The International Tobacco Control Policy Evaluation Project (ITC Project): Evaluating the Impact of the WHO Framework Convention on Tobacco Control

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Ontario Institute for Cancer Research

June 1, 2011
“Tobacco is the most effective agent of death ever developed and deployed on a worldwide scale.”

– John Seffrin, Past President, American Cancer Society and the International Union Against Cancer
Some Statistics on Global Tobacco Use

- 1.1–1.3 billion people smoke
  - 82% live in low-and middle-income countries
  - 500 million will die of tobacco-related causes
- 20th Century: 100 million tobacco-related deaths
- 21st Century: 1 billion tobacco-related deaths
- 5 million will die this year
- By 2025: 8 million will die/year
- WHO: Tobacco use is the leading preventable cause of death and disability in the world
Facing the Challenge

Estimated cumulative tobacco deaths 1950-2050

How can we most effectively flatten this curve?

Population-level interventions such as policies

What can we do?

- Primary prevention at the population level

Population Impact = Reach x Effectiveness

- What has the greatest potential impact in a country?

National-Level Policies
Framework Convention on Tobacco Control (FCTC)

- First-ever health treaty
- Unanimously adopted in 2003
- 173 nations have become Parties to the FCTC
  (The U.S. is one of the few nations that has NOT ratified the FCTC)
- Conferences of the Parties:
  COP-1: Feb 2006 in Geneva
  COP-2: July 2007 in Bangkok
  COP-3: Nov 2008 in S. Africa
  COP-4: Nov 2010 in Uruguay
Policies of the FCTC

Demand-side strategies

- More prominent warning labels
- Elimination of “light/mild” and other deceptions
- Bans/restrictions on marketing (advertising, sponsorship)
- Protection from exposure to tobacco smoke
- Higher taxes
- Support for cessation
- Education, communication, public awareness

Supply-side strategies

- Reduce illicit trade
- Reduce youth access
Potential of Policies to Flatten the Curve

Estimated cumulative tobacco deaths 1950-2050

Impact of policies depends on two main factors:
1. Intervention date
2. Effect size

The FCTC: World’s First Health Treaty

- Are these policies working?
  - Do pictorial warnings work better than text warnings?
  - Are smoke-free laws being obeyed? What factors explain why these laws may have stronger impact in one country than in others?
  - Does policy impact vary across different people (do higher taxes have stronger impact on youth?)

- WHY and HOW do policies have their impact?

To answer these questions, we need to evaluate FCTC policies across different countries
Increasing internal validity for evaluation of national-level policies

- International: control/comparison countries
- Longitudinal cohort: track *individuals* over time
- Include outcome measures for multiple policies (not just the policy that is changing tomorrow)
- Include measures of key *intermediate* outcomes of a policy (what a policy should be changing within a person BEFORE the person changes his/her behaviour): “leading indicators” of policy impact
- Include psychosocial *mediators* and *moderators* that will help us understand how and why the policy had its impact (if indeed it had an impact)
Conceptual Model of the ITC Project

Policy

Moderators

Country
Sociodemographics (e.g., age, sex, SES, ethnic background)

Past Behavior
(e.g., smoking history, CPD, quit attempts)

Personality
(e.g., time perspective)

Psychological State
(e.g., stress)

Potential Exposure to Policy
(e.g., employment status)

Policy-Specific Variables

• Label salience
• Perceived cost
• Ad/promo awareness
• Awareness of alternative products
• Proximal behaviors (forgoing a cigarette because of labels)

Psychosocial Mediators

• Outcome expectancies
• Beliefs & Attitudes
• Perceived Risk
• Perceived Severity
• Self-Efficacy/Perc. Beh Control
• Normalization beliefs
• Quit intentions

Policy-Relevant Outcomes

• Quit Attempts
• Successful Quitting
• Consumption changes
• Brand switching
• Tax/price avoidance
• Attitude/belief changes (e.g., justifications)

Economic Impact

Public Health Impact

SES as possible moderators of tobacco use and of policy impact: which policies can help close the equity gap?
Mediational Model(s) of Policy Effects

Different policies operate differently, but can be described by the same general model.
The International Tobacco Control Policy Evaluation Project (the ITC Project)

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The ITC Survey Research Team: Principal Investigators, Co-Investigators

**Canada:** Geoffrey Fong, Mary Thompson, David Hammond, Changbao Wu, Mark Zanna, Christian Boudreau, Steve Brown, Sharon Campbell, Paul McDonald, Emmanuel Guindon

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**Thailand:** Buppha Sirirassamee, Warangkana Polprasert, Philip Guest, Steve Hamann, Prakit Vateesatogkit, Aree Jampaklay, Aree Prohmmo, Chanya Sethaput

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**Uruguay:** Marcelo Boardo, Eduardo Bianco

**Brazil:** Cristina Perez, Valeska Figuerido, Tania Cavalcante, André Szklo, Paula Johns, Eliane Volchan

**Bangladesh:** Nigar Nargis, SM Ashiquuzzaman, Ummul Ruthbah, Hussain Ghulum, Iftekharul Huq, Abu S.M. Abdullah

**Bhutan:** Sonam Phuntsho, Ugyen Norbu

**Mauritius:** Premduth Burhoo, Bimla Moussa, Deowan Mohee, Véronique Le Clézio

**India:** Prakash Gupta, Mangesh Pednekar
## Content of the ITC Surveys

### Content Domain

<table>
<thead>
<tr>
<th>Content Domain</th>
<th>Number of Qs</th>
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<tbody>
<tr>
<td>Smoking History and Frequency†</td>
<td>7†</td>
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<td>→ Age started, 100 cigs,</td>
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<tr>
<td>Smoking Behaviour (current) and Dependence†</td>
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<tr>
<td>→ Cigs/day, time to first, perceived addiction†</td>
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<td>Quitting: ever tried, most recent attempt</td>
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<td>→ Duration of last attempt, planning vs. spontaneous†</td>
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<td>Quitting: Beliefs, efficacy, intentions, motivation, reasons for†</td>
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<tr>
<td>→ Perceived role of policies†</td>
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<tr>
<td>Knowledge: health effects, constituents†</td>
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<tr>
<td>→ Health conditions (e.g., lung cancer, stroke, Impotence), role of nicotine†</td>
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<td>Health Warnings†</td>
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<tr>
<td>→ Noticing, thinking about health risks, motivate quitting, emotional reaction†</td>
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<td>Anti-smoking campaigns†</td>
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<td>→ Noticing in various channels, perceived impact†</td>
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<td>Cigarette brand†</td>
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<td>→ Choice, history, perceptions, last purchase: size, price paid†</td>
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<td>Light/Mild and other supposedly reduced harm products†</td>
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<td>→ Perceptions of brand, relative risk†</td>
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<td>Cessation assistance†</td>
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<td>→ Physician mention, type of assistance sought, effectiveness†</td>
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<tr>
<td>ETS and Smoke-Free policies†</td>
<td>53†</td>
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<tr>
<td>→ Personal policies (home, car), restaurants, bars, workplace (prevalence/support)†</td>
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<td>Psychosocial beliefs about smoking (mediators) and moderators†</td>
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<td>Advertising/Promotion†</td>
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<tr>
<td>Tobacco industry beliefs and government role in TC beliefs‡</td>
<td>8‡</td>
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<tr>
<td>→ Trust in industry, need for regulation, should govt do more?‡</td>
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<td>Individual difference variables‡</td>
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<tr>
<td>→ Depression, time perspective, rebelliousness‡</td>
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<td>Demographics‡</td>
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<tr>
<td>→ Age, marital status (also whether partner smokes), income, education‡</td>
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**TOTAL NUMBER OF QUESTIONS (MAXIMUM)** 272†

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**Unique ITC Content: 170-200 Qs focusing on policy impact**

**Surveillance content**

**Mixed Surveillance and policy content**

**Surveillance content**

Throughout the policy sections there are measures relevant to monitoring.
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1 *Smokers* = cigarettes in all countries, but also includes bidis in Bangladesh and India.
2 Other: NS = non-smokers; U = Tobacco users (all forms) in Bhutan and India; SL= smokeless users in Bangladesh; NU= Non-users (all forms) in Bhutan and India
* The ITC Four Country Survey began as a cohort survey of N= 2,000 in each country. For Wave 7 (Fall 2008): N= 1,760; For Waves 8-12: N=1,500.
§ The ITC Malaysia Survey includes non-smokers in Waves 1–3.
Δ The ITC Korea Survey increased its sample size to 1,800 for Wave 2 (Fall 2008) and Wave 3 (Summer 2010).
The ITC Uruguay Survey increased its sample size to 1,500 for Wave 2 (2008).
† Tobacco prevalence in Bhutan is unknown; we conducted household surveys (1600 households, N=5,600) and estimate that 5-15% will be tobacco users.
NEARLY TWO THIRDS OF THE WORLD’S SMOKERS LIVE IN 10 COUNTRIES

ITC Surveys are being conducted in:
- Over 50% of the world’s population
- Over 60% of the world’s smokers
- Over 70% of the world’s tobacco users

Source: The number of smokers per country was estimated using adjusted prevalence estimates (see Technical Note II and Appendix III). A limitation of this approach is that adjusted estimates used to estimate the number of smokers are sometimes derived from limited country data, and for some countries large adjustments are needed. In these cases the adjusted estimates can be different from actual surveys reported by countries. Brazil prevalence data were obtained from VIGITEL 2006.
ITC Evaluation of FCTC Policies (Partial List)

**Warning labels**
- UK (2003): Text
- India (2009): Graphic
- UK (2009): Graphic
- Thailand (2006): Graphic
- Australia (2006): Graphic
- Canada (2010): Graphic, Round 2
- China (2008): Text
- Mexico (2008): Graphic
- Uruguay (2006,09): Graphic
- Brazil (2008/09): Graphic, Round 3
- Malaysia (2008): Graphic
- Mauritius (2009): Graphic

**Advertising/Promotion**
- UK (2003): Comprehensive
- Canada (2003): Last part of Comp.
- Thailand (2006): POS bans
- Mexico (2008): Comprehensive
- Canada (2008+): Re-emergence of “descriptive” ads & possible new ban
- China (2011): Comprehensive
- Many other countries: Partial

**Smoke-free**
- Ireland (2004)
- Mexico (2008+)
- Scotland (2005)
- Brazil (2008+)
- England (2007)
- Bangladesh (2009+)
- Uruguay (2006)
- Bhutan (2009+)
- France (2007/08)
- India (partial)
- Germany (2008+)
- Mauritius (2009)
  - China (2008/09 + Olympics)
  - Netherlands (Part 2–2008/09)

**Product policies**
- UK (EU): 10-1-10 regulation
- US/Canada: Reduced ignition propensity
- All countries: product; product x behavior

**Taxation**
- All countries

**Light/mild bans**
- UK (2003)
- Australia (2005)
- Canada (2006)
- Brazil + others (2009+)

**Illicit trade**
- China (2008): prevalence
- Additional in Canada/U.S.: close to reserves
- Bhutan (2009+): total ban on sales in country
“Tobacco use is unlike other threats to global health. Infectious diseases do not employ multinational public relations firms. There are no front groups to promote the spread of cholera. Mosquitoes have no lobbyists.”

ITC China Project Supplement in *Tobacco Control*

Identifying the challenges to tobacco control in China

Special Tobacco Control supplement

Findings from the International Tobacco Control (ITC) China Project

Guest Editor: Simon Chapman
1. Released October 1, 2010
2. 11 articles
3. Examples:
   - Gibson et al.: Evaluation of the UK National Health Service (NHS) Stop Smoking Services
   - Reid et al.: SES disparities in quit intentions, quit attempts, and smoking abstinence among smokers in US, UK, Canada, Australia
   - Wilson et al.: Increased recognition of NZ quitline following introduction on pictorial labels, equalizing pre-intro SES differences in noticing
IARC Cancer Prevention Handbook:
Methods for Evaluating Tobacco Control Policies
(February 2009)

• Best practices in the evaluation of tobacco control policies
• Preparation of Handbook led by ITC Project investigators
• Conceptual Model of the ITC Project used to frame the evaluation methods of the Handbook
ITC National Reports
ITC National Reports: France

Promoting Evidence-Based Strategies to Fight the Global Tobacco Epidemic

« International Tobacco Control », projet d’évaluation des politiques publiques de lutte antitabac
Présentation et principaux résultats
FÉVRIER 2009
“Just one year ago the no smoking decree came into force in pubs and restaurants. Smokers and non-smokers, each of us can be delighted about this major advance. The ITC Surveys already conducted about the impact of this policy indeed show that the measure is well-respected by the hospitality industry, and also by their customers”

Roselyne BACHELOT-NARQUIN
Minister of Health and Sports
7 January 2009
Preface from the Prime Minister, Sheikh Hasina

I am happy to learn that the ITC Bangladesh Project is going to launch its research findings on the use of tobacco and its pernicious effects on the people’s health and the society.

Bangladesh was the first to sign the WHO Framework Convention on Tobacco Control and among the first 40 countries to become parties to the Convention.

The findings of the research project manifest the enduring threat of tobacco use to the health and well-being of our people, and to the economic and social development of our country.

I hope that this report will provide valuable details of the challenges of tobacco control in Bangladesh from a multidisciplinary perspective.

I congratulate the multinational team of researchers, including the investigators from the Department of Economics at the University of Dhaka and their colleagues from the University of Waterloo in Canada, who have worked together on this very timely research initiative.

Jai Bangla, Jai Bangladesh!
May Bangladesh Live Forever.

Sheikh Hasina
Bhutan’s Minister of Health, Zangley Dukpa, at the release of the ITC Bhutan Report

<table>
<thead>
<tr>
<th></th>
<th>Frequency (Raw)</th>
<th>Current Tobacco Users (weighted %)</th>
<th>Ex-tobacco Users (weighted %)</th>
<th>Non-users of tobacco (weighted %)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Sample</strong></td>
<td>1806</td>
<td>11.1</td>
<td>4.9</td>
<td>83.9</td>
</tr>
<tr>
<td><strong>Districts (1591 households)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bumthang (390 H/H)</td>
<td>230</td>
<td>5.7</td>
<td>6.6</td>
<td>87.7</td>
</tr>
<tr>
<td>Chuksa (469 H/H)</td>
<td>538</td>
<td>15.6</td>
<td>2.5</td>
<td>81.7</td>
</tr>
<tr>
<td>Thimphu (476 H/H)</td>
<td>610</td>
<td>12.5</td>
<td>5.6</td>
<td>81.8</td>
</tr>
<tr>
<td>Trashigang (386 H/H)</td>
<td>420</td>
<td>2.4</td>
<td>6.9</td>
<td>90.7</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1036</td>
<td>4.7</td>
<td>2.9</td>
<td>92.4</td>
</tr>
<tr>
<td>Male</td>
<td>770</td>
<td>16.1</td>
<td>6.5</td>
<td>77.4</td>
</tr>
</tbody>
</table>
ITC Policy Reports
The ITC Project released a report on pictorial warnings for World No Tobacco Day (May 31, 2009): 12 page report on ITC Project findings in the domain of warning labels (in English and Chinese)
FCTC Article 14
Tobacco Dependence and Cessation

Evidence from the ITC Project

November 2010

The ITC Project: Global Surveillance of Quitting Activity and Use of Cessation Support

Guidelines for Article 14 recommend a broad range of cessation interventions including population-based approaches that have wide reach (mass communication, brief advice, and quitlines) and, where resources permit, more intensive individual approaches (specialized treatment services). The ITC Project monitors changes in tobacco control awareness and use of a wide range of cessation and treatment interventions in countries implementing new policies and programs. In accordance with Article 14, ITC surveys of smokers in 25 countries, ranging from medium- to high-income, provide evidence of high rates of quit attempts, but considerable variability around the world in the level of quitting activity and the use of various forms of cessation support. These differences reflect, in part, the history of tobacco control efforts in a country, the capacity of a country to provide cessation services or the ability of its smokers to access and afford different quit methods, and tobacco control policy priorities.

Quit Attempts

ITC surveys in 25 countries show that the majority of smokers around the world have attempted to quit smoking, at least once. Rates of ever having tried to quit range from around 66% of smokers in New Zealand, Uruguay, Mexico, and China to over 80% in most of the other ITC countries (see figure 1). The prevalence of current quit attempts varied from less than 30% of smokers in China to almost 80% in Thailand and Korea.

Advice to Quit from Health Professionals

The most viable strategies for Article 14 recognize the efficacy of health professionals providing brief advice to all and recommend that “practices are building resources and infrastructure as much as they can, and ensure that tobacco users of learn receive brief advice before other mechanisms for providing tobacco dependence treatment are put into place. There is a striking variation across ITC countries in the rate of providing health professionals in the first year and whether health professionals advised smokers to quit during this visit (see figure 2). Physician visits were most common among smokers in developed countries, whereas between 50 and 70% of smokers visited a physician or health professional in the last year. In contrast, less than 50% of smokers in Mexico and Malaysia visited a health professional in the last year.

The percentage of smokers who received advice to quit when they visited a doctor varied markedly in countries such as Thailand, Malaysia, and the US. More than two-thirds of smokers who visited a health professional reported getting advice to quit. In contrast, the Netherlands, less than 20% of smokers who visited a health professional reported getting advice to quit. Considering all smokers, there were only one country where more than half of the smokers in the population received advice to quit from a health professional (the US at 55%), Canada and Australia were other countries were relatively high (40% and 39%). In contrast, only 8% of smokers in the Netherlands received advice from a health professional to quit with Mexico and Malaysia only slightly higher at 6%.

These findings suggest the need to improve other cessation support strategies in countries where most smokers do not visit health professionals regularly and where the capacity of the health care system to play a role in promoting cessation is limited. Also, the important role that health professionals can play in reaching smokers must be more widely recognized, particularly in countries where the majority of smokers have access to, but are not currently receiving this intervention.

## Taxation of Tobacco Products in Bangladesh

Findings from the 2009 ITC Bangladesh Survey

Nigar Nargis and Ummel Hasanath Ruthbah
University of Dhaka, Bangladesh

Geoffrey T. Fong
University of Waterloo and
Ontario Institute for Cancer Research, Canada

### Table 3: Projected effect of tax and price increase on cigarette and bidi consumption in Bangladesh

<table>
<thead>
<tr>
<th>CIGARRETES</th>
<th>Increase in SD over 2009</th>
<th>SD (%)</th>
<th>Increase in price (%)</th>
<th>Decrease in number of smokers</th>
<th>Decrease in total consumption (Million packs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>49.0</td>
<td>9.5</td>
<td>16.6</td>
<td>856,096</td>
<td>460</td>
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<tr>
<td>50</td>
<td>74.8</td>
<td>10.1</td>
<td>20.7</td>
<td>1,712,091</td>
<td>932</td>
</tr>
<tr>
<td>100</td>
<td>75.4</td>
<td>10.7</td>
<td>21.7</td>
<td>2,166,287</td>
<td>1,299</td>
</tr>
<tr>
<td>200</td>
<td>149.5</td>
<td>26.1</td>
<td>44.5</td>
<td>5,424,982</td>
<td>1,885</td>
</tr>
<tr>
<td>300</td>
<td>274.4</td>
<td>40.4</td>
<td>66.4</td>
<td>4,304,978</td>
<td>2,391</td>
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<tr>
<td>400</td>
<td>292.4</td>
<td>43.2</td>
<td>76.4</td>
<td>3,625,976</td>
<td>2,797</td>
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<tr>
<td>500</td>
<td>299.4</td>
<td>43.7</td>
<td>78.4</td>
<td>3,592,970</td>
<td>2,803</td>
</tr>
<tr>
<td>600</td>
<td>299.4</td>
<td>43.7</td>
<td>78.4</td>
<td>3,592,970</td>
<td>2,803</td>
</tr>
<tr>
<td>700</td>
<td>344.2</td>
<td>45.8</td>
<td>85.8</td>
<td>3,166,287</td>
<td>3,139</td>
</tr>
<tr>
<td>800</td>
<td>344.2</td>
<td>45.8</td>
<td>85.8</td>
<td>3,166,287</td>
<td>3,139</td>
</tr>
</tbody>
</table>

### BIDIS

<table>
<thead>
<tr>
<th>BIDIS</th>
<th>Increase in SD over 2009</th>
<th>SD (%)</th>
<th>Increase in price (%)</th>
<th>Decrease in number of smokers</th>
<th>Decrease in total consumption (Million packs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>33</td>
<td>6.1</td>
<td>8.1</td>
<td>456,250</td>
<td>127</td>
</tr>
<tr>
<td>50</td>
<td>33</td>
<td>6.1</td>
<td>8.1</td>
<td>1,123,500</td>
<td>284</td>
</tr>
<tr>
<td>100</td>
<td>34</td>
<td>6.8</td>
<td>8.8</td>
<td>1,892,750</td>
<td>386</td>
</tr>
<tr>
<td>200</td>
<td>34</td>
<td>6.8</td>
<td>8.8</td>
<td>2,860,900</td>
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<td>34</td>
<td>6.8</td>
<td>8.8</td>
<td>3,753,050</td>
<td>598</td>
</tr>
<tr>
<td>400</td>
<td>34</td>
<td>6.8</td>
<td>8.8</td>
<td>4,675,200</td>
<td>708</td>
</tr>
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<td>500</td>
<td>34</td>
<td>6.8</td>
<td>8.8</td>
<td>5,665,350</td>
<td>798</td>
</tr>
</tbody>
</table>

Notes: 1. Decrease in number of smokers = Increase in price * Price elasticity of cigarette smoking participation * Estimated number of smokers in 2009.
2. Decrease in total consumption = Increase in price * Price elasticity of cigarette consumption conditional on participation * Estimated total consumption in 2009.

### Impact of varying tax levels on tobacco use

**Figure 1: Annual cigarette tax revenue (Crore Taka) from given percentage increase in supplementary duty from 2009 rate**

The Use of ITC Data to Evaluate the Impact of FCTC/Tobacco Control Policies
Evaluating Graphic Warnings in Thailand

Thailand

Malaysia

2005

2006
Enlarging the labels and adding graphic images led to substantial increases in the percentage of Thai smokers reporting that warnings make them think about health risks.
Enlarging the labels and adding graphic images also led to large increases in the percentage of Thai smokers reporting that warnings make them more likely to quit.
Significance: avoiding labels predicts future quit attempts.

Example of the mediational model for warnings: Pictorial warnings are linked to future quit attempts because they first create reactions that are associated with future quitting.
Smoking Prevalence in Bars/Pubs Before & After Ban in Ireland (04), Scotland (06), UK (07), France (08), Netherlands (08), Germany (07-08)
Fig 3. Percentage of smokers who noticed smoking in public places, before and after the Mexico City ban.

Bars and Cantinas:
- Before ban: 99.0%, 98.8%, 93.9%, 91.8%
- After ban: 90.0%, 79.7%, 70.0%

Restaurants:
- Before ban: 78.4%, 72.4%
- After ban: 38.6%, 31.9%, 14.1%, 12.9%, 9.0%

Legend:
- Tijuana
- Juárez
- Mexico City
- Guadalajara
Using ITC Findings to Demonstrate:
1. Need for strong(er) policies
2. Current policies are inadequate

“Evidence to Power”
Federal tobacco strategy turns from scary labels to stopping contraband

GLORIA GALLOWAY
Ottawa—From Tuesday’s Globe and Mail
Published Tuesday, Sep. 28, 2010 3:00AM EDT
Last updated Monday, Jan. 10, 2011 1:26PM EST

Sep 28, 2010: Health Canada announces that the ongoing initiative to revise the 10-year-old tobacco warnings is being shelved

Dec 9, 2010: Hearing held by the House of Commons Health Committee on the Govt’s decision to shelve the revision.

Dec 30, 2010: Health Minister reverses decision—the revision of the warnings will continue. New warnings are expected by the end of 2011.

ITC Canada Survey data show that every indicator of label impact has declined dramatically over the past 7 years.
On May 1, 2009, China increased cigarette taxes by 6-11%, claiming that they were doing so in accordance with the FCTC.

BUT prices have still not increased (Jun 1, 2011).

Affordability of cigarettes continues to increase.

The ITC China Survey shows clearly that price continues to be no barrier to smoking and is not a factor in motivating quitting.
China’s warning labels changed in Oct 2008

OLD warning: Side of pack
Only one message

NEW warnings: Front/back of pack
Two messages
ITC China Survey: Label change had trivial impact

Fig 23. Impact of health warnings on smokers’ perceptions and behaviours in the last month at Wave 3 (larger text warnings) vs. Wave 2 (text on side of the pack):
ITC China Survey: Label change had trivial impact

Fig 21. Percentage of smokers who ‘often’ or ‘very often’ noticed warning labels in the last month, before and after changes to warning labels

Fig 22. Percentage of smokers who said that warning labels on cigarette packages made them think of the health risks of smoking ‘a lot’, by country

Scottish, and Ireland data 2006.
South Korea, and France data 2008.
Australia, Canada, UK, US, New Zealand and Uruguay data 2008/09.
China, Thailand, Malaysia, Bangladesh, Germany, and Brazil data 2009.
Mauritius, Netherlands, and Mauritius data 2010.
SMOKING IS HARMFUL TO YOUR HEALTH
QUIT SMOKING EARLY IS GOOD FOR YOUR HEALTH
Perceptions of tobacco health warnings in China compared with picture and text-only health warnings from other countries: an experimental study

Geoffrey T Fong,1,2 David Hammond,1 Yuan Jiang,3 Qiang Li,1,3 Anne C K Quah,1 Pete Driezen,1 Mi Yan,1 for the ITC China Project Team

Table 3  Percentage of participants who correctly translated each of the two English warnings by type of participant

<table>
<thead>
<tr>
<th>Translation phrase</th>
<th>Adult smoker (n = 396)</th>
<th>Adult nonsmoker (n = 377)</th>
<th>Youth (n = 396)</th>
<th>Total (n = 1169)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Smoking is harmful to your health”.</td>
<td>26.8%</td>
<td>51.5%</td>
<td>90.4%</td>
<td>56.3%</td>
</tr>
<tr>
<td>“Quit smoking early is good for your health”.</td>
<td>10.1%</td>
<td>24.7%</td>
<td>47.7%</td>
<td>27.5%</td>
</tr>
</tbody>
</table>

< 10% of adult smokers understood both English warnings

smokers could not translate one of the two sentences on the text-only warning, and close to 90% of them could not translate the other sentence. These findings support the principle that countries should not be presenting important health messages to their people in a foreign language.
Smoking Prevalence in Restaurants in the 6 ITC cities in China compared to Other Countries Before and After Smoke-Free Laws: Ireland (04), Scotland (06), France (08), Germany (07-08), Netherlands (08), Mexico City (08), Mauritius (09)

China 87-96%
Bangladesh: Decline in beliefs about health harms of smoking: 2009–10

- There has been a very significant drop in beliefs about harms of smoking
- There is a strong need to inform the public about the harms of smoking
- Warning labels are the most cost-effective method for educating the public
Implications for beliefs about harms in Bangladesh

Number of smokers in Bangladesh (out of 21 million) who from 2009 to 2010 no longer believe that smoking causes...

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>231,000</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>1,743,000</td>
</tr>
<tr>
<td>Stroke</td>
<td>1,806,000</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1,218,000</td>
</tr>
<tr>
<td>Mouth Cancer</td>
<td>3,654,000</td>
</tr>
<tr>
<td>Impotence</td>
<td>3,297,000</td>
</tr>
</tbody>
</table>
Evidence of poor implementation of Dutch smoking ban and strong pro-tobacco attitudes compared to smokers in other ITC countries
The Dutch Health Minister continues her campaign to remove funding for tobacco control and to weaken smoke-free laws. So the ITC Project issues a second report in March 2011 showing that Dutch smokers are the least knowledgeable and least concerned of all 19 ITC countries about SHS hazards.

Dutch smokers are ignorant of harms of passive smoking, study finds

Torry Sheldon, Utrecht

Tobacco control experts are urging the Dutch government to launch information campaigns funded by a doubling of the price of cigarettes, after a new study showed an “alarming” ignorance of the dangers of passive smoking.

The study, by researchers at Maasstricht University for the International Tobacco Control Policy Evaluation Project, coincides with this week’s European conference on tobacco and health in Amsterdam, aimed at putting tobacco control higher on the political and social agenda.

In addition, the latest Tobacco Control Scale, a report on measures to combat smoking by the Association of European Cancer Leagues, placed the Netherlands 13th out of 36 countries, behind Turkey and Italy. Its position may reflect the recent decision to allow smoking again in small cafes and the low average price of a packet of cigarettes in the Netherlands, estimated at €5.05 (€4.45; €7.18), less than half the €11.24 in Norway.

The Maasstricht University study found that just 61% of Dutch smokers agree that cigarette smoke is dangerous to non-smokers. In France the percentage is 96%, and in China it is 93%. It also showed that only 20% of Dutch smokers recognize a direct link between passive smoking and lung cancer in non-smokers (96% in France). Only 9% of Dutch smokers thought about the harm to others (42% in the United Kingdom).

Geoffrey Fong, of the International Tobacco Control project, said that understanding harm was the key to tobacco control. “As a signatory to the WHO framework convention on tobacco control the Netherlands has a duty to inform its people about the dangers of smoking,” he said.

Marc Willersma, who led the Dutch study, described the findings as “alarming,” particularly as the Dutch health ministry had recently decided to discontinue funding for media campaigns to educate smokers.

“We know that there was a large degree of tolerance—that is part of our culture—but we had no idea that the basic level of knowledge was so low,” said Professor Willersma, who blamed the absence of campaigns on the health dangers of smoking. He believes that the government is afraid of appearing to be “punishing.”

He said, “The health minister has told parliament that she does not want to finance campaigns in the areas of lifestyle behaviour.”

Lies van Gennip, chief executive of Stivoro, the Dutch expert centre on tobacco control, said: “It is shocking that people in Holland know less about the damage from passive smoking than in China.”

BMJ article—Apr 9, 2011

Geoffrey Fong gives a speech in Xi’an China in April 2011 to the leading national group of tobacco control experts in China: “Things are bad in China, but at least they aren’t as bad as they are in the Netherlands.”
Summary

- ITC Project: system for understanding the natural history of tobacco use over time and impact of population-level interventions (e.g., policies)

- Evaluation = Surveillance + Design

- Allows strong opportunities for Evidence to Power

- ITC as a possible model for other domains of health where population-level interventions (policies and programs) are being considered (e.g., obesity, physical activity).
“Just as surely as the laws of gravity operate in Mumbai as they do in Lyon, the principles of causality—and the methods employed to make more confident judgments about causal relations—are constrained by neither location nor content domain.”

ITC Project Research Organizations

Core support provided by the U.S. National Cancer Institute (P01 CA138389)

Additional core funding provided by the Canadian Institutes of Health Research