control tobacco in low- and middle-income countries.

The UN High-Level Meeting on noncommunicable diseases in 2011 offered a unique opportunity to move tobacco forward strategically in the framework of other NCD issues, such as cancer, diabetes, heart disease, chronic lung disease, physical activity, alcohol, and unhealthy diets (see Chapter 22 – Rights and Treaties).

Insufficient Resources

Tobacco Control Spending VS. Tobacco Tax Revenues

Annual per capita, USD, 2009

Governments collect nearly $21 billion in tobacco excise tax revenues each year, but spend less than 2% billion combined on tobacco control.

Public Health Strategy

To mobilize public action on priority health issues, those involved with the process must identify several points:

The problem and the scale of the problem, Monitoring and surveillance, including prevalence, health, economic impact, actions taken, experience, and lessons learned from other countries.

The public health objectives, and how these should be framed.

The key decision makers, to whom they answer, if they can be influenced, and how.

Groups or individuals to be involved (inside and outside government), and how these may be most effectively used: whether there should be a coalition and how it could be managed; whether anyone should not be included; what roles are assigned to the leaders; what budget is required; and who should oversee it.

Obstacles to the public health objectives and how to overcome or circumvent them.

Strengths and weaknesses of the opposition’s position and how to respond.

Media advocacy objectives.

PREVENTION: Monitoring Tobacco Use

Surveillance: Monitoring the Tobacco Epidemic

2010

Categories derived from WHO MPOWER classifications, 2011

Complete Monitoring

Moderate Monitoring

Minimal Monitoring

No Data

If you can’t measure it, you can’t manage it. (Art of War, 61 B.C.)

General Sun Tzu, Art of War, China, Circa 500 BCE

Foreword: How to Administer the Global Adult Tobacco Survey, Russia, 2009.

If you can’t measure it, you can’t manage it.
**SMOKE-FREE AREAS**

“Because there is no safe level of exposure to secondhand smoke, smoke-free areas are the only way to completely protect non-smokers from the harm of secondhand smoke. When smoke-free areas are created, levels of smoke exposure are more than 50% lower than where smoking is permitted. When indoor smoking areas are closed, ventilation is inadequate to eliminate secondhand smoke, and the reduction in smoking among smokers is less.

A 2010 Cochrane literature review assessed 31 studies measuring exposure to secondhand smoke after smoking bans, with 19 studies including biomarkers. The review concluded there is “consistent evidence that smoking bans reduced exposure to secondhand smoke in workplaces, restaurants, pubs, and public places.”

Some countries have now banned smoking in outdoor areas, such as those of restaurants and bars, in beaches, parks, and campuses, on the rationale that smoking may expose workers, non-smokers, patrons, and children to significant levels of secondhand smoke and readily preventable risks to health.

Public support is high for smoking bans in public places, including crowded outdoor areas. In regions where smoking bans have been mandated by law, employees, customers, and business owners report high compliance and satisfaction with the results, and compliance with smoke-free regulations increases over time. Independent studies consistently show no drop in employment or tax receipts.

Smoking bans, relatively inexpensive to implement, can produce immediate economic benefits to employers in the form of reduced accidental fire risk, lower insurance premiums, higher productivity, and lower employee absenteeism.

Current challenges are how to decrease smoking in the home, and how to regulate smoking in multifamily homes and in vehicles with small children.

---

**THE PUBLIC SAYS:**

“A few weeks before the [smoking] ban came into force in Ireland, Dublin banker Jimmy Fogarty asked the barman at his local pub: ‘What are you going to do when the ban comes in?’ ‘Breathe,’ the barman replied.”

*Bulletin of the World Health Organization, Ireland, 2006*
Quit Attempts
Percent of current smokers who have ever tried to quit, 2010

A 2000 survey in Rowett of 4,000 participants found 43% of all smokers stated that they wanted to stop smoking, and about 13% had attempted to quit. The biggest perceived barrier to quitting was uncertainty about “how to quit.”

There are only two ways to reduce tobacco use: prevent youth from starting to use tobacco and encourage and help users to quit.

To make a significant reduction in global tobacco related deaths, current smokers must quit. Unless they do, tobacco deaths will rise dramatically over the next 40 years, irrespective of whether youth uptake is reduced.

Some improvement of health is seen soon after quitting, and much of the harm can be eliminated over time, even for lifelong smokers.

General tobacco control policies, such as disseminating health information, mandating smoke-free areas, and implementing tax increases, can encourage smokers to quit. Most ex-smokers quit successfully on their own (“cold turkey”), but an increasing number of programs and aids are available to help smokers stop, some more effective than others. Nicotine replacement therapies (gum, patch, and inhaled) and pharmacologic agents such as bupropion, varenicline, and newer agents such as cytohesins are now available in many countries. Some jurisdictions, such as Hong Kong, have even introduced quitting services for teens. Many people change their health behaviors easily, while others struggle through a difficult cycle of addiction.

Communication technologies—such as telephone quit lines, text messaging, online counseling, and social media—offer support. Psychological and behavioral therapies, particularly behavior modification, but also less-tested modalities such as hypnosis, meditation, and acupuncture, also have been employed.

Research says:
“States can reduce death and disease by reducing smoking prevalence. It’s that simple.”
Gary Giovino, University of Buffalo, US, 2009

The Benefits of Stopping Smoking
Heart, blood pressure, circulation, breathing show improvement
Excess risk of coronary heart disease is half that of a continuing smoker
Risk of a stroke is reduced to that of non-smokers
Risk of lung cancer is reduced to less than half that of continuing smokers, risk of many other cancers decreases
Risk of coronary heart disease is similar to that of never-smokers and the overall risk of death is almost the same, especially if the smoker quits before illness develops

National Tobacco Dependence Treatment Services
2008 Global Guidelines

Quitting Resources Available by Country

2010: Cancers derived from WHO-FCTC classifications, 2002
National Quit Line, and Both NRT and Some Cessation Services
NRT and/or Some Cessation Services
Available
No
No Data

Cessation Services
National Policy and System
Official written policy on treatment
Specialized national treatment system
Help easily available in general practice settings

Percentage of countries surveyed that have the following in place to address tobacco dependence:

NRT and/or Some Cessation Services
Available
National Policy and System
Official written policy on treatment
Specialized national treatment system
Help easily available in general practice settings

Availability of NRT

Bupropion available
Varenicline available

“General Sale” of NRT (non-Pharma Settings)

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<tr>
<td>United States</td>
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<td>General sale</td>
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Mass media campaigns about the harms of tobacco can induce quitting and prevent young people from taking up the habit, especially if implemented as part of a comprehensive tobacco-control program.

Sandra Mullin, World Lung Foundation, US, 2011

Legislative and tax interventions for tobacco control are unlikely to reduce smoking rates without public awareness and support. Mass communication, health education, and reliable information are essential elements for tobacco control success. SUSTAINED USE OF MASS MEDIA CAMPAIGNS CONTRIBUTES TO POPULATION-LEVEL DECREASES IN SMOKING PREVALENCE BY INCREASING KNOWLEDGE ABOUT THE HARM OF TOBACCO USE, ENCOURAGING QUIT ATTEMPTS, AND IMPROVING QUIT RATES.

Funding for mass media campaigns is often cited as a barrier, yet mass media is a cost-efficient way to reduce smoking, because it reaches large segments of the population. Countries can save time and resources by adapting campaigns that have performed well in other jurisdictions for use in their own, subject to appropriate local testing. Of the 23 countries reporting at least one best-practice campaign, 10 were low- or middle-income, suggesting that mass media need not be a tool of only high-income countries. Public education is a core provision of the WHO Framework Convention on Tobacco Control. Yet, as shown by the WHO Report on the Global Tobacco Epidemic 2011, most countries should be doing more to inform their citizens adequately about the illnesses and deaths caused by tobacco. In nearly 150 countries surveyed, including 110 low- and middle-income countries, there is a paucity of antitobacco public education via mass media.

The scale of the tobacco epidemic warrants that governments give priority to implementing strong and effective campaigns.

**Ads With Visceral Images Are the Most Effective**

TV is the preferred medium for anti-tobacco advertising, but in low-income countries, where TV has minimal coverage, radio is an alternative, albeit less effective option.

---

*Anti-Tobacco Mass Media Campaigns: Duration of at least three weeks,Jan 2009–Aug 2010
Categories derived from MPOWER classifications, 2011

Campaign implemented with ALL appropriate characteristics

Campaign implemented with 5–4 appropriate characteristics

Campaign implemented with 1–4 appropriate characteristics

No Data

More appropriate characteristics support a stronger campaign.

---

**The Wheel of Mass Media Communications in Tobacco Control**

Campaign planning and implementation process for mass media advertising campaigns. Behavior change happens with multiple campaigns, sustained over time. Each campaign informs the next.

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**Adults Who Noticed Anti-Smoking Information on TV or Radio**

2008–2010 or latest available

<table>
<thead>
<tr>
<th>Country</th>
<th>Notice Rate</th>
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<tr>
<td>Brazil</td>
<td>67%</td>
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<tr>
<td>Ukraine</td>
<td>60%</td>
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<tr>
<td>India</td>
<td>59%</td>
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<tr>
<td>United States of America</td>
<td>58%</td>
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<tr>
<td>Mexico</td>
<td>55%</td>
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<td>Vietnam</td>
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<td>United Kingdom</td>
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<td>China</td>
<td>44%</td>
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<tr>
<td>Japan</td>
<td>41%</td>
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<tr>
<td>Bangladesh</td>
<td>41%</td>
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*APPROPRIATE CHARACTERISTICS* are based on whether the campaign was part of a comprehensive tobacco control program; whether research informed an understanding of the target audience; and whether messages were present, as well as how the campaign was presented (place, channel, and promotion); and the extent to which campaigns were measured.
Health warnings on the packaging of all tobacco products have progressed from simple, small, weak text warnings 30 years ago to strong, graphic warnings introduced by Canada in 2001. Currently, pictorial warnings have been adopted by about one-quarter of countries, with several in their second round of such warnings.

Health messages on cigarette packaging deliver important information directly to smokers. The message is repeated and reinforced every time a smoker reaches for a cigarette. Warnings should be extended to all forms of smoking and smokeless tobacco.

In 2012, plain packaging—specifically, the introduction of plain packaging that removes all product advertising including colors, logos, and brand imagery, and enforces standardization of cigarette packaging that makes the pack the tobacco's silent salesman, calling out from retailers' shelves and displayed by smokers 20 times a day. The ad men don't simply use the pack to tell us which brand is for women and which for men, or which brands are youthful and which are sophisticated. They can also use them to send out misleading, illegal signals giving the impression that one is less harmful or less addictive than another.

The industry says:

“BAT Australia is opposed to the introduction of plain packaging. It is unfair and unworkable and will inevitably bring with it significant unintended consequences.”

David Cross, CEO, BAT Australia, 2011

Government says:

“Plain packaging means that the glamour is gone from smoking.”

Stella Manol, Former Minister of Health and Ageing, Australia, 2011

Australia was the first country to adopt legislation to require plain packaging, and did so in the face of bitter opposition from the tobacco industry, including legal threats.

Action on Smoking and Health UK (ASH), a tobacco control advocacy group, explained, “Of all the laws on tobacco control, there are few the tobacco industry fears more than plain or standardized packaging. Even where tobacco advertising is banned, the pack is the tobacco’s silent salesman, calling out from retailers’ shelves and displayed by smokers 20 times a day. The ad men don’t simply use the pack to tell us which brand is for women and which for men, or which brands are youthful and which are sophisticated. They can also use them to send out misleading, illegal signals giving the impression that one is less harmful or less addictive than another.”

The first ten countries to introduce plain packaging

In one of its strongest provisions, Article 11 of the Framework Convention on Tobacco Control compels Parties, including legal threats.

GOVERNMENT SAYS:

“A Plain packaging of all tobacco products would remove a key remaining means for the industry to promote its products to billions of the world’s smokers and future smokers.”

Becky Freeman, Simon Chapman, and Matthew Rimmer, University of Sydney, 2011

In 2008 about 70% of Chinese smokers, irrespective of age, income, and education, believed that (“fancy box”) cigarettes are less harmful compared with (“plain box”) cigarettes.

Note: The laws in China are unclear about whether they apply to all tobacco products, or only cigarettes in boxes with imported paper.
Defendants have marketed and sold their lethal products with zeal, with deception, with a single-minded focus on their financial success, and without regard for the human tragedy or social costs that success exacted.

US District Judge Gladys Kessler, 2006

3 The slogan was then used on generic billboards and in advertisements appealing to women, gay and lesbian communities, and Native American audiences.


The industry says: "[Following advertising bans, marketing] evolved to a more focused, direct one-to-one approach. Philip Morris uses the database to target smokers for discount coupons and even chances to win a vacation in 'experiential programs.' The Marlboro brand is no longer just a brand to enjoy; it is an experience Marlboro Country.


PUBLIC STATEMENTS BY BIG TOBACCO deny that their marketing targets youth or affects youth smoking incidence and initiation, despite overwhelming evidence to the contrary.

New Media May Circumvent Ad Bans

3 55 countries had banned direct advertising on point-of-sale advertising, 2011

By 2010, 65 countries had banned direct advertising on the Internet.

A comprehensive ban on all tobacco advertising, promotion, and sponsorship could decrease tobacco consumption by about 28%, independent of other tobacco control interventions, with some countries experiencing a decline in consumption of up to 55%.

By 2010, 55 countries had banned direct advertising on point-of-sale advertising, 2011

By 2010, 65 countries had banned direct advertising on the Internet.

A comprehensive ban on all tobacco advertising, promotion, and sponsorship could decrease tobacco consumption by about 28%, independent of other tobacco control interventions, with some countries experiencing a decline in consumption of up to 55%.

Content

Pro-Tobacco

Anti-Tobacco

4%

25%

6%

71%

55%

28%

30%

59%

25%

33%

67%

55%

28%

30%

59%

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Among the revenue proposals I have examined, tobacco taxes are especially attractive because they encourage smokers to quit and discourage people from starting to smoke, as well as generate significant revenues. It’s a win-win for global health. — Bill Gates, G20 Summit, France, 2011

Tobacco taxes are among the most effective and important tobacco control policies. INCREASES IN TOBACCO TAXES THAT LEAD TO HIGHER CIGARETTE PRICES ENCOURAGE SMOKERS TO QUIT, INCREASE SUCCESSFUL QUIT ATTEMPTS, REDUCE THE NUMBER OF CIGARETTES SMOKED PER PERSON, AND PREVENT INITIATION AMONG YOUTH. A 10% increase in cigarette prices reduces cigarette demand by 2.4% in high-income countries and by 2.8% in low- and middle-income countries. Youth, minorities, and low-income smokers are more likely than others to quit smoking or to reduce their consumption in response to price increases. Because cigarette prices influence youth smoking initiation, increases in price significantly reduce long-term trends in cigarette consumption. In addition to reducing cigarette consumption, higher tobacco taxes increase tax revenues, which can be used to implement and enforce tobacco control measures or to pay for tobacco-related healthcare services or other social programs. On the other hand, tax cuts allow the industry to raise their profit margins.

Excise taxes have been shown to reduce tobacco consumption throughout the world. Other taxes that have been levied on tobacco, including import duties and sales taxes, apply to a wide variety of other goods and services. There are two types of excise taxes: specific and ad valorem. The decision to choose one or both types of tax has implications for government revenue, the retail prices of tobacco products, the tobacco industry’s profits, and public health. Understanding the mechanisms of these economic tools is crucial to implementing effective, evidence-based tobacco control policy.

The WHO Framework Convention on Tobacco Control obligates signatories to adopt tax and price policies that reduce tobacco consumption. Furthermore, the World Health Organization recommends that AT LEAST 70% OF THE RETAIL PRICE OF TOBACCO PRODUCTS COMES FROM EXCISE TAXES. ONLY FIVE NATIONS HAVE ACHIEVED THIS BEST PRACTICE STANDARD.

Tobacco Excise Tax Revenue as Percentage of Total Tax Revenues

The state of New Hampshire reduced its cigarette excise tax by 50 cents per pack, and immediately thereafter the tobacco companies raised their prices by the same amount, thereby shifting revenue from the state government to the tobacco industry. It is estimated that the cut will cost the state $14 million in lost revenues over a two-year period.

At least 10% WHO Member States imposed a tobacco excise tax on tobacco products in 2008 or later. At least 27 of them used a portion of tobacco tax revenues for health purposes as of 2020.

Tobacco taxes increase tax revenues, the retail prices of tobacco products, the tobacco industry’s profits, and public health. Understanding the mechanisms of these economic tools is crucial to implementing effective, evidence-based tobacco control policy.
LEGAL CHALLENGES AND LITIGATION

Strategies in the US

Tort Litigation

The industry used three arguments (a) smoking is not a proven cause of cancer (b) tobacco farming (c) tobacco advertising, promotion, and sponsorship.

History of Tobacco Tort Litigation

The industry says:

We will continue to use all necessary resources ... and where necessary litigation, to actively challenge unreasonable regulatory proposals.

Louis Camilleri, Chairperson and CEO, Philip Morris International, 2010

Litigation against the tobacco industry has been based on grounds such as “health危害, wrongful death, health-care costs, involvement in smuggling, racketeering, conspiracy, defective product, concealment of scientific evidence, fraud, deception, misconduct, failure to warn consumers and ignorance of the dangers of tobacco smoke, negligence, and exposing the public to unreasonable danger.”

The World Health Organization encourages individuals and governments to take legal action for the purpose of tobacco control.

Litigation puts the industry on the political bargaining table, and may result in large settlements. Beyond dollar amounts, other effects of awards or settlements may include the release of internal industry documents, agreements from the industry to restrict marketing: the channeling of settlement money to public health, increased media attention to the problem of tobacco use; decreased youth access to tobacco products; and improvements in protection from secondhand smoke. However, policy changes as a direct result of litigation have been limited.

Increasingly, tobacco companies and their allies are challenging effective legislative measures adopted by countries seeking to protect the health of their citizens. These legal challenges are expensive to defend and invariably delay implementation of laws passed in the interest of public health.

In November 2010 the WHO Framework Convention on Tobacco Control (WHO FCTC) Conference of Parties adopted the Porto del Este Declaration in support of FCTC Parties that are facing legal attacks for implementing the treaty and its guidelines.

As an outgrowth of the concerns about smoking initiated by the 2004 Surgeon General’s Report and the subsequent law requiring warning labels, the tobacco industry used the presence of such labels as a defense in the claims brought by smokers. While continuing to deny a causal link between smoking and plaintiffs’ diseases, tobacco companies also began to claim that, because of the warning labels and publicity about the claimed dangers of smoking, smokers knew as much as they did, a strategy known as the “assumption of risk” defense.

Litigation against the tobacco industry is always a means to an end. The policy changes that flow from a lawsuit are almost always a result of settlement rather than a direct result of legal action.

An 18-judge panel against British American Tobacco and its subsidiaries, as of December 31, 2010, 3,161

Litigation:

The government says:

It is fair to say that we are being targeted by what can only be described as subversive and disgraceful tactics by the tobacco industry, including using every available vehicle and opportunity to try and intimidate and/or threaten us to withdraw the legislation.

Jane Halton, Secretary of the Department of Health and Ageing, Australia, 2011

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CHAPTER 84

SOLUTIONS

Jonathan Winickoff, Harvard Medical School, US, 2010

In July 2011, the World Health Organization suggested a target of a 40% relative reduction in prevalence of current daily tobacco smoking among adults over 15 years of age by 2025 (from a 2010 baseline). This does not include smokeless tobacco or some of the new forms of tobacco. The reduction has yet to be adopted by Member States, but it is a start in encouraging countries to set targets within the overall parameter.

The future is mixed. On the one hand, many nations are beginning to take even stronger measures, and smoking prevalence is lower now than it was at the beginning of the 20th century—only 1% in the US in 1920. The 2010 end goal. On the other hand, even if smoking prevalence rates decline and youth uptake is reduced, the number of smokers in the world will still rise for the foreseeable future, due principally to world population growth in low- and middle-income countries.

One major future issue is that of smokeless products and alternative nicotine delivery systems. Tobacco companies are shifting from marketing traditional cigarettes to marketing tobacco smoking among adults over 15 years of age by 2025 (from a 2010 baseline). This does not include smokeless tobacco or some of the new forms of tobacco. The reduction has yet to be adopted by Member States, but it is a start in encouraging countries to set targets within the overall parameter.

The means to curb this pandemic are clear and within reach.

Future Policy Directions

Since the first edition of The Tobacco Atlas, huge strides have been made in the global effort to reduce smoking prevalence and harms, with many countries experiencing a reduction in smoking prevalence in the past 10 years. Nevertheless, it is projected that smoking will still cause 1 billion deaths in the 21st century (see chapter 5 – outs). An overwhelming evidence about the great costs of tobacco use to human health and life, as well as to the global economy, continues to emerge and be disseminated. Countries will need to become increasingly engaged in strategies to reduce the burden of tobacco use—and it is also likely the tobacco industry will continue to resist and obstruct such measures.

Recommended Future Policies and Actions

WHO FCTC
All countries that have not signed or ratified the World Health Organization Framework Convention on Tobacco Control should do so immediately. Those that have ratified it should implement all the Articles forthwith. This includes the whole range of legislative, tax, and other measures.

MILLENNIUM DEVELOPMENT GOALS
Given the evidence and global consensus on the negative impact of tobacco on a broad range of health and economic outcomes, tobacco control goals and targets should be included in the second round of the Millennium Development Goals in 2010.

UN HIGH-LEVEL MEETING
Following the UN High-Level Meeting on noncommunicable diseases, tobacco control goals and targets should be included in the health-care curriculum.

FUNDING
Government funding for health research, surveillance, and action is still lagging behind the urgency of the problems of tobacco as a health issue (see Chapter 23 – Public Health Strategies). Substantially increased funding—ideally from a percentage of tobacco tax—at country level is needed to reflect the burden that tobacco poses to human health and economies, and particularly to combat the issue in geographic areas where the number of tobacco users is increasing.

TOBACCO INDUSTRY REGULATIONS
Given the wealth of evidence showing that nicotine is a highly addictive drug, governments should move to regulate the tobacco industry, as well as any other industry producing nicotine products, as rigorously as possible, including licensing nicotine as an addictive drug.

Tobacco Taxes
National tobacco taxes serve as a major deterrent to initiating and maintaining a smoking habit (see Chapter 29 – Tobacco Control). Countries that have yet to implement important tobacco tax policies should seek to increase taxes to at least 70% of the retail price. Thirty-two countries, currently and worldwide, in the international terminals of airports and wilderness, should be prohibited.

Health Professionals
Based on the high level of smoking among healthcare professionals (see Chapter 12 – Health Professionals) and the need for health professionals to set an example, they should not smoke, medical and other health professionals should be smoke free, and teaching on tobacco control should be systematically introduced into the healthcare curriculum.

Quitting
While support that most people who smoke want to quit (see Chapter 25 – Quitting Smoking), but many find it difficult to do so, and quitting rates remain low. Support for individual, efforts to quit must be improved. Future quitting incentives may include monetary savings through rebate and lower health-care premiums.

Messaging
Health education messages and mass media campaigns have been shown to be effective and relevant in a range of cultural contexts. These messages should continue to be developed and disseminated more effectively.

New Tobacco Products
Research reflects a general confusion among the public about a range of tobacco products and their true harm (see Chapter 35 – Alternative Delivery System). As the tobacco industry introduces novel products, often purporting that these products reduce harm, awareness campaigns and media attention are sorely needed to inform the public about the true dangers of these products and to remind that there is no safe way to use tobacco.

The Optimist Says:
My prediction for the 2020s is that most of the types of cancer that were killing many people in 2010 will still be killing many people, and that the trends in premature death from cancer will be driven mainly by the extent to which people choose to stop smoking, rather than by improvements in treatment.

Sir Richard Peto, University of Oxford, UK, 2010

The Realist Says:
“Tobacco farming. Economies with large tobacco-farming areas need assistance and support on diversifying crops. New, controllable profitable uses for tobacco that can contribute, rather than harm, human health should be pursued.”

Tobacco Farming
Economies with large tobacco-farming areas need assistance and support on diversifying crops. New, controllable profitable uses for tobacco that can contribute, rather than harm, human health should be pursued.

NOT SPOTS
Media and advocates should partner to bring increased attention and sustainability to existing geographic “tobacco hot spots” particularly when litigation is being pursued and statistical, legislative, taxation, and other tobacco control action is being challenged.

Tobacco Industry Behavior
The tobacco industry has recently and increasingly taken to using legal and trade challenges to national legislation. A global strategy and support for countries that find themselves under legal threat need to be developed (see Chapter 35 – Legal Challenges and Litigation). In addition, the industry has introduced corporate social responsibility programs promoting voluntary measures as an effective way to address tobacco control, create a “/log of being a ‘sustainable’ company, and establish partnerships with health industries. It has also aimed the use of seemingly independent front groups to challenge science and frame funded businesses to make in legislative coalitions, and engaged in political lobbying. The behavior of the industry must be exposed and regulated, and the industry should have no place in discussions of tobacco control at any level.

Political Will
What works in reducing smoking rates has been known for decades. Political will is needed to implement such policies to protect the public from Big Tobacco, to protect victims of the industry to protect themselves from products that are highly addictive and economically harmful, and to seek legal remedies against the manufacturers of these products.
BCE–19th Century
Tobacco spreads around the world as a commercial crop.

6000 BCE
American First cultivation of the tobacco plant.

Circa 1 BCE
American Indigenous Americans begin smoking tobacco and using tobacco enemies.

American Native Indian myth
“In ancient times, when the land was barren and the people were starving, the Great Spirit sent forth a woman to save humanity. As she traveled over the world everywhere her right hand touched the soil, there grew potatoes. And everywhere her left hand touched the soil, there grew tobacco.”

1493
Christopher Columbus and his crew return to Europe from the Americas with the first tobacco leaves and seeds ever seen on the continent. A crew member, Rodrigo de Jones, is seen smoking and is imprisoned by the Inquisition, which believes he is possessed by the devil.

Early 1500s
Native American crops are introduced via Egypt to Turkish traders.

1530–1600
Chinese Tobacco is introduced via Japan or the Philippines.

1558
Europe Tobacco plant is brought to Europe. Attempts at cultivation fail.

1560
Africa Portuguese and Spanish traders introduce tobacco to Sub-Saharan Africa.

France Diplomat Jean Nicol, Lord of Villermain, introduces tobacco from Portugal. Queen Catherine de Medicis uses it to treat her mummies.

1577
Europe European doctors recommend tobacco as a cure for toothaches, falling fingernails, worms, hallucinations, lockjaw, and cancer.

1592-1598
Korea The Japanese Army introduces tobacco to Korea.

1592–1598
Japan Tobacco is first introduced.

1600s
China Philosophy Fang Yuhu points out that long years of smoking “scorch one’s lung.”

1603
Japan Use of tobacco is well-established.

1604
England King James I writes A Counterblaste to Tobacco: “Smoking is a custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black, stinking fume thereof nearest resembling the horrible stygian smoke of the pit that is bottomless.”

1608–1609
Japan Ban on smoking is introduced to prevent fires.

1612
America Tobacco is first grown commercially.

1614
England Seven thousand tobacco shops open following the first sale of Virginia tobacco.

1633
Turkey Death penalty is imposed for smoking.

1634
China Qing dynasty decodes a smoking ban, during which a violator is executed. The ban is not to protect health, but to address the inequality of trade with Korea.

1650s
South Africa European settlers grow tobacco and use it as a form of currency.

1661
England John Hill conducts the first study of the malignant effects of tobacco, showing that snuff users could contract nasal polyps.

1662
England First federal tobacco tax is introduced to help finance the Civil War.

1672
Korea Foreign cigarettes and matches are introduced.

1680s
England Richard Benson and William Hedges open a tobacco shop near Philip Morris’s in London.

1687
Korea The Japanese Army introduces tobacco to Egypt by Turkish traders.

1692 & 1717
Korea Bans on smoking in Chosen are introduced to reduce fire risk.

1700s
Africa American Africans are forced to work in tobacco fields.

Europe Smoking becomes the most popular mode of tobacco use.

Circa 1710
Russia Peter the Great encourages his courtiers to smoke tobacco and drink coffee, which were seen as fashionable and pro-European.

1719
France Smoking is prohibited in many places.

1735
Sweden Botanist Carolus Linnaeus names the plant genus Nicotiana and describes two species, Nicotiana rustica and Nicotiana tabacum.

1761
England John Hall conducts the first study of the malignant effects of tobacco, showing that snuff users could contract nasal polyps.

1769
New Zealand Captain James Cook arrives smoking a pipe, and is promptly dressed in case he is a demon.

1771
France A French official is condemned to be hanged for admitting foreign tobacco into the country.

1788
Australia Tobacco arrives with the First Fleet. 11 ships that sailed from England carrying mostly convicts and cage.

1795
Germany Samuel Thomas von Swinemütt reports cancers of the lip afflicting pipe-smokers.

1800
Canada Tobacco is first grown commercially.

1813
US Phosphorus friction matches are introduced on a commercial scale, making smoking more convenient.

1840
France Frederic Chopin’s mistress, the Baroness de Dudevant, becomes one of the first women to smoke in public (in Paris).

1854
England Philip Morris begins making his own cigarettes. Old Bond Street soon becomes the center of Britain’s retail tobacco trade.

1858
China Treaty of Tianjin allows cigarettes to be imported into China duty-free.

1862
US First federal tobacco tax is introduced to help finance the Civil War.

1876
Korea Foreign cigarettes and matches are introduced.

1880s
England Richard Benson and William Hedges open a tobacco shop near Philip Morris’s in London.

1881
US First practical cigarette-making machine is patented by James Bonsack, producing 100,000 cigarettes a day, replacing the labor of 50 people. Production costs plummet, and cigarette smoking begins its explosive growth.

Circa 1890s
Indonesia Clove cigarette, the karekin, is invented.

Pre-1900
Lung cancer is still extremely rare.

1894
England Philip Morris, Esq., a tobaccoconcern and importer of fine cigars, opens a shop in London selling hand-rolled Turkish cigarettes.

1895
England Philip Morris begins making his own cigarettes. Old Bond Street soon becomes the center of Britain’s retail tobacco trade.

1908
China Treaty of Tianjin allows cigarettes to be imported into China duty-free.
20th Century

As tobacco becomes big business, science finds evidence of tobacco-related illness.

1900–1910

Edward Bernays mounts a “freedom march” of smoking into New York City’s Fifth Avenue, launching a campaign by the Tobacco Institute under Leo Burnett.

1911

The Reader’s Digest publishes a Frank Statement to the World, a full-page ad, “A FRANK STATEMENT TO THE WORLD,” warning that smoking causes cancer.

1913

The three-year community study North Carolina Healthy Lifestyle Programme shows a significant reduction in smoking.

1914

The Surgeon General’s report on smoking and health announces “the most dangerous development in the viability of the tobacco industry that has yet occurred.”

1915

The first American anti-tobacco billboards are introduced.

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Germany

Bull.”

Germany

Fritz Lickint of Dresden publishes the first formal statistical evidence of lung cancer–tobacco link, based on a case series showing that lung cancer sufferers are likely to be smokers.

Germany

The Marlboro cowboy is created.

HISTORY OF TOBACCO

20TH CENTURY
20TH CENTURY

1981
Japan: Professor Takeshi Hirama publishes the first linking passive smoking and lung cancer in the nonsmoking wives of men who smoked.

1983
Europe: ERC Group Plc. an independent market research group publishes first European Tobacco Market Report.

1984
US: FDA approves nicotine gum as prescription medicine. Following efforts to suppress its use by Philip Morris.

1985
US: Lung cancer surpasses breast cancer as number one cancer killer of women. By 1985, 75% of the world's tobacco is grown in low- and middle-income countries.

1986
Washington, D.C.: First International Conference on Tobacco and Health is held.

1987
International Network for Tobacco Control (INDEPTH) is founded.

1988
Japanese: First WHO report on the effects of smokeless tobacco is published.

1989
Pakistan: First Framingham Heart Study finds cigarette smoke increases risk of stroke.

1990
Western Pacific Region: First free year WHO Action Plan on Tobacco or Health is published.

1991
Europe: Globalink, the international interactive website and marketplace founded by the International Union Against Cancer, is inaugurated for the international tobacco control community.

1992
International Network of Women Against Tobacco (INWAT) is formed.

1993
China: Chinese Association on Smoking and Health is inaugurated. changing its name to the Chinese Association on Tobacco Control in 2014.

1994
India: First conference on women and tobacco is initiated by the IACC (International Union Against Cancer), the Union Cancer Foundation, and the Health Promotion Agency of Northern Ireland.

1995
Thailand: Major comprehensive tobacco control laws come into effect, including first ingredient disclosure provisions.

1996
Europe: European Network on Young People and Tobacco (ENPYT) is founded.

1997
Europe: European Network for Smoking Prevention is created.

1998

1999
Europe: WHO FCTC.

2000
US: US Congress passes the Family Smoking Prevention and Tobacco Control Act. It raises its tobacco tax, impose laws as prescription medicine, following the international tobacco control movement.

2001
US: Tobacco Control Resource Centre is founded.

2002
US: The Bellagio Statement that tobacco is a major threat to sustainable and equitable development is issued by members of Congress for the international tobacco control industry.

2003
Northern Ireland: First conference on women and tobacco is initiated by the IACC (International Union Against Cancer), the Union Cancer Foundation, and the Health Promotion Agency of Northern Ireland.

2004
Austria: First TABEXPO held in Vienna. TABEXPO stages exhibitions and congresses for the international tobacco control industry.

2005
International Network of Women Against Tobacco (INWAT) is founded.

2006
Europe: European Network for Tobacco Control and Eliminate Smoking (ENYPAT) is founded.

2007
US: Cigarette executives testify before Congress that in their opinion nicotine is not addictive.

2008
Northern Ireland: First conference on women and tobacco is initiated by the IACC (International Union Against Cancer), the Union Cancer Foundation, and the Health Promotion Agency of Northern Ireland.

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2019
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2020
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2030
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21st Century

2000
Framework Convention Alliance (FCA) of NGOs is formed to support the WHO Framework Convention on Tobacco Control (WHO FCTC) and related protocols.

2001
- First Luther L. Terry Awards are given for contributions to tobacco control.
- Global Partnerships for Tobacco Control is founded by Essential Action to help support and strengthen international tobacco control activities at the grassroots level.
- International Tobacco Evidnece Network (FIRE) is established, with the goal of expanding global research.
- Stockholms Foundation International Health Research Awards are established for “Trading Tobacco for Health” in selected Association of Southeast Asian Nations countries.
- South Africa Tobacco Products Control Amendment Act comes into effect, strictly regulating smoking and advertising.

2002
- FirstFogarty International Center, National Institutes of Health, allocates funding for tobacco research projects.
- World Medical Association launches the Doctors’ Manifesto for Global Tobacco Control.
- Tobacco web-based databases and educational resources for treatment of tobacco dependence are established by the Society for Research on Nicotine and Tobacco.
- The Global Network of Pharmacists Against Tobacco is launched.

2003
- Ireland Workplace smoking ban, including pubs and restaurants, is implemented, showing significantly reduced salivary cotinine concentrations among nonsmoking staff.
- World Tobacco Day is published by the American Cancer Society and World Health in Mumbai.

2004
- Ireland Workplace smoking ban is conclusively refuting extensive advertising, promotion, and sponsorship could decrease tobacco consumption by about 7%.
- United States x. Philip Morris Racketeer Influenced and Corrupt Organizations (RICO) case is the largest litigation ever undertaken by the US government, and Judge Gladys Kessler finds tobacco companies guilty of racketeering and bootlegging in the American public.
- Second edition of The Tobacco Atlas is published by the American Cancer Society and launched at the 15th World Conference on Tobacco or Health in Washington, D.C.

2005
- World Dental Federation (FDI) launches Tobacco or Health in the European Union: Past, Present and Future, the first comprehensive overview of tobacco control in the 25 EU member countries plus Nepal, Iceland, and Switzerland.
- Ghana Environment Minister Kalbert Oduro announces a ban on smoking in restaurants, educational institutions, and bars.
- Canada Complete ban on tobacco advertising, promotion and sponsorship comes into effect.
- Global Partnerships for Tobacco Control at Johns Hopkins University.

2006
- First UN High-Level Meeting on noncommunicable diseases includes tobacco as a major risk factor for the four main NCDs (cancer, cardiovascular disease, chronic lung disease, and diabetes).

2007
- The Bill and Melinda Gates Foundation and Bloomberg Philanthropies jointly pledge additional financial resources to reduce tobacco use in low- and middle-income countries, bringing the total outlay to $500 million over seven years, 2006–2013.
- India Third edition of The Tobacco Atlas is published by the American Cancer Society and World Health in Singapore.

2008
- The Global Smokers’ Partnership is formed to promote effective smoke-free air policies worldwide.
- First WHO MPOWER report on the global status of the tobacco epidemic is published, and published every two years thereafter.

2009
- India Complete ban on tobacco advertising and promotion comes into effect.
- Annual revenues from the global sale of all tobacco products so sold globally increased by half a trillion dollars.
- China grows 43% of the world’s tobacco, 3.8 million hectares of agricultural land.
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2010
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- First comprehensive overview of tobacco control in the 25 EU member countries plus Nepal, Iceland, and Switzerland.

2011
- World Economic Forum on smoking in restaurants, educational institutions, and bars.
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"Never let the future disturb you. You will meet it, if you have to, with the same weapons of reason which today arm you against the present." — Marcus Aurelius Antoninus, Roman emperor (AD 121–180)
ADDITION

Physiological or psychological dependence on a substance characterized by neurochemical changes, compulsive drug-seeking behaviors, dose tolerance, withdrawal symptoms, uncontrolled cravings, and self-destructive behaviors. Common addictive drugs include alcohol, stimulants, cocaine, heroin, and nicotine.

ADVERTISING

Any commercial effort to promote tobacco consumption, including the display of trademarks, brand names, and advertising materials, marketing of tobacco products, sponsorship of sports and other social and cultural activities, and other methods.

BCE

Before the Common Era.

BILLION

1,000 million, or 1,000,000,000.

BRAND STRETCHING

A marketing approach by tobacco companies in which cigarette brand names are attached to advertisements for nontobacco products (such as clothing).

GLOSSARY

Several words and terms that are used in the tobacco control field and tobacco health.
environmental tobacco smoke (ETS).

Also known as smokeless tobacco.

A disease).

An organization with a goal of tobacco control.

The number of deaths attributable to tobacco products.

A condition in which a blood vessel in the brain bursts or is clotted by a blood clot. This leads to an inadequate blood supply to the brain and to the death of brain cells, and usually results in temporary or permanent neurological deficits. Smoking significantly increases the risk of stroke.

A group of toxic chemicals found only in tobacco products. The most carcinogenic include N-nitrosodimethamine (NDMA), 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK), 4-(methylnitrosamino)-1-(3-pyridyl)butane (NN) and 4-amino-1-(3-pyridyl)butane (ANB). Tobacco-specific nitrosamines (TSNA) are nitrogen-containing compounds that evaporate at room temperature. VOCs contribute to respiratory disorders such as asthma and bronchitis.

A smoking cessation aid that works by inhibiting the consumption of tobacco products by burning, chewing, inhaling, or other forms of ingestion.

Varenicline

smokeless tobacco

An organic (carbon-containing) compound that evaporates at room temperature. COCs contribute significantly to indoor air pollution and respiratory disease.

Tobacco tax evasion

TOBACCO TAX EVASION

Illegal methods of circumventing tobacco taxes.

Small- and local smokers involves the purchase, by individuals or small groups, of tobacco products in low-tax jurisdictions in amounts that exceed the limits set by customs regulations, for smuggling or resale in high-tax jurisdictions.

Large-scale smuggling involves the illegal transportation, distribution, and sale of large quantities of tobacco products that generally avoid all taxes.

illegal methods of circumventing tobacco taxes.

To facilitate the sale or placement of tobacco products. Also includes special offers, gifts, price discounts, coupons, company websites, specialty item distribution, and telephone advertising used to facilitate the sale or placement of any tobacco product. Also includes allowances paid to retailers, wholesalers, full-time company employees, or any other persons involved in tobacco distribution.

Tobacco industry documents

Previously secret internal industry data, including previously undisclosed information about industry maneuvers. Includes special offers, gifts, price discounts, coupons, company websites, specialty item distribution, and telephone advertising used to facilitate the sale or placement of tobacco products. Also includes allowances paid to retailers, wholesalers, full-time company employees, or any other persons involved in tobacco distribution.

Relative income price (RIP) of cigarettes

A percentage of annual per capita income (measured by per capita GDP) required for the purchase of 100 packs of cigarettes. The lower the RIP, the more affordable cigarettes are.

Tobacco use

The consumption of tobacco products by burning, chewing, inhaling, or other forms of ingestion.
<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>REGION</th>
<th>WHO Group</th>
<th>Latest Available</th>
<th>Male and Female Crude Tobacco Use Boys' &amp; Girls' Tobacco Use</th>
<th>Total Cell and Female Crude Tobacco Use</th>
<th>Total Cell and Female Crude Tobacco Use</th>
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<tbody>
<tr>
<td>Afghanistan</td>
<td>Asia Pacific</td>
<td>Middle High</td>
<td>37.7</td>
<td>3.3</td>
<td>9.9</td>
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<td>Europe</td>
<td>High</td>
<td>28.7</td>
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**Note:** All data are from World Health Organization's 'Global Tobacco Use 2022'. Data is classified as 'female' for 'female only' and 'total' for 'total'. For more information, see data for age range.
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**NOTE:** The table above is a simplified representation of the data provided in the document. The actual table contains more detailed information.
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<td>10.3</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1.2</td>
<td>-</td>
</tr>
</tbody>
</table>

**Women who smoke in 100s, with a Tobacco light in USD**
SOURCES AND METHODS

SOURCES AND METHODS


When only electronic data were available, the capital city was selected. If the capital city was not selected, the most populous city was used. The use of electronic data is indicated on the figure, with a unique index to the citywide data sets.

Question Where Miss-Goa
Rebs Breden
Data derived from sources linked to the U.S. Government.

Percentage of Girls Susceptible to Smoking

Survey (GSHS) were used when it provided (unless otherwise noted above).

GSHS data were used for:


11 SMOKELESS TOBACCO

Indonesia

Main Map

The Global Kids+ Network.

Smokeless Tobacco

Review and Potential Impacts (p. 151-156).


Alma: Tobacco in a Global Perspective. Geneva: World Health Organization. (2006). Patterns of global tobacco use in the capital city was selected. If the capital city was not selected, the most populous city was used. The use of electronic data is indicated on the figure, with a unique index to the citywide data sets.


Alma: Tobacco in a Global Perspective. Geneva: World Health Organization. (2006). Patterns of global tobacco use in the capital city was selected. If the capital city was not selected, the most populous city was used. The use of electronic data is indicated on the figure, with a unique index to the citywide data sets.


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Sources and Methods

SOURCES

Netherlands, New Zealand, Nicaragua, Mauritius, Mexico, Moldova (Republic of), Madagascar, Malaysia, Malta, Iran (Islamic Republic of), Iraq, Israel, Indonesia, India, Georgia, Guatemala, Greece, Germany, Ghana, Gambia, Gabon, France, Fiji, Portugal, Paraguay, Pakistan, Panama, Peru, Panama, Nicaragua, Nepal, Netherlands, Mozambique, Morocco, Myanmar, Mexico, Malawi, Latvia, Liberia, Kenya, Korea, Kuwait, Kazakhstan, Japan, Jordan, Jordan, Lebanon, Laos, Kyrgyzstan, Kenya, Korea, Kyrgyzstan, Korea, Korea, Kazakhstan, Jordan, Iran (Islamic Republic of), Israel, Indonesia, India, Georgia, Guatemala, Greece, Germany, Ghana, Gambia, Gabon, France, Fiji, Portugal, Paraguay, Pakistan, Panama, Peru, Panama, Nicaragua, Nepal, Netherlands, Mozambique, Morocco, Myanmar, Mexico, Malawi, Latvia, Liberia, Kenya, Korea, Kuwait, Kazakhstan, Japan, Jordan, Jordan, Lebanon, Laos, Kyrgyzstan, Kenya, Korea, Kyrgyzstan, Korea, Kazakhstan, Jordan, Iran (Islamic Republic of), Israel, Indonesia, India, Georgia, Guatemala, Greece, Germany, Ghana, Gambia, Gabon, France, Fiji, Portugal, Paraguay, Pakistan, Panama, Peru, Panama, Nicaragua, Nepal, Netherlands, Mozambique, Morocco, Myanmar, Mexico, Malawi, Latvia, Liberia, Kenya, Korea, Kuwait, Kazakhstan, Japan, Jordan, Jordan, Lebanon, Laos, Kyrgyzstan, Kenya, Korea, Kyrgyzstan, Korea, Kazakhstan, Jordan, Iran (Islamic Republic of), Israel, Indonesia, India, Georgia, Guatemala, Greece, Germany, Ghana, Gambia, Gabon, France, Fiji, Portugal, Paraguay, Pakistan, Panama, Peru, Panama, nicotine, tobacco

SOURCES AND METHODS

SOURCES

Effect of Smoke-Free Ban 


Pollutants & Emissions

A. Global Health


B. Tobacco Control


C. Indoor Air Quality

Quint Attitudes


2 MASS MEDIA CAMPAIGNS

Main Map


The Wheel of Mass Communication


Bono vs. TV


SOURCES AND METHODS

SOURCES AND METHODS

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In 2011, the World Health Organization (WHO) released the report "The Tobacco Epidemic 2011: The Mekong Region" which highlights the current status of tobacco control efforts in the region. The report is based on data collected from countries in the Mekong Region, including Cambodia, Laos, Myanmar, Thailand, and Vietnam. The report provides an overview of the tobacco epidemic in the region, including the prevalence of smoking, secondhand smoke exposure, and the impact of tobacco on public health. It also includes information on the tobacco control efforts in place and the challenges that remain in the region.

The report finds that tobacco use remains a significant public health issue in the region, with high prevalence rates among adults and teenagers. The report also notes that secondhand smoke exposure is widespread, affecting both adults and children. The report highlights the need for stronger tobacco control policies to address these issues and improve public health outcomes.

The report recommends a range of measures to address the tobacco epidemic in the region, including increasing taxes on tobacco products, implementing smoke-free policies, and providing quitting support services. The report also highlights the importance of international cooperation and support to address the tobacco epidemic.

Overall, the report provides a comprehensive overview of the tobacco epidemic in the Mekong Region and the need for stronger tobacco control policies to address the issue. It is a valuable resource for policymakers, public health practitioners, and others working to address the tobacco epidemic in the region.
Nearly 20% of the world's population smokes cigarettes, including about 450 million men and 200 million women. An estimated 600,000 individuals die annually from secondhand smoke, and 78% of these deaths are among women and children. More than half the countries of the world have a female smoking prevalence rate of less than 10%. Smoking rates between boys and girls differ by less than five percentage points in almost half of the world’s countries.

Smokers consumed nearly 5.9 trillion cigarettes in 2009. Tobacco is grown in 124 countries, occupying 3.8 million hectares of agricultural land. China grows 43% of the world’s tobacco, which is more tobacco than the other top nine tobacco-producing countries combined.

Annual revenues from the global tobacco industry are approaching half a trillion dollars. Cigarettes account for 92% of the value of all tobacco products sold globally. The amount of smokeless tobacco sold globally increased by 59% between 2000 and 2010.

If illicit trade were eliminated, governments worldwide would gain at least $31.3 billion a year in tax revenue. Governments collect nearly $133 billion in tobacco tax revenues each year, but spend less than $1 billion on tobacco control. WHO recommends that at least 70% of the retail price of tobacco products come from excise taxes. At least 86% of WHO Member States imposed a tobacco excise tax, and at least 14% use a portion of tobacco tax revenue for health purposes. Some countries are now envisioning an end game for tobacco, with prevalence targets of under 5%.

The WHO Framework Convention on Tobacco Control has altered the landscape, proving it was possible to defy the industry and reduce tobacco use if strategies were properly applied. This all-new fourth edition expands upon the qualities that made the original an essential tool for understanding the tobacco epidemic. Full-color maps and striking graphics present carefully researched and sourced data in a clear, accessible format. Produced by a global collaboration of scientists and researchers, this easy-to-understand compendium of facts is a compelling survey of the tobacco trade and its financial and human costs— and what can be done to avert a global health catastrophe.

TOPICS INCLUDE

- The harm caused by tobacco
- Global smoking prevalence
- E-cigarettes and other emerging nicotine delivery systems
- Affordability of cigarettes
- Global smuggling of tobacco use
- Costs to society
- Illicit trade and the black market
- Public health strategies to reduce tobacco use

SINCE THE FIRST PUBLICATION OF THE TOBACCO ATLAS A DECADE AGO, ALMOST 50 MILLION ADDITIONAL PEOPLE HAVE BEEN KILLED AS A RESULT OF USING TOBACCO, AND MORE THAN 43 TRILLION CIGARETTES HAVE BEEN SMOKED. IF TRENDS CONTINUE, 1 BILLION PEOPLE WILL DIE FROM TOBACCO USE IN THE 21ST CENTURY.

Product Code: 967404
www.TobaccoAtlas.org

THE TOBACCO ATLAS
FOURTH EDITION
Completely Revised and Updated

Michael Eriksen
Judith Mackay
Hana Ross

ERIKSEN, MACKAY, ROSS
THE TOBACCO ATLAS
FOURTH EDITION
10-YEAR ANNIVERSARY EDITION

Mere lists of statistics cannot truly express the immensity of the tobacco epidemic. To understand its complexity and global reach requires an all-encompassing view that is compelling and easily comprehensible, such as that presented here in The Tobacco Atlas, Fourth Edition.

Ten years ago, the groundbreaking first edition of The Tobacco Atlas appeared as the world prepared to take unified action against tobacco. Since then, clean air laws, advertising bans, tobacco taxes, and the WHO Framework Convention on Tobacco Control have altered the landscape, proving it was possible to defy the industry and reduce tobacco use if strategies were properly applied.

This all-new fourth edition expands upon the qualities that made the original an essential tool for understanding the tobacco epidemic: Full-color maps and striking graphics present carefully researched and sourced data in a clear, accessible format. Produced by a global collaboration of scientists and researchers, this easy-to-understand compendium of facts is a compelling survey of the tobacco trade and its financial and human costs—and what can be done to avert a global health catastrophe.