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Economics of Tobacco Control Paper No. 18

# The Tobacco Epidemic in South-East Europe

## Consequences and Policy Responses

Ivana Bozicevic, Anna Gilmore and Stipe Oreskovic

March 2004

Tobacco Free Initiative  
World Health Organization





# **THE TOBACCO EPIDEMIC IN SOUTH-EAST EUROPE**

*Consequences and Policy Responses*

**Ivana Bozicevic, Anna Gilmore and Stipe Oreskovic**

**March 2004**

## Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## ECONOMICS OF TOBACCO CONTROL PAPER NO. 18

### The Tobacco Epidemic in South-East Europe: Consequences and Policy Responses

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This report is the result of the Stability Pact Partnership Project to Reduce Tobacco Dependence in South-East Europe, initiated by the Andrija Stampar School of Public Health in Croatia and funded by the Network Public Health Programs, Open Society Institute (OSI) NY. The project was carried out by the Andrija Stampar School of Public Health with support from the London School of Hygiene and Tropical Medicine.

Earlier drafts of the report were presented at the OSI conference on “Effective Advocacy and Movement Building for Tobacco Control” held in Bucharest in April 2003 and at the sixth meeting of National Coordinators from South Eastern Europe organized by the Stability Pact Initiative for Social Cohesion in Sarajevo in May 2003.

**Abstract:** This report gives an overview of the tobacco epidemic and tobacco control policies in the countries of south-east Europe: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Romania and Serbia and Montenegro. It brings together data on tobacco consumption, smoking prevalence and the disease burden from tobacco use, reviews issues on the economics of tobacco, the tobacco industry and the policy responses developed to date to control the tobacco epidemic in south-east Europe. These data, combined with the evidence presented on the impact of tobacco control policies, can be used to underpin the development of stronger national and regional tobacco control policies.

**Keywords:** tobacco, tobacco control, south-east Europe, Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Romania, Serbia and Montenegro, Yugoslavia, Former-Yugoslavia, tobacco tax, cigarettes, prevalence, smoking, cessation, tobacco dependence, passive smoking, second-hand smoke, ETS, tobacco epidemic, burden of disease, lung cancer, cigarette tax, economics of tobacco, economics of tobacco control, smoking, tobacco policy, tax policy, price elasticity, demand for cigarettes, tobacco tax revenues, tobacco industry, tobacco farming, smuggling, FCTC.

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## LIST OF ABBREVIATIONS

B&H	Bosnia and Herzegovina
BAT	British American Tobacco
CAFAO	Customs and Fiscal Assistance Office
CARDS	Community Assistance for Reconstruction, Development and Stabilisation
CEE	Central and Eastern Europe
CINDI	Countrywide Integrated Non-Communicable Disease Intervention Programme
CPI	Consumer Price Index
DALY	Disability-Adjusted Life Year
DIN	Duvanska Industrija Nis
DIV	Duvanska Industrija Vranje
EEC	European Economic Community
ERC	Economic Research Service
ESPAD	European School Survey Project on Alcohol and Other Drugs
ETS	Environmental Tobacco Smoke
EU	European Union
FCTC	Framework Convention on Tobacco Control
FR Yugoslavia	Federal Republic of Yugoslavia
FSU	Former Soviet Union
FTFA	For a Tobacco-Free Albania (NGO)
GYTS	Global Youth Tobacco Survey
HBSC	Health Behaviour in School-Aged Children
IARC	International Agency on Research on Cancer
ICD-10	International Statistical Classification of Diseases and Related Health Problems – tenth revision
ISO	International Organization for Standardisation
JTI	Japan Tobacco International
NATIONS	National Tobacco Information Online System
NATO	North Atlantic Treaty Organization
NGO	Non-Governmental Organizations
NRT	Nicotine Replacement Therapy
OECD	Organization of Economic Cooperation and Development
OSCE	Organization for Security and Co-operation in Europe
SAP	Stabilisation and Association Process
SECI	South-East European Co-operation Initiative
SEE	South East Europe
SNTR	Romanian Tobacco Company (Societatea Nationala Tutunul Romanesc)
TFI	Tobacco Free Initiative
TTC	Transnational Tobacco Company
TDR	Tobacco Company Rovinj (In Croatian: Tvornica duhana Rovinj)
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UNMIK	United Nations Interim Administration Mission in Kosovo
UK	United Kingdom
UN	United Nations
US	United States
USDA FAS	United States Department of Agriculture Foreign Agricultural Service
US FTC	United States Federal Trade Commission
VAT	Value-Added Tax
WHO	World Health Organization
WHO HFA	World Health Organization Health for All





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## FOREWORD

In 1999, the World Bank published “Curbing the Epidemic: governments and the economics of tobacco control”, which summarizes the trends in global tobacco use and the resulting immense and growing burden of disease and premature death. By 1999, there were already 4 million deaths from tobacco each year, and this huge number is projected to grow to 10 million per year by 2030, given present trends in tobacco consumption. Already about half of these deaths are in high-income countries, but recent and continued increases in tobacco use in the developing world is causing the tobacco-related burden to shift increasingly to low- and middle-income countries. By 2030, seven of every ten tobacco-attributable deaths will be in developing countries. “Curbing the Epidemic” also summarizes the evidence on the set of policies and interventions that have proved to be effective and cost-effective in reducing tobacco use, in countries around the world.

Tax increases that raise the price of tobacco products are the most powerful policy tool to reduce tobacco use, and the single most cost-effective intervention. They are also the most effective intervention to persuade young people to quit or not to start smoking. This is because young people, like others with low incomes, tend to be highly sensitive to price increases.

Why are these proven cost effective tobacco control measures –especially tax increases– not adopted or implemented more strongly by governments? Many governments hesitate to act decisively to reduce tobacco use, because they fear that tax increases and other tobacco control measures might harm the economy, by reducing the economic benefits their country gains from growing, processing, manufacturing, exporting and taxing tobacco. The argument that “tobacco contributes revenues, jobs and incomes” is a formidable barrier to tobacco control in many countries. Are these fears supported by the facts?

In fact, these fears turn out to be largely unfounded, when the data and evidence on the economics of tobacco and tobacco control are examined. The team of about 30 internationally recognized experts in economics, epidemiology and other relevant disciplines who contributed to the analysis presented in “Curbing the Epidemic” reviewed a large body of existing evidence, and concluded strongly that in most countries, tobacco control would not lead to a net loss of jobs and could, in many circumstances actually generate new jobs. Tax increases would increase (not decrease) total tax revenues, even if cigarette smuggling increased to some extent. Furthermore, the evidence show that cigarette smuggling is caused at least as much by general corruption as by high tobacco product tax and price differentials, and the team recommended strongly that governments not forego the benefits of tobacco tax increases because they feared the possible impact on smuggling, but rather act to deter, detect and punish smuggling.

Much of the evidence presented and summarized in “Curbing the Epidemic” was from high-income countries. But the main battleground against tobacco use is now in low- and

middle-income countries. If needless disease and millions of premature deaths are to be prevented, then it is crucial that developing countries raise tobacco taxes, introduce comprehensive bans on all advertising and promotion of tobacco products, ban smoking in public places, inform their citizens well about the harm that tobacco causes and the benefits of quitting, and provide advice and support to help people who smoke and chew tobacco, to quit.

In talking to policy-makers in developing countries, it became clear that there was a great need for country-specific analytic work, to provide a basis for policy making, within a sound economic framework. So the World Bank and the Tobacco Free Initiative of the World Health Organization (as well as some of the WHO regional offices and several other organizations, acting in partnership or independently) began to commission and support analysis of the economics of tobacco and tobacco control in many countries around the world.

The report presented in this Economic of Tobacco Discussion Paper makes a valuable contribution to our understanding of tobacco control issues in the countries of south-east Europe. Our hope is that the information, analysis and recommendations will prove helpful to policy makers, and help result in stronger policies to reduce the unnecessary harm caused by tobacco use.

*Joy de Beyer*

Tobacco Control Coordinator  
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## PREFACE

This document gives an overview of the tobacco epidemic and tobacco control policies in the countries of south-east Europe: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Romania and Serbia and Montenegro.

It brings together data on tobacco consumption, smoking prevalence and the disease burden from tobacco use, reviews issues on the economics of tobacco, the current status of the tobacco industry and the policy responses developed to date to control the tobacco epidemic in south-east Europe. These data, combined with the evidence presented on the impact of tobacco control policies, can be used to underpin the development of stronger national and regional tobacco control policies.

The report highlights the magnitude of the tobacco epidemic in south-east Europe and its daunting consequences for human health. It argues that tobacco control must become a priority for governmental bodies responsible for health in the region, that there is an urgent need to mobilize institutional and financial resources and develop human capacities in order to implement effective tobacco control programs.

It is hoped that this report can contribute to these efforts and that tobacco control will take its rightful place on the region's development agenda. The first chapter provides an introduction to the region. The last chapter outlines conclusions and recommendations. The interceding seven chapters provide an overview of the issues and potential solutions. Each has an executive summary at the end to assist the hard-pressed reader.





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## EXECUTIVE SUMMARY

Smoking is the single largest cause of premature mortality in the developed world. Obtaining accurate estimates of smoking's impacts in south east Europe (SEE) is hindered by the lack of accurate data. It is nevertheless estimated that in 1995 in males aged 35-69 approximately one-third of deaths in Romania and Bulgaria and somewhat more in the former Yugoslavia were attributable to tobacco. Although in females the proportion was much lower at between 5 and 10%, this represents a large increase from 1985. Data on lung cancer incidence and mortality are unreliable but nevertheless indicate the very high levels of disease compared with other countries in Europe, particularly in Croatia, Bosnia and Herzegovina, Serbia and Montenegro and among men in the region as a whole.

Cigarette consumption data are also of limited accuracy given the high rates of smuggling in the region but suggest that average per capita cigarette consumption in south-east Europe in 1999 was 35.2% higher than the European Union (EU) average and higher even than levels in central and eastern Europe. None of the countries of the region yet conduct regular national surveys of adult smoking prevalence and some have no recent nationally representative data available. The available smoking prevalence data show that male smoking rates tend to be higher than in the EU while in women, rates are more similar, and in some cases lower, than in the EU. Rates in Bosnia and Herzegovina and Serbia are particularly high in both genders. The few historical data and age specific rates suggest female smoking rates are increasing markedly while rates in men show little change. The very high rates among medical personnel are cause for concern.

Youth smoking surveys are now conducted in most countries as part of international projects and show rates broadly similar to the EU. Trends in youth smoking can only be assessed in Croatia and show an increase between 1995 and 1999 in both genders.

The collapse of communism and the end of the conflicts in the 1990s has led to major changes in the region's tobacco industry. The previously state-owned tobacco monopolies have either undergone or are undergoing privatization and the transnational tobacco companies have been increasingly active both in importing their cigarettes to, and investing in, the region. These changes can be expected to increase competition in the tobacco industry which will in turn drive down prices and increase advertising, thereby stimulating consumption.

The available statistics, combined with the changes to the region's tobacco industry, suggest that the health impacts of tobacco in SEE will continue to worsen over coming years. Tobacco will therefore remain a major threat to the health of the people of SEE unless comprehensive and immediate efforts are taken to curb its use.

Effective tobacco control requires the implementation of a comprehensive set of measures including tax increases and the control of smuggling, consumer information on the impacts of smoking, complete bans on advertising and promotion, restrictions on

smoking in public places and the provision of accessible and affordable smoking cessation services including nicotine replacement therapies.

Despite the magnitude of the health and economic problems caused by tobacco, it has historically been attributed relatively little importance as a public health issue in SEE. Indeed, most countries in the region currently lack intersectoral action plans with which to control the tobacco epidemic. There are several explanations for the lack of action. Most notably the power of the tobacco industry lobby, weaknesses of regulatory, police and judicial systems, the presence of corruption and organized crime and its links to cigarette smuggling, and the relative powerlessness of the public health lobby.

Despite these substantial barriers, many countries in the region are starting to make good progress in tobacco control, for example in implementing advertising bans, establishing anti-smoking campaigns and smoking cessation services. The situation varies widely between countries and there is obvious room for improvement, particularly in enforcing existing legislation. For example, although all countries have a ban on tobacco advertising on national television and radio, many allow other forms of advertising, and bans on indirect advertising are rare. Moreover, the industry is exploiting loopholes in the law in continuing to use billboard advertising in a number of countries where it has been banned.

It has become increasingly apparent that individual states are no longer able to control all the factors that drive the global tobacco epidemic. This has led to a growing recognition of the need for international and global partnerships to control tobacco use. In Europe, the EU plays a key role in developing supranational legislation. The European region of the WHO has also led the way on tobacco control, with a series of regional Action Plans (from 1987 onwards) and a European Strategy for Tobacco Control adopted in 2002. Globally, the adoption of the World Health Organization's Framework Convention on Tobacco Control has the potential to make an enormous contribution to decreasing the burden of tobacco-related disease but among the south-east European countries, only Bulgaria has signed the treaty, and no country has ratified it yet.

Involvement of various government bodies (ministries of finance, labor, agriculture, education, trade and customs administration) and mobilization of human and financial resources is critical to ensuring effective tobacco control. There is a wealth of evidence on the effectiveness of a range of interventions that governments can use to reduce tobacco consumption. Tobacco control is generally highly cost-effective as part of a basic public health package in middle-income countries.

Although each country needs to adopt policies to match its situation, based on our findings and evidence of effectiveness, we make the following general recommendations for improving tobacco control in SEE:

1. Comprehensive national programs to prevent and reduce tobacco use should be developed as a public health priority. This will require intersectoral collaboration from various government departments and civil society groups including non-governmental organizations.

2. The provision of information about the dangers of both active and passive smoking should be improved. This should occur through a number of avenues including mass media and counter-advertising campaigns, the improvement of health warnings on cigarette packages and a ban on misleading product descriptors such as “light” and “mild”.
3. Tobacco taxation should be increased as one of the most effective means of reducing tobacco consumption, while also raising government revenue.
4. Tobacco control measures are highly cost-effective public health interventions and should receive adequate state funding. Consideration should be given to allocating at least 1% of the tobacco taxes raised in each country to fund tobacco control activities or smoking cessation services for the poorest smokers.
5. All countries that do not yet have comprehensive bans restricting the use of direct and indirect tobacco advertising should enact them. Countries with such bans already in place need to ensure they are adequately enforced.
6. All countries should work towards ensuring smoke-free environments in work-places and public places.
7. Action against smuggling must be made a priority. This will require international collaboration, a stronger customs infrastructure and sufficiently severe penalties for smuggling. Ideally all parties in the chain between a manufacturer and a consumer should be licensed and each pack of cigarettes stamped with a serial number to enable tracking. The role that cigarette manufacturers play in smuggling should be explored, they should be made responsible for ensuring that cigarettes reach their intended final destination and be held accountable for their actions.
8. Access to smoking cessation services including nicotine replacement therapies should be widened. This could most easily be achieved by integrating smoking cessation services into primary care, deregulating conditions for the sale of cessation products and, where feasible, making such services part of a basic health insurance package. Consumers should be given better information about the treatments available.
9. Health professionals should play a more active role in tobacco control by urging their governments to recognize the importance of tobacco as a major cause of death and illness and providing smoking cessation services. Study of the health impacts of tobacco and training in smoking cessation should therefore be covered as part of the medical undergraduate and post-graduate curricula.
10. Health professionals in the region will need to quit smoking before their advice will be taken seriously. To help achieve this objective, hospitals and health clinics that are not already smoke-free should become so and medical staff should be offered access to smoking cessation services.
11. The development of new non-governmental organizations, and support for existing non-governmental organizations with expertise in tobacco control and public health advocacy, are essential for the development of effective tobacco control policies in SEE. Governments should also be encouraged to engage with such organizations.

12. Data collection systems must be improved to provide regular and accurate data on tobacco consumption and smoking prevalence. This will require data on cigarette imports, exports and sales, national surveys of smoking prevalence and ideally national household surveys which can be used to estimate household expenditure on and consumption of tobacco and thus the consumption of legally and illegally purchased cigarettes.
13. To improve the validity of tobacco-attributable mortality and morbidity data, data definitions and collection systems need to be reviewed and accurate population data provided through thorough and regular censuses. To enable assessment of tobacco-attributable mortality, questions on past smoking habits should be added to death certificates.
14. Research on tobacco should inform and guide health policy planning and fill the many gaps that currently exist in SEE. Such research might include:
  - Assessment of public understanding of the health impacts of active and passive smoking, intentions to quit and attitudes to tobacco control
  - Elasticity-of-demand studies to help set target levels of cigarette taxation, and assessment of the opportunities for, and barriers to, harmonization of prices at regional level
  - Analysis of tobacco industry activity and influence at the country and regional level, including industry relationships with governments, the media and scientists and assessment of industry advertising and marketing strategies
  - Economic analysis of the impacts of tobacco use in SEE
  - Analysis of the effectiveness and cost-effectiveness of new tobacco control measures that are implemented.
15. Ideally health impact assessments should be performed before tobacco industry privatization so that the potential negative impacts can be identified and mitigated. Governments privatizing their tobacco industries should also ensure that adequate tobacco control policies, in particular taxation controls and comprehensive advertising bans are in place before privatization occurs.
16. The countries of SEE should be encouraged to sign and ratify the Framework Convention on Tobacco Control to ensure its success as a global tobacco control treaty.

# CHAPTER 1: INTRODUCTION AND BACKGROUND

## INTRODUCTION

This report is one of the first attempts to bring together data on the tobacco epidemic and the current tobacco control policy responses to it in the countries of south-east Europe (SEE), namely Albania, Bosnia and Herzegovina (B&H), Bulgaria, Croatia, Macedonia, Romania and Serbia and Montenegro (the former Federal Republic of Yugoslavia<sup>1</sup>). Before presenting this data however, it is first necessary to provide some background on the region and its countries.

## BACKGROUND

### 1.1 Stability Pact

This research is focused on the countries of SEE that form the Stability Pact (Figure 1). The Stability Pact was established by a European Union (EU) initiative in 1999 with the aim of strengthening post-conflict restoration and economic growth in the region. In addition to the EU, many international organizations and agencies are involved, including the organizations and agencies of the United Nations (UN), the Organization for Security and Co-operation in Europe (OSCE), the Council of Europe, the North Atlantic Treaty Organization (NATO), the Organization of Economic Cooperation and Development (OECD), the European Bank for Reconstruction and Development, the European Investment Bank and others. The core countries of the Stability Pact are Albania, B&H, Croatia, Serbia and Montenegro and Macedonia, with Bulgaria and Romania also participating in most Stability Pact initiatives and projects (1).

B&H, Croatia, Macedonia and the Federal Republic of Yugoslavia became independent states in early 1990, after the former Socialist Federal Republic of Yugoslavia disintegrated. This disintegration did not happen peacefully, but was followed by wars, that started in 1991 in Croatia, 1992 in B&H, 1998 in Kosovo and 1999 in Macedonia. Kosovo, once an autonomous county in ex-Yugoslavia is now a protectorate of the UN. B&H is divided into two separate entities: the Federation of B&H and the Republika Srpska.

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<sup>1</sup> In February 2003 the Federal Republic of Yugoslavia (FR Yugoslavia) split into Serbia and Montenegro. As this research started in 2001, data collection was done for the territory of FR Yugoslavia. This is explained in the document where appropriate.



**Figure 1. Map of south-east Europe**



*Source:* European Commission/ The World Bank. Economic Reconstruction and Development in South-East Europe. Available at: <http://www.seerecon.org/>

*Note:* In 2003 the Federal Republic of Yugoslavia became the State Union of Serbia and Montenegro.

Bulgaria and Romania have been in formal negotiations with the EU on accession since 1999 while other countries (Albania, B&H, Croatia, Macedonia, Serbia and Montenegro) are preparing for negotiations on potential accession through the Stabilisation and Association Process (SAP). The SAP recognizes these countries as potential candidates for EU accession and strongly emphasizes the improvement of regional co-operation as a pre-condition for EU membership (1, 2).

The Stability Pact acts through three working tables one of which (Working Table II - Economic Reconstruction, Development and Co-operation) addresses the health sector within its Initiative for Social Cohesion. This recognizes that poor socio-economic standards and inadequate social infrastructure can contribute to social and political instability and poor health outcomes. The Initiative's Expert Sub-Group for Health is led by the World Health Organization (WHO) and the Council of Europe. Its main aim is to assist governments in defining national priorities for the health sector, reducing health inequalities and modernizing legislative and regulatory frameworks. Within the Social Cohesion Initiative collaborative multi-national networks will be developed thus providing opportunities to exchange knowledge and experience (3). Although the Stability Pact provides funding for health sector projects in each of the participating countries, none of these projects has so far addressed tobacco control issues. Instead, the focus is on harmonizing health sector legislation for EU integration, building capacity in public health and some health service functions, particularly in the areas of communicable disease control and mental health.

The CARDS (Community Assistance for Reconstruction, Development and Stabilisation) program is the main way in which the EU channels financial and technical assistance to the countries of SEE. The largest single financial allocations were made to reconstruction and economic development linked to refugee return, justice and home affairs, reform of public administration and statistics and the improvement of countries' capacities to fight organized crime (4).

## 1.2 Background data on the countries of south-east Europe

Although quite heterogeneous in terms of socio-economic development and population health status, SEE is Europe's poorest region. It has undergone enormous changes in the last 15 years with the demise of communism, conflicts among the countries of ex-Yugoslavia and economic collapse. This has considerably weakened public health and health care capacities. The collapse of communism has been shown, in studies conducted largely outside SEE, to have had an enormous and largely negative short-term impact on health (5, 6, 7). But little is yet known about the longer-term impact of these changes. Inside SEE, the consequences of the wars were daunting - two hundred thousand people were killed in B&H alone and many more left disabled. Hundreds of thousands of people were displaced. In all countries, health care infrastructures were damaged, particularly in B&H and Kosovo. The health professions inevitably had to focus their work on the provision of care to the wounded and displaced, and the control of communicable diseases, which spread during war. This of course precluded the development of effective chronic disease management and disease prevention programs including tobacco control.

The total population of the seven countries is around 44 million, with individual country populations varying from slightly more than 2 million in Macedonia to 22.4 million in Romania. GDP per capita varies widely, ranging in 2001 from US\$ 1180 in B&H to US\$ 4566 in Croatia (Table 1). In comparison with the central and eastern European (CEE) countries where the macroeconomic situation had largely stabilized by the mid 1990s, most of the SEE countries are achieving economic growth and stability more slowly. The region's economic output in 2001 remained 12% below its 1990 level while the GDP of selected CEE countries (Czech Republic, Hungary, Poland, Slovak Republic, Slovenia) was on average 19% higher (8).

**Table 1. GDP/capita (US\$)**

	1999	2000	2001	GDP in 2001 as % of 1990
Albania	1090	1103	1218	122
B&H			1180	-
Bulgaria	1577	1542	1690	82
Croatia	4399	4344	4566	89
Macedonia	1821	1771	1674	97
Romania	1585	1644	1772	86
Serbia and Montenegro	976	970	1260	49

Source: WIIW Balkan Observatory 2002/03. (8)

Unemployment rates are high, ranging in 2001 from 9.6% in Romania to 32% in Macedonia and 43% in B&H (Table 2). These figures are considerably higher than in the accession countries of CEE – the average unemployment rate in the Czech Republic, Hungary, Poland, Slovak Republic and Slovenia is 12%, under half that in most of the Stability Pact countries (8).

**Table 2. Total unemployment rate for all ages (%) and total population (number)**

	1999	2000	2001	2002	2003 (forecasts)	Population data - latest available estimates (thousands of persons)
Albania	18.0	16.8	14.6			3,435
B&H	39.0	39.4	41.0	43.0		3,900
Bulgaria	16.0	17.9	17.3	17.1	16.0	7,891
Croatia	20.4	22.3	23.1	22.2	22.0	4,437
Macedonia	32.4	32.2	30.5	32.0	32.0	2,036
Romania	11.8	10.5	8.6	9.6	10.0	22,409
Serbia and Montenegro	25.5	26.7	27.9	28.5	30.0	8,338

*Source:* WIIW Balkan Observatory 2002/03. (8)

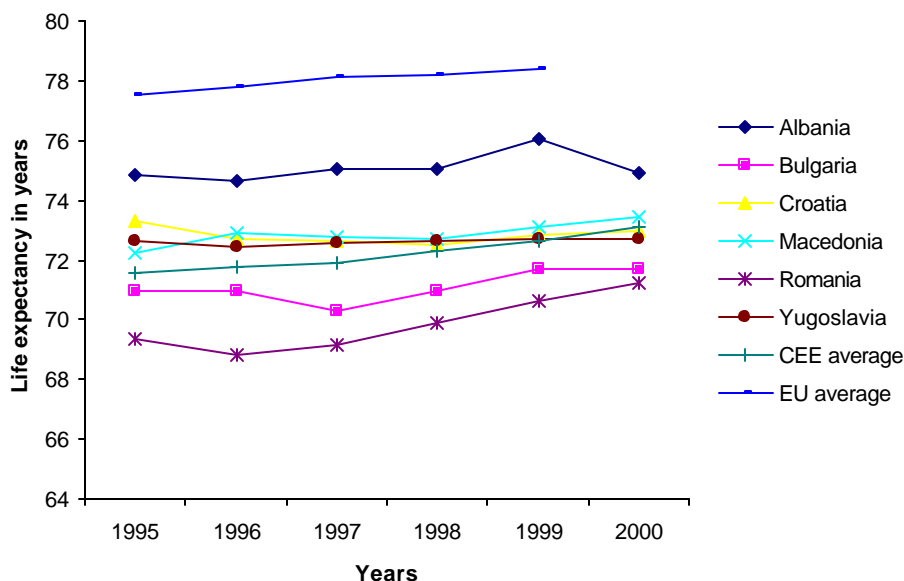
### **1.3 Health data and research in the region**

In terms of population health research, the countries of ex-Yugoslavia and Albania today represent probably the least explored region in Europe. The paucity of research relates in part to the disruption of war and transition and the absence of accurate data that resulted in particular from the large-scale and mostly unquantified population movements during wartime. But it is also due to the lack of capacity and awareness of the importance of using population health data for research and policy making (9, 10). The quality of health indicators is inadequate, particularly when compared to the EU, and for B&H most health indicators in the WHO Health for All (HFA) Database have simply not been available since 1991 (11).

Life expectancy data in the early 1990s, for example, is unreliable because of the large-scale population movements at that time. In addition, separate life expectancy data for the individual republics of former Yugoslavia (B&H, Croatia, Macedonia, Serbia, and Montenegro) are not available prior to 1990. We therefore present life expectancy data post-1995 (Figure 2). Over the last 5 years, life expectancy at birth increased in Macedonia, Romania and Bulgaria while in 2000 it decreased in Albania. In Croatia and FR Yugoslavia there were no substantial changes in the average length of life. On average, life expectancy in the SEE countries is 5.5 years less than in the EU and 0.5 years less than in CEE (11).

Other health data also need to be interpreted with caution as there is much potential for inaccuracy in population and mortality estimates during the 1990s (9, 12). Censuses undertaken in the last two years or planned for future years will enable a more accurate assessment of population health outcomes in the region.

**Figure 2. Average life expectancy at birth in CEE, EU and SEE countries**



Source: WHO HFA Database. WHO Regional Office for Europe. Copenhagen. 2003.

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## CHAPTER 2: TOBACCO USE IN SOUTHEAST EUROPE

### 2.1 Background

Tobacco use can be measured using both cigarette consumption and smoking prevalence and the two are inter-related. Consumption is measured as the number of cigarettes or weight of tobacco consumed per adult per day. Consumption data have the advantage of being easy to obtain and available in comparative form for different countries. The disadvantages are that as sales data collected for tax purposes are generally used, consumption will be underestimated where smuggling is common. Consumption will also fluctuate with price and incomes and tells us little about the number of people smoking. Reliable data on cigarette consumption are however, important, as they can be used as a proxy indicator of the future burden of tobacco-related disease in a population (1).

Prevalence data are probably a better marker of smoking behavior at a population level. They fluctuate less on a short-term basis and are more relevant to policy formulation as they help direct appropriate policies and assess their effectiveness in specific age, sex and socio-economic groups (2). Similarly, data on urban or rural residence, age of onset of tobacco use and frequency of use are also useful, particularly given the evidence on the additional health risks of starting young. Unfortunately however, population surveys are required to provide accurate data on prevalence and its determinants.

Prevalence is usually measured differently in adults and young people. Youth surveys tend to ask about smoking during a specific period of time preceding the survey, and adult surveys about daily smoking. Finally, smoking prevalence data among the medical profession are sometimes specifically recorded as this population group can act as an example to others and play a crucial role in encouraging smoking cessation. Smoking rates in this group are usually lower than in the general population (3).

This section aims to bring together the most recent and comprehensive data on tobacco consumption in the region while highlighting issues of data accuracy.

### 2.2 Methods

We aimed to identify which data were routinely collected for each country and to review all available data in the region since the beginning of the 1990s.

A number of databases and data sources were searched for this purpose including the WHO HFA Database (4), WHO European Database on Tobacco Control (5), Tobacco Control Country Profiles (6), National Tobacco Information Online System NATIONS (7) and Tobacco FactFile (8). Additional data were sought from tobacco control experts in the region and historical data from Forey et al. (9).

We attempted to identify prevalence data by gender and age group in the general population, among doctors and young people. We also sought data on the determinants of smoking, knowledge of the health impacts of smoking and levels of exposure to environmental tobacco smoke (ETS). For some indicators, information differed among data sources. The decision about the final inclusion of data was made according to the quality and consistency of surveys and by consulting national experts.

### 2.2.1 Data accuracy

Many of the surveys used to assess smoking prevalence used different methods and surveyed different population groups, which limits the comparability of data between countries.<sup>2</sup> In SEE the major limitation of consumption data is the widespread smuggling of cigarettes. We attempt to highlight these issues where appropriate.

## 2.3 Tobacco use in youth

Three major European projects have estimated youth smoking prevalence: the Health Behavior in School-Aged Children (HBSC)<sup>3</sup>, The European School Survey Project on Alcohol and other Drugs (ESPAD)<sup>4</sup> and the Global Youth Tobacco Survey (GYTS).<sup>5</sup>

HSBC included Croatia and Macedonia for the first time in 2001/2002. Croatia was the only SEE country that participated in ESPAD in 1995, but in 1999 participation extended to Bulgaria, Macedonia and Romania (10, 11). The ESPAD survey examined 15 to 16 year olds and uses the proportion who have smoked cigarettes 40 times or more in their lifetime as an indication of those who smoke more or less regularly. For the four SEE countries included in the 1999 ESPAD survey, sample sizes ranged from 2393 in Romania to 5391 in Bulgaria and response rates from 87% to 92%. The Romanian sample included students outside the 15-16 year old age range and therefore the results are not directly comparable with other ESPAD countries.

Using ESPAD data, the highest prevalence of regular smoking was found among boys in the Faroe Islands (47%) and girls in Greenland (55%). In SEE countries, the prevalence of smoking in boys was found to be 35% in Bulgaria, 31% in Croatia, 22% in Macedonia and 23% in Romania. The smoking prevalence in girls was 38% in Bulgaria, 25% in Croatia, 18% in Macedonia and 10% in Romania. In boys, rates in SEE were similar to those seen in the EU countries while rates in Romanian girls were lower and in Bulgarian girls higher than their EU counterparts (Table 3).

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<sup>2</sup> WHO has led efforts to standardize definitions and survey questions. Several countries are now adopting these standards, for example, Bulgaria's National Statistical Institute used them in the 1996 and 2001 prevalence surveys.

<sup>3</sup> The HBSC was initiated in 1982 by researchers from England, Finland and Norway and was shortly thereafter adopted by the WHO Regional Office for Europe as a WHO Collaborative Study.

<sup>4</sup> ESPAD is a collaborative project initiated in 1993 by the Swedish Council for Information on Alcohol and Other Drugs. Its main purpose is to collect comparable data on alcohol, tobacco and drugs among 15-16 year old students in as many European countries as possible.

<sup>5</sup> WHO and the US Centers for Disease Control and Prevention (CDC) developed the GYTS to track tobacco use among youth across countries using a common methodology and a core questionnaire.

Trends over time for ESPAD could only be assessed for Croatia where prevalence increased between 1995 and 1999 from 27% to 31% in boys and 18% to 25% in girls. None of the other European countries included saw a decline in use over this period.

**Table 3. Prevalence of youth smoking in EU countries included in the 1999 ESPAD survey (those who smoked 40 times and more during their lifetime)**

	<b>Males (%)</b>	<b>Females (%)</b>
Denmark	31	32
Finland	41	38
Greece	28	27
Iceland	24	26
Ireland	31	36
Italy	22	28
Norway	31	34
Portugal	18	15
Sweden	26	25
United Kingdom	24	28

*Source:* ESPAD Report 2000.

The GYTS (12) provides the most recent comparative youth smoking data for the region. The data are not however directly comparable with ESPAD data as the definition of smoking used (the current use of any tobacco product) and the age groups surveyed (13-15 year olds)<sup>6</sup> differ somewhat from those used in the ESPAD. The data are presented for the countries for which they are currently available: Bulgaria, Croatia, Macedonia, B&H, Serbia and Montenegro (Table 4). The student response rate ranged from 88% in Macedonia to 93% in Croatia. The sample size ranged from 2090 in Montenegro to 5030 in Republika Sprska and 5198 Federation of B&H.

The lowest smoking prevalence was found in both boys and girls in Montenegro (5%) and the highest in Bulgaria – 31% and 43% respectively. As GYTS data are not available for Albania and Romania, we present the findings from the study by Shuperka in Albania and the ESPAD survey for Romania. The Albanian sample, which covers an older age group and is based on a different definition of smoking cannot be compared directly with other data. The Romanian sample, as well as the other ESPAD data, cover an older age group and in general therefore indicate higher smoking prevalence.

A further study on smoking habits among medical students in Tirana, Albania carried out in 2000 found that amongst first year students, 34% of men and 5% of women smoked and that the proportions increased to 55% and 34% among fifth year students (13).

<sup>6</sup> The GYTS is designed to cover 13-15 year olds. It is a school-based survey, and the grades that include predominantly 13-15 year olds are sampled. However, these classrooms also include some older and younger students. In Bulgaria, the data presented cover only 13-16 year olds in grades 7, 8 and 9. In the other countries, the data are for all children in the classrooms sampled: primary grades 7 and 8 and the first grade of secondary school in Republic Srpska, Croatia, Serbia and Montenegro; and grades 6, 7 and 8 in Bosnia and Herzegovina.



**Table 4. Prevalence of Youth Smoking**

	Male s (%)	Females (%)	Ages or Grades	Year of survey	Definition of smoking	Source of information
Albania	49	15	15-19	1999	Those smoking every day	Shuperka R. Assessment of smoking prevalence among adult population (15+years) in Albania. 2000.
Federation of B&H Rep Srpska	19 15	12 12	Grades 6 - 8 Grades 7, 8, 1 <sup>st</sup> Secondary	2003 2003	Currently use any tobacco product	Fact sheet. GYTS Fact sheet. GYTS
Bulgaria	31	43	13-16	2002	Currently use any tobacco product	GYTS data provided by Dr T Timtcheva, published by A. Manolova, National Center of Hygiene, Medical Ecology and Nutrition 2003
Croatia	19	15	Grades 6-8, 1 <sup>st</sup> Secondary	2002	Currently use any tobacco product	Fact sheet. GYTS
Macedonia	12	8	Grades 6-8, 1 <sup>st</sup> Secondary	2002	Currently use any tobacco product	Fact sheet. GYTS
Romania	23	10	15-16 <sup>7</sup>	1999	Smoked cigarettes 40 times or more in lifetime	ESPAD Report. 2000.
Serbia Montenegro	16 5	17 5	Grades 7, 8, 1 <sup>st</sup> Secondary	2003	Smoking cigarettes 40 times or more in lifetime	Fact sheet. GYTS

Source: As stated in table. Note: Albania and Romania data are not comparable to GYTS data.

## 2.4 Tobacco use in adults

### 2.4.1 Smoking prevalence

The most recent and accurate adult smoking prevalence data available are presented in Table 5. Comparability of these data is limited as the surveys used different methods and only the Albanian, Bulgarian, Croatian and Serbian samples are national. Female smoking prevalence rates were lowest in Romania, Albania and Bulgaria and highest in the former-Yugoslav countries with rates varying from 10% to 33%. In men rates ranged from 32% to 60%. Prevalence rates in Serbia and Montenegro and B&H are higher than

<sup>7</sup> In Romania ESPAD also included other age groups

in all EU member states (Table 6), while in the other countries of SEE, male smoking rates are higher but female smoking rates are similar to or lower than in the EU. No data are available for the general population of Macedonia, although high cigarette consumption levels, and high rates of smoking among medical staff (see below), a group that usually has a lower smoking prevalence than the general population, suggest that population rates are likely to be high.

**Table 5. Prevalence of current smoking amongst adults**

	<b>Males (%)</b>	<b>Females (%)</b>	<b>Age group</b>	<b>Sample size</b>	<b>Year of survey</b>	<b>Source of information</b>
Albania (Tirana)	37.6	19.3	>25 years	1120	2001	Shapo L et al. Prevalence and determinants of smoking in Tirana city, Albania: a population based survey. Public Health 2003; 117 (4):228-36
Nationwide	60	18	15 years and older	8400	1999-2000	WHO European Country Profiles on TC 2003
B&H	49.2	29.7	18-65	3020	2002-3	Noncommunicable disease risk factor survey. Federal Public Health Institute, Sarajevo and Institute of Public Health Republika Srpska, Banja Luka. 2002/2003.
Bulgaria	38.4	16.7	18 years and older	1550	1997	Balabanova D, Bobak M, McKee M. Patterns of smoking in Bulgaria. Tob Control 1998; 7: 383-5.
	43.8	23	15 years and older	9396	2001	Health Interview Survey, National Statistical Institute, in WHO European Country Profiles on TC, 2003
Croatia	34.1	26.6	18-64 years	Approx. 10000	1996	The first Croatian Health Project. Croatian Institute of Public Health. Zagreb. 1997.
Macedonia	-	-	-	-	-	No data available
Romania	32.3	10.1	15 years and older	Not available	2000	Health status of population in Romania. National Institute of Statistics. Bucharest. 2001.
Serbia	46.0	31.0	20 years and older	9364	1999	Health status, health needs and utilisation of health services. Institute of Public Health of Serbia. Belgrade. 2000.
Serbia and Montenegro	50.9	33.3	35-64	566 men, 601 women	1994-5	Tolonen H, Kuulasmaa K, Ruokokoski. MONICA population survey data WHO 2000.

Source: as noted in table.

The gender gap in smoking prevalence is wide in all countries where data are available except in Croatia, and is particularly notable in Albania and Romania where there is also a wide gender gap among young people (Table 3).

Some historical data are available for the former Yugoslavia from small scattered surveys, and these allow some comparison with current smoking rates (9). Data suggest that smoking rates among men have been high for some time – rates around 50% were recorded from the late 1950s to the mid-1980s. By contrast female smoking rates appear to have risen from approximately 10-15% in 1969-72 to around 20% in the early 1980s and rates of 30% were recorded in Novi Sad in 1984. In Romania, surveys are available from the late 1960s, although many are from regional studies, making comparisons difficult. Nevertheless, in women there appears to be an increasing trend from the late 1960s onwards while rates in men show no clear pattern with rates varying from approximately 35% to 55%. In Bulgaria, there are few surveys for comparison although consumption data show an increase over time (9).

#### *2.4.2 Smoking prevalence amongst doctors*

In Macedonia, the only available data on adult smoking prevalence are from a survey of physicians conducted in the 1990s which found that 40% of male and 32% of female physicians smoke (personal communication, Dr Mome Spasovski). In B&H, one research study found that 53% of physicians, (male and female combined) smoked (14). A study conducted among smoking physicians at the State Hospital Sarajevo in 1996 found that doctors were smoking significantly more cigarettes per day during the war than before the war. Reasons related to “feeling nervous” (72%), “experiencing stress due to war” (18%) and “being afraid” (10%) (15). Research among general practitioners in Romania in 1997 showed that 40% of males and 19% of females smoked. According to information provided by the Serbian Ministry of Health, 37% of physicians and 52% of nurses at the Clinical Hospital Serbia smoke.

#### *2.4.3 Determinants of smoking*

Only the Albanian and Bulgarian surveys assessed the determinants of smoking. The Bulgarian survey, a random household survey of the population aged 18 years and older conducted in 1997, found that smoking was strongly associated with age. For men, the highest rate was in the age group 30-39 (48%) whereas for women, it was among those under 30 (37%). In both sexes smoking was more common in the capital Sofia and other urban settings than in rural areas. Among men, there was no significant association with education while in women, although just short of statistical significance, smoking was most common among those with secondary or higher education. The authors suggest three possible explanations for the observation that the prevalence of smoking is much higher among the young than the old: (a) selective mortality among the old, with smokers dying younger; (b) smokers quitting as they grow older; (c) a higher likelihood of those born in recent years taking up smoking, and conclude that the latter is the most important factor (16).

The research done by Shapo et al. in Albania found that smoking is most common among those aged 25-34 – the youngest age group surveyed (59% of males and 30% of females in this age group smoked). The probability of smoking was positively related to women's educational achievement although the differences did not reach statistical significance. Among men, those with secondary education were most likely to smoke, university graduates had slightly lower rates (but not statistically significantly different), both were more likely to smoke than men with only primary education. Income and employment status did not appear to have a significant effect (17). Another survey in Albania found that smoking amongst men may be less common in urban than rural areas though in women the reverse is seen (smoking prevalence of 25% in urban areas as compared with 11% in rural areas) (18).

Overall these findings suggest that widespread smoking is a relatively new phenomenon among women while smoking in men is a well established addiction. This is suggested by the small amount of historical data available (9), age specific rates which show higher rates in younger compared with older women, and in Bulgaria and Albania a positive relationship with education, a pattern traditionally seen early in the tobacco epidemic (16, 17, 19). Moreover, in Albania, the majority of female smokers reported that they had only been smoking for the last 5 years. The urban bias in women suggests the habit is being taken up initially in cities where advertising is likely to be more intense. Similar findings of high rates among women in cities compared to rural areas and amongst younger compared with older women have also been seen in the former Soviet Union (FSU) (20, 21) and in Serbia where 41% of the adult population in towns are smokers, compared with 34% in rural areas (22). The low rates of tobacco related diseases in women compared with men lend weight to this argument as we shall see in the next chapter.

## **2.5 Exposure to environmental tobacco smoke (ETS)**

In B&H, the WHO Countrywide Integrated Noncommunicable Disease Intervention (CINDI) programme, estimated in 2001 that 36% of employees were exposed to tobacco smoke in the workplace for more than 5 hours per day, 15% for between 1-5 hours and 6% for less than an hour. This highlights the ineffective implementation of a law banning smoking in workplaces which was adopted by Parliament in 1998. 66% of interviewees were also exposed to passive smoking in their households, the majority in low-income families. In comparison, a study done in Finland found that in 2000, 8% of non-smoking men and 4% of non-smoking women were exposed to ETS at work (23).

GYTS carried out in the region indicate high exposure to tobacco smoke in public places as well as very high exposure of children to ETS at home, ranging from 69% in Bulgaria to 97% in Serbia. In the survey carried out in Albania, 21% of male and 23% of female respondents said that smoking did not cause harm to non-smokers involuntarily exposed to passive smoke. There was also a high level of ignorance about the health impacts of active smoking - 21% of male and 18% of female smokers thought that smoking did not cause them harm (18).

## 2.6 Cigarette consumption

Cigarette consumption data were obtained from the WHO HFA Database (4) and ERC (Economic Research Service) Statistics International (24). For the majority of countries, the ERC data appeared to underestimate consumption, particularly for B&H and FR Yugoslavia, where differences between the two sources were almost two fold (24) and WHO data were therefore used. The exception was Albania where the WHO HFA database gave a figure of 963 cigarettes per capita in 1999 compared with 2150 in ERC Statistics. A survey by Shuperka et al. assessed cigarette consumption in the Albanian population aged over 15 years as 2848 per capita, which is high by international standards but nevertheless suggests that the ERC data were more accurate in this instance.

According to the latest available data, in 1999 citizens in the SEE countries consumed on average 2235 cigarettes per capita, which was 5% higher than in the CEE countries and 35.2% higher than the EU average (Tables 6 and 7). The highest per capita consumption was found in Macedonia and B&H and the lowest in Romania. Since 1995, cigarette consumption has been increasing in Albania, Bulgaria and Macedonia and following a fall in Romania between 1995 and 1996 has subsequently increased there, whilst fluctuating elsewhere with no clear trend. However, this per capita consumption data has limited value because of the widespread smuggling of cigarettes in SEE (see Chapter 5) and because of inaccuracies in the underlying population data.

**Table 6. Percent of regular daily smokers in the population aged 15 plus and per capita cigarette consumption in EU countries**

	Males	Females	Total	Year (for prevalence data)	Per capita cigarette consumption in 1999
Austria	30	19	24	1997	1927
Belgium	36	26	31	2000	1211
Denmark	32	29	30	2000	1635
Finland	27	20	23	2000	931
France	33	21	27	2000	1415
Germany	36	22	29	1999	1909
Greece	47	29	38	2000	2861
Ireland	32	31	31	1998	1834
Italy	33	17	25	1999	1612
Luxembourg	34	26	30	2000	2140
Netherlands	36	29	33	2000	1057
Portugal	33	10	21	1999	1649
Spain	42	25	33	1997	2270
Sweden	17	21	19	2000	711
United Kingdom	28	26	27	1998	1336
EU	33	23	28		1653

Source: WHO HFA Database. WHO Regional Office for Europe. Copenhagen. 2003

**Table 7. Per capita consumption of cigarettes in SEE countries**

	1995	1996	1997	1998	1999
Albania*	1873	1773	1579	1787	2150
B&H	-	2724	2537	2626	2562
Bulgaria	1903	2284	2237	2180	2314
Croatia	2010	2334	1945	2110	2086
Macedonia	2339	2319	2303	2341	2658
Romania	1820	1437	1397	1466	1781
FR Yugoslavia	2147	2108	2103	2100	2097
SEE average	2015	2140	2014	2087	2235
CEE average	2248	2038	2034	2049	2129
EU average	1615	1587	1598	1615	1653

*Source (for Albania):* World Cigarettes 2001. ERC Statistics International plc. The World Cigarettes I and II: The 2001 survey. Suffolk. Great Britain. 2001.

*Source (for all other countries):* WHO HFA Database. WHO Regional Office for Europe. Copenhagen. 2003.

### **Summary**

Consumption data are the only data that are routinely collected in all SEE countries but are of limited use given widespread smuggling. They nevertheless indicate the high level of cigarette consumption in the region, higher even than levels in CEE. While regular youth smoking surveys are now conducted as part of international projects, no SEE countries perform routine surveys of adult smoking prevalence. Adult prevalence data are therefore only collected during specially commissioned surveys which have tended to use different methods, thereby limiting their comparability. Nevertheless the available data illustrate the high rates of smoking particularly among men in whom the latest surveys suggest that smoking prevalence in countries of SEE is higher than in almost all EU countries. In women smoking prevalence in SEE varies more widely around the EU average but comparison with previous data and age specific trends suggest that smoking rates are increasing steadily among women. These findings suggest that unless concerted action is taken, the health threat posed by smoking in SEE will remain enormous and continue to increase in women.

- Youth smoking rates range from 5%-49% in boys and 5%-42% in girls
- Among adults, smoking rates range from 32%-60% in males and 10%-33% in females
- No data on smoking prevalence among adults are available for Macedonia.
- Surveys from Albania and Bulgaria showed that smoking in women was highest in the youngest age groups and was positively related to education.
- Cigarette consumption in SEE countries is on average 5% higher than in the CEE countries and 35% higher than in the EU, and appears to be increasing across the region.

*Summary continues on next page*

*Summary continued..*

The few available data suggest high levels of exposure to ETS and a survey in Albania suggests poor understanding of the health impact of active and passive smoking. Otherwise we know little about the knowledge residents in this region have of the health effects of tobacco, their perception of the risks related to smoking, their willingness to quit and the accessibility of smoking cessation services to tobacco users. There is a clear need to establish regular surveys that would measure the prevalence of and attitudes to smoking.

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## CHAPTER 3: BURDEN OF DISEASE RELATED TO TOBACCO

### 3.1 Background

#### 3.1.1 *The health impacts of tobacco*

The health impacts of tobacco use are daunting. It has been recognized as the single largest avoidable cause of premature death and the most important known human carcinogen (1). Half of all long-term smokers will eventually be killed by tobacco and of these, half will die during middle age, losing 20-25 years of life (2, 3).

In 1990, 3 million deaths, 6% of the world total, were caused by tobacco (Table 8). By 2020, these figures are estimated to reach 8.3 million and 12.3%. Over this period, the largest increase is expected in the developing world – a four fold rise in the number of deaths. But the impact of tobacco will be most staggering in the former socialist economies where it is estimated that by 2020 almost a quarter of deaths will be attributable to tobacco (4).

**Table 8. Deaths and disability adjusted life years (DALYs)<sup>8</sup> attributable to tobacco use in 1990 and 2020**

Region	Estimates for 1990				Estimates for 2020			
	Deaths ('000s)	% of total	DALYs ('000s)	% of total	Deaths ('000s)	% of total	DALYs ('000s)	% of total
Former Socialist Economies of Europe	515	13.6	7803	12.5	1101	22.7	12643	19.9
World	3038	6.0	36182	2.6	8383	12.3	123678	8.9
Developed Regions	1577	14.5	19410	12.1	2387	17.7	29141	18.2
Developing Regions	1460	3.7	16772	1.4	5996	10.9	94537	7.7

*Source:* Murray CJL, Lopez AD. Assessing the burden of disease that can be attributed to specific risk factors (4)

Cigarette smoke contains a mixture of particulate and non-particulate matter including nicotine, tar and carbon monoxide which broadly are responsible for the addictive, carcinogenic and cardiovascular impacts of tobacco use respectively. Nicotine has been identified as one of the most highly addictive drugs available highlighting that smokers smoke, not through choice, but because they are addicted (5, 6).

<sup>8</sup> Disability-adjusted life year (DALY): A DALY is a unit for measuring the burden of disease. DALYs are calculated as the present value of future years of disability-free life that are lost as a result of premature death or disability occurring in a particular year. (Adapted from Last JM (ed). A Dictionary of Epidemiology. 3<sup>rd</sup> edition. Oxford University Press. 1995).

There is a wealth of research evidence on the health consequences of tobacco that confirms the crucial role it plays in determining the health status of those who use it. The evidence has grown rapidly since the 1950s when Doll and Hill published a case-control study that showed cigarette smoking was an important causal factor in lung cancer (7). The same researchers later published results from a prospective study on mortality of British doctors, confirming the causal role of smoking in lung cancer and other chronic diseases (8). This 50-year follow-up study of British male doctors and the two American Cancer Society prospective studies (CPS I and II) in the United States (US) provide some of the most rigorous evidence of the negative impact of tobacco on health (6).

These and other studies confirm that smoking is causally associated with a range of diseases – cancers of the lung, oral cavity, pharynx, larynx, esophagus, bladder and kidney, respiratory diseases including chronic bronchitis, emphysema, asthma and cardiovascular diseases (9). In the majority of developed countries and transition economies, heart disease is the most widespread consequence of tobacco use, accounting for more tobacco-related deaths than cancers. This occurs, despite the higher relative risk of lung cancer than heart disease in smokers (Table 9), because of the higher underlying prevalence of heart disease in these populations.

**Table 9. Estimated relative risks of disease due to smoking by disease categories for males and females aged 35 years and older, based on data from the American Cancer Society prospective study, CPS-II (1982-1986)**

Underlying cause of death	Males	Females
IHD <sup>a/</sup> , age < 35	1.9	1.8
IHD <sup>a/</sup> , age 35-64	2.8	3.0
Cerebrovascular lesions, age <35	2.2	1.8
Cerebrovascular lesions, age 35-64	3.7	4.8
COPD <sup>b/</sup>	9.7	10.5
Cancer of lip, oral cavity and pharynx	27.5	5.6
Cancer of esophagus	7.6	10.3
Cancer of pancreas	2.1	2.3
Cancer of larynx	10.5	17.8
Cancer of lung	22.4	11.9

Source: United States Department of Health and Human Services (6)

Notes: a/ Ischaemic heart disease b/ Chronic obstructive pulmonary disease

It is estimated that 90% of lung cancers in men in developed countries are caused by smoking. Estimates in women vary depending on the stage of the tobacco epidemic. For example it is estimated that in the US and the United Kingdom (UK) where the epidemic is well established, around 85% of lung cancers are caused by smoking, whereas in countries where the epidemic is more recent and smoking prevalence has traditionally been lower, the proportion is lower (9). The age of onset of smoking is an important determinant of risk – starting at age 15 and smoking 10-20 cigarettes a day for 45 years, increases the risk of lung cancer about twice as much as does smoking 21-39 cigarettes per day starting at age 25 (10).

Smoking is also more dangerous than other risk behaviors. Extrapolations based on evidence from high-income countries suggest that, of 1000 15-year-old males currently living in middle income countries, 125 will be killed by smoking in middle age if they continue to smoke regularly, with an additional 125 killed in old age. In comparison, 10 will die from road traffic accidents, a further 10 will die due to violence and 30 from alcohol-related diseases (3).

### *3.1.2 The tobacco epidemic*

A four stage model of the smoking epidemic has been described based on observations of trends in cigarette consumption and tobacco related diseases in western countries with the longest history of cigarette use, namely the UK and the US (11). The model describes the rise in male smoking, followed by the rise in female smoking one to two decades later, a plateau and then fall in smoking prevalence and decades later the rise in tobacco related mortality in males then females. Importantly, there is a delay of a few decades between the rise in smoking prevalence and its health impact at a population level.

This delay is illustrated by the substantial changes in tobacco use and lung cancer mortality that have taken place in EU countries during the past three decades. Between 1970 and 1994 cigarette consumption changed enormously with a large decline seen in the UK (39%), Sweden (33%), and Finland (28%), a great increase in Portugal (64%) and smaller increases in several other countries. The decrease in tobacco smoking among men in the UK and Finland was followed by a drop in lung-cancer mortality a few decades later. By contrast, the increase in smoking prevalence in women seen in some countries has resulted in an increase in lung-cancer mortality. Such is the example of Norway where smoking prevalence in females increased by nearly 50% between 1960 and 1980, and lung-cancer mortality increased by 125% between 1980 and 1995. Predictions for the year 2010 show that, in the majority of EU countries (with the exception of Spain, Greece, France, and Portugal) there will be a decline in mortality from lung cancer in men but an increase in women (12). Lopez argues that it is important to look at lung cancer mortality trends in younger age groups as this largely determines how overall mortality from the disease will change in the future (9).

### *3.1.3 The health impacts of environmental tobacco smoke*

ETS is a major source of indoor air pollution, containing over 4000 chemicals in the form of particles and gases. It puts those involuntarily exposed to tobacco smoke at increased risk of a range of smoking-related diseases - lung cancer, stroke and ischaemic heart disease in adults and many health problems in children including acute respiratory tract infections, low birth weight, middle ear infections and asthma. In the US, it is estimated that passive smoking causes 3000 cases of lung cancer and 35,000-62,000 cases of ischaemic heart disease annually (13, 14).

### 3.1.4 *Measuring the health impacts of tobacco use*

Lung cancer is the most appropriate disease to examine when comparing the health impact of tobacco between countries, and mortality trends from lung cancer can be used as an indicator of past trends in smoking prevalence. Comparisons between countries are facilitated by the fact that lung cancer is almost always fatal - health care has little impact on survival, and variations in disease prevalence due to other underlying causes or differences in coding of deaths should be less with lung cancer than for other smoking related diseases (15-18). Although lung cancer is useful in this respect, as indicated above, tobacco also causes death from a number of other causes which may be greater in absolute number.

## 3.2 **Methods**

To provide an estimate of tobacco-related harm, we explored data on overall tobacco-related mortality from the WHO HFA Database (19), estimates made by Peto<sup>9</sup> of deaths attributed to tobacco in 1985 and 1995 (20) and age-specific lung cancer mortality data from the National Institutes of Statistics from the countries surveyed.

Data on incidence and mortality from lung cancer<sup>10</sup> were retrieved from the Globocan Database of the International Agency for Research on Cancer (IARC) which enables a comparison with selected western European (Austria, Belgium, France, Germany, Luxembourg, The Netherlands and Switzerland) and eastern European countries (Belarus, Bulgaria, Czech Republic, Hungary, Moldova, Poland, Romania, Russian Federation, Slovakia and Ukraine) (21).

Although we limit this section to consideration of the direct health impacts of smoking, it is worth noting that the indirect impacts, through involuntary exposure to tobacco smoke, are also likely to be considerable given the high rates of smoking in public places and the home (see Chapter 2).

### 3.2.1 *Data accuracy*

From the data sources that were investigated, only Peto's estimates and the IARC data were deemed appropriate to describe the tobacco-attributable burden of disease in SEE.

WHO HFA data on tobacco-related mortality showed discrepancies, particularly for Romania which, unexpectedly and despite its lower smoking prevalence, had considerably higher mortality rates from ischaemic heart disease, cerebrovascular disease

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<sup>9</sup> Peto et al. used the results of the second American Cancer Prevention Study (CPS –II) to indirectly estimate smoking-attributable mortality in developed countries. In the absence of direct information on smoking histories, this method uses national disease-specific mortality statistics to estimate tobacco-related mortality. To be conservative, no non-medical deaths (eg from fires), no neonatal deaths and no deaths before the age of 35 are attributed to tobacco. In addition, the calculated excess percentage of deaths from other causes attributed to tobacco is halved, thereby preventing overestimation of tobacco's impacts (at the risk of potentially underestimating its impacts).

<sup>10</sup> The term lung cancer refers to the malignant neoplasm of trachea, bronchus and lung.

and all tobacco-related diseases than the rest of the SEE countries for which data were available. In addition, death rates from bronchitis, emphysema and asthma increased almost 3-fold in Romania after 1998 compared with the period 1995-1998. These findings require further analysis particularly in terms of the coding practices that are in use and preclude the use of these data here.

No age specific lung cancer mortality data were available for B&H and Albania and data for Croatia, Macedonia and Serbia and Montenegro showed considerable fluctuations. These fluctuations, as outlined in Chapter 1, are likely to relate to inaccuracies in the underlying population data due to large-scale population movements and the high number of refugees during the wars as well as the different methods that were in use to estimate population and mortality figures (22).

### 3.3 Overall tobacco-related mortality in south-east Europe

Peto's estimates show that smoking is a major cause of premature mortality in SEE, particularly in men (Tables 10 and 11). The proportions of deaths attributed to tobacco in men aged 35-69 in 1995 were 30% in Bulgaria, 32% in Romania and 42% in the countries of ex-Yugoslavia, whereas in females, proportions were 8%, 5% and 10% respectively. The total number of deaths in middle-aged men attributed to smoking in Bulgaria, Romania and ex-Yugoslavia combined rose from 37,300 in 1985 to 60,100 in 1995 and in women from 4,000 to 6,500. As a proportion of total deaths, these figures represent increases of 15% and 34% in men and women respectively. The increase in tobacco related mortality over the period was greatest in ex-Yugoslavia countries (20).

**Table 10. Tobacco-attributable deaths / all deaths (thousands), and tobacco-attributable deaths as percent of total deaths (%) in 1985**

Countries	Males		Females	
	35-69 years	70+ yrs	35-69 years	70+ yrs
Ex-Yugoslavia <sup>11</sup>	15/ 46 (32.6)	6.7/ 55 (12.1)	1.7/ 27 (6.3)	1.2/ 65 (1.8)
Bulgaria	7.3/ 24 (30.4)	2.7/ 32 (8.43)	0.7/ 13 (5.4)	0.9/ 33 (2.7)
Romania	15/ 50 (30.0)	4.9/ 60 (8.2)	1.6/ 31 (5.2)	0.4/ 71 (0.6)

Source: Peto R. 1994. (20)

**Table 11. Numbers of deaths (thousands) attributable to tobacco/ total deaths and (%) in 1995 (estimated from projected mortality rates)**

Countries	Males		Females	
	35-69 years	70+ yrs	35-69 years	70+ yrs
Ex-Yugoslavia <sup>10</sup>	27/64 (42.2)	7.3/ 55 (13.3)	3.4/ 33 (10.3)	1.4/ 73 (1.2)
Bulgaria	9.1/ 30 (30.3)	2.1/ 37 (5.7)	1.0/ 13 (7.7)	1.3/ 41 (3.2)
Romania	24/ 74 (32.4)	3.6/ 64 (5.6)	2.1/ 40 (5.3)	0.3/ 87 (0.3)

Source: Peto R. 1994. (20)

<sup>11</sup> "Ex-Yugoslavia" includes the following states, which were previously republics of former Yugoslavia: Bosnia and Herzegovina, Croatia, Macedonia, Montenegro, Serbia and Slovenia.

### 3.4 Lung cancer incidence and mortality in south-east Europe

Lung cancer incidence and mortality data also indicate the high toll that tobacco use extracts in SEE, most notably in B&H, Croatia, Serbia and Montenegro. Estimates by the IARC for the year 2000 indicate that this region has among the highest age-standardized male lung cancer incidence and mortality rates in Europe (Table 12). The highest lung cancer incidence rates in Europe were seen in Hungary (95.5/100,000), followed by Croatia (82.5/100,000), B&H (81.2/100,000), and FR Yugoslavia (80.9/100,000), while the lowest were found in Sweden (21.4/100,000). Lung cancer mortality was highest in Hungary (86.2/100,000), followed by Poland (71.5/100,000), Belgium (70.9/100,000) and Croatia (70.3/100,000) (21).

Among women in Albania, B&H, Croatia and FR Yugoslavia, lung cancer incidence rates are now higher than the western European average (Table 13). They are not far below the highest European rates recorded in Denmark (27.7/100,000) and throughout SEE are higher than the lowest European rate recorded in Spain (4.0/100,000). Female lung cancer mortality rates in SEE were again highest in Croatia (9.4/100,000) compared with a European high in Denmark of 26.7/100,000 (21). Moreover, as female smoking rates continue to increase, female mortality from tobacco will rise for many years to come.

Concerns with these data, particularly the underlying population estimates,<sup>12</sup> make firm conclusions about the burden of disease due to tobacco, difficult. Nevertheless, the fact that in parts of ex-Yugoslavia male incidence and mortality rates were just below those seen in Hungary gives the figures some credibility.

**Table 12. Male lung cancer incidence and mortality rates, all ages, per 100,000. Estimates for 2000**

	Cases	Crude	ASR <sup>a/</sup>	Deaths	Crude	ASR
Albania	1035	65.0	79.2	710	44.6	54.7
B&H	1842	93.7	81.2	1238	63.0	54.7
Bulgaria	2968	74.2	48.9	2692	67.3	43.7
Croatia	2682	124.1	82.5	2283	105.7	70.3
Macedonia	563	55.8	46.9	473	46.9	39.8
Romania	7352	67.1	50.7	6608	60.3	45.1
FR Yugoslavia	5842	110.5	80.9	3495	66.1	47.9
Eastern Europe	126653	87.2	69.7	115091	79.2	63.2
Western Europe	75350	83.9	53.2	71024	79.1	48.9

Source: Globocan 2000. International Agency for Research on Cancer. WHO. IARC Press. 2001.

Note: a/ Age standardized death rate

<sup>12</sup> For example, the UN population data for Croatia during the 1990s underestimated the number of emigrants and thus overestimated the population size. This in turn leads to an underestimate of incidence and mortality rates.

**Table 13. Female lung cancer incidence and mortality rates, all ages, per 100,000. Estimates for 2000**

	<b>Cases</b>	<b>Crude</b>	<b>ASR<sup>a/</sup></b>	<b>Deaths</b>	<b>Crude</b>	<b>ASR</b>
Albania	183	12.1	13.0	126	8.3	8.9
B&H	366	18.3	13.2	247	12.3	8.7
Bulgaria	619	14.7	7.9	560	13.3	7.1
Croatia	532	23.0	11.8	430	18.6	9.4
Macedonia	111	10.9	8.1	89	8.8	6.6
Romania	1510	13.3	8.3	1350	11.9	7.3
FR Yugoslavia	1156	21.6	13.8	732	13.7	8.4
Eastern Europe	24420	15.1	8.8	22063	13.6	7.8
Western Europe	18183	19.4	10.7	16789	17.9	9.2

*Source:* Globocan 2000. International Agency for Research on Cancer. WHO. IARC Press. 2001.

*Note:* a/ Age standardized death rate

### **Summary**

There are major concerns with the accuracy of data on the health impacts of tobacco use in SEE. These relate in part to the scarcity of accurate population data although there appear to be additional underlying problems. Improvements are needed in all aspects of data collection and consideration should be given to including information on past smoking habits and basic socio-economic status on death certification as this would enable a more accurate assessment of the health impacts of tobacco use as well as socio-economic differentials in mortality.

The available data nevertheless show that tobacco use extracts a high toll in SEE, most notably in B&H, Croatia, Serbia and Montenegro, suggesting that the tobacco epidemic in these countries is longer-established. This is supported by the high smoking rates in these countries. Although the impact in women is less significant than in men, as female smoking rates increase, as the previous chapter intimated, mortality from tobacco will rise for many years to come.

Tobacco control therefore has the potential to prevent much morbidity and mortality in SEE. Due to the delay seen at population level between the onset of smoking and its health impacts, the most immediate impacts on mortality will be achieved by encouraging current smokers to quit and longer term impacts by preventing smoking uptake.

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## CHAPTER 4: TOBACCO INDUSTRY, TRADE AND ECONOMICS

### 4.1 Background

#### 4.1.1 *The tobacco industry in south-east Europe*

The countries of SEE grow tobacco and manufacture cigarettes and the tobacco industry has traditionally been economically and politically influential. In the socialist era the region's tobacco industries were state-owned monopolies but the collapse of communism and the opening of these markets to imports and private investments has led to major changes, most notably the growing presence of the transnational tobacco companies (TTCs) and other smaller but locally influential companies (1, 2, 3).

National monopolies have traditionally protected themselves from foreign competition through the use of protective trade measures including bans on foreign imports, high tariffs, import quotas and restrictions on the distribution and advertising of foreign brands. TTCs have sought to remove these barriers and gain entry to new markets using a number of methods including political pressure and the threat of trade sanctions. They also use a series of cleverly calculated steps to gain control of local monopolies. Firstly the establishment of a licensing arrangement whereby the state firm sells international brands<sup>13</sup>. This leads to the establishment of joint manufacturing ventures which involve the purchase of a portion of the national company by the transnational who may then invest in modernization and technology. From this position the TTCs push the local governments to denationalize and the stage is then set for them to acquire the national company. If these systems fail, contraband sales are used to gain a foothold in the market, stimulate local demand and argue for the need for privatization in order to replace smuggled goods with those manufactured locally (3, 4, 5).

Although none of the studies of trade liberalization have focused on CEE or SEE, a growing body of evidence from elsewhere shows that increased trade liberalization leads to increased cigarette consumption (6, 7, 8). Trade liberalization increases competition which drives down prices and increases advertising, which in turn lead to increased consumption. Privatization of state owned tobacco industries is likely to have similar impacts and although there have been no empirical studies of its impacts, there are growing concerns about its potential influence on tobacco control (9). The expected benefits of privatization - increased efficiency, output and profitability and reduced unit costs - can be seen as disadvantages when the product in question is damaging to health (9). By contrast the inefficiencies of state owned monopolies can be seen as beneficial to public health. It is also alleged that TTCs behave differently from state-owned monopolies – they market their products heavily, introduce new, more attractive products sold through a larger number of outlets and are more likely to challenge attempts to control tobacco use (4, 9). In the FSU, entry of the TTCs and privatization of state owned

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<sup>13</sup> Licensing has advantages to the monopoly of allowing legal sales thus decreasing contraband whilst preventing the foreign manufacturer from acquiring a direct financial interest.

monopolies was associated with a massive surge in advertising and a weakening of tobacco control measures (10).

#### 4.1.2 Tobacco agriculture

Bulgaria and Macedonia are the region's main tobacco leaf producers and exporters. Bulgaria has the largest land area for tobacco growing while Macedonia has the highest proportion of land devoted to tobacco farming (Table 14). In 1997, both were among the top 30 raw-tobacco producing countries in the world. Bulgaria produces about 0.5-0.7% of world tobacco and is the biggest producer and exporter of cigarettes in the region (11).

**Table 14. Tobacco Agriculture**

	<b>Land devoted to growing tobacco (hectares)</b>	<b>Agricultural land devoted to tobacco farming (%)</b>
Albania	7300	0.9
B&H	2000	0.3
Bulgaria	42000	0.3
Croatia	6100	0.5
Macedonia	25000	1.7
Romania	10970	0.1
FR Yugoslavia	9858	0.3

Source: Mackay J, Eriksen M. The Tobacco Atlas. World Health Organization. Geneva. 2002

## 4.2 Data sources

Information on the structure and activities of the tobacco industry were obtained largely from the ERC World Cigarette report (12). Additional information was obtained from the United States Department of Agriculture, Foreign Agricultural Service (USDA FAS) reports, media reports, through searches on the World Wide Web and from national contacts.

## 4.3 Outline of tobacco industry by country

The degree of tobacco industry privatization and the extent of TTCs penetration vary by country. The leading cigarette companies in each country are shown in Table 15. TTC investment occurred first in Romania but was delayed in the former Yugoslavia by hostilities and trade sanctions and in Bulgaria by reluctance to privatize the state owned monopoly. In these instances therefore, the TTCs have focused on importing cigarettes, many of them seemingly through illegal channels as we shall explore in the following chapter (13, 14).

**Table 15. Market share of leading cigarette manufacturing companies, based on official data (excluding smuggled products)**

	<b>Leading cigarette companies</b>	<b>Market share (%)</b>	<b>Employment in tobacco manufacturing (persons)</b>
Albania	VEVE group Dures Pogradec	60.0 30.0 10.0	2148
B&H	Mostar Sarajevo Banja Luka	Data not available	849
Bulgaria	Bulgartabak BAT Philip Morris Rothmans RJ Reynolds	96.5 1.9 1.5 1.3 1.0	10373
Croatia	Rovinj Zagreb Zadar	77.1 22.5 0.4	2946
Macedonia	Skopje Kumanovo Prilep	Data not available	5604
Romania	BAT Romania SNTR Philip Morris Romania JTI Romania Papastros	28.0 25.0 21.5 21.5 3.3	6200
Serbia and Montenegro	Nis Vranje Podgorica	72.8 17.5 5.5	5100

Source: ERC Statistics International and data obtained from national co-coordinators (12)

**ALBANIA:** According to USDA FAS sources, around 99% of cigarettes in Albania are imported and 80% of cigarettes circulating on the market are either smuggled or duty-free. Due to the large contraband market, internal economic difficulties and the fact that many Albanians perceive imported cigarettes to be of higher quality than domestically manufactured products (12), cigarette production in Albania has almost ceased. In 1998, five cigarette manufacturing facilities (two state-owned and three privately owned) were operational but only one plant (belonging to the local VeVe Group) is now active.

**BOSNIA AND HERZEGOVINA:** The 3 major factories in B&H – in Sarajevo, Mostar and Banja Luka were damaged during the war but rebuilt afterwards. In 2001 Japan Tobacco International (JTI) acquired a 60% interest in the Mostar factory and a subsidiary of the German company Reemtsma (now owned by Imperial Tobacco) recently entered into a co-operation agreement with the Banja Luka plant (12). Nevertheless, cigarette production in 2000 remained under half that in 1990.

**BULGARIA:** The Bulgarian state monopoly Bulgartabac, established by the government in 1947, was a major regional producer of cigarettes with large export markets in eastern Europe and the Soviet Union during communism. The entry of the TTCs to the FSU and economic downfall in Bulgaria had a major impact on business - by 2000 cigarette production was only approximately 35.6% of 1990 output and exports fell from 60,360 million pieces to 4,049 over the same period. Nevertheless, Bulgartabac continues to dominate the Bulgarian market and now has 8 joint ventures, 5 in Russia, and one each in the Ukraine, Romania and Serbia and Montenegro, although most are not operational due to financial problems. Bulgartabac has been in the process of privatization for some time and some of its factories have already been sold to Rothmans International, now part of British American Tobacco (BAT), and others to private Bulgarian companies. In 2000, 80% of Bulgartabac Holding was offered for sale. But in October 2002 the Bulgarian Supreme Administrative Court overruled the government privatization agency and cancelled the deal with Sofia based Tobacco Capital Partners and Dutch registered Clar Innis, backed by Deutsche Bank AG. Although the position on privatization remains uncertain and tobacco farmers have been registering their opposition, pressure from the International Monetary Fund makes privatization seem inevitable (15, 16). Meanwhile, in 2002, the first license was issued to a foreign tobacco leaf company (Sokotab/Dimon) to operate independently in Bulgaria in the purchasing and export of tobacco (12).

**CROATIA:** The Croatian tobacco market remains monopolized by the fully private tobacco company Rovinj (TDR) which supplies almost all the legitimate market (official imports are low, equivalent to only 0.4% of consumption). Rovinj produces mainly domestic brands but also makes *Marlboro* under license. Rovinj has recently expanded into the regional cigarette market, most notably to B&H (where it advertises more than their domestic companies) and Serbia. It has also diversified its interests acquiring an 80% share in two large hotel companies in 2001. Its profits are remarkably high. In June 2000, while the average salary in Croatia was approximately US\$ 400, the highest salary in the country - US\$ 75,600 - was paid to the factory's executive (17). In a 2002 survey undertaken by the leading independent Croatian news magazine, *Nacional*, current and ex-Croatian ministers, leading politicians and economists identified Rovinj as the most powerful company in the country in terms of its influence in defining and creating Croatian economic policy, particularly related to tax policy, customs administration and subsidies (18). The TTCs, particularly BAT, have been making aggressive attempts to enter the Croatian market. In 1999 BAT bought the tobacco company Zadar and started work there in 2003. Its investment in modernizing and reconstructing the factory was worth €3 million. In 2003 BAT moved its regional office from Budapest to Zagreb in order to more closely manage its operations in Croatia, B&H, Macedonia, Kosovo and Albania (19) and allegedly plans to start serious negotiations to acquire the Rovinj tobacco company. BAT obviously regards the Croatian market as a stable center for co-ordinating its expansion into other countries of ex-Yugoslavia. Rovinj cigarettes are popular in B&H, Serbia and Montenegro, so BAT could easily gain the market share that Rovinj has established there. It should be noted however, that BAT's previous attempts to invest in the Balkans received considerable criticism from European customs

investigators due to smuggling links established between the Italian mafia, the Balkan criminal underworld and the tobacco industry (20, 21).

**MACEDONIA:** Of the three cigarette factories in Macedonia, the Skopje factory was privatized and acquired by Reemtsma, via its Slovenian based subsidiary in 1999. The remaining two, Prilep and Kumanovo, have been due for privatization for several years, attracting interest from BAT and Philip Morris although no deals have yet been finalized. In 2003 the International Monetary Fund stated that “in the tobacco market, a complex system of loan guarantees and monopoly purchasing arrangements has distorted market incentives and hindered market performance” and indicated that they would work towards allowing any company, domestic or foreign to purchase and market tobacco in Macedonia (22). Before that, in 1994 and 1995 tobacco processing plants were acquired by companies from Greece and The Netherlands (Intabet). The country is a significant cigarette exporter and almost all exports are destined for Serbia and Montenegro. However, cigarette production in 2000 was about half the level achieved in 1990 due to import barriers by other republics of ex-Yugoslavia and the impact of smuggling.

**ROMANIA:** Romania, with its population of 22.4 million, is the largest market for cigarettes in SEE. The former Romanian tobacco monopoly Regia Autonoma a Tutunului was converted into a joint stock company Societatea Nationala Tutunul Romanesc (SNTR) in 1997, and privatized in 2001 with the Romanian company Inter Agro becoming the majority shareholder. However, the new owners failed to clear the debts; the company returned to state ownership and is now up for sale again (23). Meanwhile however, it is uncertain whether SNTR will be able to re-establish a market share given the growing activity of the TTCs and a few smaller operators, and the considerable illegal trade (23). All three leading TTCs have established factories in Romania. RJ Reynolds (now part of JTI) was the first to do so back in 1995. BAT began operations in 1997 and Philip Morris opened plants in 1997 and 2001. By the end of 2000, BAT had invested US\$ 100 million and had attained a 28% share of the Romanian market. In early 2002 it announced a further US\$ 3.7 million investment. Between 1990 and 2000, cigarette production increased by 60% due to expanded local production by the TTCs and duty paid consumption increased from 18.2 billion pieces to 30.7 billion pieces (12). By 2000, only 11.3% of cigarettes in Romania were imported.

**SERBIA AND MONTENEGRO:** There are four cigarette factories in the former FR Yugoslavia, two in Serbia, and one each in Montenegro and Kosovo (12). Unclear ownership issues and problems with privatization legislation had, until recently, discouraged investment, but the new Government adopted a comprehensive privatization law in mid-2001 and in July 2003 opened bids for the two Serbian plants - Duvanska Industrija Nis (DIN), the largest and most profitable, and Duvanska Industrija Vranje (DIV). Philip Morris's offer of €387 million for a 66.45 percent stake in DIN was accepted over that of its competitors as was BAT's sole offer of €50 million for a 67.81 percent stake in DIV (24).

#### 4.4 Tobacco industry tactics and influence

The tobacco industry in general and the TTCs in particular spend substantial resources trying to influence public policy and opinion. They make major contributions to politicians, educational and health care organizations (25, 26) as a way of establishing a dialog with health authorities and governments. A strategy that has recently gained prominence is the industry's use of so called "youth smoking prevention" programs which purport to aim to prevent youth smoking. In Romania, for example, BAT and Philip Morris carried out such a program with, as described in the program's adverts, the support of the Ministry of Youth and Sport and the Ministry of Health. External evaluations suggest however that these programs simply act as a form of subsidized advertising as they tend to encourage rather than prevent youth smoking (27). The industry's real intent is signaled more clearly through its other promotional activities including for example JTI's sponsored concerts for young people in Romania to advertise and promote its tobacco products (28).

Research by Szilagyi et al. on the tobacco industry in Hungary shows how TTCs used sophisticated techniques to influence government decision makers and consequently regulations on the marketing of tobacco products. This provides a useful example for other countries in the region on how these efforts can be researched, prevented and counteracted (29).

##### Summary

The end of political instability and major economic turmoil in the late 1990s has led to the TTCs taking a greater interest in investing in SEE. They already dominate the Romanian market and have recently acquired or are attempting to purchase tobacco companies that are due to be privatised elsewhere in SEE.

Privatisation of state owned companies and the entry of the powerful TTCs raises concerns for tobacco control and may lead to increased consumption through a number of mechanisms, most notably through an increase in competition which drives down prices and increases advertising. Adequate tobacco control policies will therefore be essential to preventing the potential negative impacts of tobacco industry privatisation and further trade liberalisation.

The removal of BAT's regional office from Budapest to Zagreb and possible acquisition of the Croatian tobacco factory Rovinj could also have consequences for other markets in the region, particularly in B&H and Serbia.

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## CHAPTER 5: SMUGGLING OF TOBACCO PRODUCTS

### 5.1 Background

Cigarettes are the world's most widely smuggled legal consumer product. It was estimated, by comparing annual global exports with global imports that in 1996 around 32% of global cigarette exports was missing. In the EU this leads to an annual revenue loss of US\$ 6 billion (1). Smuggling has major implications for tobacco control because maintaining cigarette prices through taxation is one of the most effective ways of controlling cigarette consumption as we shall explore further in Chapter 6.

Cigarettes are usually smuggled while in transit between the country of origin and the destination country and thus many fail to arrive at their official destination (2). «Round-tripping» is another form of smuggling where cigarettes are exported but then reappear, untaxed, in the country of origin (3).

Tobacco companies often argue that smuggling is caused by tobacco taxes being too high. However, countries where taxes are very high and cigarettes very expensive, such as Norway, Sweden, and Denmark (and until recently the UK) do not have large smuggling problems. By contrast, countries in southern Europe with low taxation rates often have high smuggling rates (3). Smuggling appears to be associated with the presence of organized crime, a culture of street selling and the complicity of the industry, all of which exist in SEE (4). Smuggling benefits the industry in a number of ways. It stimulates consumption through the sale of cheap cigarettes (the industry gains its normal profit regardless of whether cigarettes enter the legal or illegal market). It is used by tobacco companies as a strategy for entering markets which are closed to legal cigarette imports. Smuggling can be a “market softening” technique—it establishes a demand for the smuggled brand, undermines sales of local producers' cigarettes (facilitating the cheap purchase of these companies) and enables the industry to argue the need for local production of international brands to reduce smuggling.

Evidence of the TTCs complicity in smuggling is growing, in part through analysis of the industry's own records, released through litigation.<sup>14</sup> There have now been several official investigations in different parts of the world and a series of court cases accusing the industry of smuggling cigarettes (5) in which a number of senior tobacco industry executives or affiliates have been convicted (6, 7). Following a 2-year investigation by the EU's anti-fraud unit, the Commission and Member States have brought a series of actions against the tobacco industry in the US courts in an attempt to recover billions of dollars of revenues lost through smuggling (8, 9). The latest lawsuit launched in October 2002 against US-based company RJ Reynolds goes further than any previous case by

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<sup>14</sup> Further information on the tobacco industry's role in smuggling is available on a number of websites, see for example the Guardian (<http://www.guardian.co.uk/bat>) and Centre for Public Integrity websites ([http://www.publici.org/story\\_01\\_030301.htm#newsstories](http://www.publici.org/story_01_030301.htm#newsstories)).

accusing the company of direct complicity in facilitating money laundering schemes and other criminal enterprises (10).

Despite this evidence, the TTCs have used smuggling to push for privatization of local tobacco industries (2, 11-13) and to argue the need for a reduction in tobacco taxation in order to reduce the incentive to smuggle. Such arguments have been successfully used in Canada and Sweden. In Canada, taxes were reduced in response to concerns about smuggling in the early 1990s. Predictably, this led to both an increase in smoking rates among Canadians and a decline in revenue collected (14).

The World Bank emphasizes that the determinants of smuggling are much more than the price alone. Using measures of corruption based on the Transparency International Index, it concluded that the level of tobacco contraband tends to increase with the degree of corruption (15). Other factors that play a role are insufficient border control policies and the inability of the legal and police system to fight corruption and organized crime.

## **5.2 Cigarette smuggling in south-east Europe**

Smuggling of cigarettes is a widespread phenomenon in SEE. Cigarettes can be bought more cheaply on the black market, which in many countries began to flourish during the hostilities, where they are sold in the many open markets where people come to buy fruit and vegetables.

Albania and countries of the former Yugoslavia are on the smuggling route for cigarettes illegally transported to western Europe, but they are also a destination for smuggled cigarettes. In Italy, court cases and police and government reports recently revealed how Montenegrin government officials, receiving millions of dollars in kickbacks, sanctioned the smuggling of Philip Morris and RJ Reynolds cigarettes (16) with the Montenegrin prime minister, Milo Djukanovic, allegedly a linchpin in the process (17). BAT is reported to have been working closely with the major figures in Balkan cigarette smuggling and was close to agreeing a plan to build a factory in Serbia with tax concessions and preferential importer status that it was thought would facilitate large-scale smuggling in the region (18).

The degree of smuggling varies across the markets of the region. ERC Statistics International estimates that up to 25% of the cigarette consumption in Croatia and Romania comprise smuggled cigarettes, 38% in Bulgaria, 37% in FR Yugoslavia, 40% in Macedonia, 47% in B&H with rates as high as 80% reached in Albania (19). Thus, other than Croatia, the lowest rates are seen in Romania, the country with the greatest TTC presence and highest rates in Albania where the TTCs are officially absent.

As the above estimates of smuggling suggest, throughout the region there are major mismatches between official import and export data. In Albania, trade reports indicate that in 1996, 600 million cigarettes were officially imported and domestic production contributed only 483 million, yet consumption was over 3,100 million greater at around 4,200 million cigarettes. In B&H in 2000, officially recorded imports were 25.36 million

cigarettes while recorded exports from supplying countries were considerably higher – 827 million pieces, leaving 800 million cigarettes unaccounted for. The borders with Republika Srpska are particularly lax and official estimates indicate that between 150-180 tonnes of cigarettes per month are being smuggled into B&H from Republika Srpska alone (19). These illicit cigarettes are mainly international brands while the legitimate sector is comprised almost entirely of domestic brands. Exports are also an issue: in 1999 and 2000, according to official statistics, the vast majority of exports from B&H went to unknown destinations. In Bulgaria, imports traditionally constituted only a tiny proportion of the market, but once the market opened, large imports of foreign brands including illegal imports were seen. In 1995 the consumption of domestic cigarettes was around 13 billion cigarettes, with illegal imports estimated at about 5 billion (19). According to official data from supplying countries, 575.3 million cigarettes were shipped to Macedonia in 2000, but only 137 million were recorded as official imports (19). In Serbia and Montenegro, trade sanctions imposed in 1995 included a ban on the import and export of tobacco products and led to large scale smuggling. Although the ban was lifted in May 2002 (20), the problem continues. In 1998, official imports were estimated at 305 million cigarettes, while exports from the main supplying countries totaled a far greater 2,296 million (19). In 2002 the Yugoslav authorities seized 18.2 metric tons of undeclared cigarettes in a single shipment from neighboring Bulgaria. The seizure came a day after finance ministers and customs officials from Albania, B&H, Bulgaria, Croatia, Macedonia, Romania and FR Yugoslavia met in Kosovo to develop a joint strategy for combating cigarette smuggling (21).

Most is known about the situation in Croatia. Recorded exports destined for Croatia from major western producing nations are much higher than officially recorded imports. For example, in 2000, cigarette exports to Croatia from major producing countries totaled 132.4 million pieces while cigarette imports were estimated at only 34 million pieces, according to data from the Croatian Chamber of Economy and the UN (19).

Data obtained from the Croatian Ministry of Finance (Table 16) show that the number of cigarette packets taxed for consumption in Croatia fell by 22.2% in 2001 compared with 1998. Over the same period the quantity of untaxed cigarettes for export increased almost three fold. The Annual Report of the Croatian Ministry of Finance for 2000 noted the reasons “for and the negative impact of this large scale cigarette smuggling on government revenues:

*With regard to the fact that excise taxes on tobacco products at the end of 1999 grew on average by almost 19% and again from July 1, 2000 by an additional 10.5 (on average), this increase in revenue was definitely below all expectations. The answer to such a poor collection of revenues is in the fact that the number of taxable cigarettes packets in 2000 dropped by almost 20% in comparison with 1999. This decrease cannot be justified by the decrease in the number of smokers or reduced smoking in Croatia. The reason for such [a] decrease in taxed cigarettes quantities is for the largest part the increase in the informal cigarette market. The damage done to the Government budget as a result of the informal cigarette market is really high. This problem calls for*

efforts and coordination of various Government services for fighting it successfully” (22).

**Table 16. Number of cigarette packs produced in Croatia for the Croatian market and taxed and for export and untaxed**

	Number of packs for domestic market (taxed)		Number of packs for export (untaxed)	
	Number	% change from the previous year	Number	% change from the previous year
1998	467,143.519		130,830.323	
1999	462,037.091	- 1.1	171,161.085	+ 30.8
2000	376,808.382	- 18.4	308,580.911	+ 80.3
2001	363,383.168	- 3.6	369,997.674	+ 19.9

Source: Croatian Ministry of Finance. 2002.

Officially, the majority of Croatian cigarette exports go to B&H. In reality, in order to avoid excise taxes, the majority of these cigarettes return to Croatia through the so called “soft border” and appear on the black market. It was estimated in 2002 that revenues lost due to cigarette smuggling were 400 million kunas (over US\$ 57 million). The Croatian news magazine, *Nacional*, has written extensively on this issue in the last couple of years and provided very interesting data about the extent of cigarette smuggling, smuggling routes in the Balkans and the political figures involved (23).

### 5.3 Controlling cigarette smuggling

Cigarette smuggling causes major harm. It promotes smoking by lowering cigarette prices, creates unfair competition for legal cigarette sellers and local manufacturers, reduces government tax and import duty revenues and of course promotes corruption (24). Control of cigarette smuggling would therefore increase government revenues and help reduce cigarette consumption. Although the complicity of the cigarette companies in tobacco smuggling is an issue, in SEE organized crime and inadequate border controls are also major concerns. Border controls and customs and excise authorities were only recently established in each of the new independent countries of the former Yugoslavia.

The control of cigarette smuggling requires international collaboration and the Framework Convention on Tobacco Control (FCTC, see *Chapter 8*) has a crucial role to play in this area. In addition to recommending that each country monitor and collect data on cross-border and illicit trade in tobacco products, and exchange such information among appropriate national and regional authorities, the FCTC recommends a series of legislative and other measures to control smuggling (25). Legislation should ensure that all tobacco products are clearly and legibly marked with the origin of the tobacco product, whether intended for domestic consumption or the final destination for products intended for export. Alongside a tracking and tracing regime this would secure the distribution system and assist in investigating and controlling illicit trade. Appropriate penalties against smuggling, systems for destroying or disposing of counterfeit and

contraband products and confiscating proceeds derived from the illicit trade should be developed.

Other measures recommended to control smuggling include establishing mandatory licensing for all parties involved in cigarette production and distribution both within the country of origin and all countries through which the products will pass (24). These licensed parties could then be required to keep records of the movement of cigarettes from the factory to the final destination. Major cigarette companies should also be held liable for any of the brands they manufacture ending up in the illegal sector (24). Ideally, duty free sales should be eliminated (24), or at minimum tracking systems, similar to those outlined above, developed to document and control the storage and distribution of tobacco products held or moving under suspension of taxes or duties (25).

In addition to the above measures specific to tobacco smuggling, more generic infrastructural measures are needed to control smuggling in general including, for example, adequate border controls, efficient customs and excise, police and judicial systems. Although few of the specific measures have yet to be developed in SEE, a number of structural changes have recently been put in place to help control smuggling, many developed with the support of external agencies.

As part of the CARDS and similar programs, the EU has been providing support to combat smuggling. In Albania for example the EU has provided support for judicial reform and improvements to the customs service to prevent smuggling and secure revenue collection. The EU funded Customs and Fiscal Assistance Office (CAFAO) in B&H is assisting in the development of the customs and tax systems and has now developed a single customs territory (26). The Stability Pact includes tobacco smuggling within its Initiative against Organized Crime. The Initiative recognizes that organized crime is linked to the large-scale smuggling of consumer goods, particularly cigarettes, and aims to strengthen regional and international cooperation and develop and implement national strategies against organized crime. It acknowledges that the weakness of public institutions, difficulties in investigating and prosecuting crimes, the lack of human and other resources, and the limited coordination between criminal justice agencies within and between countries continue to facilitate organized crime.

Some small successes are starting to be seen. In Kosovo, of the €105 million collected each year in excise taxes at least €20 million comes from levies on cigarettes. Customs officials estimate that €8 million now eludes collection each year, an improvement over the 1999-2000 period when as much as €30 million may have escaped collection. According to UNMIK (UN Interim Administration Mission of Kosovo), due to improved tax collection, as well as a reduction in import taxes, the share of excise tax generated by cigarettes has grown substantially (27). In Croatia the Ministry for Internal Affairs and Customs Office, in collaboration with SECI (South-East European Cooperation Initiative), have since June 2002 undertaken several successful actions to combat tobacco smuggling. These efforts show that change is possible but further concerted efforts are needed. The factor most often quoted as contributing to the success of strategies against organized crime is “political will” (28).

## Summary

Cigarette smuggling benefits tobacco companies by increasing their market share, and making their cigarette brands more easily available and affordable. It thereby increases consumption and reduces government revenues. It can also be a means of entering new markets. The presence of cheap, smuggled western brands can undermine local companies, reducing their value so that they may be more easily and cheaply acquired. Despite growing evidence of the direct complicity of major tobacco companies in cigarette smuggling, they still use the presence of smuggled cigarettes to argue the need for cigarette taxes to be reduced and to make the case for privatisation of local companies.

Smuggling is a major issue in SEE. Smuggled cigarettes account for between 25% (Romania and Croatia) and 80% (Albania) of consumption, indicating that considerable government revenue is being lost.

Governments and policy makers need to be aware of the devious arguments the tobacco industry uses in this area and to remember that experiences from a number of high-income countries show that, even in the face of high rates of smuggling, tax increases bring increased revenues and reduce cigarette consumption.

Since the end of the 1990s the governments of SEE have been making concerted efforts to combat smuggling. However, further efforts and international collaboration are needed as smuggling still presents a significant obstacle to successful tobacco control in the region. Such efforts require infrastructural changes necessary to control smuggling and organized crime in general plus measures specific to the control of cigarette smuggling such as the development of a system for marking and tracking tobacco products.

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## CHAPTER 6: TOBACCO CONTROL MEASURES

### 6.1 Background

Effective tobacco control can only be achieved through the adoption of a comprehensive set of effective measures which aim is to change both individual behavior and the societal context in which decisions about smoking take place (1). This requires the enactment and enforcement of national policies and legislation and increasingly, given the global nature of the trade in tobacco, international action on tobacco.

Tobacco control policies aim to reduce morbidity and mortality from smoking and to reduce health inequalities by encouraging quitting, preventing uptake of smoking, reducing exposure to ETS and reducing consumption amongst continuing smokers. Due to the delayed health impacts of smoking, policies that simply stop young people taking up the habit will not reap benefits for a few decades. To have an impact in the next few decades, policies need to get adult smokers to quit. There is good evidence of the health benefits of quitting with the chance of survival depending on the age at quitting. Those who stop before 35 years of age have a pattern of survival that does not differ significantly from that of non-smokers. For those who stop later, survival is intermediate between that of non-smokers and continuing smokers but there are still clear benefits.

**Table 17. Cost-effective interventions to reduce tobacco use**

<b>Interventions</b>	<b>Beneficiaries/ Target Groups</b>	<b>Process Indicators</b>
Higher taxes	Smokers Potential smokers	Price of cigarettes Tax as % of final sales price
Bans/ restrictions on smoking in public and work places (schools, health facilities, public transport, restaurants, cinemas)	Non-smokers protected from second-hand smoke Helps smokers quit and continuing smokers reduce consumption	Smoke-free public spaces and places
Comprehensive bans on advertising and promotion of all tobacco products, logos and brand names	Smokers and potential smokers (especially youth)	Laws, regulations, extent to which they are respected/ reinforced
Better consumer information: counter-advertising, media coverage, research findings	Smokers and potential smokers Social attitudes to smoking	Knowledge of health risks, attitudes to smoking
Large, direct warning labels on cigarette boxes and other tobacco products	Smokers and potential smokers	Percent of box surface covered by label, message, color/font specifications
Help for smokers who wish to quit, including increased access to nicotine replacement therapy and other cessation therapies	Smokers	Number of ex-smokers

*Source:* Tobacco Control at a glance. World Bank, Washington DC. 2001.

Governments may consider a range of interventions that can limit the supply of or reduce demand for tobacco (Table 17). Demand side measures that effectively reduce tobacco consumption include increases in tobacco taxation, which have the added advantage of simultaneously increasing government revenues, complete bans on tobacco advertising and promotion, restrictions on smoking in public places, public communication and information campaigns and access to smoking cessation services including nicotine replacement therapy (NRT) (1). Control of cigarette smuggling is the most effective supply-side measure and is particularly relevant for the SEE context where cigarette smuggling is widespread.

According to Jha et al, increases in tax on tobacco, provision of information to the public, prominent warning labels, bans on tobacco advertising and promotion and control of smuggling are particularly relevant components of tobacco control in middle income countries (Table 18) (1). Above all however, it is essential to ensure the adoption of a comprehensive set of measures. This is best illustrated by countries or states that have experienced the greatest declines in cigarette consumption (2). New Zealand for example experienced one of the most rapid decreases in consumption – a halving in 15 years, with adult smoking prevalence falling from 32% in 1981 to 24% in 1996. This was the result of a comprehensive tobacco control program that included tobacco tax increases, a ban on tobacco advertising and sponsorship, restrictions on smoking in workplaces and most public transport, and tobacco packet labeling (3).

**Table 18. Relevance of tobacco control policies to middle income countries**

Raise tax	Highly relevant
Research causes, consequences and costs	Relevant
Mass information, prominent warning labels	Highly relevant
Ban advertising and promotion	Highly relevant
Restrict public and workplace smoking	Relevant
De-regulate nicotine replacement products	Relevant
Control smuggling	Highly relevant

*Source:* Jha P, Paccard F, Nguyen S. Strategic priorities in tobacco control for governments and international agencies. In: Tobacco Control in Developing Countries (1)

*Notes:* A three point scale was used: 3= highly relevant; 2=relevant; 1=somewhat relevant

A major reason for governments' inaction over tobacco is the fear that lower cigarette consumption will lead to job losses. These fears have been fuelled by the tobacco industry and a closer inspection of the industry's arguments and the data on which they are based, suggests that they have been greatly overstated (4). The economy of SEE is not heavily dependent on tobacco farming, and cigarette manufacturing uses few human resources, so the strengthening of tobacco control is unlikely to cause job losses long-term, as money previously spent on tobacco would be reallocated to other goods and services.

This chapter summarizes the most effective measures for reducing tobacco use (other than the control of smuggling which is detailed in Chapter 5) and thus tobacco-related death and disease. It gives examples of how and with what success these measures have been implemented elsewhere. The next chapter will describe which measures exist in the countries of SEE.

## 6.2 Tax policy on tobacco

«Of all the concerns, there is one – taxation – that alarms us the most». Philip Morris<sup>15</sup>

There are several kinds of taxes on cigarettes. An *excise tax* is a tax on tobacco produced for sale within a country or imported and sold in that country. It can be either *specific* (a set amount per pack) or *ad valorem* (an amount proportional to the cost of the pack). VAT (value added tax) may be charged in addition and most countries that have VAT impose it on a base that includes an excise tax and custom duty. The best international practice is that each country taxes its imports but not its exports (4).

Demand for tobacco is price-inelastic, so, on average, a price rise of 10 percent on a pack of cigarettes reduces demand by approximately 4 percent in high-income countries and by about 8 percent in low- and middle-income countries. Demand for tobacco tends to be income elastic which means that consumption will rise with an increase in income.<sup>16</sup> Taxation therefore needs to keep track with inflation and with increases in real incomes (1).

In many countries, especially those where the epidemic is well established, smoking is more common amongst the poor (especially men). Cigarette taxation is therefore regressive—that is, accounts for a higher percentage of the incomes of poorer people (5). However, the poor are more responsive to increases in cigarette taxation, being more likely to quit when prices rise, and thus price *increases* are not regressive. Similarly, children and adolescents are more responsive to price rises than older adults which makes increases in tobacco price the most effective tobacco control intervention to prevent children and adolescents from taking up smoking (6).

The World Bank recommends that tax rates should be set at levels similar to those in countries that have comprehensive and successful tobacco control policies. Tobacco taxes (excise and VAT) in these countries contribute between two-thirds and four-fifths of the price of a pack of cigarettes. Canada, France, Ireland, South Africa, Thailand and the UK are examples of countries where fiscal policy has been used to advance public health. In the early 1980s and 1990s, Canada increased its cigarette taxes and between 1979 and 1991 teenage smoking fell by nearly two-thirds, adult smoking declined, and cigarette tax revenues rose substantially. However, concerned about an increase in

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<sup>15</sup> Philip Morris International document. Smoking and health initiatives. Bates No 2023268329-49. Minnesota Tobacco Document Depository. 1995

<sup>16</sup> Over time, as national income rises, cigarette consumption tends to increase, at least in low- and middle income countries. Within countries, especially in later stages of the tobacco epidemic, people with higher incomes tend to smoke less than people with lower incomes.

smuggling and falling for the tobacco industry arguments, the government cut taxes. This led to an increase in prevalence of smoking, both among teenagers and adults and a fall in tobacco tax revenues. Elsewhere, Norway increased tobacco taxes per pack by 94% between 1990 and 1998 and saw a revenue increase of 65% (4). In South Africa, inflation eroded the real excise tax on cigarettes by about 70% between 1970 and 1990, total excise revenues fell 66% in real terms, while total consumption more than doubled from 783 to 1868 million packs. The new democratically-elected government made tobacco control an important part of its public health policies, and large real increases in excise tax rates during the 1990s caused total (real) revenues to go up by over 250%. Consumption fell to 1272 million packs, a decrease of well over 30% in just one decade (7). There are many other examples of higher cigarette tax rates generating higher total excise revenues, while reducing consumption (8).

Several US states (California, Massachusetts, Arizona and Oregon) and governments in other countries (for example, Australia, Austria, Canada, Egypt, Estonia, Finland, France, Greece, Iceland, Iran, Ireland, Latvia, Poland, Portugal, Romania and Thailand) earmark a part of their tobacco tax for tobacco-related education and counter-advertising, cancer research, funding health care for under-insured populations and/or funding of sporting and artistic events that were previously financed by the tobacco industry. Earmarked taxes could also be used to subsidize smoking cessation services for the poor, thereby reducing the regressivity of cigarette taxation (4).

### **6.3 Advertising of tobacco products**

With the advent of logos and branding the nature of advertising has changed. The tobacco industry is adept at evading and undermining bans on direct advertising by expanding indirect forms of advertising. These may include sponsorship, and the sale and promotion of branded products (clothing, lighters, watches, holidays etc) often using adverts that are identical in appearance to banned cigarette adverts. Thus, bans on direct advertising have led to a shift to indirect forms of advertising, particularly promotion and sponsorship to which the tobacco industry has allocated increasing funding.

There is evidence that complete and comprehensive bans on direct and indirect tobacco advertising that cover all media and the use of brand names and logos make an important contribution to reducing tobacco consumption. However, incomplete bans are ineffective as they simply allow the industry to transfer their advertising spend from one promotional form to another. A study that examined trends in consumption and advertising in 33 countries during 1970-1986 found that countries with the strictest controls on tobacco advertising and sponsorship had the largest annual reduction of tobacco consumption (9).

### **6.4 Restrictions on smoking in public places**

Restrictions on smoking in workplaces and public places protect non-smokers from involuntary exposure to secondhand smoke. They also help smokers quit and for those that continue to smoke help them reduce consumption (10). According to various

studies, such restrictions have reduced tobacco consumption by 4 to 10 percent in the presence of high level awareness of the health consequences of exposure to secondhand smoke (4). Complete bans are more effective than those that allow smoking in some parts of the workplace. Contrary to industry propaganda, ventilation offers little protection against second hand smoke (11, 12). Such restrictions also play a key role in denormalizing smoking.

## 6.5 Public education

In the Framework Convention on Tobacco Control (FCTC)<sup>17</sup>, the WHO recommends that at least 30 per cent - but ideally 50 per cent or more - of the display area on tobacco packages be occupied by health warnings (13). Reports from Canada and Australia suggest that plain packaging may increase the impact of health warnings (no use of color, logo or graphic design but simply a generic pack of cigarettes (13). Large pictorial labels depicting the negative health impacts of tobacco have been introduced in Canada and Brazil. Evaluations suggest that introduction of the Canadian warnings had a considerable impact on smokers' attitudes and motivation to quit (15). The EU recently introduced warnings that cover 30% of the front and 40% of the back of each pack.

It is important that the public are provided with accurate information on the health effects of tobacco, particularly as the tobacco industry has been misleading its consumers for years about the health impacts of its products. The United States Federal Trade Commission (FTC) adopted standardized testing methods for the measurement of tar and nicotine yields of cigarette smoke in the 1960s, and for carbon monoxide in 1981. The International Organization for Standardisation (ISO) adopted a similar testing method in Europe. It is now widely recognized that the FTC/ISO measurements of tar and nicotine content in cigarette smoke are seriously flawed and do not provide an adequate basis for regulation and labeling of tobacco products (16). Shopland describes how the major cigarette manufacturers knew, since the mid-1960s, that these test methods were flawed and yet continued to deceive their customers (17). The main issue is that the machine measured yields that give rise to FTC and ISO measures do not reflect the yields that occur in practice as smokers compensate for reduced nicotine yields by inhaling more deeply and more often. In addition, smokers tend to block the ventilation holes designed by the industry to reduce machine (but not actual) yields. Thus, when smoking low-tar brands, smokers' tar exposure may be as high as when smoking conventional cigarettes. There is also evidence that smokers mistakenly believe that some (relative) health benefit can be obtained by shifting from high-tar to low-tar brands, and may therefore transfer to low-tar brands rather than quitting (18). For this reason, the Scientific Advisory Committee on Tobacco Products of the WHO has concluded that the terms «light»,

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<sup>17</sup> The FCTC is the first global public health treaty negotiated under the auspices of WHO. The treaty was unanimously adopted in May 2003 by the World Health Assembly composed of all 192 WHO Member States. Signature and ratification of the treaty by Member States is in progress. The Convention requires ratification by 40 Member States for its entry into force, thereafter, countries that have not signed can become parties to the treaty by accession.

«ultra-light» and «low tar» should be banned (19). The Health Education Authority in the UK has also revealed in its studies that the tar and nicotine ratings as displayed by the industry on cigarette packages are not clearly understood by consumers (20).

More broadly, public communication programs which include paid mass-media campaigns to help to denormalize tobacco and create an emotional response in smokers are vitally important (21). Anti-smoking advertising and other media campaigns should aim to deconstruct the glamour and normalization of smoking created by years of industry generated pro-smoking imagery. The impact of such campaigns can be extended through the use of unpaid publicity and media advocacy. Telephone help-lines and national and international tobacco-free days also help to educate the public on the harmful effects of smoking and can motivate tobacco users to quit (22, 23).

## **6.6 Provision of treatment for tobacco dependence**

Tobacco dependence is listed as a disorder in the tenth International Statistical Classification of Diseases and Related Health Problems (ICD-10) (24). Treatments for tobacco dependence (see box) have the potential to reduce tobacco-related disease (23, 25) and many are highly cost-effective.

Treatments for tobacco dependence generally include:

- brief advice
- behavioral therapy
- nicotine replacement
- bupropion and other pharmaceuticals

Effective treatment can involve a variety of methods, including a combination of behavioral treatment and pharmacotherapy (e.g. nicotine replacement, non-nicotine medication such as bupropion or both). Studies have shown that physician's advice alone increases the number of quit attempts (26) but more effective interventions are now available in the form of nicotine replacement and bupropion. NRT relieves the symptoms of nicotine withdrawal by delivering a smaller dose of nicotine than cigarettes more slowly. Compared with no treatment or placebo, commercially available forms of NRT (nicotine gum, transdermal patch, the nicotine nasal spray, nicotine inhaler and nicotine sublingual tablets) increase quit rates by approximately 1.5–2 fold (27).

It is estimated that for most industrialized countries, a 3-month supply of NRT costs about half as much as a 1-year supply of cigarettes (23, 28, 29). In a study that examined life-years saved as a result of treatment, treatment for tobacco dependence compared favorably with most health care procedures (30). It is therefore recommended that treatment be made easily accessible and affordable to tobacco users as part of any strategy to reduce tobacco consumption (31). This would include making cessation services available under a basic health insurance package.

## 6.7 Importance of intersectoral collaboration in tobacco control and development of a national tobacco control action plan

Effective implementation of the above policies plus efforts to control cigarette smuggling (see Chapter 5) inevitably require cross-governmental collaboration. Table 19 describes the ministries, other than the ministry of health, that have a key role to play in developing a comprehensive tobacco control strategy. In SEE, given the enormous problems with cigarette smuggling, the ministry of internal affairs should also be involved. The involvement of non-governmental actors is also essential. Establishing a national, intersectoral tobacco control committee comprising relevant governmental departments, non-governmental organizations (NGOs) and members of the public is an important element in developing a comprehensive tobacco control policy (32). Health charities, medical associations and research organizations are appropriate organizations to involve. The development of a national tobacco control action plan can then draw on the skills of those represented in the national committee.

In Europe, countries with the most specific and detailed national action plans also tend to have the most comprehensive and effective policies (31). Ongoing evaluation of tobacco control programs is essential to ensuring their effectiveness. Evaluations should include appropriate process and outcome indicators including regular data on prevalence, determinants, and knowledge of and attitudes to smoking (23).

**Table 19. Inter-ministerial action required for tobacco control**

<b>Issue</b>	<b>Agency or ministry</b>
Taxation	Finance, Trade, Customs, Social Security
Research on causes, consequences and costs of tobacco use	National Statistics Offices, Industry, Commerce, Trade, Agriculture, Health
Mass information	Education, Telecommunication, Health
Ban advertising and promotion	Commerce, Finance, Telecommunication
Deregulate nicotine replacement markets	Commerce, Trade, Drug Controller, Health
Restrict public and workplace smoking	Commerce, Tourism, Hotels
Control smuggling	Trade, Customs, Finance
Employment and agricultural issues	Agriculture, Labor, Commerce

*Source:* Jha P, Paccaud F, Nguyen S. Strategic priorities in tobacco control for governments and international agencies. In: Tobacco Control in Developing Countries (1)



## Summary

Effective tobacco control requires the adoption and enforcement of a comprehensive set of tobacco control measures. Such measures should include:

**Tax increases:** A price rise of 10 percent on a pack of cigarettes reduces demand for cigarettes by about 8 percent in middle-income countries. The tax component of the price of a pack of cigarettes should be between two-thirds and four-fifths of the total retail price. Tobacco taxes can be earmarked to subsidise a range of primary and secondary smoking prevention measures.

**Better consumer information, complete bans on advertising and promotion and smoking restrictions in public places:** Combined, such measures can persuade between 2 and 10 percent of smokers to quit. Advertising bans must be comprehensive to prevent a shift in tobacco industry spending from one advertising form to another. Restrictions on smoking in public places help denormalise smoking, protect non-smokers from involuntary exposure to secondhand smoke and are highly effective in helping smokers quit. Prominent and clear health warnings that inform smokers on harmful effect of tobacco should occupy at least 30% of the front of a packet and 40% of the back, as is now enshrined in EU legislation.

**Treatment for tobacco dependence** including behavioral and drug therapies are effective and cost effective ways of increasing cessation rates.

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## CHAPTER 7: TOBACCO CONTROL IN SOUTH-EAST EUROPE

### 7.1 Background and Data Sources

Information on tobacco control measures was provided in chapter 6. This chapter describes the main tobacco control policies in place in SEE. National co-coordinators provided data on issues including retail prices of the most popular brands of cigarettes, levels of taxation, restrictions on tobacco advertising and smoking in public places, as well as details of activities and programs that national health institutions, mainly ministries of health, are undertaking to prevent and reduce tobacco use. Additional data were obtained from the WHO European Country Profiles on Tobacco Control (1).

### 7.2 Price of cigarettes

In 2001, cigarettes were most expensive in Croatia, but prices were low throughout the region (especially for local brands). *Marlboro* was one of the most popular foreign brands in the region and its price ranged from US\$ 1 to US\$ 2 (Table 20). In comparison *Marlboro* prices in the EU varied from US\$ 1.9 in Portugal to US\$ 6.2 in the UK (2).

**Table 20. Prices per pack of cigarettes\* for the most popular foreign and local brands in 2001 with brands ranked by popularity (based on official market share)**

	Foreign brands	Price (\$US)	Local brands	Price (\$US)
Albania	Marlboro	1.7	Veve	0.4
	Slims	0.7	DS	0.3
	L.M.	0.7		
Federation of B&H	Marlboro	1.3	Drina soft pack	0.5
	Walter Woolf	0.7	Drina hard pack	0.5
	York	0.5		
Republic Srpska	Marlboro	1.3	Ronhill	0.5
	Lucky Strike	1.1	Morava hard pack	0.3
Bulgaria	Marlboro	1.9	Victory	0.6
	Rothmans	1.7	BT	0.6
	Kent	1.9	Melnik	0.4
Croatia	Marlboro	2.0	Ronhill	1.4
	Lucky Strike	2.0	Kolumbo	1.5
	Dunhill	2.5	Filter 160	1.4
Macedonia	Marlboro	1.2	Rodeo	0.3
	Cartier	1.3	MT	0.3
	Dunhill	1.3	Makedonija	0.3
Romania	Marlboro	1.0	Carpati	0.3
	Kent	1.0	Snagov	0.4
	Viceroy	0.5		
Serbia and Montenegro	Ronhill	0.9	Best	0.4
	Lucky Strike	1.2	Classic	0.5
	Monte Carlo	0.8	Drina	0.4

Source: ERC Statistics International and data obtained from national co-coordinators (3)

\* 20 cigarettes per pack

Cigarette prices were also compared with prices of bread and apples (the cheapest fruit) to assess how affordable tobacco products are (Table 21). In Macedonia, Romania, Serbia and Montenegro one packet of the most popular domestic cigarette brand costs less or the same as a kilo of bread and in all the countries surveyed, less than a kilo of apples (in Croatia the price is the same). This clearly shows that cigarettes are affordable, particularly given the availability of smuggled cigarettes that can be bought even more cheaply.

**Table 21. Comparison of cigarette, bread and apple prices (2001, US\$)**

	<b>1 pack* of most popular domestic cigarettes</b>	<b>1 kg of bread</b>	<b>1 kg of apples</b>
Albania	0.4	0.3	1.0
Bulgaria	0.6	0.4	1.1
Federation of B&H	0.5	0.3	1.0
Croatia	1.4	1.0	1.4
Macedonia	0.3	0.5	0.5
Romania	0.4	0.5	0.6
Serbia and Montenegro	0.4	0.4	0.8

*Source:* ERC Statistics International and data obtained from national co-coordinators (3)

*Note:* \* 20 cigarettes per pack. Prices in Republic Srpska were similar to those listed for B&H.

### 7.3 Tax on cigarettes

The excise, VAT and import duties rates applied to cigarettes in SEE are shown in Table 22. Excise rates vary from 30% to 49% and import duties vary even more widely, from 15% to 98%. Romania and Bulgaria have to raise excise taxes on cigarettes to the EU minimum of 57% in preparation for EU accession although, as a result of tobacco industry lobbying, long derogations have been allowed before these rates have to be achieved (see Chapter 8). In 2002, Romania became the only SEE country to earmark tobacco taxes for health purposes, Bulgaria may do so as well if a draft law is enacted.

**Table 22. Cigarette taxation rates in SEE**

	<b>Excise tax (% of retail price)</b>	<b>VAT (%)</b>	<b>Import duty (%)</b>
Albania	38	20	15
B&H	35	20	15
Bulgaria	44	20	50
Croatia	49*	22	49
Macedonia	35	19	60
Romania	33	19	98
Serbia and Montenegro	40	21	15

*Source:* National co-coordinators (levels of excise taxes and VAT) and Tobacco Control Country Profiles 2003 available from: [http://www.who.int/tobacco/statistics/country\\_profiles/en/](http://www.who.int/tobacco/statistics/country_profiles/en/) (levels of import duty)

*Note:* \* 49.1% for category A (popular brand) cigarettes, and higher for category B (standard brands) and C (imported cigarettes and those manufactured under license).

The excise system in Croatia is somewhat more complex with rates varying according to cigarette category: category A (popular brand), category B (standard brand) and category C (imported cigarettes and cigarettes manufactured under foreign license). Excise rates have been raised steadily over recent years with the percent increase greatest for category A cigarettes although this category still remains the cheapest (Table 23).

Revenues raised from cigarette taxes also vary widely. In 2000 revenues (from excise and VAT) were less than 4% of total revenue in Serbia and Montenegro, Romania and Albania, between 4-6% in Croatia (a fall from 7.1% in 1996) and over 7% in Macedonia and Bulgaria.

**Table 23. Excise tax level changes, Croatia 1999-2000 (in local currency--kunas)**

	<b>Category A</b>	<b>Category B</b>	<b>Category C</b>
Until 30 June, 1999	3.5	4.2	7.5
Since July 1, 1999	3.9	4.3	7.0
Since 1 November 1999	4.5	4.9	8.1
Since 1 July, 2000	5.0	5.4	8.9
Per cent change in tax (June 1999 – July 2000)	42.8%	28.6%	18.7%

*Source:* Croatian Ministry of Finance. 2002.

#### **7.4 Advertising of tobacco products**

All the countries except B&H have a complete ban on national television and radio advertising for tobacco products and all except Albania, B&H and Romania have a complete ban on advertising in cinemas. B&H and Macedonia have partial restrictions on local newspaper and magazine advertising while Albania, Bulgaria, Croatia and Serbia and Montenegro and Macedonia have complete bans. Advertising at point of sale (kiosks, other retail outlets) is permitted in all countries except Serbia and Montenegro. Billboard advertising is completely banned in Bulgaria, Croatia, Macedonia and Serbia and Montenegro, partially restricted in B&H and Romania and unrestricted in Albania. However, the industry continues to flout these laws throughout the region by using billboards to display adverts which are identical to the banned cigarette adverts in every way, other than not displaying the cigarette. Such adverts are particularly common in urban settings.

Indirect tobacco advertising is completely banned only in Bulgaria and Croatia while other countries such as B&H, Romania, Serbia and Montenegro and Macedonia have complete bans on some aspects of indirect advertising such as tobacco product placement on television and in films .

#### **7.5 Sales of tobacco products**

Vending machines are banned in B&H and Croatia, partially restricted in Romania and unrestricted in Albania, Bulgaria, Macedonia and Serbia and Montenegro. Sales of single

or unpacked cigarettes are allowed only in Albania, Bulgaria, Serbia and Montenegro and Macedonia. Officially, tobacco products can only be sold to persons older than 16 years in Macedonia, whereas in B&H, Bulgaria, Croatia, Romania and Serbia and Montenegro the age limit is 18 years. Albania does not have age restrictions on sales of cigarettes although there is a draft law that specifies an age limit of 18 years. Despite these laws, minors can easily access tobacco products – the GYTS surveys cited in Chapter 2 indicate that 53%-70% of 13-15 year old children simply buy cigarettes in a store and most are not turned away because of their age.

## **7.6 Smoking in public places**

In all countries except Albania smoking is forbidden or restricted in all government, health care and educational facilities, cinemas and theatres. Bulgaria, Croatia, Macedonia, Romania have complete bans on smoking in indoor workplaces and offices (other than bars and restaurants) although enforcement is often an issue. In restaurants, smoking is partially restricted in B&H, Bulgaria, Croatia, Macedonia, Romania and Serbia and Montenegro but remains unrestricted in Albania. In reality however, non-smoking areas do not protect non-smokers from tobacco smoke as they are not usually physically separated from smoking areas and bars and restaurants are generally full of tobacco smoke.

## **7.7 Packaging and disclosure of information on tobacco products**

As outlined below, the requirements for health warnings on cigarette packaging vary widely among the countries of SEE. Most have only small warnings that are poorly specified and as yet, none has banned misleading product descriptors such as “light” and “mild”. In all countries except Albania, the information on tar and nicotine content has to be displayed on cigarette packages.

**Albania:** There are requirements to include health warnings on tobacco packaging and in tobacco advertisements. Tobacco product ingredients are measured by the government laboratory but do not have to be disclosed and products are not regulated with respect to content of nicotine, tar, additives or carbon monoxide.

**Bosnia and Herzegovina:** Tobacco product packaging must include health warnings but health warnings do not have to be displayed in tobacco advertisements. The location of the health message and the color, contrast, size of letters, content and number of messages are specified although the proportion of the package to be covered is not. Measurement of product ingredients and smoke constituents is not regulated.

**Bulgaria:** Health warnings must cover at least 4% of the pack surface. The size of health warnings and their color, letter size, contrast, content and number of messages are specified. Measurement of product ingredients and smoke constituents is required.

**Croatia:** Health warnings are required. The color, contrast, letter size, content and number of messages are all specified although the proportion of the pack to be covered

is not. information on the content of nicotine and tar has to be displayed on the package. Measurement of tobacco product ingredients and smoke constituents is required.

**Macedonia:** Health warnings are required but their location, color, contrast, letter size and number of messages are not. Content of the warning is specified. Measurement of product ingredients and smoke constituents is done.

**Romania:** There are requirements to cover 4% of a cigarette package with health messages, with specified color and letter size. As of 2004, it is planned to introduce warnings on cigarette packages that would cover at least 30% of the most visible surface area. Health warnings in tobacco advertisements need to cover at least 10% of the display area. Measurement of product ingredients and smoke constituents is not regulated.

**Serbia and Montenegro:** Health warnings must be included on tobacco product packages. The content, number and place of messages are specified but the area covered, letter size and color are not. Information on product ingredients is required and the maximum nicotine and tar content is specified.

## 7.8 Interventions to support smoking cessation

Pharmacotherapies for smoking cessation are available in all countries except Albania. However, many cessation clinics operate on a private basis and health insurance does not usually cover the costs of cessation therapies thereby limiting accessibility. Table 24 shows training for and availability of other smoking cessation interventions.

**Table 24. Anti-smoking interventions**

	<b>Training of health professionals and medical students</b>	<b>Cessation clinics</b>	<b>Help lines</b>
Albania	No	No	No
B&H	Yes	Yes*	Yes*
Bulgaria	Yes	Yes	No
Croatia	Yes	Yes	Yes
Macedonia	N/A	No	N/A
Romania	No	No	No
Serbia and Montenegro	Yes	Yes	No

*Source:* National co-coordinators

*Note:* \*In B&H, most counseling and cessation support is provided by family medicine units.

## 7.9 National action plans on tobacco control

All SEE countries officially have intersectoral coordinating committees. National action plans on tobacco have been developed in Bulgaria, B&H, Macedonia and Serbia and Montenegro. Tobacco control is beginning to involve various government departments, such as the ministries of health, finance, education and internal affairs, but little specific



information is yet available on the involvement of ministries other than the ministry of health. Nor is the involvement of non-governmental actors clearly established in all countries in the region.

This section presents information on the existing national programs and their objectives, where available.

### **Albania**

At present, tobacco control laws in Albania are weak. A recent survey carried out by the NGO "For a Tobacco-Free Albania" suggested, however, that there is public support for tobacco control: 95% of respondents would support bans on sales to children and on smoking in educational and health institutions (4). It is uncertain however what progress a draft tobacco control law proposing stricter formulations will make in the Albanian Parliament. Some recent progress has however been made and is encouraging. In 2003, a working group was appointed by the Minister of Health to draft a Tobacco Control Strategy and action plan. The draft was presented at the National Conference on Tobacco Control in September 2003 in Tirana with the support of WHO. As a result, an intersectorial committee led by the Ministry of Health will be established. Its tasks will include:

1. To analyse trends and consequences of smoking, inform the government about existing trends and propose measures accordingly;
2. To develop a national policy for reducing and preventing smoking;
3. To coordinate the activities of state bodies on preventing and restricting of smoking;
4. To establish links among and assist the activities of non-governmental organizations on the restriction and prevention of smoking.

A Program Board will be established as the executive office for monitoring the implementing the Program. The Board will have a general coordinator, regional coordinator, and permanent secretariat.

### **Bosnia and Herzegovina**

Smoking prevention forms part of the health sector reform program. Tobacco Control Strategies were developed for Bosnia and Herzegovina (both entities) as planned in the Basic Health Project (financed by the World Bank), with support from the WHO Regional Office for Europe. The Strategies focus on development and implementation of legislation based on WHO recommendations, mass media campaigns and smoking cessation programs as well as on development of intersectoral collaboration in tobacco control.

The most important early achievements include laws restricting or banning smoking in public places and banning sales of tobacco to those younger than 18, in both the Federation of B&H and Republika Srpska. In both entities, the Institutes of Public Health have opened National Tobacco Control Centres, whose tasks include maintaining data bases and documentation on tobacco control, training health professionals and others in tobacco control, and providing public information, especially related to the FCTC. WHO documents on tobacco control have been translated, health promotion materials produced

and distributed, World No Tobacco Day celebrated, and Quit and Win and other mass media campaigns implemented. Republic Srpska's Cancer Registry will enable better monitoring of the impact of tobacco use.

### **Bulgaria**

Bulgaria has been making progress in developing tobacco control policies, partly in anticipation of EU accession, but as yet has met with little success in reducing consumption.

The National Health Care Strategy "Better health for a better future of Bulgaria 2001-2010" includes targets and interventions for reducing smoking by 30% in men and 10% in women. In January 2002 the Parliament adopted a "National Program on Restriction of Smoking in 2002-2005". It proposed major institutional, legislative, price and organizational changes in relation to tobacco control including the following initiatives:

- analysis of the existing legislative base and evaluation of its effectiveness
- development and implementation of price and taxation policy to reduce smoking
- improved collaboration between the Ministries of Internal Affairs, Finance and Education to reduce illegal trade in tobacco products
- implementation of measures to protect non-smokers from exposure to tobacco smoke through the development and enforcement of measures against smoking in public buildings, work places and public transport
- implementation of the EU Tobacco Products Directive 2001/37/EC which includes large health warnings, labeling and a ban on misleading descriptors such as "light" and "mild".<sup>18</sup>

In 2002, the Intersectoral Council for Prevention and Reduction of Smoking was founded and tasked with the following:

- to develop and propose a national policy for the prevention and reduction of smoking;
- to analyze the extent of smoking and its effects, inform the government about existing trends and propose appropriate measures;
- to develop a National Program on Smoking Reduction;
- to co-ordinate the tobacco-control activities of state organizations; and
- to coordinate, connect and support the actions of the NGOs in their anti-tobacco activities.

As a result, a new Draft Public Health Law which is making its way through the legislative process proposes that 1% excise tax from tobacco products be earmarked to fund the national tobacco control program. Another bill, the Draft Law on Tobacco and Tobacco Products, that has also been submitted to Parliament, addresses harmonization of Bulgaria's tobacco control legislation (and tax levels) with EU Directives. The

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<sup>18</sup> All EU accession states have to sign up to the *acquis*, the accumulated body of EU legislation, before joining. In areas where European law exists, it takes precedence over national law and where no law exists, it has to be implemented. Thus Bulgaria will have to implement Directive 2001/37/EC and has already based its advertising regulations on those enacted (but subsequently overturned) in 1998.

Government has stated its wish to ratify the FCTC—the Council of Ministers has approved, and the only remaining hurdle is approval by the National Assembly.<sup>19</sup>

The School of Public Health undertakes educational activities in the field of tobacco control for health professionals, mainly general practitioners. The National Center of Public Health organizes health promotion activities in the mass media including World No Tobacco Day, monitors the CINDI<sup>20</sup> program, collaborates with NGOs and works on anti-tobacco legislation.

### **Croatia**

There is a National Co-coordinating Body for Tobacco Control at the Ministry of Health. Its role is to propose measures and activities to reduce smoking and to develop collaboration with governmental, non-governmental and international institutions. In March 2002 the Center for Prevention of Smoking was launched at the “Andrija Stampar” School of Public Health (5). It is responsible for providing a mass media campaign and free telephone help-lines where smokers can get advice on how to quit. National television and radio regularly broadcast programs on how to stop smoking and provide information on the dangers of tobacco products. The National Institute for Public Health organizes smoking cessation competitions (Quit and Win). Proposals to strengthen smoking cessation services in primary care are currently being considered.

### **Macedonia**

The Ministry of Health and the Institute for Social Medicine are the main institutions involved in tobacco control efforts. Under the World Bank financed Health Care Reform project smoking prevention activities were carried out in primary schools. The Quit and Win Campaign was carried out in 2002 for the first time. There is a national tobacco control action plan and a national multisectoral coordinating body for tobacco control.

### **Romania**

There is a National Committee on Tobacco Prevention established in 2002 which consists of representatives from the Ministry of Health, Ministries of Agriculture and Environment and the National Authority for Consumer Protection. Like Bulgaria, Romania will have to implement EU tobacco control legislation before joining the EU.

### **Serbia and Montenegro**

The Commission for the Prevention of Smoking of the Ministry of Health of Serbia serves as a national multi-sectoral coordinating body for tobacco control. It includes governmental and nongovernmental representatives. A similar commission in Montenegro aims to become multisectoral. Under the first intersectoral National Plan to Combat Smoking, progress was made in banning smoking in health care and other public institutions and developing a network of health care institutions that provide individual and group smoking cessation services. Other recent initiatives by the Ministry of Health include a professional meeting with health care workers from the entire country; an innovative exchange of fruit for broken cigarettes on World No Tobacco Day 2003,

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<sup>19</sup> Personal communication, World Bank staff.

<sup>20</sup> Countrywide Integrated Non-Communicable Disease Intervention Programme

celebration of a National No Tobacco Day, a mass media anti-smoking campaign, and public discussion of a new national Smoking Prevention Strategy.

### **7.10 The role of non-governmental organizations in tobacco control**

NGOs can play a key role in tobacco control and do so throughout much of the world. The Framework Convention Alliance for example played a key role in the development of the WHO's FCTC (for further details see <http://www.fctc.org/>) and in Europe, a broad group of national and regional NGOs have been vital to the development of European tobacco control policy (6). In SEE however, NGOs are still relatively new, poorly trusted and often excluded from mainstream policy formation (7). Nevertheless, a growing number of south east European NGOs have become active in tobacco control over recent years (see Appendix I). Such organizations can play a vital role, inter alia, in public health advocacy and the development of appropriate advocacy materials, raising public awareness about tobacco's health impacts and the activities of the tobacco industry, in ensuring tobacco control reaches and remains on national agendas and assisting governments in the development of appropriate policies. In SEE therefore, much could be gained from the further development of NGOs with expertise in tobacco control and advocacy and from ensuring such organizations are viewed as part of the mainstream policy agenda.

For more information on successful advocacy planning please see the sources listed in Appendix II.

#### **Summary**

Some SEE countries have quite strong tobacco control legislation, although it is often inadequately enforced, but in others legislation is weak. As in other parts of the world, smoking is less heavily regulated than other risky behaviours.

Excise taxes on the most popular domestic cigarettes range from 33% in Romania to 49% in Croatia, which is considerably lower than the 57% required in the EU. Although all countries have a complete ban on tobacco advertising on national television and radio, many allow other forms of advertising and bans on indirect advertising are rare. Greater restrictions on smoking in public and work-places and better enforcement of existing legislation in this area are needed. In many countries product labelling and regulation could also be improved.

Although further progress is needed, it is encouraging that Bulgaria, B&H, Macedonia and Serbia and Montenegro have developed intersectoral strategies (has Macedonia definitely got a strategy not just a body?) against tobacco led by their ministries of health.

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## CHAPTER 8: EUROPEAN UNION AND WORLD HEALTH ORGANIZATION POLICIES ON TOBACCO CONTROL

Many international organizations including the UN agencies, the World Bank, the EU and NGOs have identified the tobacco epidemic as a major and growing health threat. They have also recognized that in light of tobacco industry behavior, in particular its use of international trade agreements, cigarette smuggling and global marketing techniques to undermine national tobacco control policies, national measures are no longer sufficient to contain and control the global tobacco epidemic (1). This has prompted the WHO, the key technical agency in international tobacco control, to exercise its treaty making powers for the first time, in developing a binding international treaty on tobacco control, the Framework Convention on Tobacco Control (FCTC). The European region of the WHO has been a leading region in tobacco control, developing a series of regional five-year Action Plan for tobacco control, and showing strong support for the FCTC. The EU, although above all an economic organization, also plays a key role in Europe in developing supranational tobacco control legislation (2).

### 8.1 European Union policies on tobacco control and the implications of EU accession

The launch of the Europe against Cancer Program in 1987, then the EU's first public health program, acted as a catalyst for European action on tobacco. Although some member states had effective tobacco control policies in place at the time, many did not, and EU legislation therefore provided a major opportunity for tobacco control. Although many directives were passed initially, the tobacco industry lobby soon caught up with events and hampered progress. Progress has been further stymied by industry friendly states such as Germany who have resisted legislation and sought (successfully in some instances) to overturn enacted legislation (3).

The most important and currently active EU directives on tobacco control are (2,4):

- 89/552/EEC - bans television advertising of tobacco products
- 2003/33/EC - bans cross border sponsorship and advertising in printed publications, on the internet and radio <sup>21</sup>
- 2002/10/EC and 99/81/EC - require an overall excise duty (specific and ad valorem combined) on cigarettes of at least 57% and that this duty shall equate to at least €60 per 1000 cigarettes of the final retail selling price of the price category most in demand, plus a VAT rate of 13.04%. Thus the overall minimum taxation rate is 70%.

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<sup>21</sup> The 1998 Tobacco Advertising Directive (98/43/EC) specified a complete ban on direct and indirect advertising. Unfortunately, it was overturned by the European Court of Justice in a case brought by the tobacco industry and the German government. This replacement directive (2003/33/EC) only covers direct advertising and sponsorship that crosses borders, offering no protection from indirect advertising.

- 2001/37/EC - specifies a reduction in tar yield from 12 to 10 mg, sets nicotine and carbon monoxide limits, requires health warnings to cover 30% of the pack front and 40% of the back, bans misleading product descriptors such as “light” and “mild” and requires companies to disclose cigarette product ingredients and reasons for their inclusion

In addition to the fifteen current members, ten additional countries, mainly from CEE, are due to join the EU in 2004 and Romania and Bulgaria by 2007. In addition, as outlined in Chapter 1, Albania, Croatia and Macedonia have already signed the Stabilisation and Association Agreement and started the process of economic and political reforms, which is expected to enable them to achieve candidate status for EU accession. Structural reforms in these countries are under way, and although numerous problems have been encountered (5, 6), it is worth considering the potential impact of EU accession on tobacco control.

In order to accede to the EU, candidate countries have to adopt the accumulated body of EU legislation called the *acquis communautaire*, which includes the tobacco control provisions detailed above (7). Accession therefore offers some benefits to tobacco control, particularly to those countries with weak existing tobacco control legislation. Enactment of Directive 2001/37/EC for example will ensure that large and clearly specified health warnings are provided on each pack and ban the use of misleading descriptors such as “light” and “mild”, a considerable improvement for many states. One of the main potential benefits for tobacco control is the increase in tobacco taxation that will be required to bring accession states in line with EU requirements. Unfortunately however, due to industry lobbying, all accession states have been allowed to delay their tax increases, thereby minimizing the potential impact. Poland has for example been given until 2009 and the Baltic States until 2010 to bring their excise rates up to EU levels. Bulgarian tobacco producers have also sought to delay implementation of other parts of EU legislation (particularly those related to the tar and nicotine yield of cigarettes) until 2011 (8).

EU expansion also poses threats to tobacco control (for example in the expansion of tobacco subsidies as part of the Common Agricultural Policy)<sup>22</sup> while simultaneously providing major opportunities to the tobacco transnationals (2). The latter include easier access to new markets (the addition of ten new countries in 2004 plus Bulgaria, Romania and Turkey would make the EU the largest single market in the world), economies of scale for manufacturing and marketing, a more stable business environment, and potentially greater demand for cigarettes as incomes rise. Increased competition will also push down prices, further fuelling consumption (9). As an industry journal recently reported:

*Despite the obvious challenges ahead, major tobacco players are greedily eyeing up the 130 million new upwardly mobile consumers in a geographical*

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<sup>22</sup> As part of the planned Common Agricultural Policy reform the European Commission has proposed a structured reduction over 3 years of subsidy payments to tobacco farmers and the promotion of alternative crops. This proposal is currently being debated.

*area which will be far better regulated than before and an improved environment for doing profitable business. (9)*

## **8.2 The World Health Organization’s Framework Convention on Tobacco Control**

In 1987, the WHO European Region was the first region to take the initiative of launching a regional action plan on tobacco. In 1988, the First European Conference on Tobacco Policy developed a Charter for a Tobacco-Free Europe, supported by ten detailed strategies outlining how this would be achieved. Second and Third Action Plans for a Tobacco-free Europe 1992-1996, and 1997-2001 aimed to increase national capacity to reduce tobacco use and to ensure that more effective action was taken.

Progress on tobacco control has continued although in recent years the focus has shifted from European to global level with the development of the FCTC (10). A WHO European Ministerial Conference for a Tobacco-free Europe was held in Warsaw in February 2002, at the end of which Member states endorsed the Warsaw Declaration, committing themselves to developing a fourth Action Plan and a European Strategy for Tobacco Control (ESTC)—which was adopted by all member states in the region later in 2002, and declaring strong support for the FCTC (11).<sup>23</sup> The countries in south-east Europe have taken an active role in these developments, and Croatian and Bulgarian representatives were elected as members of the 9-member group that drafted the ESTC.

The origins of the FCTC date back to May 1996, when WHO member states requested in World Health Assembly resolution WHA49.17 that the WHO initiate the development of a binding international treaty on tobacco control. In July 1998, the incoming Director-General of WHO, Dr. Gro Harlem Brundtland established a Cabinet project – the Tobacco Free Initiative (TFI) to coordinate the global strategic response to tobacco through the FCTC. After nearly four years of negotiations the final text was adopted in May 2003. It outlines the basic measures countries need to take to implement comprehensive tobacco control programs (12). The FCTC emphasizes demand reduction measures but recognizes that there may be a need in some countries to help tobacco growers and workers whose livelihoods would be seriously affected if tobacco control programs succeed in reducing significantly the demand for tobacco. It also includes mechanisms for international cooperation and implementation of the Convention. Key provisions of the treaty encourage countries to:

- Enact comprehensive bans on tobacco advertising and sponsorship;
- Place rotating health warnings on tobacco packaging that cover at least 30 percent (but ideally 50 percent or more) of the principal display area;
- Ban the use of misleading and deceptive terms such as “light” and “mild”; that give the false impression that the product is less harmful;
- Protect citizens from exposure to second-hand smoke in public places including workplaces and public transport;

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<sup>23</sup> The European Strategy for Tobacco Control, published by WHO in 2002, is consistent with the provisions of the FCTC, paying special attention to tailoring the measures to the needs and status of tobacco control policies in the European region.



- Combat smuggling through the use of pack markings and tracking systems;
- Increase tobacco taxes as an important way of reducing tobacco consumption, particularly in young people;
- Hold the tobacco industry liable for costs related to tobacco use;
- Provide and promote smoking cessation programs and services.

The FCTC was unanimously adopted by the World Health Assembly on 23 May 2003. A minimum of 40 countries must now sign and ratify the FCTC before it can enter into force. It will then be legally binding only on countries which ratify it. The onus will be on national governments to implement the FCTC, its effectiveness in controlling the tobacco epidemic determined by the how effectively governments implement the obligations contained therein.

By March 25<sup>th</sup>, 2004, over 100 countries and the European Union had signed and 9 countries had ratified. Of the countries that form the focus of this report, only Bulgaria had signed the treaty and none had yet ratified it.

### **Summary**

It is increasingly apparent that individual states cannot control all the factors that drive the global tobacco epidemic. This has led to a growing recognition of the need for international and global partnerships to reduce tobacco use. In Europe, the EU plays a key role in developing supranational legislation, and internationally the WHO plays a key role.

EU tobacco control policy development has been hindered by the tobacco industry lobby and the obstructive behaviour of certain member states, most notably Germany. Nevertheless, the EU has continued to demonstrate strong commitment to reducing tobacco use, and the requirement that new EU member states align their legislation with that of the EU offers some potential benefits to accession states with weak tobacco control policies. These benefits are however countered by the threats that joining the internal market might pose for tobacco control and the delays requested in adopting certain EU directives, most notably the increased levels of cigarette taxation required.

The WHO European region was the first to develop a regional tobacco control plan, in 1987; later reviews of accomplishments and challenges formed the basis for subsequent Action Plans for a Tobacco-free Europe, and for the European Strategy for Tobacco Control, which was endorsed by all WHO European Member States in 2002.

The adoption of the WHO's FCTC has the potential to make an enormous contribution to decreasing the burden of tobacco-related diseases. This will be achieved in part by fostering international collaboration in tobacco control, which will be vital for example, to controlling cigarette smuggling in SEE. Countries in SEE should be encouraged to sign and ratify the treaty without delay.

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## CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS

### 9.1 Discussion

At the beginning of the 21<sup>st</sup> Century, the countries of SEE have achieved some progress in tobacco control, but given the important and negative impact of tobacco on health in the region, there is still much to do.

Smoking is the single largest cause of premature mortality in the developed world. According to Peto's estimates, approximately one-third of deaths in the countries of ex-Yugoslavia, Romania and Bulgaria in males aged 35-69 years in 1995 were attributed to tobacco, while in females the proportion varied from 5% to 10%. Over the ten year period 1985 to 1995, the proportion of deaths attributable to tobacco in these countries combined increased by 15% in men and 34% in women. Data on lung cancer incidence and mortality are unreliable but nevertheless indicate the very high levels of disease, particularly in Croatia, B&H, Serbia and Montenegro and among men in the region as a whole.

Smoking prevalence and consumption data suggest these health statistics will continue to worsen over coming years. Data on cigarette consumption, of limited accuracy given the high rates of smuggling, suggests that average per capita cigarette consumption in SEE in 1999 was 35% higher than the EU average and higher even than levels in CEE. Smoking prevalence data show very high rates of smoking in men, more variable rates in women although historical data and age specific rates suggest that smoking among women is increasing markedly. Rates among medical personnel in the region are also very high, as are the rates of youth smoking seen in most countries, suggesting that declines in the general population cannot be expected for some time.

These findings all highlight the fact that the tobacco epidemic will continue to pose a major threat to the health of the people of SEE if there are not comprehensive and immediate efforts to curb tobacco use. Future levels of tobacco-related mortality are likely to be high with major costs implications for health systems, society in general, and the families of people who become sick and die.

Despite the magnitude of the health and economic problems caused by tobacco, it has been attributed relatively little importance as a health policy issue in SEE. Indeed, most countries in the region currently lack intersectoral action plans for controlling the tobacco epidemic. There are several potential explanations for this. First, for a long time, capacities in public health have been weak. The absence of reliable and accurate data highlighted throughout the report, reflects and has led to a dearth of systematic, high-quality research on the determinants of population health. There is a consequent lack of evidence-based health policy that would draw attention to smoking as one, if not the most important determinant of population health status in SEE. Second, there are considerable political impediments to effective implementation and enforcement of intersectoral tobacco control strategies. These include the influential tobacco industry, high levels of

corruption, organized crime and its role in cigarette smuggling, and limitations of regulatory, police and judicial systems. Ignorance of the options available for controlling tobacco use plus unfounded fears, fuelled by tobacco industry misinformation, that comprehensive actions to reduce tobacco consumption will have harmful economic consequences also constitute barriers to action. Third, NGO and civil society movements are still relatively weak and public health and tobacco control advocacy under-developed. These problems, plus the lack of public education in these matters, serve to make implementation and enforcement of tobacco control policies problematic.

Finally, although tobacco use has major economic impacts, due to premature deaths and lost work time, which makes tobacco use an impediment to development, there is insufficient information on these issues in the region. Better information on the economics of tobacco, including for example the costs of tobacco use to the health system and employers, revenues lost due to smuggling, and the economic and health impacts of privatization are needed to inform the tobacco control debate and provide incentives for government action.

As with health policies in general, each country sets its own tobacco control strategies according to its public health and administrative capacities, and situation. Tobacco control requires multiple instruments including legislation in a variety of areas, taxation, provision of information to consumers and accessible and affordable cessation services. Involvement of various government bodies (ministries of finance, labor, agriculture, education, trade and customs administration) and mobilization of human, financial and institutional resources are therefore critical. Mobilization of financial resources could be achieved by earmarking a proportion of the taxes raised from tobacco for tobacco control activities, or through existing European Commission (for example, CARDS) and Stability Pact programs.

There is a wealth of evidence on the effectiveness of a range of interventions that governments can use to reduce tobacco consumption. Tobacco control is generally highly cost-effective as part of a basic public health package in middle-income countries. Evidence from high-income countries suggests that comprehensive tobacco control programs are affordable. In the US annual funding for tobacco control programs ranges from 0.3%-0.9% of US public spending per capita on health while in Canada it is 0.1% (1).

## **9.2 Recommendations**

Although each country needs to adopt policies and measures that match its specific needs, resources, and existing status of tobacco use and tobacco control, based on the findings of this report and on internationally recognized advice, we make the following general recommendations for tobacco control in SEE<sup>24</sup>:

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<sup>24</sup> The majority of these recommendations are based on the World Bank publications, Tobacco Control in Developing Countries and Curbing the Epidemic: Governments and the Economics of Tobacco Control that are referenced throughout this report.

## **1. Establish multisectoral national committees on tobacco control and develop national action plans for tobacco control**

Comprehensive national programs on preventing and reducing tobacco use should be developed as a public health priority. A broad coalition of players should be involved including an appropriate range of government departments and civil society groups including health charities and tobacco control organizations (where they exist), medical and research organizations. A mechanism for monitoring and evaluating national tobacco control programs should also be established. International organizations including major donors to the region should encourage the development of multisectoral initiatives to address the tobacco epidemic, support the formation and development of appropriate civil society groups and push key government ministries to collaborate.

## **2. Provide information to consumers**

Campaigns are needed in order to provide accurate information about the dangers of both active and passive smoking. Information can be provided through mass media campaigns including counter-advertising campaigns, smoking cessation events such as national awareness days against smoking and “Quit and Win campaigns”, the provision of self-help materials and telephone help lines. Health professionals can play a key role in providing information. A combination of approaches is needed.

Health warnings on cigarette packages should be made more visible. Legislation must clearly specify the size (at least 30% of the pack surface, and preferably 50%) and positioning of the warning, the font size of the letters and the color/contrast of the message. Colored photos that illustrate the consequences of smoking should be also be considered. Misleading product descriptors such as “light” and “mild” should be banned. Existing EU regulations would serve as a useful model in this area.

## **3. Increase tobacco taxation**

In all the countries of SEE, there is room for increasing tobacco taxation. This is one of the most effective means of reducing tobacco consumption and raising government revenues. Based on experience from countries with effective tobacco control policies, taxes should constitute at least two-thirds to four-fifths of the total retail price of cigarettes. As demand for tobacco is relatively price-inelastic, an increase in price of 10% will yield an approximate 8% decrease in consumption in middle income countries. Prices and taxation need to increase regularly to take account of inflation and rising real incomes and should be co-coordinated across the region.

## **4. Provide state funding for tobacco control**

Tobacco control measures are generally a highly cost-effective public health intervention, and should receive adequate state funding. Consideration should be given to allocating at least 1% of the tobacco taxes raised in each country to tobacco control activities or for financing smoking cessation counseling for the poorest smokers.

## **5. Adopt and enforce laws banning tobacco advertising**

Although some countries in SEE have quite strong tobacco control legislation in place, it is often not properly implemented or enforced, particularly in the area of tobacco advertising. Such countries need to strengthen their regulatory capacities in order to monitor and enforce the implementation of existing laws. Strengthening of civil society will contribute to this purpose.

In addition, many countries need to adopt new or strengthen existing tobacco advertising legislation. They should ensure that advertising bans are comprehensive and cover both direct and indirect advertising.

## **6. Ensure smoke-free environments**

Bans on smoking in public places are one of the most effective means of reducing smoking rates while also protecting non-smokers from the harms of second-hand smoke. All countries in SEE need to enact more comprehensive measures to protect their population from second-hand smoke and to adequately enforce such measures.

## **7. Take action against smuggling**

Action against smuggling should be made a priority in SEE. In order to decrease tobacco smuggling, the World Bank and WHO propose several measures:

- a stronger customs infrastructure
- sufficiently severe penalties for smuggling
- licensing all parties in the chain between a manufacturer and a consumer
- stamping each pack of cigarettes with a serial number to enable tracking
- requiring manufacturers to keep better records and to take responsibility for the final destination of their products
- requiring exporters to label packs with the name of the country of final destination and to print warnings in the language of that country.

Governments can combat smuggling by providing more staff to protect borders and investigate irregularities, by developing close collaboration and agreements with neighboring countries on smuggling control and harmonizing cigarette tax rates. The role of the tobacco industry should be explored and greater emphasis put on holding the tobacco industry to account for its actions. Finally, national household surveys should be used to estimate household expenditures on tobacco as this has the potential to assess expenditure on and consumption of legally and illegally purchased cigarettes.

## **8. Increase the availability of smoking cessation support**

Policy makers should consider widening access to smoking cessation services including counselling and NRT. This could be achieved by providing better information to consumers, integrating cessation advice and services into primary health care,

deregulating conditions for the sale of cessation products and making smoking cessation services available as part of a basic health insurance package, where feasible. The WHO European Strategy for Smoking Cessation Policy offers useful guidelines, support and resources for developing smoking cessation support services (2).

### **9. Encourage health professionals to take a more active role in tobacco control**

Health professionals in the region should play a more active role in tobacco control by urging their governments to recognize the importance of tobacco as a major determinant of poor health and premature mortality and to take appropriate action to reduce its use. They should also do more to provide cessation advice and services. To encourage these changes the curricula of medical undergraduate and post-graduate courses should include teaching on the health impacts of tobacco and training in smoking cessation.

### **10. Encourage health professionals to quit smoking**

Data suggest that a large proportion of health professionals in SEE smoke. These professionals will need to quit smoking before their advice will be taken seriously. To help achieve this, hospitals and health clinics that are not already smoke-free should become so and medical staff should themselves be offered smoking cessation therapies.

### **11. Support the development of non-governmental organizations and public health advocacy**

There is a need to support the development of skills in tobacco control and public health advocacy in SEE for new and existing NGOs, and for governments and policy makers to work with these organizations. This would enable tobacco control advocates to raise awareness of the health, economic and environmental impacts of tobacco and to assist policy makers in the development of appropriate and effective tobacco control measures.

### **12. Improve data on tobacco use and smoking prevalence**

A system is needed for regular monitoring of patterns of tobacco consumption and smoking prevalence by gender, age and socio-economic group. This will require regular collection of data on import, export and sales, plus national surveys of smoking prevalence. Such data should ideally be collected in a manner that will enable regional comparisons and the monitoring of trends over time. As indicated above, national household surveys can also be used to estimate household expenditure on tobacco as well as the consumption of legally and illegally purchased cigarettes.

### **13. Improve data on the health impacts of tobacco**

To improve the validity of tobacco-attributable mortality and morbidity data, data definitions and collection systems need to be reviewed. Thorough and regular censuses providing accurate population data are a pre-requisite for the analysis and interpretation



of such data. To enable assessment of tobacco-attributable mortality, questions on past smoking habits should be added to death certificates.

#### **14. Improve research to inform and guide tobacco control policies**

Research on tobacco should inform and guide health policy planning and fill the many gaps that currently exist in SEE. Research in the following areas could be strengthened:

- Assessment of public understanding of the health impacts of active and passive smoking, intentions to quit and attitudes to tobacco control
- Elasticity-of-demand studies to help determine target levels of cigarette taxation, and assessment of the opportunities for and barriers to harmonization of prices at regional level
- Analysis of tobacco industry activity and influence at the country and regional level, including industry relationships with governments, the media and scientists and assessment of industry advertising and marketing strategies
- Economic analysis of the impacts of tobacco use in SEE
- Analysis of the effectiveness and cost-effectiveness of new tobacco control measures that are implemented
- Analysis of the extent and determinants of smuggling.

#### **15. Measures to mitigate the potentially negative impacts of privatization should be considered**

Ideally health impact assessments should be carried out before tobacco industry privatization occurs so that the potential negative impacts can be identified and mitigated. Governments privatizing their tobacco industries should also ensure that adequate tobacco control policies, in particular taxation controls and comprehensive advertising bans are in place before privatization occurs.

#### **16. Ratify and Implement the FCTC**

Given the importance of international collaboration to national and global tobacco control, countries of SEE should be encouraged to sign and ratify the FCTC. Ratification and effective implementation of the treaty would enable these countries to more effectively address some of the most challenging issues in tobacco control particularly those such as controlling smuggling that require international collaboration.

### **9.3 Conclusions**

In conclusion, tobacco is an important contributor to premature mortality and health inequalities in the region. A major improvement in population health status in SEE will be achieved if tobacco consumption falls, initiation of smoking amongst young people is prevented and cessation of smoking amongst current smokers is encouraged. Because of the current and future health consequences and costs that the tobacco epidemic will pose on societies in SEE, comprehensive tobacco control measures must become a public health priority.

There are a number of challenges that the public health community in SEE will face when developing tobacco control policies and while there remains a great deal to be done, numerous promising initiatives have already been taken by various governments, academic institutions and NGOs in the region.

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## **APPENDIX I: NON-GOVERNMENTAL ORGANIZATIONS ACTIVE IN TOBACCO CONTROL**

**ALBANIA:** “For a Tobacco-Free Albania” (FTFA) is an NGO established in 1998. Its aim is to oppose the threat from tobacco and fill the gap in tobacco control activities. Its activities focus around developing information, education and communication for promoting a tobacco-free lifestyle, research, media advocacy and activities related to tobacco control legislation. Actions initiated by FTFA include celebration of the World No Tobacco Day, the media campaign and publishing of a leaflet “Stop smoking now”. The FTFA also organizes training seminars for health professionals and primary school teachers. The research activity included the nation-wide survey “Assessment and evaluation of the smoking prevalence and other indicators related to smoking among the adult population in Albania” carried out in 1999 and 2000. FTFA also participated in the working group that prepared the draft law “On the Protection from Tobacco Products”.

**BULGARIA:** There are several NGOs that are active in anti-smoking policies: “Women against smoking”, “Bulgarian Association of School Health”, “Bulgarian Red Cross” and “Combat Cancer Foundation”. They collaborate with the Ministry of Health and National Center of Public Health, particularly in provision of information to public on smoking. The objectives of the NGO “Women against Smoking” are to promote development and implementation of a long-term policy for tobacco control among the female population and to reduce the exposure of children to ETS.

**BOSNIA AND HERZEGOVINA:** There is an NGO called Sobriety that is active in tobacco control. Its main activities include publishing of journals and health promotion materials. In the Republic Srpska, the NGO “Life without Smoke” is active in tobacco control, and played an important role in carrying out research, providing public information, and helping achieve the adoption of laws on tobacco control.

**CROATIA:** The NGO Say YES to NO-smoking (<http://www.snz.hr/nepusenje/eng/>) is carrying out anti-smoking activities. It has established free telephone lines where 40 physicians, psychologists and social workers provide advice on how to stop smoking and organizes group behavioral therapies for smokers who wish to quit. Since 2002 the NGO has been carrying out the national anti-smoking media campaign that involves many famous politicians, physicians and sportsmen who gave their support to strengthen tobacco control policies. It also organizes educational programs for physicians who provide preventive services to school children at the Institutes for Public Health. The first Croatian Smoke-Out Day was organized by that NGO in March 2003.

**MACEDONIA:** There is an NGO called Opstanok that collaborates with the Health Promotion Committee and the Ministry of Health in preparing health promotion curricula at schools and media campaigns at national and local level.

**ROMANIA:** One of the most active Romanian NGOs is Aer Pur Romania (<http://www.aerpur.ro/topics.php>) founded in 1994. Major sources of funding come from the American Cancer Society and GlaxoSmithKline Romania. It collaborates with the Romanian Health Ministry and other governmental and non-governmental organizations. The main aim of the organization is to protect non-smokers by:

- continuously informing the public about the effects of active and passive smoking
- undertaking campaigns to educate children and teenagers to maintain their “non-smoking” status
- acting in line with the international strategies for smoking prevention and defending the rights of non-smokers
- seeking to create a center to assist those who have suffered from active or passive smoking or who want to give up smoking
- lobbying for the adoption of a stronger legislation on tobacco control

The organization’s target is to convince the Romanian Parliament to adopt a law that would ban smoking near children, in public or closed places (hospitals, schools and public transport). It also organizes events such as non-smoking days, Quit and Win campaigns and training courses for medical doctors. The organization has published sources in the Romanian language on tobacco control and smoking cessation, for example “What a Romanian smoker does not know?”

## **SERBIA AND MONTENEGRO**

The National No Tobacco Day celebrated on 31 January 2004 and organized by the National Committee for Smoking Prevention also included active participation of the NGO “Step by Step”. It is planned to further strengthen NGO involvement in tobacco control.

## APPENDIX II: USEFUL SOURCES FOR TOBACCO CONTROL ADVOCACY

- American Cancer Society, Campaign for Tobacco Free Kids, International Union against Cancer: Tobacco Control Strategy Planning: Strategy Planning for Tobacco Control; Advocacy and Strategy Planning for Tobacco Control Movement Building. Available at: <http://www.strategyguides.globalink.org>
- Advocacy Institute publications: Available at: [www.advocacy.org/publications.htm](http://www.advocacy.org/publications.htm)
- World Bank and Research for International Tobacco Control: Tobacco Control Policy: Strategies, Successes and Setbacks, edited by Joy de Beyer and Linda Waverley: Available at: [www.worldbank.org/tobacco](http://www.worldbank.org/tobacco) and [http://publications.worldbank.org/ecommerce/catalog/product?item\\_id=1485821](http://publications.worldbank.org/ecommerce/catalog/product?item_id=1485821)
- World Health Organization: Tobacco Control Legislation: An Introductory Guide: Available at: <http://www5.who.int/tobacco>
- Blowing Away the Smoke series: Available at: <http://www.strategyguides.globalink.org/guide06.htm>
- The Democracy Owner's Manual, by Jim Shultz. Available at: [http://rutgerspress.rutgers.edu/acatalog/\\_The\\_Democracy\\_Owners\\_Manual\\_705.html](http://rutgerspress.rutgers.edu/acatalog/_The_Democracy_Owners_Manual_705.html)
- Health 21 Hungarian Foundation. Filter online – Tobacco Advocacy Newsletter for Central and Eastern European Countries. Available at: <http://health21.hungary.globalink.org/filteronline/index.html>









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