Tobacco and Other Cancer Risk Factors Control

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1. INTRODUCTION

1.a Cancer Primary Prevention under Health Promotion perspective

The World Health Organization (WHO) estimates that some 30% of cancer cases could be avoided by primary prevention measures.

Most cancer cases are related to environmental factors. Environmental changes made by man, people consumption and lifestyles choices may enhance or decrease the risk of cancer. Evidences have demonstrated that some types of food, a sedentary lifestyle, smoking, excessive use of alcoholic beverages, excessive sun-exposure without protection, occupational environment, and sexual behavior may be related, to a higher or lesser degree, to some types of cancer (WHO, 1993).

These facts show that a lot can be done for cancer primary prevention.

1.b Tobacco hazards

Among the known cancer risk factors today, the use of tobacco has deserved a special attention, as it is a disease; a disease generated by nicotine addiction.

In 1988, the United States Health Department published a lengthy report on studies that proved tobacco to cause addiction (U.S. Surgeon General, 1988). In this report, the United States Health Department has concluded that:

1. Cigarette and other tobacco products do cause addiction.
2. Nicotine is the tobacco products component that causes addiction.
3. Pharmacological and behavioral processes that foster tobacco addiction are similar to those that promote addiction of drugs such as heroin or cocaine.

In 1993, the World Health Organization (WHO) included tobacco use as a mental and behavioral disorder in the tenth revision of the International Classification of Diseases (ICD-10) (Slade 1993, WHO, 1997).

Tobacco use is acknowledged, today, as a disease resulting from nicotine addiction, and tobacco products users are continuously exposed to about 4,700 toxic substances, 60 of them cancer-causing ones, thus users are prone to develop impairing and fatal diseases.

Thousands of studies have proven tobacco use to cause almost 50 different diseases, especially cardiovascular conditions, cancer and chronic obstructive pulmonary diseases (WHO, 1996; Doll, 1994; U.S. Surgeon General, 1989; Rosenberg, 2002). These studies showed that tobacco use causes 45% of coronary artery deaths (myocardial infarction), 85% of chronic obstructive pulmonary disease (emphysema), 25% of cerebrovascular deaths (strokes), and 30% of cancer deaths. It is to be stressed that more than 90% of lung cancer cases occur in smokers, which shows the strong correlation between this disease and tobacco use (U.S. Surgeon General, 1989; Doll, 1994).

Due to tobacco toxicity, total deaths due to its use is currently of 4 million a year, and if expansion trends are kept, deaths from tobacco use are expected to be 8.4 million a year, in the year 2020, reaching individuals in their working years (35-69 years of age) (WHO, 2001).

In Brazil, cardiovascular diseases and cancer are the main causes of disease-related deaths, and lung cancer is the main cause of death due to cancer.

In Brazil the main death causes by illness are cardiovascular diseases and cancer whose major risk factor is tobacco use.

In Brazil, deaths from tobacco use are estimated in some 200,000 a year (PAHO, 2002).

Lung cancer mortality is the leading cause of death by cancer among men and the second cause among women. In 1999, there were 14,127 deaths due to lung cancer. Among women the mortality rates by lung cancer is increasing faster than among men. An analyzes of a temporal series of lung cancer mortality from 1979 to 1999 showed that lung cancer mortality among men
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 et 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.
A framework convention is a legal agreement, an international treaty by which the signing countries agree to endeavor efforts to reach established goals. In this specific case, the purpose is to control global expansion of tobacco use and its deleterious consequences (WHO, 1998).

2. THE LOGIC OF THE TOBACCO AND OTHER CANCER RISK FACTORS NATIONAL PROGRAM

Considering that it is possible to adopt a healthy lifestyle only if one has information, opportunity and motivation to do so, makes clear the need for actions to disseminate such knowledge, creating a favorable scenario to both, encourage and foster people towards a healthier lifestyle and protect them from involuntary exposures to cancer risk factors.

Thus, under a Health Promotion perspective, the Brazilian National Cancer Institute (INCA), organ of the Ministry of Health (MS) responsible for the National Policy on Cancer Control, coordinates national actions of the Tobacco and Other Cancer Risk Factors Control Program, jointly with State and Municipal Health Secretariats and other social segments.

To promote a healthy lifestyle in order to prevent cancer, the Tobacco and Other Cancer Risk Factors Control Program develops educational actions and fosters legislative and economic actions.

The starting point for the development of educational actions is dissemination of scientific knowledge about cancer and possibilities for its prevention. However, by acknowledging that information alone does not necessarily lead to behavior changes, the Program also includes social and environmental interventions to trigger positive behavior changes once such knowledge is disseminated.

Educational actions are essential for this process and should precede and go along any cancer prevention action.

Such actions can be focused, such as awareness campaigns and information disseminated by the media.

Ongoing educational actions are essential for the disseminated information be translated into changes in attitudes and behavior towards a healthier life.

For the development of such actions, the Program has selected three community channels, such as Workplaces, Schools and Health Care Units, where information is disseminated along with actions that foster a favorable scenario for changing behavior of opinion makers and role model groups, such as health professionals, teachers, students and workers in general. In this context, for instance, the idea of the Tobacco-Free Environment Program is that continuous information on the risks of smoking, especially of passive smoking in these facilities occurs concurrently to regulation on smoking and the use of smoking restriction signs and supporting smokers from this communities channels towards cessation.
**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
health of non-smokers from environmental tobacco smoke hazards; and the fourth one concerns with measures to regulate tobacco products and its commercialization.

For this purpose the Program has been outlined. The intention is to systematize educational actions and encourage legislative and economic actions to create a setting that:

- reduces social acceptance of smoking,
- reduces stimuli for youths to start smoking and stimuli that make difficult for smokers to quit,
- protects population from risks of environmental tobacco smoke,
- reduces access to tobacco products,
- enhances availability of smoking cessation support to smokers
- controls and monitors all aspects related to marketed tobacco products, from ingredients and emissions to marketing strategies and dissemination of their features to consumers.

To reach the entire country, the Program has set a geopolitical base, so that actions could be equitably carried out nationwide. Currently, the Program counts with a number of governmental and non-governmental partnerships throughout the country.

2.a Focal educative actions: campaigns and mass media dissemination

The Tobacco-Free Community Program has two commemorative dates, the World No-Tobacco Day (May 31), and the National Day to Fight Smoking (August 29), both of them celebrated by the Ministry of Health /INCA throughout Brazil. The first one seeks to disseminate and promote tobacco-control actions in its different aspects in Brazil. For such purpose, the WHO selects a different theme each year, for all countries to disseminate tobacco control actions. The second one targets youngsters, and a theme, such as “Cigarette-Free Sports are More Radical” or “Cigarette-Free Art is the Real Show.”

Other actions involve dissemination of information through the media. For this purpose, the Program’s management network, whose work will be presented further ahead in this document, has become reference for this issue in Brazil. Thus, it has been possible to articulate with the media to disseminate actions and facts that add to tobacco control nationwide.

Another group of focused actions is to encourage and support events such as congresses, seminars, health fairs, and others with the potential to present updated information on the theme to the community. To this end, the Program developed a number of educational material, such as pamphlets, booklets and posters that may be handed out to the public, and other resources to impact the public in these events, such as the smoking doll, which allows people to see, through its transparent body, tar impregnation, and also measuring the level of carbon monoxide in the body of smokers.

The itinerant exhibition “Seeing Through Smoke” has been shown in different cities of Brazil. It displays very strikingly the different hazards posed by smoking. This exhibition includes posters, banners, videos and sculptures showing body organs damaged by smoking.

2.b Continuous educational intervention: workplaces, schools, health units

As mentioned before, the purpose of continuous actions carried out through community channels (Health Care Facilities, Schools, Workplaces) is to keep a constant flow of information on smoking, its risks for smokers, and the risks of environmental tobacco smoke for all exposed to it. In addition to this continuous dissemination of information, interventions are carried out in these microenvironments, so that opportunities and motivation for behavior changes in the groups that are part of these community channels are fostered.
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
cessation support among health professionals and looking for political and financial support for increasing the access for smoking cessation are among the actions for smoking cessation that National Tobacco control Program has been developing countrywide.

The objective of the **Smoking Cessation Program** is to enhance access for smokers to effective smoking cessation methods, thus meeting the increasing demand of smokers who seek some kind of support for this purpose. This program includes different actions:

- Dissemination of effective smoking-cessation methods (campaigns, toll-free help-line; internet);
- Training of health professionals to support smoking cessation: *Helping your patient quit smoking* Module (Minimal Contact – 4-hour training; Intensive or Formal Approach – 20-hour training);
- Introduction of smoking-cessation support at the Brazilian Public Health System (SUS);
- Implementation of outpatient units to treat smokers at the Public Health System (SUS) network;
- Mapping and disseminating the information where people can find support for quit smoking in the public health care system (campaigns, toll-free help-line; internet);

The Idea is to build a network of health care reference units where smokers who need more intensive support may be referred.

### 2.d Networking for integrating the Program management nationwide

Through a long sensitization process of decision-makers from the health area, from 1996 onwards the Tobacco Control Program has become a priority in the Ministry of Health agenda. Similarly, sensitizing state and municipal health managers has increased interest on the Program by different health-related government levels.

#### Building a network of decentralized management

Considering Brazil's continental dimension and the huge difficulties caused by regional differences, including social, economic and cultural aspects, the Program has developed strategies to decentralize actions following the logic of the Brazilian public health system, called **Unique Health System (Sistema Único de Saúde – SUS)**. The decisive step towards this objective was the strengthening of a geo-political base that could articulate a network of regional, state and municipal managers so that such actions could be spread equitably and rationally nationwide.

By organizing and articulating this national network for a regional management of the Program, tobacco-control actions are being decentralized.

The building of this decentralized management network started in 1996, and went through a number of steps:

- In 1995, the Brazilian National Cancer Institute – INCA, supported by the Ministry of Health, started to actively seek individuals from State Health Secretariats (SESs) for the management of the Program in the different States. At the same time, the National Health Fund and the State Health Secretariats signed a working agreement, being INCA the mediator of this agreement. The role of INCA was to provide technical support to State Health Secretariats in designing a Work Plan adjusted to the Global Tobacco Control Plan outlined by INCA itself. This working agreement allowed State Health Secretariats to organize their infrastructure and to keep on the program management decentralization process (campaigns, actions in health care units, workplaces and schools, treatment for smokers) in the regional level, reaching Municipal Health Secretariats. It is INCA's role to follow the progression of the actions defined by the Work Plan of each State, to assess their fulfillment and outcomes.
- Still in 1996, INCA started to develop pilot-projects to test methodology and generate implementation models for continuing educational actions in health care units, workplaces and schools, in order to promote changes in attitude regarding social acceptance of
smoking and encouraging smoking cessation in target-groups of opinion-maker groups, such as teachers, students, health professionals, employees of companies and organizations.

- Also in 1996 a process was started to train local Program management, through a human resources pilot training program within each of the 27 State Health Secretariat (SES). To this end training models and support educational material were develop for both, the Program management and its implementation in schools, health care units and workplaces.

Continuation of the agreement has allowed the expansion of the partnership network.
The organization of such network started with a human resources building capacity process for the management of the Program in States. Thus, within each State Health Secretariat (SES) there is a State Coordination office for the Program in charge of organizing and supporting local municipal actions. Coordination office at each State is also responsible for training human resources from municipal health secretaries of their State. Educational material for such training is sent by INCA to the States according to the number of municipalities involved and the different channels (schools, health care units, workplaces) where the Program is being implemented.

On their side, each municipal coordination office, with support of the State coordination office and INCA/Ministry of Health, are accountable for the development of focused and ongoing educational actions in schools, health care units and workplaces of the city.

Each state or municipal delegate is appointed by the Health Secretary, and may be from the Chronic-Degenerative Diseases Division, Family Health Program, Workers Health Program or other public-health related program. Their role include articulation of campaigns and other focused actions, encouraging, guiding and consulting health care units, companies/industries and schools in implementing the Program, encouraging city councilmen to establish municipal laws imposing measures to reduce exposure of the population to cancer risk factors, as well as assess and monitor Program implementation in the city.

Defining Responsibilities within the Program management network

A decentralized management within the Brazilian Public Health System (SUS) allows the establishment of information and implementation network on tobacco and other cancer risk factors, with competencies defined as follows:

**Federal Management – National Cancer Institute/ Ministry of Health**

- Support State Health Secretariats – SESs in structuring the Program coordination office statewide;
- Coordinate, articulate and facilitate tobacco and other cancer risk factors control actions nationwide, in partnership with state health secretariats;
- Design and reproduction of technical material to support and training methodologies to implement the Program, passing them on to state coordination offices;
- Develop or encourage the development of pilot projects to test action strategies and technical support material, passing them on to state coordination offices;
- Build capacity to qualify SES human resources for the Program local management, encouraging the necessary partnership for its implementation;
- Support the state coordination offices in decentralizing the Program management to cities and in implementing the different levels of the Program in the municipalities;
- Promote annual evaluating and planning meeting and continuing education courses for state coordination officials;
- Assess the use of funds from the working agreement to carry out the actions scheduled in the work plan designed for each state;

- Coordinate the tobacco epidemics surveillance system throughout the country;

- Monitor advancements and barriers to tobacco control in its legislative and economic aspects;

- Integrate and disseminate actions developed around the country by different media, such as the quarterly newsletter "Atualidade em Prevenção de Câncer" ("Update on Cancer Prevention"); internet, e-mail, and other mass media;

- Give technical support for National Surveillance Agency on actions for tobacco products control

- Mobilize forces that favor the establishment of a comprehensive tobacco control federal law, supporting and providing technical information to lawmakers;

- Support a Brazilian Congress on Smoking, to be held every two years;

- Support and provide technical information to individuals and organizations interested in tobacco control actions, both nationally and internationally;

- Keep and interface with national and international Governmental and Non-Governmental Organizations;

- Support and articulate partnerships with health-related Councils, Associations and Societies on a federal level;

- Carry out and encourage research on smoking and related issues, and disseminate their results;

- Publish and disseminate the Program results in different lay and mass media;

- Represent the Federal Government at the World Health Organization – WHO and other national and international organizations, in tobacco-related issues.

- Play the role of Executive Secretariat of the National Interministerial Committee for Tobacco Control, supporting the Brazilian government position in negotiating the International Tobacco Control Framework Convention,

- Articulating different segment of government for the implementation of wide actions for tobacco control such as economic actions, tobacco alternative diversification,

**State Management**

- Upon request from the Federal Management, officially appoint human resources to carry out the Program’s actions in the state;

- Define how the Program will be included in the SES organization chart;

- Provide the basic infrastructure for the Program development;

- Schedule annual actions, according to the work plan established in the working agreement, defining goals, costs and a detailed timetable, in order to get federal grants and political support for state actions;
• Articulate the implementation of the Tobacco-Free Environment in all SES offices and service facilities.

• Identify leaders: seek participation of the municipalities in the Program, considering the Public Health System (SUS) structure in each state;

• Replicate the Program management-training course for personnel from Municipal Health Secretariats.
  Note: If the state health network is structured in regions, decentralizing the program’s management should be according to the state’s organizational logic.

• Support municipal coordination offices in training personnel from regional health care units, workplaces and schools, or from other strategic programs within the health secretariat, such as teams of the Family Health Program;

• Control the distribution of the Program’s support material produced by the MS/INCA to the cities;

• Gather and consolidate evaluation data supplied by Municipal Health Secretariats, and send them to INCA, to feed the Surveillance and Monitoring System;

• Take part in evaluation and up-to-date meetings promoted by the MS/INCA every six months;

• Articulate and promote exchange of experiences among municipalities, by sponsoring annual meetings for municipal delegates.

**Municipal Management**

• Identify an individual (or individuals) to manage the program within the city, connecting him/them to the Program’s State Coordination Office.

• Have such individual(s) take the Program management-training course offered by the Program’s State coordination office.

• Include tobacco control actions in the strategic planning of the Municipal Health Secretariat - SMS, and placing the Program within the SMS organizational chart.

• Draw a work plan to implement the Program in the city. Design the Program’s implementation project for the city, and the annual actions to be carried out, with their detailed timetables, in order to get financial resources and political support from the Program’s state management;

• Provide the basic infra-structure for the Program to be developed on a municipal level;

• Articulate the implementation of the Tobacco-Free Environment Program in all SMS offices and service facilities;

• Carry out the annual campaigns organized by the Program with support from the state coordination office;
• Register all those interested in joining the Program, using a proper form;

• Sensitize and involve managers from the three institutional channels targeted by the Program (workplaces, schools, health care facilities) to implement the program;
- Train and support teams from health care units, workplaces and schools to implement the program in their facilities;

- Provide and/or support training of health professionals who will be part of the team that will duplicate the Program’s actions;

- Pass on the support material supplied by MS/INCA and State Secretariats to the institutional channels (workplaces, schools, health care units) and monitor their distribution;

- Gather data of the campaign activities in the city (events held, target-audience, number of participants, media coverage), and passing them to the state coordination office.

- Collect data on the Program implementation in health care units, workplace and schools to assess the implementation process with the tested tools and methodology supplied by the MS/INCA, consolidating them in a report to be sent to the SES.

- Articulate and promote implementation of municipal legislation for tobacco control, in accordance with federal legislation.

**Defining criteria for evaluation of the decentralization process**

For the program to meet the expectations of awareness and motivation towards positive behavior changes, it is important that the municipal level to be quite well structured, because in this level one has higher contact with the population. The municipal team influences the community directly, and should be well trained and supported by the other levels so that changes proposed by the Global Plan for Tobacco and Other Risk Factors Control in Brazil can be accomplished. To better systematize the Program’s implementation stages in the state or city, implementation progression criteria have been established over four levels, for the process to be more timely and effective. It is a requirement for moving to the next level that the previous one be completed. Their structure is as follows:

**Level 1**

It is considered on Level 1 each municipality that has been qualified for the program management, and where a basic political, physical and administrative structure is implemented, allowing coordination and development of focused actions on a local level (at least one annual campaign).

**Level 2**

At this level, the city should already have a political and administrative structure that allows development of focused actions (level 1) and systematic and ongoing actions in health care units, workplaces and schools.

**Level 3**

For this level, the cities should have implemented a political and administrative structure that allows development of level 1 focused actions, the systematic and ongoing actions at health care units, schools and workplaces (level 2) and has organized a basic Evaluation System for the Program.

**Level 4**

In this level, the Program is implemented in accordance with levels 1,2 and 3, and goes on to develop systematic actions in legislative and economic areas, including encouragement, support and lobby for approving specific legislation, and the implementation or accreditation of outpatient units or centers for a formal treatment of tobacco addiction within the local public health system.
2.e Building partnerships with the organized civil society

Going beyond the government level, the Program has sought to establish partnerships with non-governmental organizations, scientific societies and professionals associations. These partnerships have been instrumental to enhance the reach of educational actions, and for strengthening a social control that can support the Program against actions from the tobacco industry.

Examples of such partnerships are INCA’s support to the Brazilian Congresses on Smoking, that are held since 1994 jointly with scientific societies and non-governmental associations, such as the Brazilian Tobacco-Control Committee, the Pneumology Society, among others.

Another example of partnership was the holding of a Consensus Meeting on the Approach and Treatment of Smokers in 2000, with participation of different health-related scientific societies and associations, and Professional Boards

More recently INCA kick out a process to enhance the participation of organized civil society on tobacco control efforts and to support the Framework Convention negotiation process. For this purpose in September 2002 INCA held the First Social Mobilization Forum – For a smoke free world – that gathered representatives of 50 different NGOs. This process is going on with the partnership of the NGO Rede de Desenvolvimento Humano (REDEH) that is multiplying this Forum all over the country.

2.f Multisectorial action for tobacco control: the National Tobacco Control Comission

As mentioned before, by acknowledging the need for transnational strategies to refrain tobacco use worldwide, in the World Health Assembly all 191 WHO-member countries were encouraged to implement joint actions in accordance with an international agreement, the Tobacco Control Framework Convention, which is being discussed since 1999. To meet the demands generated from such discussion, the Brazilian Government created, by Decree 3136 of August 13, 1999, the National Committee for Tobacco Control. This represented a new stage for the Brazilian Tobacco Control Program, going beyond the scope of the Ministry of Health (MS) and becoming a Program of the Brazilian State.

It is up to the National Tobacco Control Commission to assess national data and information on the issue to advise the President of Brazil in defining the country’s position when negotiating WHO’s 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, considering the different aspects involved in tobacco control. The Minister of Health is the Chairman of this Commission, and the Executive Secretariat is an INCA expert.
Considering that the tobacco problem extrapolates 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 subsidies, 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.

<table>
<thead>
<tr>
<th>Intended Goal</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualify <strong>4000</strong> Brazilian cities to implement the Tobacco and Other Cancer Risk Factors Control Program</td>
<td><strong>3525 cities were qualified</strong> for the Program</td>
</tr>
</tbody>
</table>

**Focused Educational Actions – Level 1 – Campaigns**

<table>
<thead>
<tr>
<th>Intended Goal</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement level 1 of the Tobacco and Other Cancer Risk Factors Control Program in <strong>40% of the cities</strong> qualified for the Program</td>
<td><strong>63% of the qualified cities (2208) have developed Program activities of level 1</strong> (celebration of at least one campaign on smoking), among the 3073 qualified cities from states that sent us information on the campaigns.</td>
</tr>
</tbody>
</table>
## Continuing Educational Actions in Health Care Units - Health and Coherence Program

<table>
<thead>
<tr>
<th>Intended Goal</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach a total of 150 health care units with the Program implemented or in the process of implementation</td>
<td>2071 health care units with the Program implemented or in the process of implementation</td>
</tr>
</tbody>
</table>

## Continuing Educational Actions in Schools – Health Knowledge Program

<table>
<thead>
<tr>
<th>Intended Goal</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach a total of 3,000 schools with the Program implemented or in the process of implementation</td>
<td>5437 schools with the Program implemented or in the process of implementation</td>
</tr>
</tbody>
</table>

## Continuing Educational Actions in Workplaces - Prevention Always Program

<table>
<thead>
<tr>
<th>Intended Goal</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach a total of 150 workplaces with the Program implemented or in the process of implementation</td>
<td>814 workplaces with the Program in the process of implementation</td>
</tr>
</tbody>
</table>

## Continuing Educational Actions – Smoking Cessation Program – Helping your patient to quit smoking Module (Intensive Approach of the Smoker)

<table>
<thead>
<tr>
<th>Intended Goal to 2001</th>
<th>Actual Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a total of 5 Outpatient units to treat smokers in Public health care facilities</td>
<td>A total de 50 Health Care units were qualified in 2001 33 are already attending patients</td>
</tr>
</tbody>
</table>

## Legislative Actions

Tobacco control legislative actions were highly favored over the past three years.

### 1999

- One of the major advancements was the regulation, control and inspection of cigarettes, cigarillos, cigars and any other tobacco-smoking product by the National Agency for Sanitary Surveillance (ANVISA), which was created by Federal Law 9782, in January 26, 1999. By this regulation, the Government could trigger other measures for tobacco products control and inspection.

  - Next, Interim Regulation 1814 changed article 3, § 2nd of Federal Law 9.294/96, complemented by the Ministry of Health Ordinance 695, of June 2, 1999, has determined the warnings printed in cigarette packs and advertisement to be replace for more direct and effective sentences on the hazards smoking causes. At this time, two messages that had not been printed because of resistance from the tobacco industry were introduced: “Nicotine is a drug and causes addiction” and “Smoking causes sexual impotency”.

  - In August 1999, Decree 3136 created the National Committee for Tobacco Control, in charge of advising the Brazilian government for the international negotiations to draw the Framework Convention for Tobacco Control. This National Committee includes delegates from the Ministries of Health, Foreign Relations, Agriculture, Economy, Justice, Education, Development, Industry and International Trade, and Agrarian Development.
In the year 2000, Federal Law 10167, of December 28, 2000, was a major advancement for tobacco control, as it regulated that:

- Tobacco-products advertisement are restricted 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.
- Forbids the use of tobacco-smoking products in aircrafts and other collective transportation vehicles.
- Raises the amount of taxes in case of non-compliance of the Law.
- Determines competent organs to check compliance of the Law.

In February 2001, Ministry of Labor Ordinance 6 forbids those less than 18 years of age to work in tobacco harvest, beneficiation or industrialization.

Next, ANVISA Resolution 46 comes in effect, establishing maximum amounts of tar, nicotine and carbon monoxide in the primary smoke chain for cigarettes sold in Brazil. This Resolution also forbids the use of terms such as light, ultra light, or others that may convey to smokers a false idea of safety for the use of tobacco products. It is to be mentioned Brazil was the first country in the world to forbid the use of such terms.

Brazilian Central Bank Resolution 2833, of April 25, 2001, forbids concession of public financing for tobacco crops, within the scope of PRONAF, whether in partnership or integration with tobacco industry.

Interim Regulation 2134-30, of May 24, 2001 Determines that advertisement material and packs of tobacco smoking products, except when for export, should present written warnings along with pictures that illustrate their meaning. ANVISA Resolution 104 complemented interim Regulation 2134-30, by defining the warning sentences, their graphic features and the pictures that should be printed. It also imposes the printing of the Quit-Smoking Help Line in the packs and advertisement material of tobacco smoking products, and forbids the use of any label or device that prevent or makes difficult to read the warnings.

Finally, ANVISA Resolution 105 regulates annual registry of smoking products and require tobacco companies to present periodically reports on products they market, along with information on sales, and physical and chemical features of such products. This Resolution also imposes an R$100,000.00 a year tax for each marketed brand. This money is for the creation of a databank (SISTAB) to storage information supplied by the industry, the building of a lab at INCA for the necessary lab analyses to check compliance to legislation, and sponsoring of lab researches and clinical trials on the biological effects of nicotine addiction.

First, the Interministerial ordinance 1498, of August 22, recommends health and teaching institutions to implement tobacco smoke-free environment, and awards merit certificates to those that stand out in tobacco-control campaigns.

On August 29, in celebration of the de National Day to Fight Smoking, Ministry of Health Ordinance 1575 was signed. It 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.

- In August 2002, Interim Regulation 66 raised the amount of the fines for non-compliance with control stamps regulations established by the IRS. They relate to non-use of the stamps, the use of counterfeit stamps, or stamps different than those that should be used for a specific type of product. It can, thus, be an important instrument to prevent such practice.
- Also in August 2002, Internal Revenue Service Regulating Order 194 created the Program to Generate Special Fiscal Information Return Form for cigarette taxation. This Program allows the IRS a direct control of cigarette manufacturing companies in terms of registration, distribution, import and export of cigarettes, and payment of related taxes. The main purpose of this measure is to identify tax evasion.
- ANVISA Resolution 304, of 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. It also 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. This measure has an important role in preventing people to start smoking, as if such is done in products for children, it may induce them to a hazardous behavior, as they may consider smoking something natural and unpretentious, favoring them towards this practice.
- Finally, Decree 4488, of November 26, 2002, changes the Industrial Products Tax (IPI) bracket for cigarettes. This raise is expected to increase final price by 15%, especially for Fiscal Class I products, where fall about 60% of cigarettes smoked in Brazil.

Current Federal Legislation according to the subject they regulate

<table>
<thead>
<tr>
<th>PROTECTION AGAINST ENVIRONMENTAL TOBACCO SMOKE EXPOSURE RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interministerial ordinance 3257 (September 22, 1988)</td>
</tr>
<tr>
<td>Recommends smoking restraining measures in workplaces, and determines the designation of smoking areas, isolated and with proper ventilation.</td>
</tr>
<tr>
<td>Interministerial ordinance 1498 (August 22, 2002)</td>
</tr>
<tr>
<td>Recommends health and teaching institution to implement tobacco-free environment programs.</td>
</tr>
<tr>
<td>Law 9294 (July 15, 1996)</td>
</tr>
<tr>
<td>Forbids the use of cigarettes, cigarillos, cigars, pipes or any other tobacco product in collective area, whether public or private, such as government offices, hospitals, classrooms, libraries, workplaces, theaters and movies, except in the proper smoking designated areas.</td>
</tr>
<tr>
<td>Decree 2018 (October 1st, 1996)</td>
</tr>
<tr>
<td>Regulates Law 9294/96 by defining the concept of collective area and smoking designated area.</td>
</tr>
<tr>
<td>Ministry of Health Ordinance 2818 (May 28, 1998)</td>
</tr>
<tr>
<td>Forbids smoking in any facility of the Ministry of Health, whether in the Capital City, states and cities.</td>
</tr>
<tr>
<td>Law 10167 (December 27, 2000)</td>
</tr>
<tr>
<td>Forbids the use of smoking tobacco products in aircrafts and any other collective transportation.</td>
</tr>
</tbody>
</table>
### 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

<p>| Constitution of Brazil (October 5, 1988) | Establishes that tobacco advertisement should comply with legal restrictions and should warn on the hazards of its use. |
| Inteministerial 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. |</p>
<table>
<thead>
<tr>
<th>Legislation/Regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law 10167 (December 27, 2000)</td>
<td>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.</td>
</tr>
<tr>
<td>DISSEMINATION OF INFORMATION TO THE PUBLIC</td>
<td></td>
</tr>
<tr>
<td>Law 7488 (June 11, 1986)</td>
<td>Establishes August 29 the National Day Against Smoking, which should be celebrated throughout the country.</td>
</tr>
<tr>
<td>Interministerial ordinance 3257 (September 22, 1988)</td>
<td>Awards merit certificates to companies that stand out in tobacco-control campaigns.</td>
</tr>
<tr>
<td>Interministerial ordinance 1498 (August 22, 2002)</td>
<td>Awards merit certificates to health and teaching institutions that stand out in tobacco-control campaigns.</td>
</tr>
<tr>
<td>National Agency for Sanitary Surveillance Resolution 46 (March 28, 2001)</td>
<td>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.”</td>
</tr>
<tr>
<td>Interim Regulation 2134-30 (May 24, 2001)</td>
<td>Determines advertisement material and packs of tobacco products, except when for export, should present written warnings along with pictures that illustrate their meaning.</td>
</tr>
<tr>
<td>National Agency for Sanitary Surveillance Resolution 104 (May 31, 2001)</td>
<td>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.</td>
</tr>
<tr>
<td>TOBACCO PRODUCTS CONTROL AND INSPECTION</td>
<td></td>
</tr>
<tr>
<td>Decree 2.637 (June 25, 1998)</td>
<td>Determines that cigarette sales in Brazil, including their exposure for sale, should be done in packs, boxes or other containers, with 20 units.</td>
</tr>
<tr>
<td>Law 9782 (January 26, 1999)</td>
<td>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.</td>
</tr>
<tr>
<td>Law 10167 (December 27, 2000)</td>
<td>Defines the fine to be applied for non-compliance of the Law. Determines the competent organs to enforce compliance of the Law.</td>
</tr>
<tr>
<td>National Agency for Sanitary Surveillance Resolution 46 (March 28, 2001)</td>
<td>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 and 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.</td>
</tr>
<tr>
<td>National Agency for Sanitary Surveillance Resolution 105 (May 31, 2001)</td>
<td>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.</td>
</tr>
<tr>
<td>Internal Revenue Service Regulating Order 194 (August 29, 2002)</td>
<td>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.</td>
</tr>
<tr>
<td>FRAMEWORK CONVENTION FOR TOBACCO-CONTROL</td>
<td>[\text{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.</td>
</tr>
<tr>
<td>TOBACCO CROPS FINANCING</td>
<td>Brazilian Central Bank Resolution 2833 (April 25 2001) Forbids concession of public financing for tobacco crops, within the scope of PRONAF(^<em>), whether in partnership or integration with tobacco industry. (^</em>)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.</td>
</tr>
<tr>
<td>TAXATION ON TOBACCO PRODUCTS</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 not 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 quit 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 were30.6 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.


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

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)

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

* 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.
FEDERAL COORDINATION

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ABIFUMO. 2001 Illegal Cigarette Trade. National and International Aspects. Presentation made by Milton de Carvalho Cabral at the I International Seminar on Frauds in the Cigarette Business, promoted by the Brazilian IRS from August 14 to 16, 2001, Brasília, DF.

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Data from CONPREV/INCa/MS


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Ministério da Saúde - Compilação da legislação federal relacionada ao controle do tabagismo no Brasil –CONPREV/INCa/MS.


Appendices

Appendix
NEW WARNINGS
### CIGARETTE PER CAPITA CONSUMPTION
Brazil 1980 – 2000

#### Cigarette Consumption - Population over 15 years of age

<table>
<thead>
<tr>
<th>Year</th>
<th>Population over 15 years of age</th>
<th>Total official consumption (billions of units)</th>
<th>Informal consumption* (billions of units)</th>
<th>Per capita consumption over 15 years of age (official)</th>
<th>Per capita consumption acima dos 15 anos (informal)</th>
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<tbody>
<tr>
<td>1980</td>
<td>73,655,455</td>
<td>142,7</td>
<td>-</td>
<td>1937,40</td>
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<td>1998</td>
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</table>

* Consumption figures from production-export data from 1993 to 1999: Source for population over 15 years of age: IBGE

**Source for informal market figures 1992 to 2000: IRS

Note: For the years 1989 to 1992, consumption figures are different then the production-export data: 1989-165.4 billion units 1990-163.4 billion units 1991-155.8 billion units 1992-128.6 billion units