Smokers: why do they start – and continue?

Simon Chapman

Although smoking nauseates beginners, they are encouraged to persevere by various attractions such as its associations with maturity, glamour and friendship, as well as the evident pleasure it offers for those who overcome the body’s initial revulsion. Once the pleasure is attained, addiction is the main reason for not stopping, especially when reinforced by easy availability, positive associations and the belief that quitting is terribly difficult. These facts, well known and used by the tobacco industry, also provide the basis for control strategies.

In 1992, matches and lighters were struck under an estimated 5,392,000,000,000 cigarettes throughout the world (1). Yet some 400 years before, Sir Walter Raleigh’s servant, on first seeing smoke drifting from Raleigh’s mouth, reportedly doused his employer with a bucket of water, sensibly reasoning that where there was smoke there must be fire. When tobacco first appeared in Europe, there were understandably no words in European languages for this intrinsically strange ritual. Smoking was often referred to as a form of alcohol drinking (“dry drunkenness”) or as “fog sucking” (2).

Since then, tobacco smoking has become commonplace throughout the world. So often a subject of humour about the peculiarities of the human condition, smoking remains frequently depicted in literature, cinema and the advertising and promotional activities of the tobacco industry as emblematic of modernity, freedom, success and personal potency. At the same time, it has become vilified as the greatest single cause of premature death in the developed world, and increasingly, in less developed countries as well. The United States Surgeon General, Dr. Antonia Novello, said in the preface to the 1990 Surgeon General’s report on tobacco: “It is safe to say that smoking represents the most extensively documented cause of disease ever investigated in the history of biomedical research.”

In this article, I will discuss two of the most basic questions asked in the tobacco control field: why do people start smoking? And why do they continue smoking, often for all the remaining (albeit frequently shortened) years of their lives? These questions have spawned a huge international research literature which has drawn on scholarship from pharmaco-
logical, behavioural, sociological, anthropological and economic disciplines. I will try to summarize some of the more salient conclusions from this literature, while also introducing a few personal perspectives that I have formed during twenty years of experience in this area.

Large proportions of smokers wish that they did not smoke and had never taken it up. ... Most smokers attempt to stop smoking on many occasions.

Why do people start smoking?

Ask almost anyone about their first experience of smoking and you will be regaled by animated recollections of coughing, retching, acute respiratory distress and general embarrassment. If smoking could be considered as simply an act of inhaling smoke into the lungs, and not subject to the different social, cultural, historical and commercial contexts in which this act always takes place, it would be reasonable to ask why anyone would voluntarily seek to repeat such an unpleasant experience.

The answer of course, lies in the fact that smoking, wherever it takes place, is imbued with a multitude of important cultural meanings which shape the very anticipation and experience of smoking. Many of these meanings beckon the young nonsmoker as distinctly positive and beguiling, and their attraction is frequently irresistible. It is critical to the attempt at both understanding the initiation and continuation of smoking and in seeking to reduce its prevalence to appreciate that to smoke is never just to smoke. Depending on where it occurs throughout the world and the age, sex and socioeconomic status of the smoker, early attempts at smoking can be attempts to signify some of the following:

- **A rite of passage into adult life.** In some societies smoking is considered a normal sign of having attained adulthood. In certain less developed countries with relatively rigid social structures, smoking remains largely an adult behaviour seldom seen in children. In such cultures when a youth reaches adult age, a range of newly acceptable behaviours, including smoking, define the public display of adult status. In cultures with more flexible social and sex role stratification, there is considerable “leakage” from childhood to adulthood roles, with smoking by young teenagers being common, even though defined as problematic and frequently punished by disciplinary figures like parents and teachers.

It is my view that one of the most powerful weapons against teenage smoking is likely to lie in the declining rate of smoking among adults in countries where this is now happening. If an important motivating factor in children’s smoking is to display to their peers that they wish to be regarded as adults, then when adult smoking becomes less and less common (as is occurring in many countries with major tobacco control programmes such as Australia, Canada, New Zealand, and Sweden) it will be increasingly difficult for children to see smoking as an adult way to behave. It is interesting to speculate whether in countries with rapidly declining adult smoking prevalence, that a critical point might be reached (say, adult smoking prevalence of 10%) where smoking will come to be seen as an obviously childish activity like blowing bubble gum. Just as children and teenagers become acutely conscious of particular fashions, hairstyles, pop culture and colloquialisms, it may be that teenagers trying desperately to divest themselves of childish identification symbols will come to shun smoking.
An anti-authoritarian gesture. In many cultures, part of the passage from childhood to adulthood involves ritualized attempts at rejecting parental definitions of appropriate childish behaviour. Many child psychologists would argue that an important and developmentally healthy part of the transition from childhood to adulthood involves children challenging limitations placed on their behaviour: questioning authority, and experimenting with behaviour denied to them for reasons that often seem arbitrary or capricious. If children grow up in a culture being told that smoking is an unhealthy, senseless thing to do, and yet every day see adults smoking whom they admire and whose power and privileges they envy, it is understandable that the credibility of admonitions against smoking seem to many children to be hollow and perhaps hypocritical. Curiosity is an important quality in child and adolescent development that frequently expresses itself in parentally disapproved ways. In such contexts, experimental smoking by children is very understandable. The challenge for tobacco control workers is to move beyond the blunt denial of curiosity and suppression of healthy levels of anti-authoritarianism, and into approaches that steer such undercurrents into less destructive forms of expression.

Being a man. In most less developed countries, there are strong social proscriptions against smoking by women, with the result that smoking is far less common among women than men in those countries (3). So in addition to being a part of growing into adulthood, smoking can be an important part of the process of male socialization.

Modernity and affluence. In less developed economies, cigarettes – particularly American brands that carry heavily advertised associations of western culture – are relatively expensive consumer goods and therefore connote affluence and modernity. Although expensive, they are none the less within reach of even the poorest strata of society in the form of single sticks.

Just as it is impossible to be “half pregnant, it is nonsensical to argue that some forms of tobacco advertising should be restricted but other forms should be allowed to continue.

Throughout the developing world certain brands of cigarettes are promoted to be identified as a form of social currency used to signal that the smoker is a participant in modernity and not merely a spectator of it.

Cigarettes as fashion accessories. Many cigarette advertisements, particularly those aimed at women, depict smoking as integral accoutrements of style – as an important part of the presentation of self in everyday life. Cigarettes provide the smoker with a vast repertoire of small behavioural options and props which are not easily substituted by the nonsmoker. With a cigarette, one can deploy a large range of signifying gestures, postures and rituals with associations established through literature and film (for example the unruffled toughness of Humphrey Bogart, or the Parisian café intellectualism of Jean-Paul Sartre).

Hospitality and friendship. In some countries, to offer a cigarette is to extend goodwill. Community health workers in Australia, for example, report that it is common for Arab families, even when they may not smoke themselves, to stock up on a range of brands of cigarettes to offer around to guests. A corollary of such behaviour is that to refuse an offered cigarette is to risk communicating rejection of such goodwill.
For many, the easier and less socially risky course is to accept a cigarette – a habit that can rapidly turn polite smokers into regular, dependent smokers.

**Social class norms.** Tobacco use, particularly in western societies, is increasingly becoming concentrated in lower socioeconomic groups: ex-smokers and never-smokers are found in greater concentration in more affluent and educated groups (4). Some of the most commonly found predictors of an individual’s smoking are having a spouse, siblings, a peer group, a social network and a set of workmates who tend to smoke. Put simply, these correlates and predictors are really proxies of socioeconomic status: if a person’s family, friends and workmates are mostly smokers, there will obviously be many expectations and cues for that person to smoke as well, and fewer opportunities, discourses and restrictions that foster negative attitudes towards smoking.

Some of the most important tobacco control initiatives in such societies in the near future are going to be those which target smoking in low socioeconomic groups. It has become almost mandatory for health promotion workers to talk about the importance of such targeting, but unfortunately there is little indication that tobacco control initiatives have the same impact on the poor and less educated as they do on more affluent groups.

**Tobacco advertising and promotion**

Tobacco advertising is the organized, planned, deliberate and often highly researched attempt to promote smoking. It is quite nonsensical to argue – as the tobacco industry repeatedly does – that tobacco advertising should be understood as strictly the promotion of a particular brand being advertised. Just as one cannot promote the virtues of a make of car without promoting the act of driving, one cannot advertise a brand of cigarette without simultaneously recommending smoking itself. The corpus of tobacco advertising imagery throughout the world is a catalogue of attempts to create and reinforce associations with smoking that are compatible with continuing and rising sales. All of the associations of smoking described above – to which could be added associations of luxury, international travel, excitement, sexuality, companionship, uniqueness, relaxation ... the list could go on for many pages – are associations that have nothing *intrinsically* to do with tobacco or smoking. They are all associations which arise because advertising has constantly attached such meanings to cigarettes in the effort to appeal to very ordinary human emotions, hopes and yearnings. These are not emotions which exclusively appeal to smokers. Any adolescent girl, unsure of herself as she navigates new areas of experience like romance, career and everyday adult interaction, will understand the promise of a product that will say to others “here is a girl who is exciting, sophisticated, alluring and elegant”.

Advertising is the tobacco industry’s front line in its corporate mission to its shareholders: to increase smoking throughout the human community and thereby to raise profits. This is the way that advertising is understood by the marketers of every other commodity – it is plainly absurd to suggest that tobacco is somehow uniquely different. Tobacco advertising is essentially incompat-
Smokers: why do they start – and continue?

However, just as it is impossible to be “half” pregnant, it is nonsensical to argue that some forms of tobacco advertising should be restricted but other forms should be allowed to continue. It is nonsensical to argue for example (as some tobacco industry voluntary codes of advertising restraint have proposed) that tobacco advertisements should not be placed near schools, when the very same advertising is permissible a few metres away from some arbitrary boundary line, to be seen by the very children who were the reason for the voluntary restriction. Such absurd contradictions abound in all countries where governments have only half-grasped the nettle of banning all forms of tobacco advertising.

This is a stinging nettle which can cause some pain to governments in the form of withdrawal of financial support, major propaganda campaigns against politicians, backlashes from tobacco-sponsored sporting and cultural groups who support the industry if this sponsorship is threatened, and alliances with other industries like alcohol, sugar and fast food whose owners sometimes believe that, if tobacco advertising is banned, advertising of these products might subsequently be banned too.

The argument against tobacco advertising is ultimately an extremely obvious one: any government commitment to reducing smoking and the diseases caused by it is directly counteracted by tobacco advertising. If children are told at school on Friday that smoking is one of the most unhealthy things that they can do, and then go to a football match on Saturday and see their sporting heroes avidly endorsing a brand of cigarettes, they will understandably experience some confusion. Such conflicts erode the credibility of health education and make it hard to believe in the sincerity of government commitments to reducing tobacco use.

Access to tobacco

In every country in the world, cigarettes and tobacco are among the most accessible of all consumer goods. At the most remote trading posts deep in the mountains of Papua New Guinea, the frugal stock typically consists of tea, sugar, salt, tinned fish and cigarettes. Throughout the world, someone wanting to smoke can readily obtain cigarettes from street vendors, suburban stores, petrol stations, tobacconists, supermarkets and endless other retailers.

The universal easy access to tobacco products can be contrasted with common regulatory policies on access to alcoholic beverages and to many pharmaceuticals. Many countries, recognizing that alcohol and pharmaceuticals have huge potential for misuse and abuse, regulate the availability of these products through restrictions on the number of retail outlets per head of population, hours of opening, minimum age of purchase, and strict enforcement of laws that govern these restrictions.

Themes of escape, sensuality and fantasy in tobacco brand names and advertising aimed at low socioeconomic groups all skilfully address the understandable yearning for pleasure among those least able to afford the real thing.

By contrast, the discussion on placing such restrictions on tobacco products has barely begun. While some countries have laws defining minimum age for purchase of tobacco
products, studies of ease of purchase show that the law is ignored by a large proportion of retailers (6), who continue to serve child and adolescent smokers. No country at present limits the number or distribution of retail tobacco outlets in a given community or the times of purchase, and this results in a universal failure to address this issue.

Ask almost anyone about their first experience of smoking and you will be regaled by animated recollections of coughing, retching, acute respiratory distress and general embarrassment.

Singapore recently banned duty-free sales of tobacco products. With this one small exception, tobacco products appear to be still regarded in the mind of governments as convenience goods, much like bread, milk and grocery items with no restrictions to access.

Studies in Australia (7) and the United States (8) have shown that concerted efforts at retailer education, coupled with the use of compliance checks involving under-age children attempting to purchase cigarettes, can lead to dramatically reduced levels of selling from the targeted shops. However, questions remain as to whether this actually leads to reduced experimental and regular smoking among teenagers in the targeted neighbourhoods – resourceful smokers may develop ways of obtaining cigarettes from shops outside their residential areas.

Lack of anti-tobacco information

In the face of widespread pro-tobacco advertising campaigns and the other sorts of pro-smoking public attitudes described above that make the choice to smoke an easy one, public health authorities have comparatively few resources with which to “deglamourize” smoking and to present information about its consequences for health. While some studies have described the press as a major vehicle for carrying news stories about the dangers of smoking, others have shown that in the case of magazines, there is an apparent inverse relationship between a publication’s acceptance of tobacco advertising and the coverage given to anti-smoking stories. Magazine owners apparently do not like to bite the hand that feeds them, and tobacco advertising thus acts to “censor” the appearance of anti-tobacco stories while such magazines give comprehensive coverage to other public health issues.

Purchasing of significant advertising broadcast time or column space is an option which is generally open to health agencies in affluent countries. However, lack of resources and higher priority being placed on controlling diseases of poverty have resulted in few developing countries so far conducting any substantial public information campaigns, with most of them confining their efforts to symbolic publicity gestures on World No Tobacco Day. Widespread awareness and concern about tobacco’s effects on health cannot be expected until the major educational institutions in countries (schools, the mass media and the church) give prominence to the issue.

Why do smokers continue to smoke?

Pleasure

Perhaps the most underemphasized yet obvious reason why many smokers continue to smoke is that they derive pleasure from both the pharmacological effects of smoking and the social rituals that surround the act. The psychopharmacology of nicotine has been studied extensively, but not the pleasure involved. It is my impression that an explanation of this underemphasis by tobacco con-
control strategists and health educators lies partly in the subtle legacy of a puritanical heritage that characterized much of the “anti-tabagisme” movement early this century. In the tobacco control literature, exploration of the implications arising from the fact that many smokers immensely enjoy their smoking is so uncommon that it almost seems heretical to venture into the area.

Many researchers and commentators in tobacco control have sought to explain away smokers’ pleasure as deriving from the repeated temporary relief from actual and anticipated physiological and psychological withdrawal symptoms that each cigarette affords – as if the pleasure of smoking cannot be explained independently of some circular withdrawal-relief-withdrawal-relief mechanism. Reluctance to explore actively the pleasure smoking offers may have prevented us from gaining a fuller understanding of how less destructive pleasures could be promoted as substitutes.

This neglect seems likely to be of particular relevance to the widespread lack of success that tobacco control efforts have had in groups of low socioeconomic standing. Some researchers, particularly those writing from feminist perspectives, have described the way that cigarettes represent one of the few affordable pleasures and moments of escape from tedious and mind-numbing, menial occupations (9). Themes of escape, sensuality and fantasy in tobacco brand names and advertising aimed at low socioeconomic groups all skilfully address this understandable yearning for pleasure among those least able to afford the real thing.

However, many surveys of smokers have revealed that large proportions of smokers wish that they did not smoke and had never taken it up. Depending on how the question is asked, sometimes up to 80% of smokers will express some degree of regret. Plainly, social contexts in which smoking is increasingly vilified can produce a gap between what people feel obliged to say to researchers and what they genuinely feel. None the less, most smokers attempt to stop smoking on many occasions during their smoking history.

The challenge for tobacco control workers is to move beyond the blunt denial of curiosity and suppression of healthy levels of authoritarianism, and into approaches that steer such undercurrents into less destructive forms of expression.

Addiction

The pharmacology of tobacco explains little to nothing about why people start smoking, but a great deal about why many smokers continue for many years, often regularly expressing remorse at having taken it up. There is a vast body of literature that reports research on addiction to nicotine. It shows that this addiction is comparable in many respects to addiction to opiates, with craving, tolerance and withdrawal symptoms all occurring in many smokers.

There is an important disadvantage in giving strong emphasis to the addictive qualities of tobacco. To many smokers, being regularly reminded that they are addicted can carry the implication that their smoking is controlled by mysterious physiological processes beyond their volitional control. Rampant fatalism and abnegation of the will to stop smoking is a potentially negative consequence of widespread promulgation of the fact that smoking is addictive.

The dominant public discourse on quitting smoking characterizes the process as traumatic, difficult and frequently unsuccessful.
Much of this discourse is led by clinicians who work with smokers who come to see them for assistance in quitting. If the media wish to discuss smoking cessation, they invariably invite specialist cessation therapists to speak on the subject. The public are then exposed to descriptions of the process which emphasize its difficulty and the angst that can be expected, for these descriptions match the experience of the smokers seen by therapists and cessation clinics. However, help-seeking smokers are very atypical of smokers in general: community-based studies of ex-smokers repeatedly show that more than 90% of ex-smokers stop smoking without recourse to any professional help or guidance whatsoever. In most countries where smoking control policies and programmes have existed for several decades, there are now as many ex-smokers in the population as current smokers. The usual “natural history” of smoking cessation in such settings is one where a smoker gradually becomes more motivated to quit, makes an average of three to four unsuccessful attempts to stop (10) and then succeeds. In fact, many ex-smokers recall the process of stopping as less traumatic than anticipated: in a large British study of ex-smokers, 53% said that they found it “not at all difficult” to stop, with a further 27% agreeing that it was “fairly difficult” (11).

Will-power is a necessary but not sufficient condition for success in giving up smoking: the main prerequisite is simply will. It is a truism that a smoker who does not have the will to stop smoking will not stop, regardless of any strategy being used other than being totally deprived of cigarettes. As the German philosopher Nietzsche wrote, “he who has a why, will always find a how”.

A critical component of efforts to encourage smokers to quit therefore lies in maximizing motivation. Traditional emphases in this regard have included public information campaigns about the health consequences of active and passive smoking, and attempts to de glamourize smoking and portray it as socially unacceptable, polluting and personally filthy behaviour.

“Smoking-friendly” environments

In societies where there is little media discussion of smoking as a health hazard, where tobacco products are cheap, where governments do not run public awareness and education campaigns against smoking, where tobacco advertising flourishes, where the medical profession does not perceive smoking to be a serious problem (and still commonly smokes itself) and where no restrictions on smoking operate, smokers will find their day-to-day lives largely devoid of influences that will motivate them to quit. The price of cigarettes bears an important relation to total consumption in communities. Raising the real price of tobacco products is arguably the single most important tobacco control policy that governments can adopt.

If the “litmus test” of the effectiveness of tobacco control policies is the negative reaction of the tobacco industry, then controlling smoking in enclosed public places like workplaces, public transport and restaurants must qualify as extremely important policies. When smoking is banned in such places – as is the case in an increasing number of countries – smoking opportunities over a 24-hour period are greatly reduced and hence consumption and tobacco sales are also reduced. Thus exposure to passive smoking is reduced, but more importantly smokers’ own consumption falls considerably.

Finally, perhaps the strongest single predictor of a nation’s tobacco consumption is the economic well-being of its citizens. In very poor nations, a large part of the population simply cannot afford to smoke, or if they can,
only very occasionally. A study of the relation between gross national product and cigarette consumption in 124 countries found that in countries with a GNP of less than US $3000 per capita, 54% of the variation in consumption could be explained by the variation in GNP. No such link was found in countries with GNPs of more than US $3000 per capita (12). The major implication of this for health planners would appear to be that cigarette consumption will generally remain low in poor countries, with perhaps a few exceptions (China), for as long as those countries remain impoverished.

References

Editor's note
On retailer strategies see also Amanda Amos's article, "How women are targeted by the tobacco industry", in World health forum, 1990, 11: 416–422.
Discussion

Smoking in China

Chen Minzhang

The reasons for starting and continuing to smoke given by Simon Chapman are quite valid for China. This has important implications for the control of smoking and I very much share his views. Surveys made in China show that reasons for smoking include the following:

- inadequate understanding of the harmful effects of smoking;
- attractive tobacco advertising;
- the presence of so many other smokers;
- young people’s rebelliousness and lack of mature judgement;
- inadequate legislation to control smoking;
- addiction;
- unhealthy ideas of consumption;
- the use of tobacco in social life;
- pleasure.

The surveys also show that lower education levels are associated with higher smoking levels. The proportion of illiterate males over the age of 15 who smoke is 68%; for those who have completed primary school it is 66%; for those with a secondary education it is 53%; and for those with a tertiary education it is 45%.

Young people appear to start because of curiosity, advertising and peer pressure, whereas adults do it more to meet social expectations. As for continuing, the influence of others is the main factor for young people whereas for adults it is lack of recreational opportunities. Addiction and social pressures are the main source of difficulty in stopping. However, the most important reason for starting and continuing to smoke is ignorance of the harmful effects of smoking.

A survey of college and high school students made in 1991 showed that most of them believed smoking was harmful, but many thought the harm was not very serious. Young people are easily influenced by their society, and although all parents advise their children not to smoke, 34% of the adults are smokers themselves. Furthermore, the stars in popular films are frequently smokers. On the one hand this age group is still too young to make sound judgements about tobacco products, and on the other it is the age at which one feels rebellious towards authority. These factors combine to make smoking alluring. Another survey, made in 1993, showed that 80% of primary schoolchildren and 95% of those at secondary school noticed and understood the billboard advertisements for tobacco. Sports and other activities sponsored by tobacco companies also certainly deeply influence young people.

Countermeasures

We have made full use of the mass media to educate the public about the harmful effects of active and passive smoking. We have also promoted throughout China the view that smoking is an uncivilized way to behave, and called on leaders, health workers and teachers to take the lead in creating a smoke-free environment. We ask parents to set a good example to their children, and nonsmokers to
advise smokers to stop. We also give awards for smoke-free work units, institutions and families. In addition, some legislation is aimed at reducing tobacco use, such as the Law to Protect Young People, the Tobacco Act, and sections of the Regulations on Sanitation in Public Places, and the Law on Advertising.

Health education activities include classes in the primary and secondary schools on resisting the appeal of cigarette advertisements. Through the primary health care services, farmers in the rural areas are informed about the harmful effects of smoking, and about how to quit. There are also “healthy city” programmes aimed at encouraging people to avoid smoking and lead a healthy life. Health workers are strongly encouraged not to smoke, so that they can set a good example. Such activities usually start as pilot projects, and if the results are encouraging they are expanded to the whole country.

The surveys indicate that 75% of those who smoke are doing so by the time they are 24 years old, but recent data suggest that the number of young people smoking is increasing. Our top priority in tobacco control, therefore, is to educate the young against smoking so as to prevent them from starting and reduce the overall number of new smokers. The main strategy is to publicize the harmful effects of smoking. Some progress can be reported. For instance a programme involving 30,000 college and secondary school students was able to register a drop from 30.5% to 20.2% over a period of five months in the number of college students who smoked, from 12.7% to 9.3% among older secondary school boys, and from 4.1% to 3.6% among younger ones.

A major feature of China’s smoking control efforts has been the mobilization of primary-school children to advise their parents to stop smoking. In 1989 a health education campaign was conducted in 23 primary schools to do this. Copies of a Letter to Parents were distributed to all homes, together with some other information on smoking. The children told their parents what their teachers had said about smoking, and advised them to stop. The number of smokers among these parents dropped by 5%, and at the same time 95% of the schoolchildren learnt about the harmful effects of smoking and decided to be nonsmokers in the future. The same strategy has been used in many parts of China.

Not only individuals but the public as a whole is harmed by smoking, so we must keep up the fight against it. We believe that with sustained effort, as well as collaboration in exploring and expanding effective strategies, tobacco use will eventually be eliminated throughout the world.

Smoking in Thailand

Hatai Chitanondh

Dr Chapman has given us the reasons why people start smoking and why they continue. In Thailand the last national survey on smoking was made in 1991. It showed that the

Dr Chitanondh is President of the Asia and Pacific Association for the Control of Tobacco, and Executive President of the National Epidemiology Board, 403/4 Nitkarn Lane, Linchee Road, Bangkok 10120, Thailand.
The average age of initiation was 18.4 years for men and 25.3 for women. Students start smoking at the early age of 14.2 years, apparently because of peer pressure, while people without secondary education start at 21.9. In terms of occupational groups, unemployed people start at 21.7 years of age, and housewives and household helpers at 24.9. These figures suggest that Thais start smoking later than people in industrialized countries. For instance, in the United States a study found that 75% of those who smoked regularly were already doing so by the time they were 18 years old.

The most frequently cited reason for starting (37.6%) was peer pressure, followed by the desire to experiment (34.3%); the psychopharmacological effects of nicotine make the transition from experimenting to regular use swift. Only 8% of the respondents gave the desire to socialize as a reason for starting. This to some extent reflects the success of campaigns aimed at discrediting the practice of offering cigarettes as a gesture of goodwill or hospitality. The next reason for starting was to “relieve stress” (5.8%), then “working conditions” (for instance to repel mosquitoes in the paddy field, 4%).

Next came the desire to “imitate VIP or actor” (3.1%). It was encouraging to find this so near the bottom of the list, as much effort has been made in Thailand to prevent potential role models in the media and public life from presenting smoking as a part of their image. I myself have organized letter-writing campaigns among schoolchildren to ask famous people not to smoke while being interviewed by the media and to ask newspaper editors to select pictures in which respected figures do not set a bad example by smoking. Unfortunately, however, foreign films and television programmes often glamorize smoking, and the tobacco industry can reach millions of impressionable young people in this way, influencing them more than any advertisement.

Finally, wanting “to be smart” was the reason given by 1.7% of the respondents for starting. Probably, the main reason for this being such an infrequent motive is the popularity of the education campaign slogan, “it’s smart not to smoke”, which has become a household expression.

The top three reasons given for stopping were “found out that smoking is not good” (53%), “doctor’s advice” (13.2%) and “fear of disease” (12.8%). All three are closely related and probably reflect the impact of public education campaigns. Next came “to save money” (3.1%), “spouse’s request” (1.4%), “parents’ request” (1.1%), “children’s request” (0.9%), and “friend’s or relative’s request” (0.4%).

The following measures in particular have been important in our efforts to control tobacco consumption in Thailand.

- **Prevention of smoking in children.** This has been effected in three main ways:
  - there are no cigarette vending machines in Thailand;
  - it is illegal to sell tobacco to a person under 18 years of age and this is enforced with a fine of 2000 baht (US$ 80) for offenders, as well as stickers on cigarette racks advising customers that under 18-year-olds will not be served;
— retailers in the vicinity (within 200 metres) of schools are not given a licence.

**Total ban on tobacco advertising and promotion.**
In 1992 the Tobacco Product Control Act came into effect. It prohibits tobacco advertising in all media, and bans all promotional activities, including giving out free samples or other incentives. There are only two items which are exempt from the ban: live telecasts from abroad, and printed media produced abroad and imported without being specifically made for distribution in Thailand. Sponsorship of events is illegal if it publicizes a tobacco company’s logo.

**Unrestricted access to tobacco information.**
Since none of the media have been dependent on an income from tobacco companies, they have never been subject to “censorship” by these companies, and can write without inhibitions about tobacco control activities.

Although Thailand has done well, there are still many weaknesses in its tobacco control programme. In particular, the Ministry of Public Health and the Ministry of Education need to formulate jointly an effective education programme on smoking for use in the schools. In addition to the anti-tobacco laws and some occasional public events and activities, there needs to be an overall long-term strategy to combat smoking. The tobacco companies are finding ways to circumvent the current restrictions, for instance by sponsoring sporting events shown on cable television, and little or nothing is being done to prevent them.

---

**The clean-air case against smoking**

_James L. Repace_

While Dr Chapman refers to “smoking-friendly” environments he has not considered the environment as becoming physically polluted. Most nations now practise some form of pollution control to protect human health from the effects of chemical contaminants in food, drink and air. The notion of standards of acceptability for such contaminants has taken hold, and control measures appropriate for different environments have evolved. For example, in outdoor air pollution control, dilution is the basic strategy for dealing with stationary combustion sources, and in industrial plants and homes alike, chimneys are used to deposit acid gases and fly ash into the upper air, so that the wind carries them away from human habitation into the very large volume of the atmosphere. For indoor air pollution control in industrial workplaces the basic strategy is to confine toxic chemical contaminants to small fume hoods which are exhausted outdoors by means of local ventilation.

By contrast, for non-industrial buildings, architects and builders pretend that there are no airborne contaminants to be removed other than the bioeffluents of human metabolism, and accordingly provide for only the minimum amount of air supply needed for human respiration at low levels of activity. Further, the design of such buildings permits airborne contaminants to spread rapidly throughout the building envelope, subject to dilution with outdoor air at rates of exchange determined by concern for energy conser-

---

James Repace is a physicist with the United States Environmental Protection Agency. Address for correspondence: 101 Felicia Lane, Bowie, MD 20720, USA. The opinions expressed are those of Mr Repace.
vation (heating and cooling systems), rather than health. Moreover, building occupants in non-industrial settings do not usually worry about pollution control or the air quality in offices, restaurants, public buildings, homes, and institutions, so polluting practices such as smoking have been to a large extent tolerated.

The widespread practice of smoking in buildings exposes occupants to the by-products of biomass combustion in small volumes under conditions where airborne contaminant removal is slow and uncertain. Moreover, it is well known from decades of scientific study that the deliberate breathing of the toxic and carcinogenic gases and particles derived from the burning of tobacco products massively increases the risk of premature death from respiratory and cardiovascular diseases and cancer. Astonishingly, however, it has been widely assumed on faith (when it has been thought about at all) that the tobacco aerosol is essentially harmless when breathed involuntarily at the concentrations normally encountered in buildings.

Recently, epidemiological techniques have been used to critically examine this assumption. Epidemiologists have compared the number of deaths caused by smoking-related diseases in the nonsmoking wives of smokers to that in the nonsmoking wives of nonsmokers. This comparison is expressed as an "odds ratio". The results of 30 such studies of passive smoking and lung cancer in nonsmokers are shown in Fig. 1, and the results of 12 such studies of passive smoking and heart disease are shown in Fig. 2. The negative study at 89% statistical power in Fig. 1 reflects confounding by indoor coal smoke. The odds ratios shown are adjusted downward to account for the misclassification of smokers as nonsmokers. However, they are not adjusted upwards to reflect the fact that the nonsmoking controls have significant exposures to tobacco smoke outside the home. Despite the downward bias in the odds ratios, it can be clearly seen that for both lung cancer and heart disease mortality, there is a preponderance of positive results: 24 out of 30 lung cancer studies and 11 out of 12 heart disease studies. Many of the individual studies were not statistically significant owing to small sample size and inability to find unexposed controls, but if these figures were simply the result of chance, one would expect as many negative results as positive ones. Moreover, the cultural diversity of the study populations, the dose-response trends, and uniformly statistically significant results at the highest exposure categories, give strong support to the conclusion that these results are a true reflection of the mortality caused by passive smoking.

In view of the total weight of evidence, which includes biological, physical and chemical, as well as epidemiological data, a national consensus has been reached among the United States scientific, medical, public health, environmental, and occupational health authorities that the breathing of tobacco smoke at the concentrations to which people are exposed in commercial, industrial, and residential buildings is a major cause of preventable morbidity and mortality. Quantitative risk estimates suggest that passive smoking accounts for 40,000 to 60,000 deaths from heart disease and lung cancer annually among nonsmokers in the United States.

The lifetime risk to workers of fatal lung cancer is estimated at one in 1000 and that of
**Fig. 1**

Thirty studies carried out in Asia, Europe and North America, on passive smoking and fatal lung cancer

[Diagram showing a scatterplot with adjusted odds ratio on the y-axis and statistical power (%) to detect a true 1.5 odds ratio on the x-axis. Positive studies are indicated by squares above the 1.5 odds ratio line, while negative studies are below.]


**Fig. 2**

12 studies made in Asia, Europe and North America, on passive smoking and fatal heart disease

[Diagram showing a scatterplot with adjusted odds ratio on the y-axis and study number (in order of ascending statistical weight) on the x-axis. Positive studies are indicated by squares above the 1.5 odds ratio line, while negative studies are below.]

fatal heart disease at one in 100, so the United States Occupational Safety and Health Administration has proposed indoor air quality control regulations covering all private enclosed workplaces, which would require that smoking either be restricted to enclosed and separately ventilated chambers or excluded entirely from the workplace.

As the principles of occupational and environmental health are extended to pollution control in non-industrial buildings, the practice of burning tobacco indoors, like spitting tobacco juice, may be expected to fade into history as a harmful practice once widespread but no longer tolerated.

Addiction: the industry can’t do without it

Ruth Roemer

In 1972, a tobacco industry conference sponsored by the Council for Tobacco Research was held on the Caribbean island of St Martin. In answer to the question, “Why do people smoke?” the conference concluded: “The primary incentive to cigarette smoking is the immediate salutary effect of inhaled smoke on body functions.” It added that nicotine was the active constituent of cigarette smoke, and “without nicotine, the argument goes, there would be no smoking.” (1).

The significance of nicotine was no secret in the industry. In 1967 a document from one tobacco company reported the statement by the scientific adviser to the board of directors of another company that “We are in a nicotine rather than a tobacco industry” (2). And in 1972, a psychologist, William J. Dunn, Jr., wrote, “Think of the cigarette pack as a storage container for a day’s supply of nicotine. Think of the cigarette as a dispenser for a dose unit of nicotine. Think of a puff of smoke as the vehicle of nicotine” (1).

Making cigarettes seductive and available

Little can be added to Dr Simon Chapman’s thoughtful and penetrating analysis of why people become smokers, except to underline two important features that he mentions:

- the seductiveness of tobacco advertising, which is so at variance with the consequences of tobacco use;

- the ready availability of cigarettes in all societies, providing easy access for young people who are the most vulnerable potential smokers.

Studies in a number of countries have shown the powerful effect of advertising on tobacco consumption. A compelling reason for New Zealand’s total ban on advertising and promotion of tobacco, enacted in 1990, was the finding of a study in 22 countries, commissioned by the New Zealand Toxic Substances Board, that the greater the degree of restriction on tobacco advertising the greater the average annual fall in tobacco consumption. In order to combat the rising percentage of young people, particularly young women, in New Zealand who smoke, the Board rejected a partial ban on tobacco advertising and advertising sponsorship in favour of a total ban.

In France, 32.5% of adolescents between the ages of 12 and 18 – 1.5 million young people – were smoking in 1990, and each year 250,000 young people start to smoke. Confronted with this high prevalence of smoking among young people, France enacted the law of 1993.
banning all advertising, promotion, and sponsorship of tobacco and tobacco products.

In the United States, certain cartoon advertisements "had an astounding influence on children's smoking behavior", resulting in an increase in the proportion of smokers under the age of 18 who chose this particular brand from 0.5% to 32.8%, accounting for an estimated rise in sales from $6 million per year to $476 million per year, representing one-quarter of all this company's sales (3). In the State of California (USA), smoking prevalence increased sharply among 16-18-year-olds following the cartoon advertising campaign (4).

With respect to the wide availability of cigarettes and children's easy access to them, Dr Chapman is quite right in saying that we have only begun to deal with this problem. It is important to pass and enforce youth-specific legislation banning sales to minors, prohibiting sales from vending machines, and strengthening educational programmes in schools. In addition, new strategies are needed: licensing tobacco sellers, limiting the number of tobacco sales outlets, and restricting sales to government stores. At the same time, broad tobacco control legislation and programmes affecting the whole population and promoting a smoke-free society are essential if success is to be achieved in preventing young people from smoking.

**Keeping tobacco addictive**

Why do smokers continue to smoke in the face of the overwhelming health risks of tobacco use and even though 77-80% of them would like to quit (5)? Because nicotine is addictive, and it is difficult to stop. The tobacco industry has known for a long time that nicotine is addictive and concealed this knowledge, stopped all research to find a "safer" cigarette, prohibited publication of findings by its scientists concerning the addiciveness of nicotine, manipulated the nicotine content of cigarettes and actually produced and used high-nicotine tobacco. An exposé of this strategy and the industry's continued denial that tobacco is addictive began in February 1994. It appeared in a series of articles in the *New York Times* and the *Los Angeles Times*. Dr David A. Kessler, Commissioner of the United States Food and Drug Administration (FDA) announced that for the first time the FDA would be willing to regulate the nicotine in cigarettes if it could be shown that nicotine was addictive, that the tobacco companies were able to increase and decrease the amount of nicotine in cigarettes, and that they maintained a certain level of nicotine to assure the addictiveness of their product.

In April 1994, testimony before the Health and Environment Subcommittee of the Energy and Commerce Committee of the United States House of Representatives revealed that in 1983, five years before the Surgeon General declared that nicotine was an addictive substance, researchers for a tobacco company had concluded that it was. In fact, Congressman Henry A. Waxman, chairman of the Subcommittee, stated that

---


the nation's largest tobacco company had had relevant information for years about the important role that nicotine plays in inhibiting smokers from quitting, but the

The company had developed a genetically engineered tobacco that more than doubled the amount of nicotine delivered in some cigarettes.

industry denied that nicotine was addictive. As the Congressional hearings continued, Congressman Waxman released a report made in 1981 by a tobacco company executive describing how higher nicotine levels can be achieved in cigarettes by using specific blends of tobacco and suggesting that these blends should be added to low-tar cigarettes to enhance their nicotine content significantly. In testimony before the Subcommittee, the executive denied that the company had set nicotine levels for particular brands of cigarettes.

But on 22 June 1994 new evidence emerged of the tobacco industry’s concealment of its knowledge of the addictiveness of tobacco and its utter disregard for the public’s health. Dr Kessler testified at a Congressional hearing that a certain tobacco company had developed a genetically engineered tobacco that more than doubled the amount of nicotine delivered in some cigarettes. The tobacco was grown in Brazil, imported to the United States, and used in five domestic brands of cigarettes, including three brands labelled “light”. Over 3.5 million pounds (c. 1700 tonnes) of the specifically developed high-nicotine tobacco is in warehouses in the United States.

As the investigative reporters for the New York Times and the Los Angeles Times researched these events, it turned out that three tobacco companies had engaged in research to develop a “safer” cigarette, but the laboratories of all three had been closed, the research stopped, and the effort to develop a safer cigarette ended.

Thus, the industry stopped research and turned to the strategy of “sowing doubts about the facts” and creating “controversy” about smoking and health in the public’s mind. Everyone knows that the tobacco industry has denied any causal relationship between smoking and disease and has dismissed the overwhelming clinical and epidemiological evidence as “only statistical”. What has not been known is the evidence that is just now emerging that for 40 years the industry has pursued “a two-track approach to the health dangers of cigarettes, saying in public that there was no proven risk, while privately debating how to deal with the very risk they were denying”, as P.J. Hilts succinctly put it in the New York Times (16 June 1994). These shocking revelations explain why smokers continue to smoke: because they are hooked on an addictive substance.

But this information also opens new avenues for tobacco control strategies. Clearly, it becomes of great importance to control maximum levels of tar, nicotine, carbon monoxide, and additives in tobacco and to reduce those levels progressively until the smoker no longer gets a “buzz” from a cigarette.

In 1980, Sir George Godber, former Chief Medical Officer of the United Kingdom’s Department of Health and Social Security stated, “There is no hope of finding a safe cigarette”. This may be true, but there is hope of enacting legislation to empower governments to set maximum levels of harmful substances in tobacco that are much lower than current levels and then to reduce these levels further and further.
Smokers: why do they start – and continue?

Help and treatment for addicted smokers

Michael Russell

The expressed purpose of Dr Simon Chapman’s article is to discuss why people start smoking and why they continue smoking, the answers to which “provide the basis for control strategies”. What emerges is a powerful and convincing case for a total ban on all forms of tobacco advertising and promotion, along with other social, economic and political changes to discourage tobacco use. This is what the article is really all about. Despite concluding that “addiction is the main reason for not stopping”, he says not a word about the recent advances in help and treatment for addicted smokers and the scope for its widespread delivery through primary care, especially general practitioners (family physicians). Indeed, he does not even acknowledge any need for effective treatment as an integral part of policies to control smoking. This oversight cannot be due to ignorance.

Without doubt tobacco-related diseases will never be adequately controlled and prevented without effective political action. It is therefore not altogether surprising to find Dr Chapman putting politics first. He is well known as a formidable and effective political activist. When expressing dissatisfaction with the Sixth World Conference on Smoking and Health in Tokyo in 1987, he is on record as saying that “if you are seriously in the business of controlling smoking you must be seriously in the business of politics”. In developing countries where smoking prevalence is rising, the development of comprehensive tobacco control strategies is by far the most important issue. However, in developed western countries, which have had smoking control programmes of increasing intensity for some 20 or more years, the issue is more complex, requiring a scientific assessment of the best way forward before political action is taken to secure implementation.

The main strategies used in these programmes have been aimed predominantly at motivation and include health education, use of mass media, posters, warnings on cigarette packets and other forms of publicity about the health risks of smoking, high tobacco taxation, restrictions on smoking in public places, and on access and sale of cigarettes to young teenagers, and bans on all forms of advertising and promotion of tobacco products. All can be organized at a national level. Their main effect is to turn people against smoking to prevent nonsmokers from starting and motivate smokers to try to stop, but they are of little direct help in overcoming dependence.

Smoking cessation is determined by the balance between two opposing forces: motivation to stop and level of dependence. The traditional strategies affecting motivational
processes have collectively achieved significant success. In many western countries the smoking population has been motivated to stop. Some 75–80% of smokers want to stop and try to stop. For many, good motivation is sufficient and they succeed in stopping without specific help. As a result the prevalence of cigarette smoking has declined steadily over the past twenty years and in several countries is now below 30%.

This success should not cause the complacent view that present strategies are sufficient. There are signs that rates of decline in smoking are slowing. There are still 14 million cigarette smokers in the United Kingdom and 50 million in the United States, for example. According to estimates of Richard Peto and others, one half of all current smokers alive in the world today will die as a result of their smoking, one in four before the age of 60 (losing an average of 20–25 years of life) and another one in four after the age of 70. Since these estimates are based on present trends, a more effective strategy to enhance cessation is urgently needed.

Dr Chapman has underestimated the serious obstacle to cessation posed by nicotine addiction and believes that the way ahead to enhance cessation lies in maximizing motivation to quit, using the same traditional motivational strategies of the last 10–20 years. Pointing to the millions of ex-smokers in the population, 90% of whom quit without formal help, he implies that specific help and treatment are not necessary. What is not said is that these are a self-selected minority and that 75% of them recall having been advised to stop by a doctor. The facts are that although 75–80% of smokers want to quit and about a third have made at least three serious attempts, only 45% of smokers succeed in stopping permanently before the age of 60, and many will have died before reaching this age. Many continue smoking despite crippling bronchitis and emphysema, angina or amputations of the feet. Of smokers who survive a heart attack, 70% are smoking again within a year, 38% while still in hospital within 5 days of transfer from intensive care. Nicotine dependence is clearly a major barrier to successful cessation. The effect on cessation of Dr Chapman’s strategies to maximize motivation would be doubled by integrating new strategies to deliver help and treatment for overcoming the nicotine dependence barrier.

A substantial increase in smoking cessation rates at a national level are within our grasp as a result of the development of effective nicotine replacement treatment (NRT) and advances in our understanding of how it could be most effectively delivered to the millions of dependent smokers for whom it would make the difference between success and failure to achieve cessation. Numerous clinical trials have shown that NRT reduces the severity of withdrawal symptoms and approximately doubles cessation rates achieved with placebo or support and behavioural methods. When used as an adjunct to intensive support in specialized clinics NRT products are equally effective, with success rates averaging around 25–30% sustained, lapse-free, biochemically validated cessation throughout one year.

It is only through the primary care system that large enough numbers of smokers can be reached to produce a significant reduction in national prevalence. Some 75% of the population visit their general practitioner (GP) at least once over the course of a year, more
than 90% over a three-year period. By taking 1–2 minutes of their routine consultations with all patients who are smokers, and using their own individual style to give firm advice to stop smoking, together with a leaflet and an appointment for follow-up, GPs without special training can achieve a success rate of 5% sustained cessation for one year, compared with less than 1% in non-intervention controls. If practised routinely by all GPs, the yield of ex-smokers resulting from this modest success rate of 5% would, in the United Kingdom for example, amount to around 500 000 per year. This substantially exceeds current rates of ‘spontaneous’ unaided quitting. As it is, of the much quoted 90% of ex-smokers who say they quit without formal help, some 75% recall having in the past been advised to stop by a doctor.

Brief advice from the doctor to quit is mainly a motivational intervention and is insufficient for the majority of dependent smokers. The use of NRT as an adjunct to brief advice plus a booklet can double the long-term success rates. This approach, practised routinely in the United Kingdom’s primary care system, would yield over one million ex-smokers per year.

The more actively the doctors participate the better, but as a minimum it would take less than one minute to ask about smoking and provide the initial motivational boost of advice to stop, which only they can offer face-to-face in such a personally relevant way, and to ask again and reinforce the impact of their message at every subsequent contact. To facilitate this, most GPs in the United Kingdom now have smoking status on their computer systems. With support of this kind from medical staff, other health care staff can do the rest. In the United States, a variety of systematic schemes of this kind, some more intensive, are being developed and assessed in primary and other health care settings. For those not involved in specific programmes, the key fact is that whatever is being done to help people stop smoking, the addition of nicotine replacement treatment will double success rates.

It is hoped that Dr Chapman, together with other tobacco control activists and policy-makers everywhere, will be persuaded that much more can be achieved by integrating newly developed tobacco addiction treatment strategies into comprehensive tobacco control programmes.

The symbolic power of tobacco

Patricia Hudelson

The symbolic meaning of an object is defined by social circumstances, and the same object can have different meanings for different people, or even for the same person in different contexts. Thus a national flag can symbolize both pride and shame, freedom and oppression. Likewise the many forms of tobacco — including pipes, cigars, cigarettes, snuff, and chewing tobacco — have been used as symbols of personal, social and cultural identification. As Dr Chapman points out, cigarette smoking has been associated with anti-authoritarianism, masculinity, modernity, affluence, sexuality and other socially constructed meanings.

Tobacco companies’ success at assigning meaning to tobacco has resulted in enormous economic benefits, despite the widespread detrimental effects of smoking. Cigarette companies research the aspirations of their target populations and then create advertisements that link tobacco with those

Dr Hudelson is a Research Fellow at the London School of Hygiene and Tropical Medicine. Her address is 8 rue du Vieux-Collegé, 1204 Geneva, Switzerland.
aspirations. Such advertisements manipulate symbolic meanings and eclipse the suffering and premature death that tobacco consumption causes.

We should carefully research positive images of nonsmoking that might deter particular target audiences from smoking.

Because symbolic meaning is not inherent to an object, meaning can change. Tobacco had symbolic meaning long before cigarette companies came into existence. Historically, it figured prominently in secular public ceremonies, peace- and war-related rituals, religious practices, and health and medicinal therapies. It is only in recent history that tobacco has attained its current symbolic meaning; therefore, it is safe to say that it could change again.

Public health officials are interested in reducing the number of people who initiate smoking and increasing the number of people who decide to quit. Efforts have been aimed at increasing people’s knowledge of the dangers associated with tobacco use, and creating structural impediments to smoking (such as nonsmoking work environments). While these attempts have been quite successful in many places, they do not address the symbolic meaning of tobacco and cigarette smoking. Evidently, for those who choose to smoke, the symbolic meaning of smoking continues to have more influence than knowledge of its associated health risks.

In order to modify the symbolic meaning of tobacco, it may be appropriate to look to the methods and approaches used by tobacco companies themselves, and carefully research those images (especially positive images of nonsmoking) that might deter particular target audiences from smoking. Creating public awareness of the way in which current images of smoking are used to manipulate us, and encouraging the creation of alternative images, may be one way to change the symbolic meaning of tobacco.

Smoking in Africa

Samuel Hynd

The message of Dr Simon Chapman is clear, well developed and topical. The hazards of smoking are now reasonably well known, but the very fact that such a discussion is necessary is an indication of how insufficiently they are understood. His article goes to the heart of the matter: the first puff and the agonizing experience of the first inhalation, with all the spluttering, coughing, tears and nausea that go with it. It is amazing that in spite of this bad start, and with all the knowledge available on the harm involved, so many millions of people go on to join the mass of habitual smokers. That the habit reduces life expectancy is taken for granted by life insurance companies, who treat it, like any other negative data on the medical record, as a risk factor, and raise their premiums accordingly.

Dr Chapman makes some significant points about why people, especially the young, set out on the path to addiction. He neglects one, however, which perhaps goes a little deeper than others, and may be called “the forbidden fruit factor”. We often hear about David and Goliath in anti-tobacco literature (the little health services against the giant tobacco companies), but not so often about Adam and

Dr Hynd is the Chairman of the National Council on Smoking, Alcohol and Drug Dependence, P.O.Box 384, Manzini, Swaziland.
Eve. This is the story about how being told “Do not touch” can trigger the deeply human response of “Let’s try”. It begins in the days of innocence, before the first puff, and is perhaps implied in Chapman’s article but deserves more emphasis.

The promotion of tobacco, through advertisements, brand names and all the rest, often plays on this human weakness. Even health professionals, with all they see of patients and even their own colleagues dying of cancer, emphysema, bronchial and other smoking-related diseases, are susceptible to it. The role of the media in regard to this strange desire to smoke is especially striking in the developing world where we are aware of how fragile our society is, already devastated as it is by poverty, famine, drought and disease.

We are constantly bombarded with messages encouraging us to take up or keep up this hazardous habit as an essential part of “a real man’s” or “a real woman’s” lifestyle. Films and television soap operas show the heroes and heroines as smokers, and these images have a stunning impact on young people aspiring to adulthood. Even in the poorest countries such images and messages are abundant, and young people respond to them either because they have no better information or because warnings only add to the glamour.

In Africa football is a major popular sport, supported by the government and various national clubs. When our organization approached top government officials about the curtailment or withdrawal of tobacco company sponsorship of and advertising at sports events, we were told that these activities were entirely dependent on such financing, and could not take place without it. This dependence, however it came about, naturally implies that the government approves of smoking, and the voices of those concerned about health remain relatively unheard. It is not generally known in Africa, for instance, that the national football team of Scotland declared itself to be nonsmoking, or whether others have done likewise.

Dr Chapman implies that pleasure is the main reason for continuing and addiction comes second, but in our experience it is the other way round. Few find real pleasure in smoking, but when they are confronted with good reasons for stopping, such as the physical and financial damage they are doing themselves, they invariably say it is easier to stop drinking alcohol than to stop smoking. Dr Chapman refers to a British study of ex-smokers which attributes success in stopping to will-power, but in our experience there is little evidence of this even when the sufferer really wants to stop. Addiction therefore does appear to be the more fundamental reason for continuing.

Perhaps at present the most effective way to discourage smoking in Africa is for the affluent societies to continue to expand their banning of smoking in public places, health facilities and sports stadiums. This tells us more clearly than words that smoking is something to be deplored and that the harm it does is taken seriously.

In the light of all these findings, including Dr Chapman’s, we feel that our most basic and effective message, in developed and developing countries alike should be: “TO STOP SMOKING, DON’T START”. ■
Control strategy for governments

M. Adrianza

The impact of tobacco on health, in terms of individuals and socially, economically and ecologically, is so great that every ministry of health has to decide what to do about it. Tobacco control must form part of the national health policy and be closely linked to the other relevant government departments.

Tobacco is now recognized as a leading risk factor for health because of the large number of toxic and carcinogenic agents it contains, its addictiveness, and its widespread availability and use. Whether consumed actively or passively, it can damage human life at every stage of development, from embryo to old age. In his article Dr Chapman has described why people start smoking and what makes them continue. At the same time, smoking is probably the most preventable of all major health hazards. Everyone is free to avoid it, give it up, discourage it and refrain from subjecting others to it.

It can damage human life at every stage of development, from embryo to old age. At the same time, however, smoking is probably the most preventable of all major health hazards.

To translate prevention from a possibility into reality a strategy is needed. Governments should have a programme aimed at reducing or eliminating the illness and death caused by smoking. The programme should be run by a multidisciplinary committee in the Ministry of Health, and work both within the health sector and intersectorally, as follows.

Within the health sector

- Work with international and local control programmes towards banning smoking in schools, hospitals, public transport vehicles and other public places.
- Use the best communication resources available in the observance of World No-Tobacco Day, emphasizing targets and progress made towards objectives.
- Establish epidemiological surveillance systems to monitor and control the harmful effects of tobacco.
- Stimulate research to dispel the myths about the economic benefits derived from tobacco revenues and taxes.
- Carry out surveys on cultural and behavioural trends in relation to smoking.
- Encourage the relevant scientific societies, such as those concerned with cancer, respiratory diseases, cardiology and gynaecology, to initiate smoking control activities, starting with their own members.

Intersectorally

- Support the establishment of health legislation against tobacco use by restricting the cultivation, manufacture, advertising and sales of tobacco products, with special regard for the protection of nonsmokers, children and pregnant women.
- Ensure compliance with existing legislation.
- Organize joint activities with the departments of education, environment, communication, trade and industry, with special emphasis on World No-Tobacco Day.

Dr Adrianza is President of the Venezuela Libre de Humo Foundation, Instituto Diagnostico, Av. Anauco, St Bernardi, Caracas, Venezuela.
Keep the Council of Ministers regularly informed about international and national findings and decisions regarding tobacco use.

Each country should establish and maintain a broad-ranging control programme of this kind. At the same time, they need to be able to count on the support of international bodies such as WHO.

---

**Combating addiction in developing countries**

Judith Mackay

It is striking how universally Dr Chapman’s observations apply. Teenagers in Indonesia or Laos give the same reasons for smoking as teenagers in Australia or the United States: they see smoking as a rite of passage into adult life, an opportunity to join the sophisticated and beautiful people. In China, adolescents say they are influenced by the smoking habits of their parents, brothers and sisters, friends and teachers; they are curious; they want ‘something to do to relieve boredom’; and they wish to appear grown up. As in the West, most children in Asian countries who will become smokers start experimenting before their teens, then become daily smokers by their early twenties. Of particular concern is that more girls are taking up the habit, hitherto traditionally reserved for boys.

**A rite of passage into adult life.** Chapman is correct in asserting that children have an exaggerated view of the numbers of adults who smoke.

Because children in Hong Kong thought “most adults smoked” (although only 16% do so), the government produced large posters showing 100 young adults seated at a football stand; 84 held up large no-smoking signs, colourfully illustrating that “most adults don’t smoke”. Children need to know that only about one third of adults throughout the world smoke; it is a minority habit.

**Modernity and affluence.** Youth in Asia smoke Western cigarettes to show their sophistication and affluence. Some male smokers carry a packet of prestigious and expensive foreign cigarettes with openings at the top and bottom. They offer a foreign cigarette from the top opening to a colleague or young woman they wish to impress, but will shake out a cheap, local cigarette from the lower opening for their own private use. Even in countries like Singapore with excellent tobacco control programmes and where smoking among young people has been declining over decades, newly popular western influences are thought to be responsible for the recent increase in smoking among teenagers.

**Hospitality and friendship.** The common custom of cigarettes being used as a gesture of goodwill and hospitality throughout Asia is slowly dying out, and with it the spittoon, showing that entrenched social attitudes can change.

**Tobacco advertising and promotion.** With few exceptions, tobacco advertising and sponsorship is pervasive throughout Asia, promoting glamorous, wealthy, sophisticated, sporty
images. Cigarette advertisements displaying idealized western cultures and lifestyles is another questionable aspect of tobacco advertising in developing countries. These advertisements also target women; one of the best examples is from Hong Kong, where only 1% of women under the age of 40 years smoke, yet ‘women’s’ cigarettes have been launched, clearly designed to create a market. A large range of ‘non-tobacco goods’ bearing cigarette names are also being marketed, such as stylish men’s clothing, chic sports gear, cowboy boots, even ‘holidays’.

Governments in developing countries are often unfamiliar with this new kind of promotion and with the legislative and other measures needed.

Dr Chapman refers to a painful withdrawal when governments ban tobacco sponsorship, and arts and sports lose financial support. But there is a “win-all” remedy, pioneered in Dr Chapman’s own country, and which has been copied by many governments. In 1987, a small tax levy on tobacco in the Australian State of Victoria was used by the Victoria Health Promotion Foundation to fund health promotion and offer alternative sponsorship to sports and arts organizations. The result? When offered viable alternative funding, sports and arts organizations voted enthusiastically, leaving, en masse, their previous tobacco sponsors. There are benefits to governments which, by establishing the scheme tobacco and sports and arts broken, the elimination of cigarette advertising from the events, and removal of the membership of tobacco companies on prestigious boards and committees along with their corporate ringside seats.

**Access to tobacco.** It is difficult to restrict access to cigarettes in many developing countries, where street vendors (often children themselves) sell cigarettes singly. The tobacco companies’ support for bans on sales to children raises the suspicion that the measure is ineffective. In fact, the suggestion that tobacco is an adult-only activity may even encourage some children to take up the habit, just to “be adult”.

**Lack of anti-tobacco information.** Commercial censorship, the stifling by tobacco advertising revenue of the media from reporting the hazards of tobacco appropriate to the magnitude of the problem, is a particularly serious problem in countries where many of the population are still unaware that smoking is harmful.

Dr Chapman mentions the need for schools, the mass media and the church to give prominence to tobacco issues; this should be broadened to include all religions. At one memorable meeting on tobacco control in 1986 in Malaysia, representatives from all religious groups participated in a joint plenary panel discussion. Grounds for discouraging smoking were found in all their different religious doctrines. In addition, environmental or women’s groups, youth leaders, economists, consumer activists should be involved; in fact, there is a place for everyone in tobacco prevention.

But anti-tobacco information may not influence youth. In contrast to the seductive images offered by the tobacco companies, most health education in developing countries

---

**Smokers are at different stages of readiness to quit, and a different approach is needed for each stage.**

and using the tobacco tax in this way, are seen to be supporting sports and arts. There are benefits to health organizations, which receive funding, and also see the link between
is ‘gloom and doom, death and dying’. This may encourage middle-aged smokers, concerned about their health, to quit, but it has much less effect upon young people, to whom 50 seems very old, and dying is too far in the future to have any immediate relevance. Studies from Indonesia and other countries in Asia confirm that knowledge of health risks does not prevent children from starting to smoke.

Health education portraying positive lifestyles has been only marginally more successful. Evidence from many Western countries shows that the numbers of children smoking has remained steady; in the United Kingdom, for example, a survey has shown that since 1982 and despite publicity and stricter laws, about 10% of 11–15-year-olds have been regular smokers. Donald Reid, Director of the Association for Public Health in London, has shown that interventions aimed primarily at youth, such as school health education, may delay but not prevent smoking. As long as young adults smoke, children will want to smoke. We don’t know whether school programmes would have greater influence in more traditional societies, where there is stronger respect for authority.

Additional factors linked with smoking are the influence and example of peer and sibling use, lack of parental guidance, low levels of academic achievement, low esteem and lack of “refusal skills”. Children need to be taught, through “skills building”, how to say no when their friends offer them a cigarette. And children need to learn to distinguish between good and bad, and learn, for example, the truth about tobacco advertisements.

The reasons for continuing. Smoking undoubtedly gives pleasure to smokers, but so does a “fix” to heroin addicts, or a drink to alcoholics. Still, Dr Chapman is correct to stress the importance of recognizing the pleasure of smoking, and how women in particular view it as a “friend”; without such understanding quitting programmes will be less successful.

Addiction. Heroin addicts in Hong Kong say it is easier to give up heroin than tobacco. Yet Dr Chapman’s caution is right: it is important not to create a self-fulfilling prophecy that it is hopelessly hard to quit. Most quitters manage to do so on their own after a few attempts, and at least half of them recall that quitting was not particularly difficult.

Many health professionals find that advising people to quit is a lesson in frustration and failure. Professor Robyn Richmond from the University of New South Wales, Australia, suggests this may be because doctors tend to give the same advice to all smokers, whereas in reality they are at three different stages, and need different advice:

- **Group 1: Those not ready to stop**
  This group needs a bit of advice, a pamphlet, a welcome to return if they change their mind, but not (yet) an all-out attempt to get them to quit.

- **Group 2: Those unsure about stopping**
  This group needs more discussion about smoking and quitting, with a definite offer of support if they decide to try.

- **Group 3: Those ready to stop now**
  This group requires the most active intervention by the doctor, with specific advice and follow-up.

Professor Richmond suggests that quitting rates will be much more successful when the different interventions suggested are used.