

Methods

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“BE IT RESOLVED, that each country work to ensure continued updating of “tobacco control country profiles” to create benchmarks and milestones for strategic planning, as well as to measure forward global movement in countering the tobacco epidemic”

– 11th World Conference on Tobacco OR Health. Chicago, August 2000.¹

Monitoring the Tobacco Epidemic: Past, Present, and Future

Article 20 of the draft World Health Organization (WHO) Framework Convention on Tobacco Control calls for nations to “establish progressively a national system for the epidemiological surveillance of tobacco consumption and related social, economic and health indicators” and “to cooperate with competent international organizations to progressively establish and maintain a global system to regularly collect and disseminate information on tobacco production, manufacture and the activities of the tobacco industry which have an impact on the Convention or national tobacco control activities.”²

The *Tobacco Control Country Profiles* (the *Profiles*) strives to fulfill this need for international tobacco surveillance to support global tobacco control. This second edition of the *Profiles* updates the first edition published in 2000 and the 1997 WHO publication, *Tobacco or Health: A global status report*.^{3,4} The *Profiles* complements the 2002 WHO publication, *The Tobacco Atlas*, and supports evolving online surveillance systems, such as the National Tobacco Information Online System (*NATIONS*), UICC GLOBALink, and WHO TFI online country profiles.⁵⁻⁸

The *Profiles* presents selected tobacco surveillance measures to describe the current tobacco situation in 196 countries and territories around the world; 192 WHO Member States, two WHO associate Member States (Puerto Rico and Tokelau), Hong Kong (Special Administrative Region of China), and the West Bank and Gaza Strip (presented together). The *Profiles* has two overall objectives. First, it provides government and nongovernmental organizations with an updated, standardized reference source for information about tobacco and its use in their countries and territories. Second, it identifies gaps requiring further research attention. Gaps in the data highlight priority areas for future surveillance.

Methods

The *Profiles* organizes each country profile into five categories: sociodemographic situation, smoking prevalence, tobacco economy, smoking-related disease impact, and

tobacco control regulation. The data, current as of May 2003, are compiled from numerous national and international sources, including databases maintained by WHO TFI Geneva, WHO Regional Offices, United Nations Statistics Division (UNSD), World Bank Group, national government agencies, such as the United States Department of Agriculture (USDA), national Ministries of Health and statistical offices, and non-governmental institutions, such as academic researchers, public health organizations, and tobacco control advocates.

For some countries, data in one or more of the *Profiles'* five categories are incomplete or missing. A short line (–) at an entry signifies that data were unavailable for inclusion in the monograph. For some indicators, such as smoking prevalence and national legislation, different sources provide contradictory data. Conflicting data were reconciled by consultation with WHO TFI, respective WHO regional offices, WHO country focal points, and/or other experts. Although data quality and availability vary by region and country, the *Profiles* databases are continuously updated and revised as new data become available. Readers are encouraged to contribute updated information to WHO.⁹

Structure of the Monograph

The methods section provides readers with guidance for navigating the monograph, to reproduce data calculations, and to locate the primary and secondary references for the data in the country profiles. The methods section is divided into five sub-sections, corresponding to the five data categories in the *Profiles*. The sub-sections describe each tobacco surveillance indicator and the methods and sources used to collect the data.

Following the methods section, six tobacco control experts representing each WHO Regional Office provide summaries of regional tobacco consumption trends, health outcomes and tobacco control prospects. The six WHO regions are the African Region, the Region of the Americas, the Eastern Mediterranean Region, the European Region, the South-East Asia Region, and the Western Pacific Region. Countries and territories for each region are listed in the Table of Contents. Each regional summary includes a tobacco

surveillance summary, a discussion of recent tobacco control activities and a description of future challenges.

Two appendices to the monograph supplement the individual country profiles. Appendix A is a directory of WHO Regional Offices, country focal points and WHO collaborating centers. Appendix B contains detailed information about national tobacco control laws and regulations cited in the country profiles. The name of the law, the source of the information about the law, and a brief description of the law are included, when available.

Sociodemographic Situation

Population. Population data for each nation by age and sex are presented for the years 1995, 2000, 2025, and 2050. Figures in the table are expressed in millions (1,000,000) and the data are divided into two age groups: “All adults” (persons age 15 years and older) and “All youth” (persons under age 15 years old). The number of females is shown under the total for each population group. Figures for the years 2025 and 2050 are projections generated by the UN Population Division (UNPD) and provided in the 2000 revision of “World Population Prospects: 1950-2050.”¹⁰

The UNPD prepares population figures biennially for most countries to provide a consistent set of population data for UN program planning and activities. The UNPD population database does not include 19 countries and territories monitored in the *Profiles*. Population data for Andorra, Antigua and Barbuda, Cook Islands, Dominica, Grenada, Kiribati, Marshall Islands, Monaco, Nauru, Niue, Palau, San Marino, Sao Tome and Principe, Seychelles, St. Kitts and Nevis, St. Vincent and the Grenadines, Tokelau, Tonga, and Tuvalu are drawn from the United Nations Food and Agriculture Organization population database.¹¹

Real Gross Domestic Product. Real gross domestic product (GDP) per capita derived from purchasing power parity calculations (PPP) is presented for the years 1975, 1980, 1985, 1990, 1995, and 2000.¹²

GDP measures the total value of all final goods and services intended for use within the domestic territory of a given country during a single year. GDP per capita is a measure of this output per person. GDP per capita serves as an estimate of a nation’s standard of living and is usually correlated with other qualitative standard of living measures, such as health status and literacy rates (although these measures are not themselves components of the GDP computation). Increasing GDP per capita over time suggests improving national economic health which is likely to result in increased access to health care, public education, and other services. GDP figures derived from PPP calculations use standardized international dollar price weights rather than conversions at

official currency exchange rates and provide a better comparison of economic health among countries. PPP adjusts output according to variations in spending power. For instance, \$1,000 converted at PPP rates will purchase the same amount of goods and services in the United Kingdom as it purchases in Austria. Conversely, GDP data derived from conversions at official currency exchange rates can fluctuate as a result of domestic and international financial events that are mostly unrelated to the domestic output of goods and services.

Other sociodemographic indicators relevant to the assessment of tobacco use include life expectancy, literacy rates, labor force structure, and human development indexes.¹³ Data related to these indicators are not presented in the *Profiles*. Readers may wish to refer to the WHO country profiles, United Nations Statistics Division country profiles, the United Nations’ *Human Development Report*, World Bank country data, and/or other references to augment the sociodemographic profiles presented in this monograph.¹⁴⁻¹⁷

Smoking Prevalence

Because cigarette smoking is the most common mode of tobacco consumption in most countries, smoking prevalence is a useful measure of the extent of the tobacco epidemic. Each country profile includes the most recent available data on the prevalence of tobacco or cigarette smoking by gender among adults, youth, and health professionals (physicians, nurses, and/or medical students). Smoking prevalence refers to the proportion (expressed as a percent) of smokers in a study population. The age range defining “adult” and “youth” and the calendar year of the survey appear in the title of each table. Footnotes under the prevalence tables provide further detail about the definition of “smokers,” geographic area (if not nationally representative), and the source citation. Citations to original sources are provided so that readers may reference primary publications for complete study details.

Direct comparison of smoking prevalence rates reported in different countries may be difficult because different studies, even if conducted in the same year, tend to use different methods for sampling study populations and defining smoking behavior. Except in cases where a standardized survey instrument is deployed in several countries, as in the Global Youth Tobacco Survey (GYTS), directly comparing smoking prevalence rates derived from different studies requires careful consideration.¹⁸

The following questions should be considered when evaluating the comparability of smoking prevalence surveys:

- What type of tobacco do respondents report smoking?
- What frequency of smoking defines a “smoker?”

- What is the age range defining “adult” and “youth” and how were the respondents selected?
- Where was survey conducted? Was the survey conducted throughout the country or territory?

When available, surveys using WHO’s standard definitions of smoking were selected for inclusion in the *Profiles* to increase comparability between studies. WHO guidelines state that respondents who report smoking at the time of the survey, or “current smokers” should be further categorized as “daily” or “occasional” smokers. “Daily” smokers are defined as individuals who smoke any tobacco product at least once a day, including those who smoke everyday except days of religious fasting. “Occasional” smokers are individuals who smoke any tobacco product, but not every day.¹⁹

Surveys vary in their ability to describe an entire nation’s smoking behavior depending on the sample design. The most reliable estimates of smoking prevalence come from population-based, cross-sectional surveys because they are most representative of the country’s population at a given point in time. Specific criteria were established for including smoking prevalence data in the *Profiles*, based on the principles of survey research. Priority was given to the most current and nationally representative estimates of smoking prevalence for each country’s adult, youth, and health professional populations.

Smoking prevalence studies were collected from several sources, including articles and reports from the peer-reviewed medical and scientific literature, WHO sources, Ministries of Health, national statistical offices, and tobacco control organizations. Inclusion criteria for consideration of prevalence surveys required the following minimum information: 1) date of the survey or its publication, 2) characteristics of the respondents (age and/or gender distribution), 3) details about sampling techniques and data collection, and 4) some description of the questions used in assessing smoking behavior. If several studies from the same country met these criteria, they were ranked by geographic coverage (national, regional, or other), date of the study, sample size, response rates, and methods. The most current and representative studies of smoking prevalence were selected for inclusion in the *Profiles*. For a small number of countries, no surveys met the inclusion criteria. In those cases, the best available information on smoking prevalence is provided.

Table 1 lists the countries and territories for which smoking prevalence information was available and the year in which the data were collected. Italicized years denote the publication year instead of the survey year.

Table 1. Years of smoking prevalence statistics in the *Profiles*

Countries and Territories	Adult	Youth	Health Professional
Afghanistan	–	–	–
Albania	1999-2000	1990-1991	2000
Algeria	1997-1998	1999	1999
Andorra	1997	1997	–
Angola	–	–	–
Antigua and Barbuda	–	2000	–
Argentina	1999	2000	1997
Armenia	2000-2001	1997	–
Australia	2001	2001	1996
Austria	2000	1997-1998	2001
Azerbaijan	1999	–	–
Bahamas	1989	2000	–
Bahrain	2001	1995	1994
Bangladesh	2001	1997	1985
Barbados	1991-1994	1999/2002	–
Belarus	2000	1999	–
Belgium	2001	1998	1991
Belize	–	1992	–
Benin	1988	–	–
Bhutan	–	–	–
Bolivia	1999	2000	1987
Bosnia and Herzegovina	1995	–	1996
Botswana	1988	–	–
Brazil	2000	1997	2000
Brunei Darussalam	1988	–	–
Bulgaria	1997	1999	1996
Burkina Faso	–	1998	–
Burundi	1995	1996	–
Cambodia	1999	1999	–
Cameroon	1994	1996	–
Canada	2001	2001	1998-1999
Cape Verde	–	–	–
Central African Republic	–	–	–
Chad	1993-1994	1993-1994	–
Chile	2001	2000	1992
China	1998	1999	1996
China - Hong Kong (Special Administrative Region of China)	2000	1999	1987
Colombia	1999	2001	1991
Comoros	–	–	–
Congo	–	–	–
Cook Islands	1998	1980	–
Costa Rica	2001	1999	1993-1994
Côte d'Ivoire	1977	1990	–
Croatia	2000	1999	1993
Cuba	1995	2001	1995
Cyprus	1998	1998	–
Czech Republic	2000	1999	1998
Democratic People's Republic of Korea	1985/2000	–	–
Democratic Republic of the Congo	1998	1998	–
Denmark	2000	1999	1996
Djibouti	1999	1995	–
Dominica	–	2000	–
Dominican Republic	1993	1986	1986
Ecuador	1991	2001	–
Egypt	2000	2001	1993
El Salvador	2000	2000	–
Equatorial Guinea	–	–	–
Eritrea	–	–	–
Estonia	2000	1999	–
Ethiopia	2002	1997-1998	1985
Fiji	1999	1999	1991
Finland	2000	1999	1995
France	2000	2000	1994

Table 1. (continued)

Countries and Territories	Adult	Youth	Health Professional	Countries and Territories	Adult	Youth	Health Professional
Gabon	–	–	–	Papua New Guinea	1990	1996-1997	1990
Gambia	1996-1997	–	–	Paraguay	1995	2001	1989
Georgia	1999	1997	1996	Peru	1999	2000	1993
Germany	2000	2001	1992-1993	Philippines	2001	2000	1987
Ghana	1997	2000	–	Poland	1997-1999	1999	1995
Greece	2000	1999	1992	Portugal	1995-1996	1999	1991
Grenada	–	2000	–	Puerto Rico (associate Member State)	2000	1995	–
Guatemala	1989	1989	2002	Qatar	1999	1999	–
Guinea	1998	–	–	Republic of Korea	1996	1998-1999	1998
Guinea-Bissau	–	–	–	Republic of Moldova	1999	1998	1998
Guyana	–	2000	–	Romania	1995	1994-1996	2000
Haiti	1990	2001	–	Russian Federation	1992-1998	1999	1996-1999
Honduras	1988	1996	–	Rwanda	1992-1994	1998	–
Hungary	1999	1999	1998	Saint Kitts and Nevis	–	–	–
Iceland	2000	1999	2000	Saint Lucia	1991-1994	2001	–
India	1998-1999	2000	1998	Saint Vincent and the Grenadines	1997	2001	–
Indonesia	2001	2000	1985	Samoa	1995	1994	1994
Iran (Islamic Republic of)	1999-2000	1997-1998	1998	San Marino	1990s	–	–
Iraq	1990	1990	–	Sao Tome and Principe	1998	1998	–
Ireland	1998	1999	2000	Saudi Arabia	1996-2001	2001	1999-2000
Israel	1999-2001	1997-1998	1995-1996	Senegal	1998	1998	1999
Italy	2002	1999	1998-1999	Serbia and Montenegro	1994-1995	1984-1985	1989
Jamaica	1994-1995	2001	–	Seychelles	1994	1991	–
Japan	2000	1999	2000	Sierra Leone	1998	1994	–
Jordan	1999	1999	–	Singapore	2001	2000	1985
Kazakhstan	2000	–	–	Slovakia	1998	1999	1999
Kenya	2000	2001	1986	Slovenia	2001	1999	1996
Kiribati	1999	1981	–	Solomon Islands	1989	1989	–
Kuwait	1996	2001	1990	Somalia	–	–	–
Kyrgyzstan	1998	1998	–	South Africa	2000	1999	1986
Lao People's Democratic Republic	1995	1999	1996	Spain	2001	2000	1995
Latvia	1999	1999	1993	Sri Lanka	2001	1999	–
Lebanon	1998	2001	1999	Sudan	1999	2001	1980
Lesotho	1992	1992	–	Suriname	–	2000	–
Liberia	–	–	–	Swaziland	1994	1998	–
Libyan Arab Jamahiriya	1997	–	–	Sweden	2000-2001	1999	2001
Lithuania	2000	1999	1992	Switzerland	2000-2001	1997-1998	1989
Luxembourg	1998	1998	1991	Syrian Arab Republic	1999	1999	1998
Madagascar	–	–	1993	Tajikistan	–	1990s	–
Malawi	1996	2001	–	Thailand	2001	1999	1989
Malaysia	1995	1996	1993-1994	The former Yugoslav Republic of Macedonia	–	1999	–
Maldives	2001	–	–	Timor-Leste	1995	–	–
Mali	–	2001	–	Togo	–	–	–
Malta	1995	1999	2000	Tokelau (associate Member State)	1991	1994	–
Marshall Islands	–	–	–	Tonga	1991	1991	1994
Mauritania	–	2001	–	Trinidad and Tobago	1977-1986/1995	2000	–
Mauritius	1998	2001	1992	Tunisia	1997	2001	1994
Mexico	1998	2000	1997	Turkey	1997-1998	1995	1993
Micronesia (Federated States of)	1994	–	–	Turkmenistan	1990	–	–
Monaco	–	–	–	Tuvalu	1975-1981	1975-1981	–
Mongolia	2001	1998	1990	Uganda	1995	1995	–
Morocco	2000	2001	1994-1995	Ukraine	2000	1999	1998
Mozambique	–	–	–	United Arab Emirates	1996	2002	1991-1992
Myanmar	2001	2001	–	United Kingdom	2001	1999	1985/1997
Namibia	1994	–	–	United Republic of Tanzania	1998-1999	1995	–
Nauru	1994	1975	–	United States of America	2000	2000	1991
Nepal	2000	2001	–	Uruguay	1995	2001	2000/2001
Netherlands	2001	2000	1989	Uzbekistan	1991	1989	–
New Zealand	2001	2001	1996	Vanuatu	1998	1988	–
Nicaragua	1988	2001	–	Venezuela	1996	1999	2000
Niger	–	1990s	–	Viet Nam	1997-1998	1995	2002
Nigeria	1990	2001	2000	West Bank and Gaza Strip	1997	2001	1999
Niue	1980	1980	–	Yemen	1998	1997	–
Norway	1999-2000	1999	1993	Zambia	1996	1996	–
Oman	1995	1995	–	Zimbabwe	1995	1999	–
Pakistan	1996	1990-1994	1993				
Palau	1998	2000	2001				
Panama	1998	1998	1993				

Despite the focus on cigarette smoking in the *Profiles*, the prevalence of other smoking tobacco and oral tobacco use better reflects the tobacco situation in some countries and sub-regions within countries. The South-East Asia regional summary discusses consumption of betel, bidis, gutkha, kretek, and other types of tobacco more widely used than cigarettes in some countries (p. 38).

Tobacco Economy

The *Profiles* presents data related to the economics of tobacco control, including trade and agricultural production statistics and information about the global cigarette trade, including cigarette prices, taxes, and duties. Readers may wish to consult specialized publications for assistance in interpreting tobacco-related economic data and for discussion of the broader economic issues surrounding the adoption of new tobacco control policies.^{20,21} For a thorough examination of the economic merits of tobacco control and refutations of arguments that tobacco control activities have a negative impact on a nations' economic health, readers are encouraged to review two important publications, *Tobacco Control in Developing Countries* and *Curbing the Epidemic*.^{22,23}

Cigarette production, trade, and consumption. Cigarette production, import, and export data were selected from various databases by following the selection process described below. Total and per capita consumption figures were calculated from the selected manufactured cigarette production and trade data.

As a large amount of the cigarette production and trade data published and available are of poor quality, the best source for each country's indicators was selected according to the following process. Production and trade data from the following data sources were compared: ERC Statistics International, FAOStat Statistical databases, Official Statistics of the countries of the Commonwealth of Independent States (CIS), United Nations Industrial Commodity Production Statistics Database, Commodity Trade Statistics Data Base (COMTRADE), and United States Department of Agriculture databases (USDA).²⁴⁻²⁸ When available, data from national sources were also considered. When the data were identical or very similar, the most complete source (the one with the most data points) was used. On some occasions similar data from different sources were merged to expand data coverage.

When data from any of the sources conflict with another, they were compared and contrasted with data reported in *Tobacco or Health: A global status report*, the Pan American Health Organization's *Tobacco or Health: Status in the Americas*, *World Tobacco File*, *OECD Health Data 2000*, and

by the Tobacco Merchants Association.²⁹⁻³³ If no consensus emerged, the data are not reported. On rare occasions, cigarette consumption calculations yielded unrealistic estimates (for instance, negative consumption numbers). These estimates were also not reported. For the purposes of the calculations, when cigarette production and trade are expressed in weight, one gram in weight is converted to one cigarette stick, with the results presented above.

United Nations databases use international classifications (albeit different ones) to group commodities. The following commodity codes were used to identify the relevant data:

- United Nations Industrial Commodity Production Statistics Database. International Standard Industrial Classification of all Economic Activities (Revision 2): Code 3140-07.
- United Nations Statistics Division. Commodity Trade Statistics Data Base (COMTRADE); Standard International Trade Classification (Revision 2): Code 1222.
- FAO Cigarettes (includes cigarettes of tobacco substitutes): Code 0828.

The formula used for computing cigarette consumption is the following:

- *Total cigarette consumption* =
Production + Imports – Exports

Total cigarette consumption can be useful for gauging the size of a tobacco market but it does not allow for comparisons across time and between countries. To compare levels of cigarette consumption between countries, a per capita rate of consumption can be calculated to provide an indicator of individual consumption. Dividing total cigarette consumption by the population age 15 years and older is the method used for deriving per capita cigarette consumption. The age group 0-14 is omitted because of its limited contribution to tobacco consumption.³³ However, differences between countries in demographic distribution and tobacco use prevalence in the 10-20 age group can be significant and diminish the comparability of derived measures of per capita consumption. In the present case the formula used to obtain per capita consumption figures is as follows:

- *Per capita cigarette consumption* =
(Production + Imports – Exports) / (Population age 15 years and older)

United Nations Population Division provided population figures.³⁵ Per capita cigarette consumption was calculated only for observations where consumption and population data are available.

It is important to note that these estimates may underestimate or overstate true consumption for several reasons such as smuggling and stockpiling. Readers are encouraged to review economic publications for more detail on the

advantages and disadvantages of estimating tobacco use on the basis of aggregate data.³⁶

Tobacco leaf statistics. The *Profiles* presents tobacco leaf import, export, and production figures for 1970, 1980, 1990, 1995, and 2000. Data on production and trade of tobacco leaf and the tobacco land area harvested annually were derived from the statistical database of the United Nations' Food and Agriculture Organization (FAOStat).³⁷ Production and trade data are presented in metric tons. The United Nations' Commodity Trade Statistics Database (COMTRADE) provided data on total exports,³⁸ expressed in thousands of United States dollars. The amount of land devoted to tobacco growing is presented both in total hectares and as a percent of the total agricultural area. Total agricultural area is defined as the sum of the area encompassed by arable land, permanent crops, and permanent pastures.

Employment in tobacco manufacturing. Employment in tobacco manufacturing is reported for 1970, 1980, 1990, and 1995, when available. Employment figures were drawn from the United Nations Industrial Development Organization's (UNIDO) Industrial Statistics Database.³⁹ UNIDO collects information from four sources in order to maintain the database:

- 1) industry data from country questionnaires,
- 2) national publications, including industrial censuses and annual surveys,
- 3) published and unpublished international sources, and
- 4) national data compiled by statisticians working in each country.

Taxes and duties. The *Profiles* presents information on national taxes and duties applied to cigarette sales. Since most taxes and duties are established through legislation or decree, more information about the imposition of tax and duty fees may appear in Appendix B, the Legislative Appendix. ERC Statistics International and the Tobacco Merchants Association are the main data sources for information on cigarette taxes and duties.^{40,41} The tax and duty data are divided into three categories: excise taxes, sales taxes, and import duties. Excise taxes are cigarette-specific taxes levied in the form of a value added tax per pack or per cigarette. General sales taxes or value added taxes (VAT) apply to all goods, including cigarettes. Import duties refer to taxes specifically applied to imported foreign cigarette brands sold in domestic national markets.

Table 2 lists the units of measure and abbreviations used in the tax and duty section and Table 3 lists the abbreviations used to describe economic trade blocs mentioned in the *Profiles*.

Table 2. Abbreviations used for units of measure in the tax and duty section of the *Profiles*

cig(s)	cigarette(s)
CIF	Cost Including Freight charges
ECU	European Currency Unit
FOB	Free on Board
g	gram
IDA	Institute for Agricultural Development
kg	kilogram
LCU	Local Currency Unit
max	maximum
min	minimum
mm	millimeter in length
MPPC	Most Popular Price Category
TVO	Taxes sur la valeur ordinaire
US\$	United States Dollars
VAT	Value Added Tax

The *Profiles'* tax tables do not reflect the trade relationships among European Union (EU) member states and between the EU and countries that receive preferential trade status from it. For trade within the EU among its member states, cigarettes are not subject to any import duties. The member states established a community integrated tariff system (TARIC), through which duties are applied to imports from non-EU countries. TARIC was established by the 1958 Treaty of Rome as part of the European Economic Community. The EU tariff schedule is based on the Customs Cooperation Council Nomenclature, also called the Harmonized System. It was introduced to provide a standard tariff classification regime for all products imported and exported throughout the world.

Under the Lome Convention, the EU also extends various preferential tariff treatments to imports from the developing countries in Africa, the Caribbean and the Pacific Rim. Tariff preferences also extend to over 100 developing countries (except China) under the Generalized System of Preferences. This system of duty-free and preferential trading in the EU is not noted separately in each country's tax and duty table.

Prices. The *Profiles* presents the retail price of a single package of domestic and imported manufactured cigarettes, including applicable taxes and duties. Prices in local currency were converted to United States dollars to allow comparison between countries. When a currency exchange rate was not available, the local price is presented alone. Limitations on cross-country comparisons of cigarette prices should be recognized.⁴² In most countries, 20 cigarettes constitute a package of cigarettes. When this is not the case, prices were weighted so as to represent the price in terms of 20 cigarettes. Whenever possible, Marlboro brand cigarettes were selected to represent the price of foreign cigarettes to provide a measure of standardization.

Table 3. Abbreviations used for economic trade blocs described in the tax and duty section of the *Profiles*

ASEAN	Association of Southeast Asian Nations
CACU	Central African Customs Union
CACM	Central American Common Market
CARICOM	Caribbean Community and Common Market
CEFTA	Central European Free Trade Area
CIS	Commonwealth of Independent States
COMESA	Common Market for Eastern and Southern Africa
ECOWAS	Economic Community of West African States
EEC	European Economic Community
EFTA	European Free Trade Association
EU	European Union (formerly EEC)
GCC	Gulf Cooperation Council
MERCOSUR	Common Market of the South (Argentina, Brazil, Paraguay, and Uruguay)
MFN	Most Favored Nations
NAFTA	North American Free Trade Agreement
SA	South American or South America
SAARC	South Asian Association for Regional Cooperation
SACU	South Africa Customs Union (Namibia, Botswana, Lesotho and Swaziland)
UEMOA	Economic and Monetary Union of West Africa (also WAEMU)
WTO	World Trade Organization

The primary source for cigarette price data is the Economist Intelligence Unit (EIU), an economic and market research firm based in the United Kingdom.⁴³ The EIU surveys cigarette and pipe tobacco prices biannually as part of its Cost of Living Survey in 129 cities or a total of 82 countries. The EIU conducts price surveys during March (“Spring”) and September (“Autumn”) and reports prices for two types of cigarettes, Marlboro (the most popular international brand) or nearest equivalent international brand and a popular domestic brand. The most popular price category (MPPC) reflects the price at which more cigarettes are sold than any other price. The EIU survey is not limited to one retail location in each city, but includes the price of the same product in three different retail locations: a “supermarket”, a “mid-price store”, and a “specialized shop”. This survey method results in three price categories: *low*, *middle*, and *high*. For the purposes of the *Profiles*, the price of foreign and domestic cigarettes, if available, represents the *low* category. In cases where the EIU conducted its survey in two or more cities in the same country, the average of the city prices serves as the country price.

Other sources of price data include the ERC Statistics International, *Tobacco Journal International*, Tobacco Merchants Association, and country reports on the economics of tobacco control produced by consultants for the WHO Regional Office for South-East Asia.⁴⁴⁻⁴⁶

Market share by cigarette manufacturer. The *Profiles* presents data on cigarette market share held by the top five companies in each country, where data are available. Table 4 provides abbreviations used to identify manufacturers.

Table 4. Abbreviations used to identify tobacco companies in the market share section of the *Profiles*

AAMS	Amministrazione Autonoma dei Monopoli Di Stato
BAT	British American Tobacco
BAT PD	BAT Pesci Dohanygyar
CNTIEC	CNTIEC-Kazakhstan (China National Tobacco Import and Export Corporation)
CTC	China Tobacco Corporation
DIN	Tobacco Industry Nis
DIV	Tobacco Industry Vranje
DKP	Duvanski Kombinat Podgorica
GTC	Golwin Tobacco Company
ITCC	International Tobacco and Cigarette Company
JTCC	Jordan Tobacco and Cigarette Company
JTI	Japan Tobacco International
PM	Philip Morris
PMI	Philip Morris International
PWT	Przedsiębiorstwo Wyrobów Tytoniowych
RE	Reemtsma
RJR	R.J. Reynolds
RLTT	Regie Libanaise des Tabacs et Tombacs
RO	Rothmans
Seita	Societe Nationale d'Exploitation Industrielle des Tabacs et Allumettes
SIAT	Societe Industrielle et Agricole du Tabac Tropical
SIT	Slovak International Tabak
SITABAC	Société Industrielle des Tabacs du Cameroun
SNTR	Societatea Nationala Tutunul Romanesc
Tutun CTC	Tutun-Chisinau Tobacco Factory – China Tobacco Corporation
UTC	Union Tobacco and Cigarette Company
VST	Vizar Sultan Tobacco
WWT	Wytworni Wyrobów Tytoniowych Poznan
ZPT	Zakłady Przemysłu Tytoniowego w Krakowie

Cigarette market share data were compiled from ERC Statistics International, the Tobacco Merchant’s Association, and the *Maxwell Consumer Report on International Tobacco*.⁴⁷⁻⁴⁹

Smoking-Attributed and Smoking-Related Disease Impact

The *Profiles* includes estimates of smoking-related or smoking-attributed deaths in 182 nations. Mortality estimates are derived from three main sources; Peto, Lopez, Boreham, Thun, and Heath (1994, updated 2003), WHO Mortality Database (2003), and GLOBOCAN 2000 (2001).⁵⁰⁻⁵³ Table 5 lists the countries by source of mortality estimate and Table 6 provides the year for the mortality estimate published in the *Profiles*.

Table 5. Sources for mortality estimates appearing in the Profiles

Source of Mortality Data	Countries
WHO Mortality Database (WHO)	Albania; Antigua and Barbuda; Argentina; Bahamas; Bahrain; Barbados; Belize; Brazil; Chile; Hong Kong SAR; Colombia; Costa Rica; Croatia; Cuba; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Fiji; Guyana; Iceland; Israel; Kuwait; Malaysia; Malta; Mauritius; Mexico; Monaco; Mongolia; Nicaragua; Panama; Paraguay; Philippines; Puerto Rico; Qatar; Republic of Korea; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and Grenadines; San Marino; Sao Tome and Principe; Seychelles; Singapore; South Africa; Thailand; The former Yugoslav Republic of Macedonia; Trinidad and Tobago; Uruguay; Venezuela
GLOBOCAN 2000	Afghanistan; Algeria; Angola; Bangladesh; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brunei Darussalam; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; Central African Republic; Chad; Comoros; Congo; Cote d'Ivoire; Cyprus; Democratic People's Republic of Korea; Democratic Republic of the Congo; Djibouti; Equatorial Guinea; Eritrea; Ethiopia; Gabon; Gambia; Ghana; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; India; Indonesia; Iran (Islamic Republic of); Iraq; Jamaica; Jordan; Kenya; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Madagascar; Malawi; Mali; Mauritania; Morocco; Mozambique; Myanmar; Namibia; Nepal; Niger; Nigeria; Oman; Pakistan; Papua New Guinea; Peru; Rwanda; Samoa; Saudi Arabia; Senegal; Serbia and Montenegro; Sierra Leone; Solomon Islands; Somalia; Sri Lanka; Sudan; Suriname; Swaziland; Syrian Arab Republic; Togo; Tunisia; Turkey; Uganda; United Arab Emirates; United Republic of Tanzania; Vanuatu; Viet Nam; Yemen; Zambia; Zimbabwe
Peto, Lopez, et al. (update 2003)	Armenia; Australia; Austria; Azerbaijan; Belarus; Belgium; Bulgaria; Canada; Czech Republic; Denmark; Estonia; Finland; France; Georgia; Germany; Greece; Hungary; Ireland; Italy; Japan; Kazakhstan; Kyrgyzstan; Latvia; Lithuania; Luxembourg; Netherlands; New Zealand; Norway; Poland; Portugal; Republic of Moldova; Romania; Russian Federation; Slovakia; Slovenia; Spain; Sweden; Switzerland; Tajikistan; Turkmenistan; Ukraine; United Kingdom (Great Britain and Northern Ireland); United States of America; Uzbekistan

Table 6. Source and year for mortality estimates appearing in the Profiles

Country	Source	Year	Country	Source	Year
Afghanistan	Globocan	2000	China	Peto, et al. (1998). Emerging tobacco hazards in China: 1. Retrospective proportional mortality study of one million deaths. <i>British Medical Journal</i> 317(7170): 1411-1422; Peto, et al. (1999). Tobacco- the growing epidemic. <i>Nature Medicine</i> 5(1): 15-17.	1990
Albania	WHO	2000	Hong Kong SAR	WHO	2000
Algeria	Globocan	2000	Colombia	WHO	1998
Angola	Globocan	2000	Comoros	Globocan	2000
Antigua and Barbuda	WHO	1995	Congo	Globocan	2000
Argentina	WHO	1997	Costa Rica	WHO	2000
Armenia	Peto, Lopez, et al. (update 2003)	2000	Cote d'Ivoire	Globocan	2000
Australia	Peto, Lopez, et al. (update 2003)	2000	Croatia	WHO	2000
Austria	Peto, Lopez, et al. (update 2003)	2000	Cuba	WHO	2000
Azerbaijan	Peto, Lopez, et al. (update 2003)	2000	Cyprus	Globocan	2000
Bahamas	WHO	1997	Czech Republic	Peto, Lopez, et al. (update 2003)	2000
Bahrain	WHO	2000	Democratic People's Republic of Korea	Globocan	2000
Bangladesh	Globocan	2000	Democratic Republic of the Congo	Globocan	2000
Barbados	WHO	1995	Denmark	Peto, Lopez, et al. (update 2003)	1998
Belarus	Peto, Lopez, et al. (update 2003)	2000	Djibouti	Globocan	2000
Belgium	Peto, Lopez, et al. (update 2003)	1995	Dominica	WHO	1994
Belize	WHO	1998	Dominican Republic	WHO	1998
Benin	Globocan	2000	Ecuador	WHO	2000
Bhutan	Globocan	2000	Egypt	WHO	2000
Bolivia	Globocan	2000	El Salvador	WHO	1999
Bosnia and Herzegovina	Globocan	2000	Equatorial Guinea	Globocan	2000
Botswana	Globocan	2000	Eritrea	Globocan	2000
Brazil	WHO	1995	Estonia	Peto, Lopez, et al. (update 2003)	2000
Brunei Darussalam	Globocan	2000	Ethiopia	Globocan	2000
Bulgaria	Peto, Lopez, et al. (update 2003)	2000	Fiji	WHO	1999
Burkina Faso	Globocan	2000	Finland	Peto, Lopez, et al. (update 2003)	2000
Burundi	Globocan	2000			
Cambodia	Globocan	2000			
Cameroon	Globocan	2000			
Canada	Peto, Lopez, et al. (update 2003)	1998			
Cape Verde	Globocan	2000			
Central African Republic	Globocan	2000			
Chad	Globocan	2000			
Chile	WHO	1999			

Table 6. (continued)

Country	Source	Year	Country	Source	Year
France	Peto, Lopez, et al. (update 2003)	1999	Paraguay	WHO	1994
Gabon	Globocan	2000	Peru	Globocan	2000
Gambia	Globocan	2000	Philippines	WHO	1996
Georgia	Peto, Lopez, et al. (update 2003)	2000	Poland	Peto, Lopez, et al. (update 2003)	2000
Germany	Peto, Lopez, et al. (update 2003)	2000	Portugal	Peto, Lopez, et al. (update 2003)	2000
Ghana	Globocan	2000	Puerto Rico	WHO	1999
Greece	Peto, Lopez, et al. (update 2003)	1999	Qatar	WHO	1995
Guatemala	Globocan	2000	Republic of Korea	WHO	2000
Guinea	Globocan	2000	Republic of Moldova	Peto, Lopez, et al. (update 2003)	2000
Guinea-Bissau	Globocan	2000	Romania	Peto, Lopez, et al. (update 2003)	2000
Guyana	WHO	1996	Russian Federation	Peto, Lopez, et al. (update 2003)	2000
Haiti	Globocan	2000	Rwanda	Globocan	2000
Honduras	Globocan	2000	Saint Kitts and Nevis	WHO	1995
Hungary	Peto, Lopez, et al. (update 2003)	2000	Saint Lucia	WHO	1995
Iceland	WHO	1997	Saint Vincent and the Grenadines	WHO	1995
India	Globocan	2000	Samoa	Globocan	2000
Indonesia	Globocan	2000	San Marino	WHO	2000
Iran (Islamic Republic of)	Globocan	2000	Sao Tome and Principe	WHO	1987
Iraq	Globocan	2000	Saudi Arabia	Globocan	2000
Ireland	Peto, Lopez, et al. (update 2003)	2000	Senegal	Globocan	2000
Israel	WHO	1998	Serbia and Montenegro	Globocan	2000
Italy	Peto, Lopez, et al. (update 2003)	1999	Seychelles	WHO	1987
Jamaica	Globocan	2000	Sierra Leone	Globocan	2000
Japan	Peto, Lopez, et al. (update 2003)	2000	Singapore	WHO	2000
Jordan	Globocan	2000	Slovakia	Peto, Lopez, et al. (update 2003)	2000
Kazakhstan	Peto, Lopez, et al. (update 2003)	1999	Slovenia	Peto, Lopez, et al. (update 2003)	2000
Kenya	Globocan	2000	Solomon Islands	Globocan	2000
Kuwait	WHO	2000	Somalia	Globocan	2000
Kyrgyzstan	Peto, Lopez, et al. (update 2003)	2000	South Africa	WHO	1996
Lao People's Democratic Republic	Globocan	2000	Spain	Peto, Lopez, et al. (update 2003)	2000
Latvia	Peto, Lopez, et al. (update 2003)	2000	Sri Lanka	Globocan	2000
Lebanon	Globocan	2000	Sudan	Globocan	2000
Lesotho	Globocan	2000	Suriname	Globocan	2000
Liberia	Globocan	2000	Swaziland	Globocan	2000
Libyan Arab Jamahiriya	Globocan	2000	Sweden	Peto, Lopez, et al. (update 2003)	2000
Lithuania	Peto, Lopez, et al. (update 2003)	2000	Switzerland	Peto, Lopez, et al. (update 2003)	1999
Luxembourg	Peto, Lopez, et al. (update 2003)	2000	Syrian Arab Republic	Globocan	2000
Madagascar	Globocan	2000	Tajikistan	Peto, Lopez, et al. (update 2003)	1999
Malawi	Globocan	2000	Thailand	WHO	1994
Malaysia	WHO	1997	The former Yugoslav Republic of Macedonia	WHO	2000
Mali	Globocan	2000	Togo	Globocan	2000
Malta	WHO	1999	Trinidad and Tobago	WHO	1998
Mauritania	Globocan	2000	Tunisia	Globocan	2000
Mauritius	WHO	2000	Turkey	Globocan	2000
Mexico	WHO	2000	Turkmenistan	Peto, Lopez, et al. (update 2003)	1998
Monaco	WHO	1987	Uganda	Globocan	2000
Mongolia	WHO	1994	Ukraine	Peto, Lopez, et al. (update 2003)	2000
Morocco	Globocan	2000	United Arab Emirates	Globocan	2000
Mozambique	Globocan	2000	United Kingdom (Great Britain and Northern Ireland)	Peto, Lopez, et al. (update 2003)	2000
Myanmar	Globocan	2000	United Republic of Tanzania	Globocan	2000
Namibia	Globocan	2000	United States of America	Peto, Lopez, et al. (update 2003)	1999
Nepal	Globocan	2000	Uruguay	WHO	2000
Netherlands	Peto, Lopez, et al. (update 2003)	2000	Uzbekistan	Peto, Lopez, et al. (update 2003)	1998
New Zealand	Peto, Lopez, et al. (update 2003)	1999	Vanuatu	Globocan	2000
Nicaragua	WHO	2000	Venezuela	WHO	2000
Niger	Globocan	2000	Viet Nam	Globocan	2000
Nigeria	Globocan	2000	Yemen	Globocan	2000
Norway	Peto, Lopez, et al. (update 2003)	2000	Zambia	Globocan	2000
Oman	Globocan	2000	Zimbabwe	Globocan	2000
Pakistan	Globocan	2000			
Panama	WHO	2000			
Papua New Guinea	Globocan	2000			

The WHO Collaborating Center for Chronic Disease Control at the University of Oxford, in collaboration with the American Cancer Society, and the Imperial Cancer Research Fund provided estimates for smoking-attributed deaths in 44 developed countries. The estimates first appeared in “Mortality from Smoking in Developed Countries, 1950-2000” and the original paper, including discussion of the methods used to derive tobacco-attributed mortality, was published in *Lancet*.^{54,55} In February 2003, updates and revisions to these estimates became available and are presented in the *Profiles* categorized by cause, age group, and sex.⁵⁶ Trends in total smoking-attributed mortality among men and women, age 35 to 69, between 1955 and 2000 are shown graphically. Only mortality during middle age (35 to 69 years) is presented in the graph because in developed countries, smoking causes relatively few deaths before middle age, while it is responsible for about one-third of deaths among men during middle age and a growing proportion of deaths among women during middle age.

The *Profiles* presents the crude numbers of deaths and age-standardized mortality rates for diseases most commonly associated with tobacco use. The CDC developed this list of smoking-related diseases through previous analyses of the impact of cigarette smoking on mortality and years of potential life lost before age 65 in the United States.⁵⁷ Because this categorization of disease better reflects the proportion of deaths due to smoking in developed countries than in developing countries, some modifications were made to the CDC’s list of conditions to concentrate on the effects of tobacco use in developing countries. First, tobacco-related pediatric diseases, such as low birth weight, respiratory distress, sudden infant death syndrome, and burns were eliminated from the list so that the mortality tables for developing countries include only adult mortality for diseases among persons in middle age. Second, acute respiratory conditions, such as pneumonia and influenza, were excluded from the list, as was asthma, while chronic respiratory conditions, such as bronchitis, emphysema, and chronic airway obstruction, were included. In developing countries, mortality due to acute respiratory diseases may be less likely to be associated with tobacco consumption than in developed countries. Diseases responsible for significant global mortality and for which tobacco’s causal association is well-established were selected from the remaining conditions.

Smoking-attributed mortality estimates for China were prepared by the Chinese Academy of Medical Science, the Clinical Trial Service Unit and Epidemiological Studies Unit at Oxford University, Cornell University, and the Chinese Academy of Preventive Medicine.^{58,59} Smoking-attributed

mortality estimates, however, were not calculated for other developing countries.

Table 7 lists the disease categories presented in the *Profiles’* mortality tables, the conditions included in each category, and the corresponding ICD-9 or ICD-10 codes used in the WHO Mortality Database.

Table 7. Select smoking-attributed diseases

Disease Category	Included Conditions	ICD-9	ICD-10
Trachea, lung and bronchus cancer	Trachea, lung and bronchus cancer	162	C33-C34
Lip, oral cavity, and pharynx cancer	Lip, oral cavity, and pharynx cancer	140-149	C00-C14
Ischemic heart disease	Acute myocardial infarction	410-414	I20-I25
Stroke	Cerebrovascular disease	430-438	I60-I69
	Atherosclerosis	440	I70
	Embolism, thrombosis and other diseases of the arteries, arterioles & capillaries	441-448	I71-I78
Other diseases of the circulatory system	Diseases of the pulmonary circulation & other forms of heart disease	415-417	I26-I28
		420-429	I30-I51
Respiratory disease	Bronchitis, chronic & unspecified, emphysema	490-492	J40-J42, J43
Chronic airways obstruction		496	J44

Mortality rates in 50 countries were calculated from data provided in the WHO Mortality Database which reports the statistics submitted to WHO by individual Member States.⁶⁰ According to WHO, these mortality data are limited to countries that report cause of death information in an appropriate format and have reasonably adequate death registration coverage. Where information is available, death rates age-adjusted to the 2000 World Standard Population and truncated to ages 35+ are provided. Age standardization is based on the new WHO World Standard Population.⁶¹

In countries with small populations, incremental changes in the number of deaths may cause substantial variability in apparent mortality rates from one year to another. Furthermore, WHO does not provide death rates for some countries because of low coverage by their death registration systems. Thus, death rates for the following countries should be interpreted with caution: Bahamas, Barbados, Belize, Brazil, Ecuador, Egypt, Guyana, Malta, Mongolia, Nicaragua, Paraguay, Philippines, and Qatar. Data for countries and territories whose reports to WHO were based on hospital or institutional death registration are not included in the *Profiles*.

Cancer statistics for 86 countries are derived from the International Agency for Research on Cancer (IARC). IARC estimates of annual cancer mortality in 2000 are available through the electronic database, GLOBOCAN 2000.⁶² The methods used by IARC to derive these estimates are described in the *International Journal of Cancer*.⁶²

Total mortality from selected smoking-related diseases is reported for developing countries where specific tobacco-attributed mortality estimates are unavailable. Readers should note the difference between tobacco-related and tobacco-attributed mortality estimates. Also, while mortality numbers and rates provide valuable information about the differential burden of tobacco-related disease around the world and allow some comparison among countries, they do not reflect the total burden of disease caused by smoking.

Infrastructure for Tobacco Control

National Tobacco Control Provisions. The *Profiles* presents information regarding tobacco control laws, regulations, or policies. These national laws, regulations, and ministerial, royal, or presidential decrees reflect each country's legal and regulatory infrastructure for tobacco control. The *Profiles* divides national tobacco provisions into five categories: advertising and sponsorship, sales and distribution, tobacco product regulation, smoke-free environments, and other provisions. Within these five categories, 44 specific provisions are monitored. An "X" is placed in the appropriate column signifying the status of a provision in the country, i.e. "banned," "required," "restricted," "regulated," "not regulated," and "unknown." If a provision is not applicable, the label "N/A" is entered in the far left column.

Table 8 provides a list of the provisions in each category and an explanation of that provision. Table 9 (see p. 24) defines terms used to describe the national tobacco control provisions. When information was not found regarding a provision, the status is unknown; however, the absence of the provision from the sources reviewed does not necessarily mean that the provision does not exist. Also, the presence of a tobacco control provision in legislative text or secondary reports from country representatives does not necessarily imply that the measure is enforced. Voluntary measures are not recognized in the legislation tables but may be mentioned in the appendix, if applicable. When available, more detailed explanations of tobacco control provisions are provided in Appendix B.

Table 8. Definition of legislative variables used to describe national tobacco control legislation

Status	Definition
Banned	Prohibited by national legislation and/or regulations
Restricted	Restricted by national legislation and/or regulations
Required	Required by national legislation and/or regulations
Regulated	Regulated by national legislation and/or regulations
Unknown	No data available

Legislative data for the *Profiles* were compiled from WHO Regional Offices, the NATIONS website, ERC Statistics International, World Tobacco File, The Maxwell Consumer Report, WHO's International Health Legislative Digest (IDHL), Legislative Action to Combat the World Tobacco Epidemic, USDA reports and databases, and the Tobacco Merchant's Association.⁶⁴⁻⁷⁴

The CDC also gathered legislative data for the *Profiles* by searching the following sources: 1) national government homepages and country-specific sites on the Internet, 2) Lexis-Nexis International Tax Directory, 3) Library of Congress, Global Information Legal Network, and 4) the personal database of Dr. Judith Mackay of the Asian Consultancy on Tobacco Control.

In addition, requests for the full text of tobacco laws and regulations were made to WHO's Health Legislative Unit and WHO Regional Offices. When the full text of the provision was available, characterization of its content was derived solely from the original text. The name of the organization that reviewed the text of the law is listed in Appendix B.

Tobacco Control Organizations. Appendix A of the *Profiles* is a directory of WHO Regional Offices, WHO Collaborating Centers, and WHO country focal points. These offices serve as the focal points for tobacco control in their respective countries and regions. All contact information was provided by the WHO Regional Offices.

UICC's GLOBALink directory of tobacco control organizations serves as the most up-to-date and comprehensive online directory of international tobacco control advocates and organizations.⁷⁵

Conclusion

The *Profiles* monograph is intended to serve as a reference tool for those working in the fields of tobacco control and surveillance research. Readers should direct questions about the data to the American Cancer Society's Department of Epidemiology and Surveillance Research or to WHO's Tobacco Free Initiative.^{76,77}

Table 9. Definition of terms used in the *Profiles* to describe national tobacco control legislation

Category	Provision	Definition
Advertising and sponsorship	Advertising in certain media	Bans or restricts the media in which advertisements can appear, such as television or radio; international magazines and newspapers are not included
	Advertising to certain audiences	Bans or restricts the audiences which can be targeted by advertisements, such as youth or women
	Advertising in certain locations	Bans or restricts the locations in which advertisements can appear, such as on billboards or at points of sale
	Advertisement content or design	Bans or restricts the advertisement by placing restrictions on content, such as associations and the use of celebrities
	Sponsorship or promotion for certain audiences	Bans or restricts tobacco companies from displaying any tobacco-identifying information at events they sponsor for certain audiences, such as women or youth
	Sponsorship advertising of events	Bans or restricts the display of any tobacco-identifying information in advertisements for events sponsored by tobacco companies
	Brand stretching	Bans or restricts the display of any tobacco-identifying information on non-tobacco products, such as clothes
Sales and distribution	Sales to minors	Prohibits the sale of tobacco products to persons under a predetermined age
	Sales by minors	Prohibits the sale of tobacco products by persons under a predetermined age
	Place of sales	Bans or restricts the sale of tobacco products in certain locations, such as schools or hospitals
	Vending machines	Bans or restricts the use of vending machines for the sale of tobacco products
	Free products	Bans or restricts the distribution of free tobacco products or tobacco product samples
	Single cigarette sales	Prohibits the sale of cigarettes not included in cigarette packs
	Age verification for sales	Requires proof of age for the purchase of tobacco products
Tobacco product regulation	Misleading information on packaging	Bans or restricts words or phrases on tobacco packaging, such as "light" or "healthy"
	Manufacturer licensure	Requires a license to produce tobacco products
	Package health warning / message	Requires a statement to appear on tobacco product packaging informing the consumer of the health dangers of tobacco consumption
	Label design on packaging	Requires health warnings with specific language, placement, color or size
	Ingredient / constituent information on package label	Requires the amount of tar, nicotine and/or other ingredients/constituents in the product to be displayed on the tobacco product package
	Amount of tar	Limits the amount of tar that may be produced by a single cigarette
	Amount of nicotine	Limits the amount of nicotine that may be released by a single cigarette
	Amount of other ingredients / constituents	Limits the amount of ingredients/constituents (other than tar or nicotine) that may be released by a single cigarette
	Product constituents as confidential information	Requires that reports to government agencies about product ingredients and/or constituents remain confidential
	Product constituents as public information	Requires public disclosure of ingredients and/or constituents reported to government agencies
	Constituent disclosure by brand	Requires public disclosure of ingredients and/or constituents by brand
Constituent disclosure in the aggregate	Requires public disclosure of ingredients and/or constituents but not by brand	
Smoke-free environments	Smoking in government building (incl. worksites)	Bans or restricts smoking in government buildings, including government worksites
	Smoking in private worksites	Bans or restricts smoking in private worksites
	Smoking in educational facilities	Bans or restricts smoking in educational facilities
	Smoking in health care facilities	Bans or restricts smoking in health care facilities
	Smoking on buses	Bans or restricts smoking on buses
	Smoking on trains	Bans or restricts smoking on trains
	Smoking in taxis	Bans or restricts smoking in taxis
	Smoking on ferries	Bans or restricts smoking on ferries
	Smoking on domestic air flights	Bans or restricts smoking on domestic air flights
	Smoking on international air flights	Bans or restricts smoking on international air flights
	Smoking in restaurants	Bans or restricts smoking in restaurants
	Smoking in nightclubs and bars	Bans or restricts smoking in nightclubs and bars
	Smoking in other public places	Bans or restricts smoking in other public places, such as cinemas or sports arenas
Other Provisions	National tobacco control committee	Establishes national tobacco control programs or institutions
	Tobacco control education / promotion	Requires the government to conduct or sponsor educational programs regarding tobacco
	Anti-smuggling provisions	Establishes national regulations regarding the smuggling of tobacco products
	Litigation enabling provisions	Provides the government or citizens the ability to recover damages caused by tobacco-related illnesses from the tobacco companies

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- See Appendix A for a complete directory of WHO Regional Offices and country focal points. Tobacco Free Initiative, World Health Organization, 20 Avenue Appia, CH1211 Geneva 27, Switzerland. Fax (41 22) 791 48 32. Email: tfi@who.int. Available at URL: <http://www5.who.int/tobacco/>
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