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Packaging & labeling: health warnings and misleading claims

The limited space for labeling on tobacco products serves two competing interests:

a) *Providing space for health warnings, and consumer information.*
b) *Promoting the brand and claims of the producer.*

Without any government regulation about the size and type of health warnings, the tobacco industry tends to make the health warning small so that more space is available to promote their product

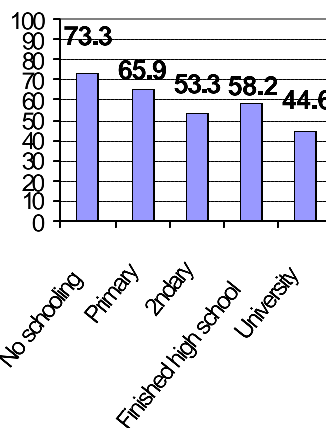
Health warnings

Health warning labels on tobacco product packaging and advertisements help inform consumers about the negative impacts of tobacco use. The effectiveness of the health warning depends on the size of the message, its color and typeface, and whether the message is the same or changes.

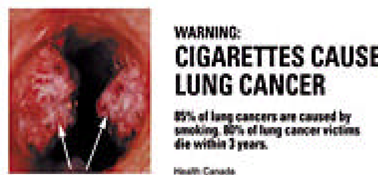
How does Indonesia compare on health warning labels?

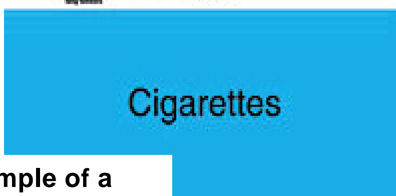
The existing legislation in Indonesia requires health warnings on cigarette packages but no other tobacco product. No minimum size exists for health warnings, and only one message is authorized for use. People are so accustomed to the same message every time for all brands, the health warning only serves to indicate a tobacco advertisement. A substantial proportion of the population has no formal education. Indonesian males with no formal education and less than a primary school education have a very high smoking prevalence (73.3%).

% of male smokers by education, 2001



Where formal educational levels are low, smokers may not fully understand the health warning and pictures may be more effective.





Example of a cigarette package in Canada[1]

What makes health warning labels effective?

1. LARGE SIZE.

The **Framework Convention on Tobacco Control (FCTC)** requires that health warnings comprise at least 30% - and ideally 50% - of the display area on tobacco product packaging.

2. EASY TO READ.

Black and white colors sharply contrast and are easy to read. Some countries specify in their legislation the typeface and size of the health warning.

3. CLEARLY WORDED.

Most smokers underestimate health risks associated with smoking. The message needs to be simple and explicit.

4. ROTATING.

Health messages must rotate. People become accustomed to the same message every time, and the meaning loses its impact.

5. ACCOMPANIED BY PICTURES.

Pictures are more effective than words – particularly where smokers have low levels of formal education.

Misleading product claims

PP 19/2003 bans tobacco branding and labeling characterized by misleading descriptions or claims that disguise negative health effects. This includes words, graphics or picture that creates a false or erroneous impression or disguise the health hazards associated with tobacco.

Why "light and low" tar and nicotine branding is consumer fraud

At present the existing standards for measuring tar and nicotine levels are based on tobacco industry standards and do not reflect health impact.

Cigarette ratings for tar, nicotine and carbon monoxide are currently determined by machine testing (ISO standards) promoted by the tobacco industry in 1967.

These methods to rate tar, nicotine and carbon monoxide do not predict actual intake or health impact – or the behavioral changes associated with people smoking different types of cigarettes.

In fact, low tar cigarettes typically also have lower levels of nicotine. Because people smoke to obtain a level of nicotine that satisfies their addiction, switching to cigarettes with "low tar" may result in people smoking (and buying) more cigarettes to achieve the desired level of nicotine that satisfies their addiction.

In short, branding cigarettes "light" and "low" has become a popular tobacco industry marketing technique that aims to convince smokers that they are using less dangerous product.

This is consumer fraud because consumers are misled to believe that the health effects of "mild" and "lights" are less harmful.

It all results in higher cigarettes sales.

The **Framework Convention on Tobacco Control (FCTC)** prohibits misleading language, such as "light", "mild" or "low tar.

Online Resources

US Federal Trace Commission. Up in Smoke: The truth about tar and nicotine ratings; and The 2000 report on tar and Nicotine Ratings
http://www.ftc.gov/bcp/menu-tobac.htm

ASH UK: Regulation and disclosure: ASEAN inter-sessional meeting, 2002.
http://www.ash.org.uk/html/international/pdfs/as_regulation.pdf

US National Cancer Institute 2001. Monograph 13: Risks Associated with Smoking Cigarettes with Low Tar Machine-Measured Yields of Tar and Nicotine
http://cancercontrol.cancer.gov/tcrb/monograph/13.index.html

WHO 2002. Tobacco Atlas
http://www5.who.int/tobacco/page.cfm?sid=84

WHO 2000. Advancing knowledge on regulating tobacco products.
http://www5.who.int/tobacco/page.cfm?tld=96

The World Conference on Tobacco or Health 2000. Tobacco Warning Labels and Packaging
http://tobaccofreekids.org/campaign/global/docs/ets.pdf

[1] Cigarette package health warnings in Canada from "Picture this: smoking kills" JAMA. 2000 Feb 23;283(8):993.

EXAMPLES: CLEAR HEALTH WARNINGS

SMOKINGKILLS

TOBACCO SMOKE HARMS THOSE AROUND YOU

QUITTING NOW CAN SAVE YOUR LIFE

Issued by:
Tobacco Control Task Force
Ministry of Health
Jl H.R Rasuna Said Blok X-5, Kav 4-9
Jakarta 12950

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Framework Convention on Tobacco Control (FCTC)

During the 56th World Health Assembly (WHA) in May 2003, the 192 member states of the World Health Organization (WHO) unanimously adopted the **Framework Convention on Tobacco Control (FCTC) –** the world's first public health treaty.[1] Its goal is:

"To protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke."

The FCTC is a legally binding instrument within a global public health strategy to support member states in developing national tobacco control programs to prevent tobacco-related illnesses and deaths. The Government of Indonesia participated fully in all negotiations. In attendance were representatives from the Ministry of Health; the Food and Drug Administration, as well as Finance, Trade and Industry and Foreign Affairs

The treaty is open for signature by Member States between June 2003 and June 2004, and will come into force as a legally binding instrument after 40 countries have ratified it. By the end of February 2004, 95 countries had already signed the treaty and nine had ratified it.

6 key articles of FCTC

1. Price and tax measures.

An increase in tobacco taxes leads to both health and economic benefits.

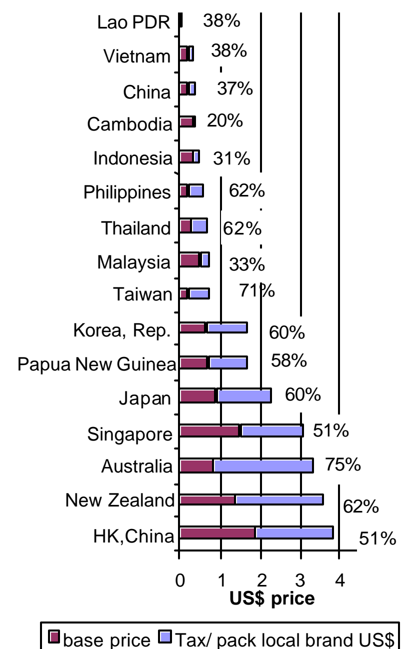
- *Health benefits*. An increase in tobacco prices reduces consumption, especially among children, youths, and infrequent smokers.
- *Economic benefits.* Studies in Indonesia have demonstrated that an increase in tobacco prices via taxes will result in a net increase in total government income.

How does Indonesia compare on price and tax measures?

The FCTC stipulates that public health objectives should be considered when implementing tax and price policies on tobacco products, and duty-free sales of tobacco products should be restricted.

To have a public health impact, the sales price must be high enough to reduce consumption – one way of keeping prices high is through regular tax increases. Taxes as a percentage of the final selling price are much lower in Indonesia compared with other countries. In Singapore, for example, cigarette taxes are 51% of the sales price compared with an average of about 31% in Indonesia.[3] Increasing taxes would generate positive health outcomes and increases in government revenue.

Cigarette tax as a % of sales price, 1999[3]



2. Advertising, sponsor-ship, and promotion.

Tobacco industry advertising, promotion of tobacco products, and sponsorship of sports and cultural events aims to create an environment where tobacco use is familiar and acceptable. This encourages children and youth to experiment with tobacco.

Partial bans on tobacco product advertising are not effective in reducing tobacco consumption.

Partial or limited bans on advertising tobacco products have little or no effect because the tobacco industry seeks alternative ways of advertising, such as more subtle, paid advertisements in movies. [4]

How does Indonesia compare on comprehensive bans on advertising, promotion, and sponsorship?

The FCTC requires parties to implement comprehensive bans on advertising, sponsorship, and promotion of tobacco products under consideration of local laws.

Advertising. Since a TV advertising ban was lifted in 1991, almost no restriction exists on tobacco advertising in Indonesia. Only daytime TV tobacco advertising is prohibited from 5 AM to 9.30 PM in the **existing legislation (PP 19/2003).**

Sponsorship. All major tobacco companies in Indonesia often sponsor sport and cultural events. Tobacco advertising associates smoking with images of success and happiness.

Promotion. The distribution of free product samples is prohibited in PP 19/2003, but the distribution of discount coupons is common in addition to single stick sales.

3. Labeling: health warnings and misleading claims

The limited space for labeling on tobacco products serves two competing interests:

a) *Providing space for health warnings, and consumer information.*
b) *Promoting the brand and claims of the producer.*

Without clear government regulation about the size and type of health warnings, the tobacco industry tends to make small health warnings so that more space is available to promote their product.

Promote health warnings. Tobacco contains nicotine, a highly addictive substance.[5] The effectiveness of the health warning depend on the size the message; color, typeface and pictures; and whether the message is the same or changes.

Prohibit misleading claims, including "light," and mild," and "low tar" branding. Misleading claims aim to disguise the health hazards associated with tobacco. Branding cigarettes "light" and "low tar" is a marketing technique, which aims to convince smokers that they are using a less dangerous product. At present, the methods for measuring tar and nicotine levels are based on tobacco industry standards and do not reflect health impact. [6]

How does Indonesia compare on product labeling?

FCTC requires that health warnings comprise at least 30% - and ideally 50% - of the display area on tobacco product packaging. Health warnings should also be rotated. Misleading language is also prohibited, such as "light", "mild" or "low tar."

The existing legislation in Indonesia requires health warnings on cigarette packages but no other tobacco product. No minimum size exists for health warnings, and only one message is authorized for use. People become accustomed to the same message every time for all brands, and the message loses its impact.

"Light," "low," or "mild" tar and nicotine branding is a popular marketing technique.

4. Clean air laws

The majority of Indonesian adults do not smoke. Restrictions on smoking in public places prevent non-smokers from being exposed to passive or **environmental tobacco smoke (ETS).**

ETS is a human carcinogen. [7] Pregnant women exposed to ETS have higher rates of poor birth outcomes, including low birth weight, stillbirths, and birth defects.[8] More than 43 million Indonesian children are living with smokers and are

exposed to passive or environmental tobacco smoke (ETS) in their homes. Exposure to ETS among infants and children have increased rates of respiratory and ear infections, and a reduced rate of lung growth.[9]

How does Indonesia compare on clean air laws?

The FCTC requires clean air laws that protect non-smokers from ETS on public transport, in workplaces, and in public places. PP 19/2003 bans smoking in mosques, public health and educational facilities, areas with child activities, and public transportation. Enforcement is uncommon.

5. Disclosure and ingredient regulation

Up to 1400 natural and synthetic additives could be included in tobacco products. While many are safe in food, the potential negative health effects of being inhaled are not known for most of the additives.[10]

How does Indonesia compare on regulation and disclosure of contents?

FCTC requires that manufacturers disclose the content and important set of emissions of tobacco products to regulatory agencies.

PP 19/2003 contains no regulations on emissions and disclosure of content and additives. The exception is the disclosure of tar and nicotine levels on the package, which is used as an industry marketing technique for "light" and "low" tar and nicotine branding (prohibited under the FCTC as misleading claims).

6. Smuggling

Smuggling tobacco products undermines national tobacco control policies because smuggling avoids taxation, thereby keeping the price of tobacco low and encouraging consumption.[11]

Some of the most important factors that contribute to smuggling include the tobacco industry's role in facilitating smuggling to get into new markets, existence of criminal gangs, unlicensed distribution, and lax anti-smuggling laws and enforcement.

How does Indonesia compare on policies that minimize smuggling?

FCTC requires measures to minimize smuggling including tobacco product packaging that states the final destination; and cooperating in strengthening legislative action against illegal cross border trade.

PP 19/2003 does not have any specific articles that address smuggling. Regional cooperation to minimize smuggling is currently limited. In general, cigarette smuggling is not considered a serious crime,

Online Resources

[1] The text of the FCTC
http://www.who.int/tobacco/fctc/text/final/en/

[2] Framework Convention Alliance, April 2003. Highlights of the FCTC.
http://www.fctc.org

[3] World Bank 2002. Indonesia briefing
http://www1.worldbank.org/tobacco/pdf/country%20briefs/Indonesia%20.pdf

[4] WHO 2002. The Tobacco Atlas.
http://www5.who.int/tobacco/page.cfm?sid=84

[5] See the US National Institute on Drug Abuse. Nicotine Addiction.
http://www.drugabuse.gov/ResearchReports/Nicotine/nicotine2.html

[6] US National Cancer Institute 2001. Monograph 13: Risks Associated with Smoking Cigarettes with Low Tar Machine-Measured Yields
http://cancercontrol.cancer.gov/tcrb/monographs/13/index.html

[7] US NIH 2002. Smoking and Tobacco Control: Health effects of exposure to Environmental Tobacco Smoke;
http://cancercontrol.cancer.gov/tcrb/monographs/10/

[8] Chan-Yeung and Ward. Respiratory health effects of exposure to environmental tobacco smoke: An invited review. http://www.blackwell-synergy.com/links/doi/10.1046/j.1440-1843.2003.00453.x/abs

[9] WHO 1999. International Consultation on Environmental Tobacco Smoke and Child Health. NCD/TFI/ETS/99.
http://www.who.int/tobacco/health_impact/youth/ets/en/

[10] WHO 2000. Advancing knowledge on regulating tobacco products.
http://www5.who.int/tobacco/page.cfm?tld=96

[11] Tobacco Control in Developing Countries, Oxford University Press.
http://www1.worldbank.org/tobacco/tcdc.asp

Issued by:
Tobacco Control Task Force
Ministry of Health
Jl H.R Rasuna Said Blok X-5, Kav 4-9
Jakarta 12950

Framework Convention on Tobacco Control (FCTC)

The process of ratification

Step 1. May 2003. World Health Assembly adoption

In May of 2003, the World Health Assembly unanimously adopted the FCTC.

Step 2. Treaty signing

Signature to the FCTC opened on 16 June 2003. Signature is not a legally binding step, but an indication that the country intends to determine its position with regard to the treaty.

While signing the treaty does not commit the country to proceed to ratification, it does create an obligation to refrain from acts that would defeat the treaty's objectives, or to take measures to undermine it. By the end of February 2004, 95 countries and the European Union had already signed the treaty. The FCTC remains open for signature at the UN headquarters in New York until 29 June 2004.

Step III. Treaty ratification

Ratification consists of two steps. First, the appropriate arm of the State (for example, the Parliament) agrees to undertake the relevant treaty obligations in accordance with the relevant constitutional procedures.

Second, the government deposits an instrument of ratification with the UN Secretary-General. Upon ratifying, a country becomes a contracting party of the treaty. As soon as 40 countries ratify the treaty, it becomes law or enters into force for those countries. A country may ratify the treaty any time after it has signed. After 29 June, 2004, states will need to accede to the treaty to become a contracting party which means that they must have already ratified the terms of the treaty within the country.

Step IV. Protocols

Separate, more specific, agreements, or "protocols" may be written to supplement the treaty. Protocols are specific substantive obligations to implement the objectives of the convention. Some possible protocols for the FCTC include smuggling and cross-border advertising. Protocols are subject to independent ratification. The current treaty text states that only parties to the Convention may be parties to any protocols.

Step V. Treaty becomes international law

Ninety days after the FCTC has been ratified by at least 40 countries, it becomes international law and is subject to those rules and procedures. The treaty will only regulate relations between countries that have both ratified it.

Step VI. Conference of the Parties

Within one year after the treaty enters into force, the Conference of the Parties (COP) convenes. The COP will monitor the implementation of the treaty, and promote the mobilization of financial resources, and negotiate additional protocols.

See Framework Convention Alliance, April 2003. Highlights of the FCTC. http://www.fctc.org

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Tobacco: its devastating health consequences

Tobacco use is one of the fastest growing causes of death in the world. One in two long-term smokers dies from tobacco-related illnesses. And these deaths are completely preventable.

Diseases attributable to tobacco use in Indonesia

Tobacco kills one person every 10 seconds. More than 70,000 scientific articles have conclusively demonstrated that tobacco use causes illness and death.[1] Indonesian data (2001) estimate that tobacco use caused more an estimated 9.2% of total deaths. Globally tobacco use cases 8.8% of total annual deaths.

Chronic respiratory illness. Approximately 56 to 80% of chronic respiratory illnesses are attributable to tobacco use. Tobacco use in Indonesia is estimated to cause 4.4% of total deaths from chronic obstructive pulmonary disease, chronic bronchitis and emphysema.

Cardiovascular diseases. Globally, tobacco use accounts for an estimated 22% of cardiovascular diseases. It is also a contributor to hypertension.

Cancer. Tobacco use in Indonesia causes 90% of lung cancer cases, and 70% of mouth cancer cases.

Fertility and Impotence. Women who smoke may experience reduced or delayed ability to conceive. For men, smoking increases the risks of impotence by 50%.[2]

Health risks of Environmental Tobacco Smoke (ETS)

Inhaling other people's tobacco smoke, known as environmental tobacco smoke (ETS), is harmful to health.[3] Tobacco smoke contains over 4000 chemicals, including 43 known carcinogens. ETS is carcinogenic to humans, and there is no "safe" level of exposure.[4]

Yet, over half (57%) of Indonesian households have at least one smoker and almost all smokers smoke at home (91.8%). Nonsmokers married to smokers have an increased risk of lung cancer by 25 to 35%, and also heart disease.[5]

Exposure during pregnancy. Maternal smoking during pregnancy OR maternal exposure to ETS at home is associated with negative birth outcomes, including low birth weight, stillbirths, and birth defects.[6]

Exposure to children. More than 43 million Indonesian children are living with smokers and exposed to environmental tobacco smoke (ETS). The Jakarta Global Youth Survey among school children reported that 83.5% of children were exposed to ETS in public places.[7]

Children exposed to passive smoke experience poor lung growth, and increased rates of respiratory and ear infections, asthma.[8] Such early health damage may contribute to poor adult health.

Nicotine: A highly addictive substance

A landmark report of the US Surgeon General examined nicotine addiction and concluded:[9]

- Cigarettes and other forms of tobacco are addictive.
- Nicotine is the drug in tobacco that causes addiction.

Nicotine is an alkaloid poison found only in tobacco. It is highly addictive to the brain and central nervous system. Over the long term, nicotine depresses the ability of the brain to experience pleasure. Thus, smokers need ever-greater amounts of nicotine to achieve the same level of satisfaction for their addition.[11]

The highly addictive nature of nicotine is clearly illustrated in the discrepancy between wanting to quit smoking and successfully quitting. Surveys among Jakarta schoolchildren demonstrated that 20.4% smoked regularly. Among

these children, 80% wanted to stop smoking – but could not.[7]

The benefits of quitting smoking start immediately

6 hours after quitting
Pulse and blood tension return to normal
12 hours
Carbon monoxide (CO) leaves circulatory and respiratory systems
1 day
Lower blood pressure and stronger cardiovascular activity
1 year
Risk of heart attack reduced to half
Compared with smoker
5-15 years
Risk of stroke reduced to non-smoker level
10 years
Risk of lung cancer reduce to half of active smoker
15 years
Risk of heart attack reduced to non-smoker level if quitting occurs before the onset of disease
WHO Tobacco Atlas 2002. Quitting.
http://www.who.int/tobacco/statistics/tobacco_atlas/en/

Why low tar cigarettes are equally harmful to health

Cigarette ratings for tar, nicotine and carbon monoxide are currently determined by machine testing (ISO standards) developed by the tobacco industry in 1967. These methods to rate tar, nicotine and carbon monoxide do not predict actual intake or health impact – or the behavioral changes associated with people smoking different types of cigarettes.[11] In fact, low tar cigarettes typically also have lower levels of nicotine. Because people smoke to obtain a level of nicotine that satisfies their addiction, switching to cigarettes with "low tar" may result in people smoking (and buying) more cigarettes to achieve the desired level of nicotine that satisfies their addiction.

Branding cigarettes "light" and "low" has become a popular tobacco industry marketing technique that aims to convince smokers that they are using less dangerous product.

The Framework Convention on Tobacco Control (FCTC) prohibits misleading language, such as "light," "mild" or "low tar.

Clove cigarettes

Clove cigarettes comprise 60-70% tobacco and, therefore, possess all of the health hazards of tobacco cigarettes.

How much do Indonesian households spend on tobacco products?

Households spend a high proportion of monthly income on tobacco products. In 2001, spending on tobacco amounted to 9.6% of average monthly expenditures. Spending on tobacco products is higher than spending on fish (6.2%); vegetables (5.1%), and meat, eggs, and milk combined (6.4%).

Online Resources

[1] WHO 2003. Tobacco and Health in the Developing World. http://europa.eu.int/comm/health/ph_determinants/life_style/Tobacco/Documents/who_en.pdf

[2] Tengs TO, Osgood ND.The link between smoking and impotence: two decades of evidence. Prev Med. 2001 Jun;32(6):447-52. Abstract available: http://www.ncbi.nlm.nih.gov//entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=11394947

[3] WHO 2003. Comprehensive Reports on Passive Smoking by Authoritative Scientific Bodies. http://www.who.int/tobacco/health_impact/reports/en/

[4] US National Institutes of Health 2002. National Cancer Institute. Smoking and Tobacco Control Monograph #10: Health effects of exposure to Environmental Tobacco Smoke; http://cancercontrol.cancer.gov/tcrb/monographs/10/

[5] Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *BMJ* 1997; 315:980-8. http://bmj.com/

[6] Chan-Yeung and Ward. Respiratory health effects of exposure to environmental tobacco smoke: An invited review. http://www.blackwell-synergy.com/links/doi/10.1046/j.1440-1843.2003.00453.x/abs

[7] Jakarta Global Youth Tobacco Survey http://www.cdc.gov/tobacco/global/gyts/GYTS_factsheets.htm

[8] WHO 1999. International Consultation on Environmental Tobacco Smoke and Child Health. NCD/TFI/ETS/99. http://www.who.int/tobacco/health_impact/youth/ets/en/

[9] US Surgeon General 1988. The health consequences of smoking: nicotine addiction. http://profiles.nlm.nih.gov/NN/B/B/Z/G/_/nnbbzg.pdf

[10] US National Cancer Institute 2001. Monograph 13: Risks Associated with Smoking Cigarettes with Low Tar Machine-Measured Yields. http://cancercontrol.cancer.gov/tcrb/monographs/13/index.html

[11] US Federal Trade Commission. Up in Smoke: The truth about tar and nicotine ratings; http://www.ftc.gov/bcp/menu-tobac.htm

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Clean air policies & environmental tobacco smoke

The majority of Indonesian adults do not smoke.

About one in three adults smoke (31.5%). Smoking in public places violates the rights of non-smokers to clean air and imposes physical and financial costs on others.

What are the health risks of Environmental Tobacco Smoke (ETS)?

Tobacco smoke contains over 4000 chemicals, including 43 known carcinogens. ETS is carcinogenic to humans, and there is no "safe" level of exposure.[1]

Yet, over half (57%) of Indonesian households have at least one smoker and almost all smoke at home (91.8%). Nonsmokers married to smokers have an increased risk of lung cancer by 20 to 30%,[2] and heart disease.[3]

Exposure during pregnancy. Maternal smoking during pregnancy OR maternal exposure to ETS at home is associated with negative birth outcomes, including low birth weight, stillbirths, and birth defects.[4]

Exposure to children. More than 43 million Indonesian children are living with smokers and are exposed to passive or environmental tobacco smoke (ETS).[5] The Jakarta Global Youth Tobacco Survey reported that 84% of schoolchildren surveyed were exposed to ETS in public places.[6]

Children exposed to passive smoke experience poor lung growth, and increased rates of respiratory and ear infections, and asthma.[7] Such early health damage may contribute to poor adult health.

How does Indonesia compare on clean air laws?

The FCTC requires ratifying countries to implement laws that protect non-smokers from ETS on public transport, in workplaces, and all public places.[8]

PP 19/2003 bans smoking in mosques, public health and educational facilities, areas with child activities, and public transportation. These bans are not always enforced.

Would clean air laws have a negative impact on business?

No. On the contrary, US studies showed that bans on indoor smoking increased business and employment in service industries.[9] Furthermore, employees in workplaces with smoking bans consume fewer cigarettes, and are more likely to quit compared with employees in workplaces without clean air policies.[10]

Research has also conclusively demonstrated that banning or severely restricting smoking in the workplace pays economic dividends. It reduces costs to the employer in cleaning, maintenance, risk of fires, and property damage from tobacco smoke.

The US government estimated that each smoker cost his employer between US$ 2000 and 5000 annually in increased health insurance premiums, absenteeism, lost productivity, and property damage.[11]

Why not just separate smokers from non-smokers?

Some public places separate smokers from non-smokers, but this does not protect non-smokers from the carcinogenic effects of people smoking in the same room.

Even the most sophisticated ventilation technology available cannot remove the harmful toxins from ETS from the air.[12]

Opposition by the tobacco industry: international experience

Internationally, the tobacco industry has spent millions of dollars to discredit scientific evidence of the negative health impacts of environmental tobacco smoke (ETS) because it poses a major harm to their business interests. [13]

Issued by:
Tobacco Control Task Force
Ministry of Health
Jl H.R Rasuna Said Blok X-5, Kav 4-9
Jakarta 12950

Online resources

[1] U.S. National Institutes of Health. 10th Report on Human Carcinogens. Dec 2002. Tobacco and Related Exposures. http://ehp.niehs.nih.gov/roc/tenth/profiles/s176toba.pdf

[2] US NIH 2002. Smoking and Tobacco Control: Health effects of exposure to Environmental Tobacco Smoke; http://cancercontrol.cancer.gov/tcrb/monographs/10/

[3] International Agency Research on Cancer (IARC) Monograph; Evaluation of Carcinogenic Risks to Humans. Tobacco Smoke and Involuntary Smoking July 2002. http://monographs.iarc.fr/htdocs/indexes/vol83index.html

[4] Chan-Yeung and Ward. Respiratory health effects of exposure to environmental tobacco smoke: An invited review. http://www.blackwell-synergy.com/links/doi/10.1046/j.1440-1843.2003.00453.x/abs

[5] Pradono and Kristanti. 2002. Passive Smokers, the Forgotten Disaster. Institute of Health Research and Development, Ministry of Health

[6] Global Youth Tobacco Survey 2000. http://www.cdc.gov/tobacco/global/gyts/GYTS_factsheets.htm

[7] WHO 1999. International Consultation on Environmental Tobacco Smoke and Child Health. NCD/TFI/ETS/99. http://www.who.int/tobacco/health_impact/youth/ets/en/

[8] Framework Convention Alliance, Highlights of the FCTC. http://www.fctc.org

[9] Scollo, et al 2003. Review of .. studies on the economic effects of smokefree policies on the hospitality industry, Tobacco Control 13(20) http://tobaccoscam.ucsf.edu/pdf/ScolloTC.pdf

[10] World Bank2002. Smoke free workplaces at a glance. http://www1.worldbank.org/tobacco/AAG%20SmokeFree%20workplaces.pdf

[11] WHO 2002. The Tobacco Atlas. http://www5.who.int/tobacco/page.cfm?sid=84

[12] US National Center for Tobacco Free Kids 2001; Ventilation Technology does not Protect People From Second-Hand Tobacco Smoke; http://tobaccofreekids.org/research/factsheets/pdf/0145.pdf

[13] Ong & Glantz. Tobacco Industry Efforts to Subverting International Agency for Research on Cancer's second-hand smoke study. The Lancet 355: 9211 April 8, 2000 http://www.thelancet.com/journal/vol355/iss9211/contents

Tobacco and Indonesia: a perspective

1.	Number of Indonesian children exposed to environmental tobacco smoke at home	43 million
2.	Proportion of Jakarta school children exposed to tobacco smoke in public places	84 %
3.	Estimated number of human carcinogens in tobacco smoke	43
4.	Proportion of adult women who smoke	1.4%
5.	Proportion of adult men who smoke	62 %
6.	Average percent of monthly household expenditures for tobacco products	9.6 %
7.	Average percent of monthly household expenditures for meat, eggs and milk	6.4%
8.	Average annual spending on tobacco for a smoker in the poorest income quintile	Rp 1,440,000
9.	Proportion of Indonesian formal labor force that relies on tobacco	<3 %
10.	Average monthly wages in tobacco manufacturing as % of other industries (2000)	63 %
11.	Women as a proportion of the total tobacco manufacturing employment	82 %
12.	Proportion of smokers that started before they were 19 years old	69 %
13.	Proportion of long-term smokers that will die because of a tobacco-related illness	50 %

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Tobacco prices and tax policies for promoting health

What do tobacco prices have to do with promoting health?

Keeping the price of tobacco products high is a simple and effective way of generating positive health outcomes and increased government revenue. [1]

Raising tobacco prices will:

- **Reduce consumption, especially among children and infrequent users.**
- **Increase government revenue from tobacco taxes.**
- **Reduce burden of disease for tobacco-related illnesses.**

Reduce consumption, especially among children, infrequent users and the poor. Children in particular have less disposable income. High prices keep tobacco out of the reach of children.[1]

Increase government revenue from tobacco taxes. Most studies have demonstrated that the demand for tobacco is not highly responsive to price, or the percentage increase in price (via taxes) is less than the percentage reduction in demand. Therefore, an increase in tobacco taxes will result in a net increase in total government income. [2]

Reduce burden of disease for tobacco related illnesses.

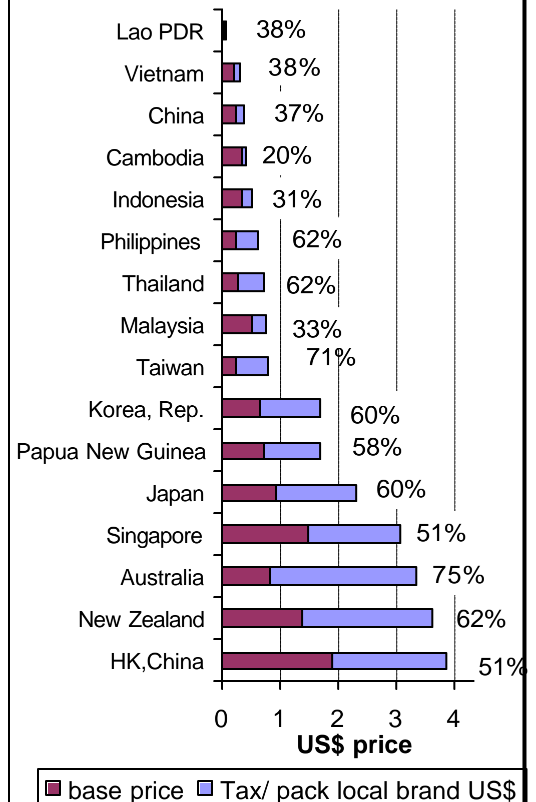
In 2001, millions of Indonesians suffered from severe illness related to active tobacco use: including cancers of the lung, mouth and throat; hypertension; heart, cerebro-vascular, and respiratory diseases, among others. It is estimated that several hundred thousand Indonesians died from active and passive tobacco use in 2001. These conditions and the associated health care costs are completely avoidable.

Tobacco excise taxes

Low tobacco prices in Indonesia are due in part to low tax levels, because the excise tax is an important component of the cost. Since 1999, the tax rate in Indonesia has been the second lowest in the region (31%) after Cambodia (20%).[3]

The tax levels on tobacco products are established to meet annual GoI revenue targets. The Ministry of Finance set the tax rate based on a "minimum" base price per stick. Both tax and base price vary by the type of cigarette and scale of production. In 2003, the lowest rates apply to small-scale hand-rolled manufacturers (4%) and the highest rates apply to large-scale machine-rolled manufacturers (40%).[4]

How low can you go?[5]
The average price of cigarettes (US$, 1999) and tax share as a % of base price, SE Asia region[3]



The "minimum" base price is used only to establish the tax rate. In effect, the industry charges a lower price at point of sale.

Because the tax is not always passed onto the consumer and prices remain low, the public health impact is minimal.

The response to the tiered tax and base price scales is two-fold:

1) At the manufacturing level, the tiered rates provide

an incentive for large firms to buy up or contract small firms to manufacture cigarettes and take advantage of the lower tax and pricing rates.

1) At the individual level, the big differences in tax rates by type of tobacco product can result in price differences at the point of sale. Thus, tobacco consumers simply substitute one type of tobacco product to another cheaper product.

What would happen if the GoI increased the price of tobacco by 10%?

Consumption would decrease by 3.5% - 6.1%. Several studies have demonstrated that a 10% increase in tobacco prices will decrease consumption by 3.5 % - 6.1%. The effect of tobacco price increases will be the strongest among those groups most sensitive to price changes, including children, infrequent users, and the poor.

Government tax revenue would increase by 6.7%-9.0%. The percentage decline in consumption (3.5 - 6.1%) is less than the percentage price increase (10%). This results in an increase in tax revenue for the government. Several studies in Indonesia have demonstrated that a 10% increase in tobacco prices will increase government revenue by 6.7% - 9.0%.

Keeping the price of tobacco products high is an effective way of generating positive health outcomes and increased government revenue.

Single stick sales increase accessibility for children and youth

Despite having low prices per pack, single stick sales are very common. Selling cigarettes by the stick further increases accessibility – particularly for youth. Sampoerna reported in 2001 that single sticks sales accounted for 30% of their total sales volume.[5]

Taxation and the poor

The poor are most harmed by tobacco use itself.[6] Higher tobacco taxes would be progressive in 2 ways.

1) First, the poor are more sensitive to price increases –and thus gain health and financial benefits.

Low-income people are more likely to quit or reduce consumption in response to a price increase.

A reduction in tobacco use avoids long-term health damage and treatment costs from active and passive tobacco use. Smokers and their family members exposed to environmental tobacco smoke (ETS) would have positive health benefits.

Furthermore, money not spent on tobacco products can be used for other goods that do not result in long-term health damage.

Overall, the poorest households spend, on average, 9.1% of monthly expenditures on tobacco products. A reduction in tobacco use would free up resources for other goods and services that could be beneficial to the family as a whole.

2) Second, high-income smokers will bear the financial burden of a tobacco tax increase.

Smoking prevalence is lower among high-income adult men (57.4%) compared with low-income men (62.9%). High-income smokers, however, tend to buy more expensive tobacco products and larger quantities of tobacco. In 1999, the average per pack price for a high-income smoker was Rp 3,410 compared with Rp 2,609 for a low-income smoker. In addition, high-income smokers consume about 12.5 sticks per day, compared with 10 sticks per day among low-income smokers.

The tax burden, therefore, would be borne by higher-income smokers who spend more money on tobacco, consume more tobacco, and are less responsive to price increases.

Tobacco taxes can benefit low-income smokers who reduce spending on tobacco (and contribute less to the tax).

Fears and Facts:

Despite strong evidence that tobacco taxation is a win-win solution, fears exist that increasing tobacco taxes will also have negative impacts.

But how do these compare with the facts?

Will higher tobacco taxes reduce overall government revenue from tobacco tax?

FACT. Historically, raising the prices of tobacco products has never resulted in a decline in government revenues anywhere in the world.[3]

Government revenue from tobacco excise taxes in Indonesia has steadily increased over time and accounted for 7.6% of total government revenues in 2002, or approximately Rp 23 trillion.

With higher taxes, smaller quantities of cigarettes are sold. Consumption is reduced, and the effect is stronger on those most sensitive to price – such as children and adolescents. But a higher tax per pack generates higher total revenues – even in countries with high taxes and prices.

Will higher tobacco taxes lead to smuggling (and loss of excise tax revenue)?

FACT. The most important determinants of smuggling are weak law enforcement, low penalties for violation of laws, and unlicensed distributors.

The reality is that tax is a small part of the smuggling issue.[7] Other more important factors include the tobacco industry's role in facilitating smuggling to get into new markets, existence of criminal gangs, unlicensed distribution, and lax anti-smuggling laws and enforcement. Regionally, Singapore has one of the highest levels of cigarette taxation but the lowest level of smuggling.[3]

Country	Smuggling as % of domestic sales (1995)	Tax share as % of total cigarette price
Singapore	**2%**	**51%**
Indonesia	**5%**	**31%**
Malaysia	**18%**	**33%**
Vietnam	**28%**	**38%**
Cambodia	**37%**	**20%**

In addition, 88% of Indonesian smokers prefer *kreteks*, which are produced domestically.

Will an increase in tobacco taxes cause massive unemployment?

FACT. Less than 3% of the formal labor force relies on tobacco farming and production to make a living.

Agriculture. Overall, less than 1% of full-time employment in the agricultural sector was related to tobacco farming. The total number of tobacco farm workers in Indonesia is estimated at 2.3% of the total agricultural labor force. Tobacco farming is seasonal, however, and does not provide full-time work. Using the amount of land farmed, it is estimated that tobacco farming provides approximately 1.05% of full time work in the agricultural sector.

Furthermore, less than 1% of available arable land is devoted to tobacco cultivation, and most is limited to two provinces: Central and West Java.

Industry. Tobacco manufacturing contributes about 1.2 % of employment in the industrial sector. The vast majority are women who earn 2/3rds of the average wages in the industrial sector.

Globally, it has been demonstrated that the single most important factor affecting employment in the tobacco industry is new technology that improves efficiency.

The mechanization of *kretek* production in the 1970s is the main factor that affected labor. The tobacco industries contributed 38% of manufacturing employment in 1970 compared with 5.6% in

2000. Labor costs comprise nearly 12% for SKT compared with 0.4% for SKM.

Conclusions

Tobacco kills ½ of its users, cutting 20-25 years off a healthy life.

The immediate economic need is reducing the increase in tobacco use, and its devastating health impacts.

Keeping the price of tobacco products high is an effective way of generating positive health outcomes and increased government revenue.

Online Resources

[1] World Bank 2000. Tobacco Control in Developing Countries. http://www1.worldbank.org/tobacco/tcdc.asp

[2] Hu 1997. Cigarette taxation: lessons for international experience. Tobacco Control 6: 136-40. http://tc.bmjjournals.com/cgi/reprint/6/2/136.pdf

[3] World Bank,: Indonesia brief http://www1.worldbank.org/tobacco/pdf/country%20briefs/Indonesia%20.pdf

[4] USDA Gain Files. 2003. Indonesia Tobacco and Products Annual 2002. http://www.fas.usda.gov/gainfiles/200210/145784183.pdf

[5] Logo for Sampoerna Mild. PT. Handjaya Mandala Samp Sampoerna http://www.indoexchange.com/jsx/hmsp/financial/spreadsheet-annual-index.html

[6] de Bayer, Lovelace, and Yurekli. 2001 Poverty and Tobacco. Tob Control 10 http://tc.bmjjournals.com/cgi/content/full/10/3/210

[7] World Bank 2002. Tobacco Control in Developing Countries. http://www1.worldbank.org/tobacco/tcdc.asp

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WHO 2003. Economics of tobacco use and control in the developing world. http://europa.eu.int/comm/health/ph/programmes/world_bank_en.pdf

Prabhat Jha, Joy de Beyer dan Peter Heller, 1999; "Death & Taxes: Economics of Tobacco Control,' Finance & Development, Vol. 36, No. 4 http://www.imf.org/external/pubs/ft/fandd/1999/12/jha.htm

Jha & Chaloupka. The economics of global tobacco control. BMJ 2000 321: 358-61. http://bmj.com/cgi/content/full/321/7257/358

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Jl H.R Rasuna Said Blok X-5, Kav 4-9
Jakarta 12950

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Myths and Facts about Tobacco in Indonesia

In the debates about tobacco control, arguments are put forth about the importance of tobacco to Indonesian society and economy. But how do these arguments compare with the facts? Here are some of the most common myths -- and facts – about tobacco.

Myth 1. Research about the health risks of tobacco is inconclusive.

FACT. More than 70,000 scientific articles have conclusively demonstrated that tobacco use and exposure to passive (environmental) tobacco smoke is harmful to health.[1]

Globally, tobacco use kills 4.9 million people annually. About ½ of long-term smokers die of their habit, cutting 20 to 25 years off of a healthy life.

More than 70,000 scientific articles have conclusively demonstrated that active tobacco use and passive exposure causes a broad range of serious health problems including cancers of lung, mouth, and other organs; heart diseases; and respiratory diseases.

Clove cigarettes contain 60-70% tobacco and therefore possess all of the health risks of tobacco products.

Myth 2. Prohibiting smoking in public places violates smokers' rights.

FACT. Smoking in public places violates the rights of non-smokers to clean air and causes negative health outcomes in others.

Tobacco smoke contains over 4000 chemicals; 43 are known to be carcinogenic to humans.[2] Non-smokers married to smokers have a 20-30% increased risk of lung cancer. Maternal exposure to passive tobacco smoke during pregnancy is associated with an increase risk of low birth weight, stillbirth, and complications during labor.[3] Particularly among children, passive smoke increases the incidence of respiratory illnesses and reduces lung capacity.[4]

Myth 3. Most Indonesian adults smoke.

FACT. The majority of Indonesian adults do not smoke.

About 31.5% of Indonesian adults smoked in 2001. Tobacco industry marketing aims to create an environment that promotes consumption of tobacco as a part of social norms, particularly among children and adolescents.[5] Tobacco industry sponsorship of sports and cultural events, for example, ensures that children are exposed to tobacco products at an early age.

Myth 4. People make informed decisions about spending their money on tobacco products.

FACT. Most smokers start their habit when they are children or adolescents.

About 70% of Indonesian smokers start before they are 19 years old. Children and teenagers do not have the capacity to evaluate the health risks of smoking and the highly addictive nature of nicotine.

Myth 5. Tobacco control will cause massive unemployment.

FACT. Less than 3% of the formal labor force relies on tobacco farming and industry to make a living.

Agriculture. Tobacco farming is seasonal and does not provide full-time work. Less than ½ million full time workers dependent on tobacco farming as measured by full-time equivalents. Agriculture data showed the total number of tobacco farmers in 2002 were 900.000. Overall, tobacco farming provides 1% of employment in the formal sector. Furthermore, less than 1% of available arable land is devoted to tobacco cultivation, and 96% of tobacco farming is done in only three provinces:

Central, East Java, and West Nusa Tenggara.

Industry. About 1.2 % of the total industrial sector workforce is involved in tobacco manufacturing or 0.3% of total workforce. The vast majority are women who earn 2/3rds of the average wages in the industrial sector.

Globally, the single most important factor affecting employment in the tobacco industry is new technology that improves efficiency.

The mechanization of kretek production in the 1970s was the most important determinant of labor. Labor costs comprise nearly 12% for hand-rolled *kreteks* compared with 0.4% for machine-rolled. Whereas the tobacco industry contributed 38% of manufacturing employment in 1970s, employment declined sharply after mechanization. Today, tobacco industries employ an estimated 5.6% of employment in manufacturing.

Myth 6. Promoting comprehensive tobacco control policies will hurt the Indonesian economy.

FACT. Money not spent on tobacco products will be spent on other goods and services.

In Indonesia, one low-income smoker spends more than Rp 1 million per year on tobacco products. Money not spent on tobacco products can be spent on other commodities that do not result in long-term health damage. In the long term, reducing the number of smokers will have economic gains.

The reality, however, is that tobacco consumption is increasing rapidly. Even with successful tobacco control policies, the WHO predicts an increase in global tobacco consumers from 1.1 billion (1999) to 1.6 billion by the year 2025. [1]

Myth 7. Higher tobacco taxes will lead to reduced government revenue

FACT. Historically, raising the price of tobacco products has never resulted in a decline in government revenues anywhere in the world. [6]

With higher taxes, smaller quantities of cigarettes are sold, but the tax per pack is higher. This generates larger total revenues, even in countries with high taxes and prices. Even very substantial cigarette tax increases can both reduce consumption and increase government tax revenue.

Myth 8. Higher tobacco taxes will lead to smuggling (and loss of excise tax revenue).

FACT. The most important determinants of smuggling are weak law enforcement, low penalties for violation of laws, and unlicensed distributors.

The reality is that tax is a small part of the issue. [6] Other more important factors include the tobacco industry's role in facilitating smuggling to get into new markets, existence of criminal gangs, unlicensed distribution, and lax anti-smuggling laws and enforcement. Regionally, Singapore has one of the highest levels of cigarette taxation but the lowest level of smuggling. [7]

Country	Smuggling as % of domestic sales (1995)	Tax as % of cigarette price
Singapore	2%	51%
Indonesia	5%	31%
Malaysia	18%	33%
Vietnam	28%	38%
Cambodia	37%	20%

In addition, an estimated 88% of Indonesian smokers prefer *kreteks* – produced and distributed domestically.

Online resources

[1] WHO 2002. Tobacco Atlas. http://www5.who.int/tobacco/page.cfm?sid=84

[2] US NIH 2002. Health effects of exposure to Environmental Tobacco Smoke; http://cancercontrol.cancer.gov/tcrb/monographs/10/

[3] Chan-Yeung and Ward. Respiratory health effects of exposure to environmental tobacco smoke http://www.blackwell-synergy.com/links/doi/10.1046/j.1440-1843.2003.00453.x/abs

[4] WHO 1999. Consultation on Environmental Tobacco Smoke and Child Health. http://www.who.int/tobacco/health_impact/youth/ets/en/

[5] Tobacco Free Kids How do you sell death? http://www.tobaccofreekids.org/campaign/global/reports.shtml

[6] World Bank 2002. Tobacco Control in Developing Countries. http://www1.worldbank.org/tobacco/tcdc.asp

[8] World Bank 2002. Indonesia briefing http://www1.worldbank.org/tobacco/pdf/country%20briefs/Indonesia%20.pdf

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Jakarta 12950

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Comprehensive ban on advertising, promotion & sponsorship

A cigarette is made of paper, glue, tobacco, cloves, and up to 600 chemicals. It is designed to deliver nicotine – a powerfully addictive substance – and kills half of its users.

A movie star with a cigarette in her hand, however, becomes a powerful advertisement for smoking among youth who want to be modern and fashionable.

The tobacco industry claims that advertising does not recruit new smokers but only encourages current smokers to stay or switch to different brands. This claim is false.

A landmark US Surgeon General report concluded that tobacco advertising increases consumption in several ways, including: [1]

- **Creating an environment where tobacco use is seen as positive and familiar.**
- **Reducing smoker's motivation to quit.**
- **Encouraging children to experiment with tobacco.**
- **Discouraging open discussion of the hazards of tobacco use because of tobacco industry advertising revenues.**

Advertising tobacco products, therefore, is a major public health issue.

Tobacco advertising increases consumption by creating an environment where tobacco use is positive and familiar.

"Indonesian (tobacco) companies have almost total freedom to advertise their products in any format and through almost any communication vehicle."

Sampoerna 1995 annual report

Since a TV advertising ban was lifted in 1991, almost no restriction exists on tobacco advertising in Indonesia.

The exception is daytime TV advertising – prohibited from 5 AM to 9.30 PM in the existing legislation (PP 19/2003).

Between 1990 and 2001, the increase in cigarette consumption in Indonesia was the one of the highest in the world – comparable to Bulgaria, Turkey, and Pakistan.

10 countries with large increases in cigarette consumption, 1990-2000[2]

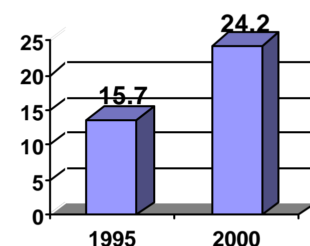
	% increase
Pakistan	65 %
Turkey	58 %
Bulgaria	56 %
Indonesia	**54 %**
Romania	25 %
Argentina & Chile	22 %
Korea Rep	20 %
Algeria & Portugal	19 %

Encouraging youth to experiment with tobacco: indirect advertising. [3]

"Today's teenager is tomorrow's potential regular customer … The smoking patterns of teenagers are particularly important to Philip Morris."

1981 report to Philip Morris

Sponsorship and promotions are key components of the tobacco industry's strategy in reaching youth. All major tobacco companies in Indonesia sponsor sporting events, youth events, and music concerts. The result is that Indonesian children are strongly influenced by advertising that associates smoking with success and happiness. A rapid increase in consumption in boys 15-19 years age group can be seen between 1995 and 2000.



Increase in % of Indonesian boys 15-19 yrs smoking regularly

Distribution of free product samples is prohibited in the existing legislation (PP 19/2003), but discount coupons are commonly distributed. In addition, cigarettes are sold by the

stick – making them accessible to youth.

Discouraging open discussion of the health hazards of tobacco use because of tobacco company revenues.

Globally, tobacco companies spend an estimated US$ 8 billion annually on advertising, sponsorship and promotions.[4]

Print or electronic media that rely on tobacco company revenues may be reluctant to promote tobacco control messages for fear of loss of revenue. This creates a major imbalance in the availability of accurate information for consumers.

In Indonesia, cigarette advertisements comprise only one part of TV revenues, or about 7% of income from major types of advertising in the 1st half of 2002. [5]

In contrast, ad income from toiletries and cosmetics is 4 times greater than cigarettes.

TV advertising revenue, January – June 2002 (AC Nielson)

	Rp bill	%
Toiletries/cosm	821	27%
Beverages	444	14%
Medicine/drugs	407	13%
Food	368	12%
Hshd products	304	10%
Services: all	254	8%
Cigarettes	**207**	**7%**
Hshd equip	153	5%
Automotive	131	4%
Total: top categories	**3089**	**100%**

Tobacco companies also utilize extensive outdoor billboard advertisement, which comprised an estimated 6.9 % of total billboard advertising revenue in 1996.

Comprehensive vs. Partial Bans

Evidence demonstrates without a doubt that comprehensive tobacco advertising bans reduce tobacco consumption.

But partial bans have little or no effect. When some types of advertising are banned, companies simply shift from one type of advertising to another. [6]

Partial bans on tobacco product advertising, sponsorship, and promotion are not effective in reducing tobacco consumption.

In the U.K. and the US, television advertisements for tobacco were banned in 1965 and 1971. A subtle but effective system of indirect advertising began in movies, however, with famous actors paid to smoke or show cigarette packaging.

During the 1990s, nine out of ten Hollywood films featured tobacco. Stories with charismatic actors are a powerful way to attract new smokers – especially teens and young adults. [7]

Online Resources

[1] US Department of Health and Human Services. 1989. Reducing the Health Consequences of smoking: 25 years of progress. Surgeon General's Report. http://profiles.nlm.nih.gov/NN/B/B/X/S/

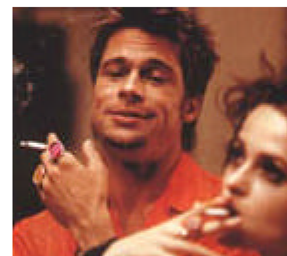
[2] World Bank 2002. Indonesia briefing http://www1.worldbank.org/tobacco/pdf/country%20briefs/Indonesia%20.pdf

[3] Tobacco Free Kids 2001. How do you sell death? http://www.tobaccofreekids.org/campaign/global/reports.shtml

[4] WHO 2002. The Tobacco Atlas. http://www5.who.int/tobacco/page.cfm?sid=84

[5] Brand Appearances in Contemporary Cinema Films, Lancet 2001,357: 29-32. http://pdf.thelancet.com/pdfdownload?uid=llan.357.9249.original_research.14762.1&x=x.pdf

[6] World Bank 2002. Tobacco Control in Developing Countries. Chapter 9. Tobacco Advertising and Promotion. http://www1.worldbank.org/tobacco/tcdc.asp



[7] UCSF Smoke Free Movies http://www.smokereemovies.ucsf.edu/

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Public awareness and education about tobacco

Do active and passive smokers know their risks?

One of the arguments against tobacco control is that smokers themselves make informed decisions about spending their own money.

But do they?

This argument assumes that smokers know and understand the risks of smoking, and that a smoker's behavior does not affect others. Tobacco use, however, violates both of these assumptions.

1) First, many Indonesians do not understand the health risks of smoking.

One of the difficulties in understanding the health risks of tobacco use is the delay of 20 to 25 years between the time someone starts to smoke and the onset of many diseases, such as lung cancer.
Another difficulty is that the tobacco industry attempts to systematically refute scientific evidence about the health impact of smoking. Since the mid-1950s, tobacco industries in industrialized countries hid facts about the health hazards of smoking, fought to undermine tobacco control laws in many countries, and attempted to buy influence against tobacco control measures. [1]

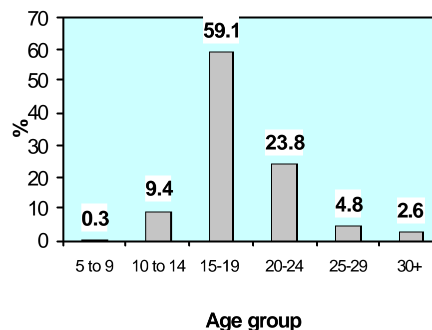
2) Second, tobacco contains nicotine – a highly addictive substance.

Despite the fact that smokers who quit can reduce their health risks, very few succeed because they underestimate the highly addictive nature of nicotine.[2]

3) Third, most smokers start their habit when they are children or adolescents.

Nearly 70% of Indonesian smokers start before they are 19 years old. Children and teenagers do not have the capacity to evaluate the health risks of smoking and the highly addictive nature of nicotine.

Age of smoking initiation, 2001



4) Fourth, smokers impose physical and financial costs on others.

Another assumption about consumer sovereignty is that the smoker alone bears all "costs" of his habit. Smokers, however, impose physical and financial costs on others. These costs include health risks to others from passive or **environmental tobacco smoke (ETS)**, and health care costs to the society. [4]

***

Is your youth prevention program effective?

The average age at uptake among Indonesian smokers declined from 18.8 years in 1995 to 18.4 years in 2001. Smoking habits that begin during childhood are more difficult to stop. Children who smoke are at high risk of developing tobacco-related diseases in mid-life.

Teaching an individual child not to smoke is not effective within an environment where tobacco is inexpensive and accessible, and tobacco advertising is widespread. [5]

Youth programs can only be effective if they are integrated into a comprehensive campaign that includes:

- Keeping tobacco prices high
- Comprehensive advertising and promotion bans
- Clean air laws
- Education about risks
- Helping people stop smoking.

Why is the tobacco industry sponsoring research and youth prevention programs?

Supporting programmatic interventions and research in tobacco control is costly. Within many parts of the world, however, the tobacco industry is promoting youth smoking prevention programs and research.

Why?

Programmatic interventions. It has been demonstrated that industry sponsored prevention programs distract time and funding from interventions that work.

*"If we can frame ... action on the youth access issue... we will be protecting our industry for decades to come."***

Philip Morris, 1995

Research. The tobacco industry also finances research on the health effect of tobacco. But their goal is to protect their business interests.

Tobacco funded researchers in the US reported that findings conflicting with the promotion of tobacco products has not been disclosed or edited to omit sensitive words, such as cancer.[6]

It is essential that tobacco control research is conducted and funded by researchers who are independent of the tobacco industry.

Is your youth prevention program effective? A quick test

a) Does it advocate any of the following messages?

- "Youth should not smoke."
- "Smoking is an adult decision."
- "Only adults should smoke."
- "Just say no."

b) Does it stress peer pressure without acknowledging the role of the environment, such as bans on advertising and promotion?

c) Does it emphasize restricting youth access to tobacco products via prohibiting sales to minors and voluntary cooperation of tobacco retailers?

d) Does it involve a "partnership" between the tobacco industry and government, educators, or non-governmental institutions?

e) Is the tobacco industry promoting the program as a part of its "responsible marketing" policy?

If you answered "YES" to any of the above questions, then the youth smoking prevention program is likely to be ineffective.

Rather than protecting youth from tobacco, it may actually encourage an increase in youth smoking.

** "The Truth about the Tobacco Industry's Youth Smoking Prevention Programmes." WHO Western Pacific Region. http://www.wpro.who.int/tfi/docs/Seeing_bneath_d_surface.pdf

Leadership is needed

Gaining the support of political and community leaders is crucial in promoting tobacco control and healthy environments in Indonesia.

Online Resources

[1] Report of the Committee on Experts of Tobacco Industry Documents July 2000; Tobacco Company Strategies to Undermine Tobacco Control at the World Health Organization http://tobacco.who.int/repository/stp58/who_inquiry.pdf

[2] See the US National Institute on Drug Abuse. Nicotine Addiction. http://www.drugabuse.gov/ResearchReports/Nicotine/nicotine2.html

[3] Sampoerna Intelligence Reports 2003

[4] US National Institutes of Health 2002. National Cancer Institute. Smoking and Tobacco Control Monograph #10: Health effects of exposure to Environmental Tobacco Smoke; http://cancercontrol.cancer.gov/tcrb/monographs/10/

[5] Ling et al 2002. It is time to abandon youth access tobacco programmes; Tobacco Control 11: 3-6. http://tc.bmjjournals.com/cgi/content/full/11/1/3

[6] WHO 2002. The Tobacco Atlas. http://www5.who.int/tobacco/page.cfm?sid=84

[7] WHO 2000. The World Conference on Tobacco or Health 2000: Tobacco Fact Sheet: School and Community Based Programs http://tobaccofreekids.org/campaign/global/docs/programs.pdf

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Tobacco consumption & prevalence in Indonesia

Tobacco Consumption

The Republic of Indonesia is one of the largest consumers of tobacco products in the world.

Indonesia ranks fifth among countries with the highest aggregate levels of tobacco consumption in the world.

Countries with the highest tobacco consumption, 2002[1]

	2002 tobacco consumption
PR of China	1,697,291
US	463,504
Russian Feder.	375,000
Japan	299,085
Indonesia	**181,958**
Germany	148,400
Turkey	116,000
Brazil	108,200
Italy	102,357
Spain	94,307

Indonesia has experienced a steep increase in tobacco consumption during the last 30 years: from 33 million sticks per year in 1970 to 217 million in 2000.

Between 1970 and 1980, consumption increased by 159 %. Contributing factors were the positive economic climate and the mechanization of the cigarette production in 1974.

Between 1990 and 2000, a further 54% increase in tobacco consumption occurred –despite the financial crisis.

Smoking prevalence

Nearly one in three adults smoke.
Smoking prevalence among adults increased to 31.5% in 2001 from 26.9 % in 1995.

More than 6 in 10 men smoke, but few women do.
In 2001, 62.2% of adult males smoked, compared with 53.4 % in 1995. Only 1.3% of women reported smoking regularly in 2001.

More rural men smoke.
Smoking prevalence among rural adult males is 67.0 % compared with 58.3 % in urban areas.

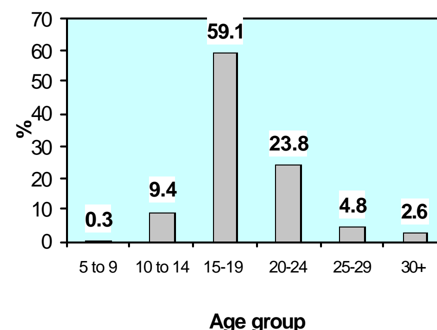
73% of males with no formal education smoke.
More than 7 in 10 males with no formal education smoke (73.0%), compared with 44.2% of those who finished SLTA.

Low income males: higher prevalence but lower consumption.
The lower the income the higher the smoking prevalence. 62.9% of low-income males smoke regularly compared with 57.4% among high-income males. But higher income means higher consumption. High-income males smoke an average of 12.3 sticks per day compared with 10.2 among low-income males.

Age at initiation

Nearly all (68.8%) smokers start their habit before 19 years of age, when they are children or teenagers.

Age of smoking initiation, 2001

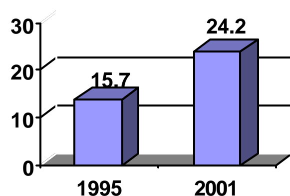


The average age smokers start their habit declined from 18.8 years in 1995 to 18.4 years in 2001.

Prevalence increases rapidly after 10 to 14 years of age among males.
Smoking prevalence increases rapidly with age among males: from 0.7% (10-14 years), to 24,2 % (15-19 years), jumping to 60.1 % among 20 to 24 year olds.

Boys 15-19 years old experienced a 65% increase in consumption between 1995 and 2001—higher than any other group.

Increase in % of Indonesian boys 15-19 years smoking regularly



Exposure to environmental tobacco smoke (ETS) or passive smoke

More than 43 million children are exposed to passive or environmental tobacco smoke (ETS). Over half (57%) of households have at least one smoker and almost all smoke at home (91.8%). It is estimated that more than 43 million children are living with smokers and are exposed to passive or environmental tobacco smoke (ETS).[2] ETS is a human carcinogen.[3]

Infants and children exposed to ETS have increased rates of respiratory and ear infections, asthma; and reduced rates of lung growth.[4]
Non-smoking adults regularly exposed to ETS have higher rates of lung and other cancers.[5]

Online Resources

[1] USDA data on consumption for Indonesia is based on production http://www.fas.usda.gov/psd/complete_files/TOB-1222000.csv

[2] Pradono and Kristanti. 2002. Passive Smokers, the Forgotten Disaster. Institute of Health Research and Development, Ministry of Health

[3] U.S. National Institutes of Health. 10th Report on Human Carcinogens. Dec 2002. Tobacco and Related Exposures. http://ehp.niehs.nih.gov/roc/tenth/profiles/s176toba.pdf

[4] WHO 1999. International Consultation on Environmental Tobacco Smoke and Child Health. NCD/TFI/ETS/99. http://www.who.int/tobacco/health_impact/youth/ets/en/

[5] US NIH 2002. Smoking and Tobacco Control: Health effects of exposure to Environmental Tobacco Smoke; http://cancercontrol.cancer.gov/tcrb/monographs/10/

WHO 2002. The Tobacco Atlas. http://www5.who.int/tobacco/page.cfm?sid=84

NOTES
Adult smoking prevalence for 15 years or older from Susenas national household survey.
DATA reported for 2001 unless otherwise indicated.

Issued by:
Tobacco Control Task Force
Ministry of Health
Jl H.R Rasuna Said Blok X-5, Kav 4-9
Jakarta 12950