

Tobacco Control Policies in Brazil: a 30-year assessment

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Abstract *The article presents a review of Brazilian tobacco control policies from 1986 to 2016, based on contributions from political economics and analyses of public policies. The institutionalization of tobacco control in the country was marked by more general changes in health policies and by specific events related to the theme. Brazil's international leadership role, a robust National Tobacco Control Policy, the role of civil society and the media all contributed to the success of tobacco control in this country. However, challenges remain regarding crop diversification in tobacco farms, illegal trade in cigarettes, pressure from the tobacco industry and the sustainability of the Policy. This study reinforces the importance of bearing in mind the relationship between the domestic and international context, and the articulation between different governmental and non-governmental sectors and players when analyzing complex health policies. Continuity and consolidation of the tobacco control policies depend on the persistence of a broad institutional framework to guide the State's actions in social protection, in accordance with Unified Healthcare System guidelines.*

Key words *National Tobacco Control Program, Tobacco, Public health policy*

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Introduction

There are 1.1 billion smokers worldwide¹, and about one third of all adults and half of all youth are regularly exposed to tobacco smoke^{1,2}. Estimates indicate that tobacco use is related to some 50 diseases³ and is responsible for as many as 6 million deaths each year¹. Tobacco use costs about 1.8% of the annual global GDP each year¹, which is a major cause for concern, as are the environmental damages such as soil contamination, fires and deforestation^{4,5}.

In the 2000s, governments increased and expanded public policies aimed at reducing the negative impacts of tobacco use⁶. Brazil is an international reference in tobacco control, and has been implementing appropriate measures for more than three decades⁷.

This article offers an assessment of thirty years of the Brazilian tobacco control policy - 1986 to 2016 -, and is based on economic policy references⁸, analyses of public policies^{9,10} and in particular historical institutionalism^{11,12}. This study is predominantly qualitative and comprises a review of the literature, document analyses, secondary data base analyses, direct observation of domestic events and the Brazilian tobacco control policy, and semi-structured interviews with key policy players.

International Scenario: Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) is the first international public health convention negotiated under the auspices of the World Health Organization (WHO)¹³. Adopted by consensus by the 56th World Health Assembly in 2004, and effective as of 2005, the FCTC is binding on all 181 signatory states¹⁴. The convention lists measures to reduce the supply and demand of tobacco, scientific and technical cooperation, environmental protection and legislative and legal measures to address criminal and civil liability¹³. Stricter implementation of the FCTC has been mentioned as one of the elements on the “2030 Agenda for Sustainable Development”¹⁵

An assessment in 2016, based on data provided by the signatory states, shows that implementation of the FCTC addressed primarily protection against exposure to tobacco smoke (mentioned by 88% of the signatory states), followed by measures related to packaging and labeling of tobacco products and their sale by and to minors

(mentioned by 76% and 71% of the signatory states respectively). However, reports show limited adhesion to some of the FCTC measures, in particular those related to criminal and civil liability (30%). Support and economically feasible options for those who grow, process or sell tobacco were the least mentioned by the signatory states (15%). 87% of the signatory states in the Americas mentioned measures focused on illegal trade in cigarettes and research, surveillance and exchange of information. In all signatory states, support for alternative activities that are economically feasible was the measure cited less frequently - only 13% of the countries in the Americas (Figure 1).

Brazil has played a key role since the start of FCTC negotiations. As a developing nation with a robust tobacco control program already in place, Brazil was made Vice-President of the Working Group open to WHO member states, which prepared the first draft of the convention. In addition to presiding the FCTC Intergovernmental Negotiation Body, Brazil led the working group that prepared the first Conference of Parties, which comprised all states that signed the convention that serves as a guideline for the Secretariat work, and negotiates the bases for implementing the convention at biannual meetings¹⁶. Brazil remained an international leader for tobacco control in subsequent years, and in 2014 a Brazilian was appointed to head the FCTC Secretariat.

Institutionalizing tobacco control in Brazil

Implementation of tobacco control measures is uneven across countries, and in this regard, Brazil has one of the most advanced policies in the world^{17,18}. Brazil is an international reference in tobacco control, and one of the first countries to regulate the description, content and emissions of tobacco products, placing graphic warning images on cigarette packs¹⁹.

From the perspective of economic policy, which considers three dimensions of healthcare policy - social protection, economics and power²⁰ - it is worth pointing out that tobacco control is a complex issue that involves different organizations, strategies, players and interests (Figure 2).

The first movement to control tobacco use in the country started in the 1960s, with debates on tobacco-related diseases²¹. In subsequent efforts, some states focused on implementing activities to control smoking, and organized national events focused on tobacco control as a major policy (1979: “Salvador Letter” and the “National

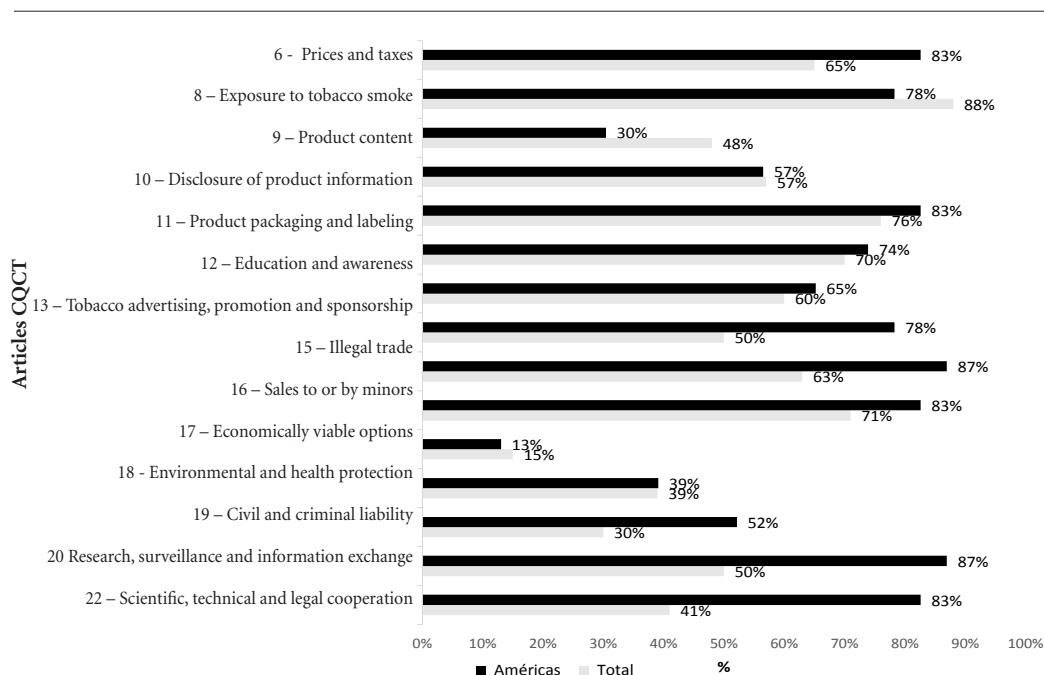


Figure 1. Share of Signatory States according to measures in the Framework Convention on Tobacco Control, implemented in the six regions defined by the World Health Organization and in the Americas^b, 2016.

Note: ^a Includes the 133 Member States that sent reports on the progress of implementing the cycle in 2016 to the FCTC Secretariat: Afghanistan, South Africa, Germany, Saudi Arabia, Algiers, Antigua and Barbuda, Australia, Austria, Azerbaijan, Bahamas, Bahrein, Belgium, Belize, Benin, Bhutan, BosniaHerzegovina, Brazil, Burkina Faso, Burundi, Cameroon, Canada, Chile, China, Colombia, Congo, Cook Islands, Costa Rica, Ivory Coast, Croatia, Cyprus, Denmark, Djibouti, Domenica, Ecuador, Egypt, El Salvador, United Arab Emirates, Slovenia, Spain, Estonia, Philippines, Finland, France, Gabon, Gambia, Georgia, Ghana, Greece, Granada, Guatemala, Guinea, Guiana, Honduras, Hungary, Iceland, India, Iran, Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Libya, Lithuania, Luxembourg, Macedonia, Madagascar, Malaysia, Maldives, Mali, Malta, Mauritania, Mauritius, Mexico, Micronesia, Moldova, Montenegro, Myanmar, New Zealand, Nicaragua, Niger, Nigeria, Norway, Oman, Netherlands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Poland, Portugal, Kenya, Kiribati, Kyrgyzstan, United Kingdom of Great Britain and Northern Ireland, Republic of Korea, Check Republic, Democratic Republic of Congo, Russia, St. Lucie, Samoa, San Marino, Senegal, Serbia, Seychelles, Sierra Leoa, Singapore, Sri Lanka, Saint Christopher and Nevis, Syria, Surinam, Swaziland, Sweden, Tanzania, Thailand, Togo, Tonga, Trinidad & Tobago, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, European Union, Vanuatu, Vietnam, Yemen and Zimbabwe. ^b Includes the 23 Member States in the Americas that sent reports on the progress of implementing the cycle in 2016 to the FCTC Secretariat: Antigua and Barbuda, Bahamas, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Domenica, Ecuador, El Salvador, Granada, Guatemala, Guiana, Honduras, Jamaica, Mexico, Panama, Paraguay, Saint Christopher and Nevis, St. Lucie, Surinam and Trinidad& Tobago.

Legend: FCTC - Framework Convention on Tobacco Control

Source: Prepared by the authors based on the 2016 FCTC progress report¹ and country reports on implementing the FCTC².

1. WHO Framework Convention on Tobacco Control. 2016 global progress report on implementation of the WHO Framework Convention on Tobacco Control. 2016.; 2. WHO FCTC Implementation Database [Internet]. [cited on 30 October 2017].

Available at: <http://apps.who.int/fctc/implementation/database/>

Program Against Smoking”; 1980: “1st Brazilian Conference to Fight Tobacco Use”; 1985: creation of the “Advisory Group of the Ministry of Health for Tobacco Control in Brazil”^{7,22}.

Ever since, tobacco control has been embedded in Brazil and marked by more general changes in health policies and specific events related to the theme (Figure 3). The first milestone we point

out came in 1986, when the National Program to Fight Smoking (NPFS or PNCF in Portuguese) was created, becoming the guidelines for Federal tobacco control measures when a “Advisory Group” was created. The NPFS is under shared management of the Ministry of Health and the Brazilian Social Security’s National Institute for Medical Care²³.

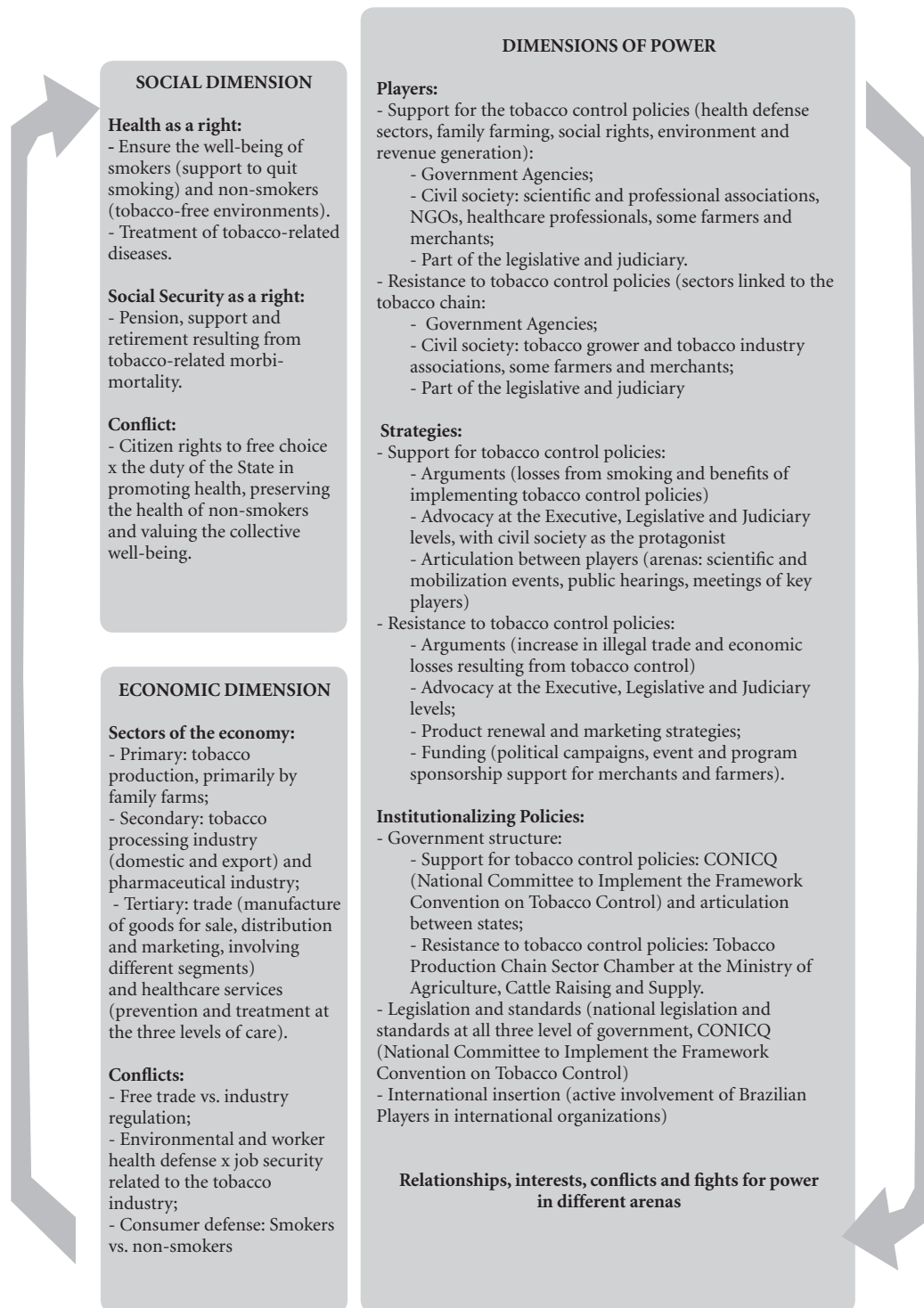


Figure 2. The three dimensions of the tobacco control policy

Note: This figure is intended to place tobacco control in Brazil in context, and includes the results of a broad literature review on the theme, and some of the initial results of field-work that helped enhance the analytical reference. This survey did not intend to exhaust all of the dimensions and aspects listed in the figure.

Source: Prepared by the authors.

The 1988 Federal Constitution²⁴ was important for tobacco control in the country, and was used to justify subsequent anti-tobacco laws²¹. The concept of health as a right of all and duty of the State, and the development of the Unified Health System (SUS) are important backdrops for developing measures to prevent tobacco use and help people stop smoking. The SUS is detailed in the Organic Health Law^{25,25}, and includes health prevention, promotion and recovery measures, as well as health surveillance, vector control and health education. The system is guided by the principles of decentralization, comprehensiveness and community involvement, and includes inter-sector articulation to implement policies and programs in the interests of health²⁶.

In this scenario, the National Cancer Institute (INCA), part of the Ministry of Health Health-care Attention Department, took over coordination of the National Tobacco Control Program nation-wide measures in 1989²⁷. The Program attempts to reduce the social acceptance of tobacco use by keeping young people from taking up the habit, protecting people from exposure to tobacco smoke and support for those wishing to quit smoking²⁸. Between 1990 and 1993, the program was coordinated by the central management of the Ministry of Health in Brasília, and returned to the umbrella of the INCA in 1994. In 1996 the National Coordination of Tobacco Control and Primary Cancer Prevention (CONTAPP) was created, covering the National Tobacco Control

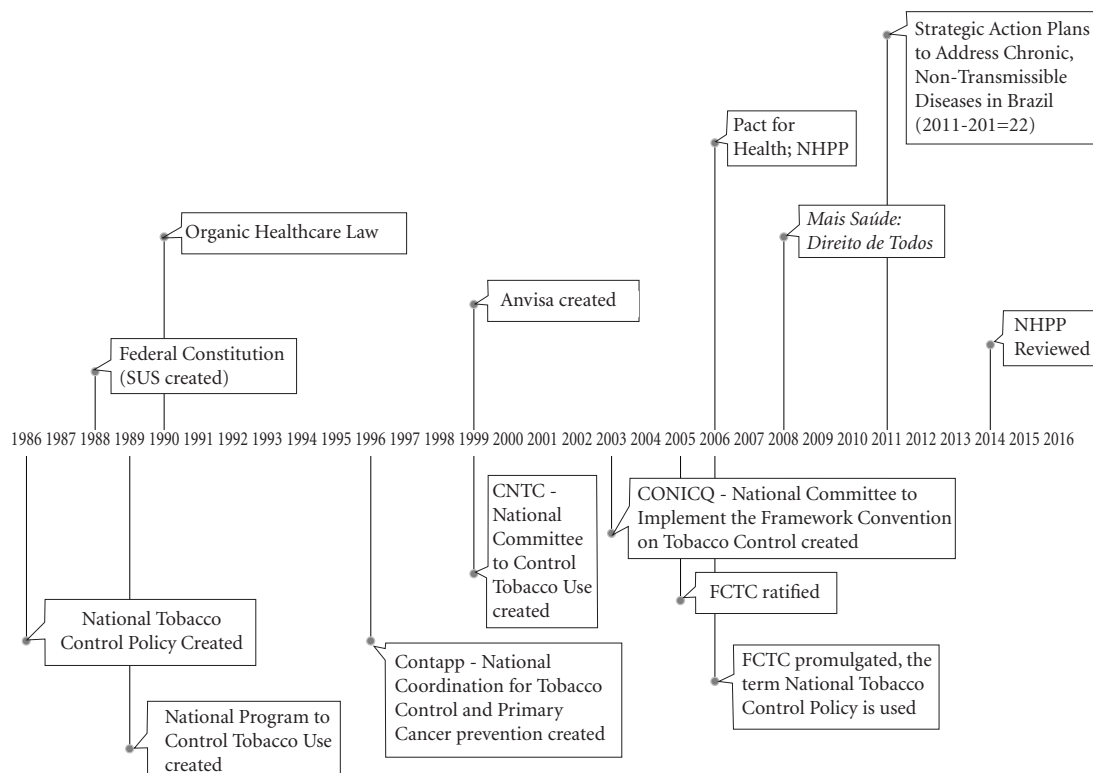


Figure 3. Timeline for institutionalizing tobacco control in Brazil

Note: The upper portion shows a list of general public health milestones in Brazil. The lower portion shows specific tobacco control milestones.

Legend: Anvisa - National Health Surveillance Agency; CONTAPP - National Coordination of Tobacco Control and Primary Cancer Prevention; CNTC - National Tobacco Control Committee; CONICQ - National Commission for the Implementation of the Framework Convention on Tobacco Control; NPFS - National Program to Fight Smoking; NHPP - National Health Promotion Policy; SUS - Unified Healthcare System.

Source: Prepared by the authors.

Program and other programs for prevention against cancer risk factors²⁹.

Anvisa, the National Health Surveillance Agency created in 1999, enabled more effective measures to control and inspect tobacco products that those previously developed by the Ministry of Health²¹. That same year, the National Tobacco Control Committee was created (NTCC or CNCT in Portuguese) to represent Brazil at the international negotiations of the FCTC³⁰.

In the 2000s, events related to the FCTC marked the trajectory of tobacco control in Brazil. In 2003, when the convention was adopted, the NTCC was replaced by the National Commission for the Implementation of the Framework Convention on Tobacco Control (CONICQ), incorporating new bodies in different sectors³¹. Brazil ratified the FCTC in 2005, and it became effective across the country in 2006. Numerous measures focused on tobacco control were then incorporated into the National Tobacco Control Policy (NTCP or PNCT in Portuguese)³². Thus, an inter-sector State policy was created, articulated between the three Federal levels³³.

Within the context of a national health policy, some initiatives enabled implementing tobacco control measures in this country. The 2006 Health Pact highlights tobacco use as one of the priorities for health promotion³⁴. That same year, the National Health Promotion Policy (NHPP or PNPS in Portuguese) included the prevention and control of tobacco use, with education, legislative and economic measures, and measures to foster tobacco-free environments and support for people trying to quit smoking³⁵. Education and legislative measures are also part of the 2008 program entitled *Mais Saude: Direito de Todos* (More Health, the Right of All)³⁶.

Tobacco control remained a strong point of the national health policy throughout the second half of the 21st century. The “Strategic Action Plan to Combat Chronic Non-communicable Diseases in Brazil, 2011-2022” includes reducing the number of smokers as one of its targets, with measures that include surveillance, research and health promotion related to tobacco use³⁷. The 2014 review of the NHPP kept tobacco control as a priority, encouraging educational, legislative, economic, environmental, cultural and social measures³⁸.

The legal and normative framework contributed to embedding tobacco control in the period. Federal Law # 9,294/1996 and its subsequent regulation (Decree # 2.018/1996, Law #10,167/2000, Law # 12,546/2011 and Decree # 8,262/2014) en-

abled significant progress towards placing warnings, restricting advertising of tobacco products and forbidding smoking in enclosed spaces. We highlight the role of rules and regulations implemented over the past decades in the form of the various Ministry of Health directives and Anvisa resolutions to regulate tobacco products, and Central Bank measures also aiming at regulating tobacco production.

Assessment of the Brazilian tobacco control policy measures

Over the past three decades, Brazil has implemented numerous tobacco control measures, most of them aiming at reducing the demand for tobacco. One of the key measures has been periodic adjustments of the main cigarette taxes and their retail sales price. We stress the changes in 2011 involving the tax on industrialized goods (IPI) and a minimum price for selling cigarettes. Despite the illicit trade in tobacco products, Brazil’s experience shows that higher taxes can increase government revenue and at the same time reduce the number of smokers³⁹.

Promoting tobacco-free environments has been one of the most successful measures of the Brazilian tobacco control policy. Starting in the late 1980s, smoking restrictions advanced, strengthened by city, state and federal laws. Since 2011, smoking has been prohibited in public and private enclosed spaces, with only a handful of exception (churches, tobacco stores, studios and healthcare institutions)^{40,41}.

Warnings of the health hazards of smoking on cigarette packs and advertising, used since 1988, have been reformulated and images added to make the population even more aware. When Anvisa was created in 1999, tobacco product regulation became an important element of Brazilian policy, controlling registration, packaging and content. The Tobacco and Derivatives lab inaugurated in 2012 is the sixth such public lab in the world and the first in Latin America dedicated to the analysis of tobacco-derived products⁴².

The fundamental strategy to build awareness and educate the public on the damages caused by tobacco use is to organize campaigns on the main commemorative dates related to tobacco control. The National Day Against Tobacco (August 29, created in 1986), and the World No Tobacco Day (May 31, created in 1987), mobilize players in all three spheres of government to promote activities related to preventing tobacco use and encouraging people to quit smoking. We also point to the

development of educational efforts in schools, healthcare units and the work environment, such as *Programa Saber Saúde* (Know Health Program), which has already reached 2,389,126 students in 14,280 schools in 1,212 cities³³. Since the *Saber Saúde* distance education course was created in 2012, 1,390 professionals in education have been trained all over the country⁴³. Creating monitoring centers or observatories has helped share knowledge related to tobacco control. Since 2011, the National Tobacco Control Policy Monitoring Center has provided updated information on the different sectors involved in implementing the FCTC. The “Tobacco Industry Strategy Monitoring Center”, created in 2016, is a global project created by the FCTC Secretariat to monitor, analyze and disclose tobacco industry activities⁴⁴.

We also point to the progress made in limiting tobacco product advertising and publicity. Brazil started limiting tobacco advertising in the media in the 1980s, and also prohibited any messages linking tobacco-products and well-being. Federal Law # 10,167/2000 makes it illegal for tobacco brands to sponsor cultural and sports events, and prohibits tobacco advertising in the major media vehicles. Since 2011, advertising has been limited to displays at points of sale⁴¹.

Support for people to quit smoking is an important component of the FCTC, and is considered a measure to reduce the demand for tobacco. Since 2004, smokers are offered free treatment by the SUS, mostly at the primary healthcare units. The number of units providing treatment, the number of smokers seen and who stopped smoking, abandonment and quitting rates all show major progress. In 2013, 1,308 units provided services to 154,207 smokers, 71,327 of whom quit smoking (Figure 4). Abandonment and quitting rates were 28% and 53% respectively. The supply of medication to help people stop smoking expanded to 77% (Figure 5). Furthermore, the Ministry of Health has provided telephone support for smokers since 2001 - *Disque Saúde 136* (health call service 136).

One of the measures used to reduce the supply of tobacco is to fight illegal trade, and diversify the crops planted in traditional tobacco growing areas. Despite interference by tobacco companies to fight measures to reduce tobacco use, major strides have been made in the past 30 years, especially in the south. In the late 1990s, rules were defined for cigarette marketing, including special registration, control seals and export taxes. Starting with combined activities of the Federal Revenue Service and Federal Police to fight cigarette

falsification and contraband, in particular a program known as Scorpios - the System to Control and Track Cigarette Production created in 2007, efforts to fight the illegal trade of cigarettes have been quite successful. In 2016, R\$ 581 million in cigarettes confiscated due to tax infractions were destroyed⁴⁵.

Considering that Brazil is the second largest producer and the largest exporter of tobacco leaves in the world⁴⁶, in 2005 it created a Program to Diversify Tobacco Farming Areas, ratified by the FCTC. Between 2011 and 2016 more than R\$ 60 million were invested in technical support and farm extension (Ater) in the main tobacco-producing municipalities, affecting over 20 thousand families⁴⁷. Among the crop diversification strategies are criteria for approving Family Farming credit (Pronaf) for tobacco farmers working in partnership or as part of a tobacco processor. Starting in 2016/2017 farmers have had to show that at least 20% of their gross income came from non-tobacco related activities. For the 2020/2021 harvest the requirement will be 50%⁴⁸.

Finally, research and surveillance activities have also been key for the NTCP. Since 1997, the INCA has been the “WHO Collaborating Center for Tobacco Control”, and is a Latin American reference when it comes to producing materials, training human resources and providing technical support for controlling tobacco use⁴³. A number of studies are performed in Brazil from time to time to monitor tobacco use indicators. One such example is Vigitel (Telephone Survey of Chronic Disease Risk and Protection Factors), which has been conducted since 2006. Other examples include Petab (Special Survey on Tobacco Use) (2008), PeNSE (National Survey on Student Health) (2009, 2012, 2015), PNS (National Health Survey) (2013) and the ITC Project (Assessment of the Tobacco Control Policy) (2009, 2012, 2016/17). In addition to these, the “Strategic Action Plan to Combat Chronic Non-communicable Diseases in Brazil, 2011-2022” includes surveillance, research and health-promotion measures related to tobacco use.

Closing Remarks

In recent decades Brazil has implemented cross-sectoral measures to control tobacco use, leading to a significant reduction in the number of smokers - from 35% of the population in 1989 to 15% in 2012⁴⁹⁻⁵². It is worth pointing out that in the period there has also been a change in the

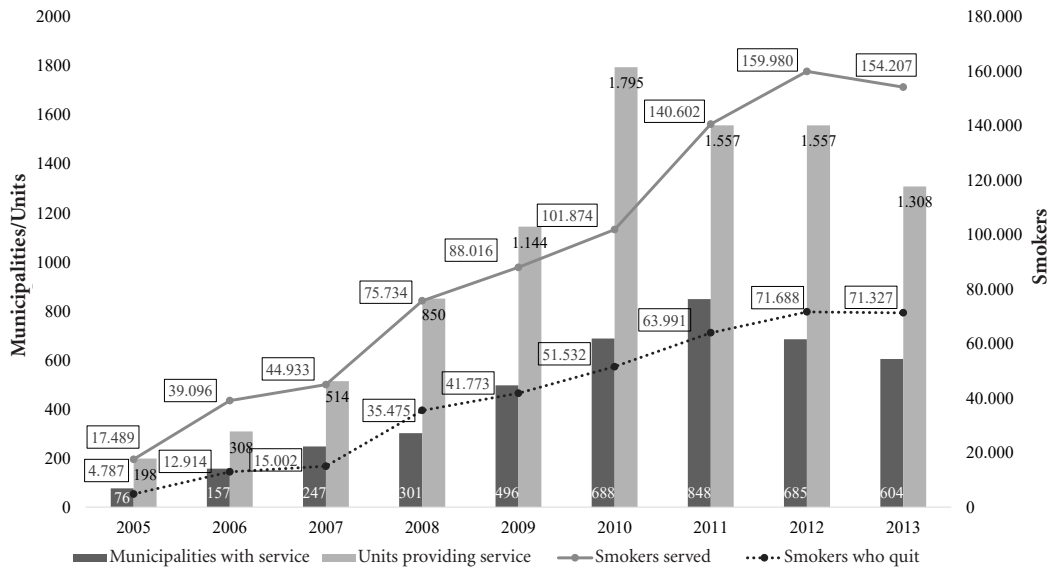


Figure 4. Treatment of smokers by the Unified Health System - 2005 - 2013.

Source: Data provided by the National Cancer Institute.

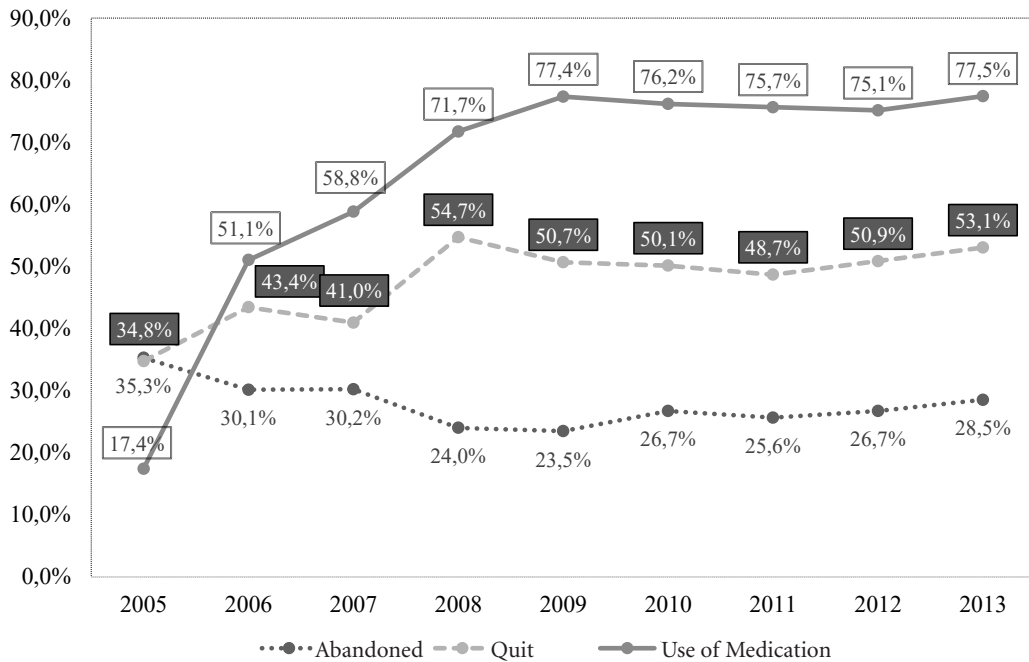


Figure 5. Progress made in indicators of program abandonment, use of medication and quitting, 2005 - 2013.

Source: Data provided by the National Cancer Institute.

social acceptability of tobacco use, which went from being broadly disseminated in the 1980s and 1990s to being rejected in the 2000s⁵³⁻⁵⁵.

The active involvement of Brazil in designing the FCTC was decisive for its leading role in global control of tobacco use and developing partnerships with international organizations. The insertion of tobacco control policies into a universal public healthcare system, developing a specific legal and legislative framework, policy coordination at the national level and the involvement of different sectors, implementation of the FCTC and policy decentralization have all been essential to institutionalize tobacco control in Brazil.

The creation of Anvisa and its legal mandate to regulate tobacco products in the country and oversee national laws in this area was of particular importance. The consolidation of CONICQ as the strategic body for government coordination of the policy is a commitment of mutual accountability of the different government agencies involved in tobacco control⁵⁶.

We also call attention to the role of civil society and the media, in particular the Alliance to Control Tobacco Use, healthcare organizations (especially medical associations), consumer associations and the associations to defend tobacco growers. These players have been key for the NTCP, conducting surveys on diverse themes, promoting different ways of training the different people involved, campaigns on dates that commemorate tobacco control and continuous advocacy with the Executive, Judiciary and Legislative powers.

However, there remain important policy challenges⁵⁷. Strengthening the National Program to Diversity Areas Planted with Tobacco, and greater articulation of the players involved in this theme, especially agro government bodies, the civil society and the tobacco-producing municipalities and states are currently limits for tobacco control. In 2016 responsibility was transferred from the Ministry for Agricultural Development to the Special Department for Family Farming and Agrarian Development, under the umbrella of the office of the chief of staff (Casa Civil), presents an additional hurdle to mobilizing human and financial resources for the program.

Fighting illegal cigarette trade and NTCP protection from interference from the tobacco industry are further challenges. We especially mention the urgency for ratifying the Protocol to

Eliminate the Illegal Trade in Tobacco Products, allocating financial resources to the players involved with the policy promoted by tobacco processing companies, expansion to new products and policy judicialization, especially as regards product regulation by Anvisa.

It is also important to strengthen CONICQ and its ability to take action. This means addressing limiting factors such as the low priority that tobacco control has on the agenda of some of the Committee agencies, conflicts between the economics and health aspects of tobacco control and resistance on the part of the Tobacco Producing Sector Chamber, part of the Ministry of Agriculture, and organizations linked to the tobacco industry.

This study reinforces the importance of including the relationship between the domestic and international situation, and articulation between various government and non-government sectors and players when analyzing complex health policies. Brazil has submitted pioneering initiatives and several Brazilian players have influenced tobacco control negotiations at the international level. Since the FCTC was adopted, Brazilian policy has been strongly influenced by the international scenario in a two-way relationship⁵⁷. Also, despite tobacco control in Brazil being based on health sector strategies, control being recognized primarily based on fighting the morbi-mortality related to tobacco use, NTCP advances depend heavily on the commitment of other sectors, in particular those related to agriculture and the economy. Articulation between the Executive, Judiciary and legislative, as well as the media and civil society is essential to ensure that tobacco control is fully embedded in Brazil.

Finally, sustainability of the NTCP is a major challenge, given the dynamics of government agendas and the political and economic instability that the country experiences from time to time. Keeping the theme on the agenda of the healthcare sector and expanding legislative, economic, regulatory and education activities are essential. Facing the economic interests of the tobacco industry is a determinant to ensure progress is made in areas that remain fragile. The continuation and consolidation of a tobacco control policy over the medium and long terms require a persistent and ample institutional framework to guide the activities of the State in social protection, as per the SUS guidelines, where health needs come before economic interests.

Collaborations

LH Portes, CV Machado and SBR Turci helped with study design and drafting, and data analysis and interpretation. All authors provided a critical review of the content and approved the final version.

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