Tobacco and Other Cancer Risk Factors Control

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increased 57%, whereas among women it increased 122% (Ministry of Health / Brazilian National Cancer Institute, 2002)

It is important to stress that the current scenario of lung cancer mortality results from the gradual increase of the habit of smoking, which started some 50 years ago, especially in males. Among women, after years of social reprove and moral oppression of women smokers, they become a potentially promising target from the point of view of the tobacco industry, and marketing strategies lead them to smoke more and more, even though they start later in life then men. As a result, the late effects of such tobacco use expansion among women are beginning to show. Cancer mortality statistics among Brazilian women show that since 1995, lung cancer mortality exceeded cervix uteri cancer mortality, and currently ranks second among cancer deaths in women.

In addition to the risks posed for smokers, from the 70s onwards there were published researches proving that children exposed to environmental tobacco smoke had higher respiratory illnesses rates higher than those who were not exposed.

Researches on passive smoking have piled up over the 1980s, and a major consensus report on the risks of passive smoking was published in 1986 by the US National Academy of Sciences National Research Council and the US Surgeon General. This report of the US Surgeon General presented three major conclusions:

1. Passive smoking causes diseases, including lung cancer, in healthy non-smokers.
2. Children of smoking parents, when compared to children of non-smokers, present higher rates of respiratory affections, in addition to respiratory symptoms and slightly decreased pulmonary function as they grow up.
3. The sheer separation between smokers and non-smokers in the same air space may reduce, but does not prevent non-smokers exposure to tobacco environmental smoke.

Recent meta-analysis studies have shown that among non-smokers constantly exposed to environmental tobacco smoke, the risk of developing lung cancer is 30% higher than in non-smokers non-exposed (Hackshaw et al, 1997). In the United States, tobacco smoke is estimated to be accountable for some 3,000 annual deaths due to lung cancer among non-smokers (United States Environmental Protection Agency, 1993). And risks for cardiovascular diseases among non-smokers exposed to environmental tobacco smoke are 24% higher than among non-smokers (Law at al, 1997).

Women and children are at higher risk due to passive exposure in their household. Furthermore, effects of passive smoking also come from exposure at the workplace, when there is no safety and health regulations to protect workers from involuntary exposure.

1.c Tobacco consumption trends

Around the world

In spite of all the established scientific knowledge on smoking risks, consumption trends are worrisome. In early 90s, some 1.1 billion people around the world used tobacco products. By 1998, this figure was of 1.25 billion. (WHO, 2001).

In this scenario consumption trends among women and youngsters are of special concern, as tobacco companies have more and mores focused these groups as targets for their marketing strategies.

Overall, some 9% of women in developing countries and 22% in developed countries smoke cigarettes.

Furthermore, World Bank data show that almost 100,000 youngsters worldwide start smoking at each day, 80.000 of them from developing countries. Mean age for starting to smoke is 15, and 70% of those who try smoking become addicted. These facts lead WHO to consider tobacco use a pediatric disease (World Bank, 1999).

In Brazil

In 1989, a countrywide survey (The National Research on Health and Nutrition - PNSN), showed that 32.6 % of the population over 15 years old or more were smokers. There were near of 28 million smokers in the group over 15 years old. Among them 16,7 million were males and 11,2 million were females (Ministério da Saúde, 1998).

Since than, further existing prevalence data has been collected through a variety of methods and data collection instruments and evolving different groups, what makes it difficult to evaluate the smoking prevalence trends in the country as whole.

By the other hand, in 2001 a survey among 2479 people living in Rio de Janeiro municipality (Ministério da Saúde/INCA 2002b) showed that the smoking prevalence had decreased from 30% in 1989 to 21% in 2001.

Besides this, the monitoring of cigarette per capita consumption shows a reduction of more than 32% between the years 1989 and 2001, even considering the estimates of consumption from illegal market. In 1989 cigarette per capita consumption was 1772 and in 2001 it was 1194.

1.d Social determinants for use of tobacco products

Tobacco is today the second most used drug among youngsters worldwide and in Brazil. This is probably due to the way smoking fills in to society. Being easy to get, their low cost, and years of marketing and advertising actions associating tobacco products to beauty, success, freedom, power, intelligence, and other qualities young people desire, created a positive image of smoking, what lead to its wide social acceptance. The success of these strategies is translated by the fact that 90% of smokers start smoking before the age of 19.

Thus, for tobacco to be effectively controlled, one must realize smoking is not limited to an individual dimension, but derives from a social, political and economic scenario that has historically and deceitfully encouraged individuals to smoke and making it difficult for smokers to quit. Therefore one must address all the issues behind this context.

1.e Trade liberation and the global expansion of tobacco

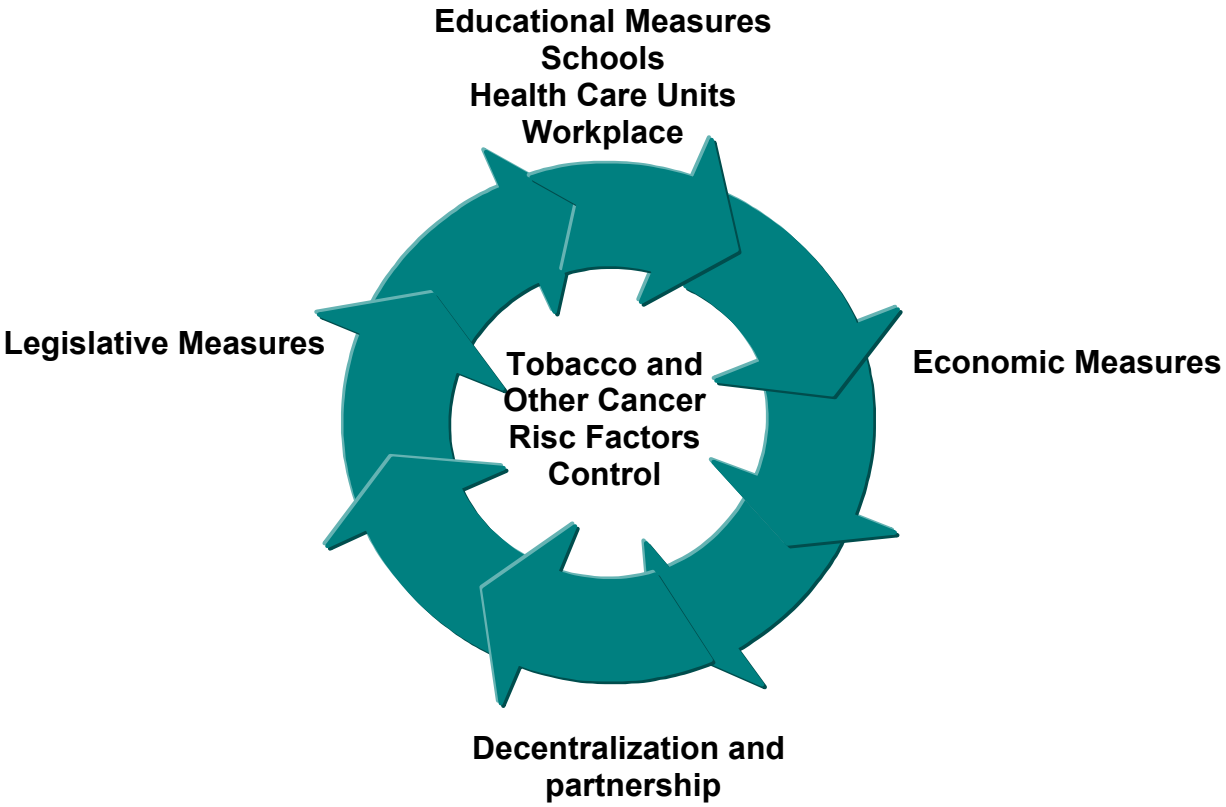
Even though the use of cigarettes has been decreasing in most developed countries, cigarette smoking around the world has increased in about 50% from 1975 to 1996. It has increased rapidly in developing countries, especially of Asia. Today, 25% of world's smokers live in China. Differently from developed countries, tobacco control initiatives and policies are incipient in many of these countries (World Bank, 1999; WHO, 2001).

World Bank studies have shown that liberation of trade and opening of markets are major factors for such scenario, therefore decisive for increase of tobacco use, especially in low and middle-income countries. How does it happen? Over the past few years, international trade agreements have liberated the trade of goods and services around the world. Cigarettes were no exception, even though it cannot be considered a good, as there is no benefit for those who use it. Liberation of trade has implied in opening markets all over the world for tobacco products, especially cigarettes, leading to a fall in prices and increase in marketing and advertisement. Thus, globalization of the economy made major transnational tobacco companies focus their expansion efforts to countries of low production costs and high potential for consumption; this explains the high market expansion in Eastern European, Latin American, Asian, and African countries over the past few years. Countries such as Japan, Thailand and Taiwan have experienced a major increase in cigarette consumption once major transnational tobacco companies entered in their internal markets (World Bank, 1999).

This is why, by acknowledging expansion of tobacco consumption as a global hazard, the 53th World Health Assembly – the most important WHO governing body, comprised by delegates of the 190 member countries – has drawn a Resolution requesting the General Director a Tobacco-Control Framework Convention to be designed in accordance with article 19 of WHO bylaws. It is the first International Convention sponsored by the WHO.

Legislative and economic actions are social mediations that potentiate educational actions. It is up to the different social segments to warn, demand, encourage and pressure lawmakers to establish legislation that lead to political, environmental and economic changes to support the behavior changes necessary to reduce cancer and other tobacco and other risk factors-related diseases incidence and mortality.

In this scenario, it is to be mentioned laws imposing information to the population on the risks of tobacco use, protecting people from environmental tobacco smoke and from inducing smoking through advertisement. Furthermore, it is also necessary to impose measures making difficult the access of youngsters to tobacco products, such as increasing taxation and prices, controlling sales and, especially, the illegal market.



Through this Program, the Ministry of Health/ INCA has been developing actions that promote positive behavior changes in the population and contribute to reduce cancer risk factors exposure. Within the scope of such actions, it is to be mentioned those focusing tobacco-control, promoting physical exercises and healthy meals, restraining exposure to solar radiation. Actions to promote healthy meals, physical exercise and reduced exposure to solar radiation are done through campaigns. The Program, however, is working to incorporate educational intervention methods in health care facilities, workplaces and schools like it is being done by the National Tobacco Control Program, which will be presented next.

From this point onwards, only the National Tobacco Control Program is addressed. This is because this is such a specific factor, and the first to be addressed by the cancer prevention program, generating a model that can be applied to promote other behaviors and styles, such as nutrition habits and the practice of physical exercises.

The National Tobacco Control Program systematizes 4 major strategy groups: the first, to prevent people from starting smoking, mainly children and teens; the second is the development of actions to encourage smoking cessation; the third group includes measures to protect the

Three major community channels were selected: schools, workplaces, and health care facilities, as these channels greatly interact with the community and are formed by major opinion makers, such as teachers, students and health professionals:

Tobacco and other cancer risk factors in WORKPLACES**: PREVENTION ALWAYS PROGRAM**

This program operates in a systematic way with occupational health professionals and other key players of companies and organizations towards a tobacco smoke-free environment and to reduce the number of employees who smoke by supporting them to quit smoking.

For this purpose, the **Smoking-Free Workplace Program** includes a set of educational, regulatory and organizational actions to encourage changes in the culture of the organization that lead industry and company employees reduce smoking. Its activities include continuous dissemination of information on the risks of smoking, especially of passive smoking, implementation of regulation to restrain smoking in the workplace, the display of smoking restriction signs and qualification of occupational health professionals to support smoking cessation and treating nicotine dependence of the employees.

Tobacco and other cancer risk factors in SCHOOLS: **HEALTH KNOWLEDGE PROGRAM**

This program advocates the inclusion of strategies to promote a healthy lifestyle in the school curriculum, including facts about smoking. To portray smoking as a social unaccepted behavior, the program focuses teachers, students and school employees, and all aspects related to smoking (health, ecology, citizen rights, history, economic) are addressed at different times by different disciplines.

One of the major focus of this program is to foster a critical awareness in children and teens in regards to marketing manipulations used to promote deleterious lifestyle, including smoking.

In the set of actions developed at schools is included the **Smoking-Free Schools Module.** It includes a set of educational, regulatory and organizational actions that encourage tobacco-related behavior changes among teachers, other school workers and students and the community that interacts with the school.

Tobacco and other cancer risk factors in HEALTH CARE FACILITIES: **HEALTH AND COHERENCE PROGRAM**

This program seeks to prepare health care facilities to provide effective smoking cessation support for smokers that go for a routine visit. It is thus essential that health care facilities comply with their role of showing healthy habits and lifestyle.

This means that health care units should be smoke free, and their professionals should act as behavior models for the community.

This is the idea behind the **Tobacco-Free Health Care Facilities Program.** It includes a set of educational, regulatory and organizational actions to foster cultural changes concerning social acceptance of smoking in health care facilities, and, at first, to support health professionals who smoke to quit the habit. Thus, the Program includes the training of health professionals to support smoking cessation efforts of other health care facility employees. Later on, they will be trained to include smoking cessation support for their patients.

2.c Smoking Cessation Program

In the National Tobacco Control Program context, strategies for smoking cessation have been broad in a sense of creating a demand for smoking cessation and supporting it.

This means that national Program has been developing strategies to promote the smoking cessation in the population, to create a social context that stimulates smoking cessation, and at the same time to increase the access for smoking cessation to support the demand.

So making campaigns to stimulate and inform about the benefits of smoking cessation, stimulating and supporting the implementation of smoke free policies, training skills for smoking

Considering that the tobacco problem extrapolate the health dimension, the creation of a National Commission for tobacco control opened new possibilities for tobacco control in Brazil, as it made possible to endeavor close discussions of important aspects of tobacco with other government segments such as finances, agriculture, agrarian development, work and job, justice and others. Since its creation it was possible many advances in the field of regulation of tobacco products and its advertising, controlling illegal market, taxation, tobacco subsides, among others.

2.g Mobilizing Legislative and Economic Actions

Tobacco control actions go beyond the scope of the Ministry of Health (MS); this is why discussions on the subject include different dimensions.

Within the scope of legislative actions, the National Tobacco Control Program has compiled and created a databank on existing tobacco-control related laws in Brazil; it has encouraged and advised lawmakers on creating tobacco-control laws; it has disseminated such laws in the community and identified and articulated mechanisms that allow their enforcement.

Within the economic scope, it is believed that incorporation of economic measures to educational actions supported by legislative actions, which is being done in Brazil for 11 years now, may pro-actively support the program.

Using Economics as a referential, for actions in this area to be successful one must have a strict legislation, especially in taxation, price and agricultural policies. Thus the need for this Program to be articulated to other government areas, being a comprehensive Program, a Program of the Brazilian State.

3. PROGRAM OUTCOMES

3. a Process Outcome

Educational actions

Assessment of the Tobacco and Other Risk Factors Control Program (PNCTOFR) has been done over the Annual Meeting of the Program's State Coordinators, promoted by the Ministry of Health/INCA, and from information sent to INCA throughout the year.

To check the Program development in the states, state coordinators were asked to provide information on the number of cities with human resources qualified for regional program managing number of trained professionals, number of health care units, workplaces and schools where the Program has been implemented, among other information.

However, there was no time for 2002 data to be consolidated, and the following information relate to Program goals accomplished up to the **year 2001**, and were collected from **information sent by the states**.

Intended Goal	Actual Outcome
Qualify **4000 Brazilian cities** to implement the Tobacco and Other Cancer Risk Factors Control Program	**3525 cities were qualified** for the Program

Focused Educational Actions – Level 1 – Campaigns

Intended Goal	Actual Outcome
Implement level 1 of the Tobacco and Other Cancer Risk Factors Control Program in **40% of the cities** qualified for the Program	**63% of the qualified cities (2208) have developed Program activities of level 1** (celebration of at least one campaign on smoking), among the 3073 qualified cities from states that sent us information on the campaigns.

PREVENTION OF TRANSIT ACCIDENTS	
Law 9503 (September 23, 1997)	Forbids driving under the influence of any torpid-causing, or physical or psychical addictive drug, or driving the vehicle with one hand only, except when signaling with the hands, changing the gear or activating any equipment or device of the vehicle.
RESTRICTING ACCESS TO TOBACCO PRODUCTS	
Law 10167 (December 27, 2000)	Forbids sales via mail, distribution of samples and sales of tobacco products in health and teaching facilities.
PROTECTION TO YOUNGSTERS	
Law 8069 (July 13, 1990) – Children and Adolescent Statute.	Forbids selling, supplying or handing products whose ingredients may cause physical or psychical addiction.
Law 10167 (December 27, 2000)	Forbids children and adolescents to take part in tobacco-products advertisement.
Ministry of Labor Ordinance 06 (February 5, 2001)	Forbids those less than 18 years of age to work in tobacco harvest, beneficiation or industrialization.
National Agency for Sanitary Surveillance Resolution 304 (November 7, 2002)	Forbids production, import, commercialization, advertisement and distribution of food in the shape of cigarette, cigar, cigarillo or any other smoking product, whether or not derived from tobacco. Forbids the use of food packs that simulate or resemble cigarette packs, as well as the use of brand names from smoking products, whether or not derived from tobacco.
TREATMENT AND SUPPORT TO SMOKERS	
Ministry of Health Ordinance 1575 (August 29, 2002)	Consolidates the National Tobacco-Control Program, creating, within the Public Health System (SUS), the Reference Centers for Smokers Approach and Treatment, which should be registered, and approve the Clinical Protocol and Therapeutic Guidelines for Nicotine Addiction. Thus, the cognitive-behavioral approach and drug therapy for smokers, with Nicotine Replacement Therapy and Buprione are offered to the Brazilian population for free.
ADVERTISEMENT OF AND SPONSORSHIP BY TOBACCO PRODUCTS	
Constitution of Brazil (October 5, 1988)	Establishes that tobacco advertisement should comply with legal restrictions and should warn on the hazards of its use.
Law 8078 (September 11, 1990) – Consumer Protection Code.	Forbids mischievous and abusive advertisement.
Interministerial ordinance 477 (March 24, 1995)	Recommends TV stations to avoid broadcasting images of known personalities smoking. Recommends organs and agencies within the Public Health System to refuse sponsorship, collaboration, support or promotion of public health campaigns by the tobacco industry.

Law 10167 (December 27, 2000)	Restrains tobacco-products advertisement to the display of posters, displays and banners inside sales places only, being forbidden in magazines, newspapers, TV, radio, and outdoor posters. Forbids advertisement by electronic media, including via Internet, indirect advertisement, the so-called merchandising, and advertisement in stadiums tracks, stages or similar places. Forbids sponsorship of international sports and cultural events by the tobacco industry, from 2003 onwards.
DISSEMINATION OF INFORMATION TO THE PUBLIC	
Law 7488 (June 11, 1986)	Establishes August 29 the National Day Against Smoking, which should be celebrated throughout the country.
Interministerial ordinance 3257 (September 22, 1988)	Awards merit certificates to companies that stand out in tobacco-control campaigns.
Interministerial ordinance 1498 (August 22, 2002)	Awards merit certificates to health and teaching institutions that stand out in tobacco-control campaigns.
National Agency for Sanitary Surveillance Resolution 46 (March 28, 2001)	Imposes that the amounts of tar, nicotine and carbon monoxide be printed in cigarette packs, along with the warning "There are no safe levels for use of these substances."
Interim Regulation 2134-30 (May 24, 2001)	Determines advertisement material and packs of tobacco products, except when for export, should present written warnings along with pictures that illustrate their meaning.
National Agency for Sanitary Surveillance Resolution 104 (May 31, 2001)	Regulates the printing of written warnings and pictures in packs and advertisement material of smoking products. Imposes printing of the Quit-Smoking Help Line phone number in packs and advertisement material of tobacco products. Forbids the use of any label or device that prevents or makes difficult the warnings to be seen.
TOBACCO PRODUCTS CONTROL AND INSPECTION	
Decree 2.637 (June 25, 1998)	Determines that cigarette sales in Brazil, including their exposure for sale, should be done in packs, boxes or other containers, with 20 units.
Law 9782 (January 26, 1999)	Regulates the National Sanitary Surveillance System. Establishes the National Agency for Sanitary Surveillance (ANVISA), responsible for regulating, controlling and inspecting cigarettes, cigarillos, cigars and any other smoking product, whether or not derived from tobacco.
Law 10167 (December 27, 2000)	Defines the fine to be applied for non-compliance of the Law. Determines the competent organs to enforce compliance of the Law.

National Agency for Sanitary Surveillance Resolution 46 (March 28, 2001)	Establishes maximum amounts of tar, nicotine and carbon monoxide in the primary smoke chain of cigarettes marketed in Brazil to 10 mg/cig, 1 mg/cig e 10 mg/cig respectively, effective September 2002. Forbids the use in packs or advertisement material of descriptive terms such as classes, ultra low amounts, low amount, smooth, light, soft, moderate amount, high amount, and other terms that may induce consumers to misinterpret the existing amount of ingredients in the cigarettes.
National Agency for Sanitary Surveillance Resolution 105 (May 31, 2001)	Regulates registration of tobacco-products manufacturers, import or export companies, and of all the products they handle, requiring presentation of reports on the product, ingredients, sales and production.
Internal Revenue Service Regulating Order 194 (August 29, 2002)	Approves the Program to Generate Special Fiscal Information Return Form for cigarette taxation. This Program allows the IRS a better control of companies already established and in the process of establishing themselves in terms of registration, distribution, import and export of cigarettes, and payment of related taxes. This helps the IRS to control the distribution chains of such companies, to identify tax evasion.
FRAMEWORK CONVENTION FOR TOBACCO-CONTROL	
Decree 3136 (August 13, 1999)	Creates the National Committee for Tobacco Control, in charge of supporting Brazil in international negotiations for the Tobacco-Control Framework Convention. This National Committee includes delegates from the Ministries of Health, Foreign Relations, Agriculture, Economy, Justice, Education, Development, Industry and International Trade, and Agrarian Development.
TOBACCO CROPS FINANCING	
Brazilian Central Bank Resolution 2833 (April 25 2001)	Forbids concession of public financing for tobacco crops, within the scope of PRONAF*, whether in partnership or integration with tobacco industry. *PRONAF – National Program to Strengthen Family Agriculture, established by the Brazilian Central Bank Resolution 2191 (August 24, 1995) to financially support agricultural activities from family manpower.
TAXATION ON TOBACCO PRODUCTS	
Internal Revenue Service Regulating Order 60 (May 30, 1999)	Regulates taxation on cigarettes, imposing an Industrial Products Tax (IPI), in reais (R$, Brazilian currency) per score, according to their fiscal class. This Regulating Order distributes cigarette brands in four classes (I to IV), being classes I and II for brands sold only in packs, and classes III and IV for brands sold both in packs and boxes.

Decree 4488 (November 26, 2002)	Changes the Industrial Products Tax (IPI) bracket for cigarettes. This will make cigarette prices raise from 8% to 17% by the end of 2002, depending on their fiscal class.
MEASURES TO RESTRAIN ILLEGAL CIGARETTE MARKET	
Decree 2.876 (December 14, 1998)	Establishes a 150% tax bracket for cigarette export to South and Central America, including the Caribbean. Later on, this bracket came to include raw material used in cigarette manufacturing.
Internal Revenue Service Regulating Order 95 (November 28, 2001)	Regulates cigarette control stamps. Determines that cigarette export should be made directly from the manufacturer to the importer abroad, and that questionable stamps should be further examined. Thus, the government strengthens inspection policies on export cigarettes and is more attentive to suspicious control stamps.
Interim Regulation 66 (August 29, 2002)	Raises fines for control stamps that do no comply with IRS regulations.

The impact of new warning pictures on the population:

Since February 2002, tobacco-products manufacturers must print warnings on health hazards along with pictures in the packs of their products (pictures are shown in the appendix).

A survey carried out by DATAFOLHA in April 2002 with more than 2000 people of 126 Brazilian cities showed that 73% of the interviewees supported the measure, and 67% of smokers said they were more willing to quite smoking once they saw these new pictures.

3. b Results Outcome

The expected outcomes of the National Tobacco Control Program involve increasing the knowledge of the population on cancer risk factors with focus on tobacco use, the risks of active and passive smoking, reducing social acceptance of smoking, and reducing overall smoking and prevalence of smokers.

To gather information related to the population knowledge, opinion and attitudes, and on the prevalence of smokers, periodic national surveys should be carried out, so that effectiveness of the Program's measures can be assessed. This type of surveys should be done on a periodic basis for one to monitor overall smoking trends and for specific groups, thus adjusting the types of actions to be implemented.

Smoking Prevalence

National Survey on Smoking in Brazil, National Enquiry on Health and Nutrition, 1989

According to the 1989 National Health and Nutrition Survey (PNSN), there were 30.6 million smokers in the population over 15 years of age, being 18.2 million (40.3%) males and 12.4 million (26,24%) females.

The Ministry of Health, through INCA and Epidemiological Surveillance National Center (CENEPI) started a new national survey on health and lifestyle in 2002.

Survey on smoking in the city of Rio de Janeiro 2001

This survey showed that in the city of do Rio de Janeiro there was a significant decrease in prevalence of smokers, which fell from 30% in 1989 (PNSN) to 21% in 2001 (INCA/Conprev). This reduction was higher for age groups 20 to 24 years (29% in 1989 to 12% in 2001), and 25 to 34

years (from 41% to 18%). The survey also showed that prevalence reduction among males was higher than among females, which indicates the need of higher efforts focused to women.

Survey of the Brazilian Center for Information on Psychotropic Drugs (CEBRID)

Periodical surveys carried out in 10 Brazilian Capital cities by CEBRID shows that cigarette experimentation is increasing among students age 10 to 18.

Prevalence of tobacco use in life among students (10 to 18 years old) – 10 Brazilian capital cities – 1987,1989, 1993 e 1997

Year	Belém	BH	DF	Curitiba	Fortaleza	Porto Alegre	Recife	RJ	Salvador	SP
1987	**22**	**23,2**	**22,4**	**18,4**	**21,6**	**20,8**	**20,5**	**22,7**	**17,9**	**25,4**
1989	**30,3**	**34**	**27,7**	**24,1**	**24,7**	**29,7**	**21,6**	**27,1**	**22,8**	**31,8**
1993	**29,9**	**37**	**26,7**	**29,9**	**25,7**	**31,7**	**25,6**	**25,5**	**19,3**	**29,1**
1997	**27,1**	**34,3**	**33,7**	**41**	**32,8**	**44,1**	**26,7**	**26,9**	**30,5**	**30,7**

These surveys showed also an increasing experimentation trend among female students. In 1997, experimentation among girls was significantly higher than among boys in 3 of these 10 capital cities the enquiry was held: Porto Alegre, Rio de Janeiro and São Paulo.

Prevalence of tobacco-use in life among elementary and high-school students of the public school system in 10 Brazilian capital cities, per gender (1997)

City	males %	females %	Non-informed %	ratio m/f
Belém*	31,8	23,9	18,9	1,3
Belo Horizonte*	38,0	32,4	24,7	1,2
Brasília*	36,0	31,9	30,5	1,11
Curitiba	40,1	41,4	43,3	0,9
Fortaleza*	37,7	29,7	28,4	1,3
Porto Alegre*	38,7	49,8	32,5	0,8
Recife	29,4	25,6	10,8	1,2
Rio de Janeiro*	23,4	29,9	21,7	0,8
Salvador	33,5	30,2	13,6	1,1
São Paulo*	29,2	32,2	23,5	0,9

* difference among genders is statistically significant

A recent assessment on the use of psychotropic drugs among elementary and high-school students of the public school network in Manaus, carried out by CONEN at Amazonas, showed tobacco to be the second most consumed drug (12,55%), and the age group for its first use was 13 to 15 years (Cebrid, Bulletin 45, June - August 2001).

These studies evidence the need for actions towards youngsters, especially females.

Per capita Cigarette Consumption in Brazil

The monitoring of annual cigarette per capita consumption shows a reduction of more than 32% when comparing this consumption in 1989 and in 2001 (included the estimates of

consumption from illegal market). In 1989, the annual cigarette per capita consumption was 1772 and in 2001 it was 1194.

4. NEXT STEPS

4.a The need for municipal regulation of Federal Law 9294/96, which restrains smoking in closed environments.

One of the basic legislative measures for tobacco control is Federal Law 9294/96, which forbids smoking in closed environments, and Law 10167/00, that delegates enforcement and punishment to sanitary city officials. However, lack of regulation on a city level has not made law enforcement effective.

Even though Brazilian society has demanded definition of whom to resort to report non-compliance of the law, cities are not yet broadly engaged in this action. It is necessary to mobilize city official to promote regulation of the law, defining the municipal organs responsible for enforcing this law and applying fines for non-compliance.

4.b Regulation of cigarette sales

The lack of control mechanisms is a hurdle for enforcing regulations concerning the Sales of tobacco products in Brazil.

For instance, Decree 2637, of June 25,1998 forbids the sales of single cigarette units, known as retail sale, imposing sales of 20 unit packs. However, cigarette retail sale is seen in both the illegal market and in regulate cigarette sale businesses.

Another problem is the sale of cigarettes to minors, which is forbidden by the Children and Adolescents Act – Law 8.069/90, article 81. Many a time, cigarette selling stores don't even ask for an ID to check the age of the buyer, what is much more frequent if the sale is made in the illegal market.

The ease for youngsters to buy tobacco products is a significant factor for them to try smoking, and its is necessary to pay special attention to put into practice mechanisms to enforce existing legislation.

There is the intention to introduce cigarette vending machines in Brazil, following what exists elsewhere, which may be a facilitating way for one to start smoking.

The Ministry of Health (MS) is well aware of the problem, and is supporting Bills that forbid such automatic vending machines to be introduced in Brazil.

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