SMOKING: BRUNEI DARUSSALAM PERSPECTIVE

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TOBACCO CONTROL MEASURES

The government of His Majesty The Sultan dan Yang DiPertuan Negara Brunei Darussalam is committed to tobacco control. Legislation, Administrative Directives and comprehensive health education programmes have been in place as early as 1970s.

Control on Tobacco Products

Radio Television Brunei and all cinemas in Brunei Darussalam imposed a voluntary ban on all advertisements on cigarettes since 1976. Advertisement of cigarette and cigarette products are banned from any billboard. However, cigarettes advertisements still appear in some print media.

Custom Act, 1991, required that all cigarettes imported into Brunei Darussalam to carry four rotating Government health warnings, which cover 20% of each of the largest surfaces. This was followed by a 200% increase in tobacco taxation in 1 December 1994.

Protection for Non-Smokers

In 1990, Ministry of Health prohibited smoking in all buildings under the ministry. Through an administrative order issued by the Prime Minister Office, all government buildings were declared smoke free as from September 1994. To discourage students from taking up smoking, measure against smoking was made one of the main thrusts of the 'Health Promoting Schools Initiative' launched in October 2001. With effect on 1 January 2002 all schools are declared cigarette and smoke free, and health education and health promotion programmes in school were enhanced.

Royal Brunei Airlines start to prohibit smoking in all its flight from 1 April 1998. This was followed by smoking prohibition in the terminal building of Brunei International Airport in 1999. Some restaurants and private offices voluntarily provide separate areas for smokers.

Health Education and Health Promotion.

The Ministry of Health has been actively promoting anti smoking campaigns since 1988. Health education programmes are organized and disseminated through health talks, forum, television promos, exhibitions, posters, leaflets, essay competitions and health talks in schools. The "World No Tobacco Day" is celebrated every year. Facts on tobacco and its health hazards are incorporated into the school curriculum of primary 6, and form 2 and 3 students.

One of the main action plans for the National Health Promotion Committee, formed in March 2000, is tobacco control. The National Health Care Plan (2000-2010): A Strategic Framework for Action also identifies Tobacco as a priority agenda for health promotion in Brunei Darussalam. Ministry of Health's health promotion web site contains smoking as one of its topics.

Tobacco Import

Brunei's imports of tobacco into Brunei Darussalam shows a decline from 1999 to 2000.

Table 1: Brunei Imports of Tobacco, 1999 – 2000

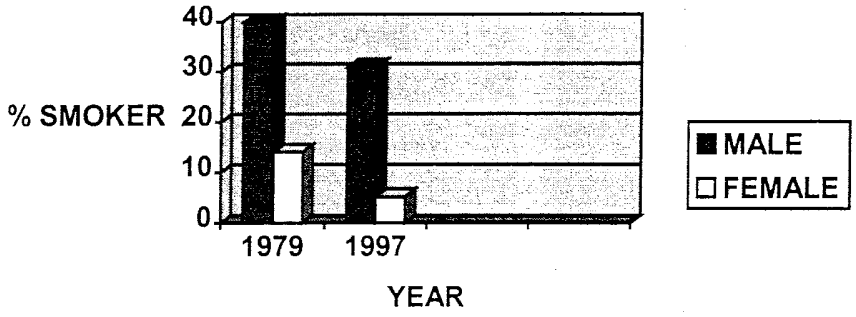
Years	Quantity in Kg	Value in B $
1999	93,776.57	5,012,986
2000	81,130.80	4,132,009
2001(Jan-Sep)	67,393.10	3,487,397

Trend in smoking

The earliest available data on smoking prevalence in Brunei Darussalam was provided by a survey carried out in 1979. Figures from the survey showed that 40% of male Bruneians smoked, while for females, it was 14%. Of all the smokers, 61.3% were Malay, 2.3% belonged to other indigenous groups, and 12.1% were Chinese.

The smoking prevalence for males and females dropped from 40% for males and 14% for females in 1979 to 30.9 % for males and 5.2% for females in 1997 (Figure 1).

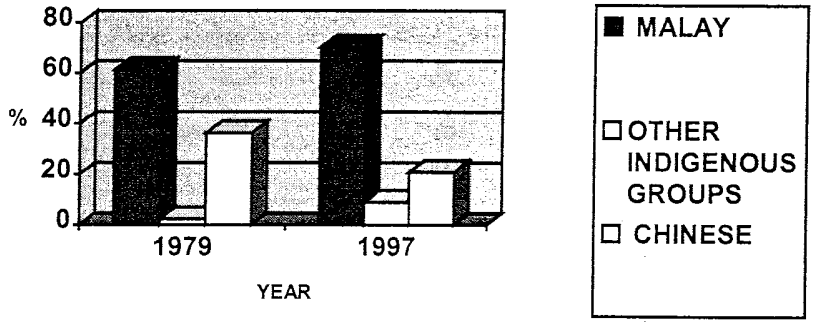
FIGURE 1: PREVALENCE OF SMOKING BY SEX 1979 & 1997



Source: 1979 Tobacco or Health Global Status Report
1997 National Nutritional Survey

Figure 2 showed the percentage of smokers by ethnic groups. Interestingly, the percentage of smokers among the Malay and other indigenous groups increased compared to the Chinese.

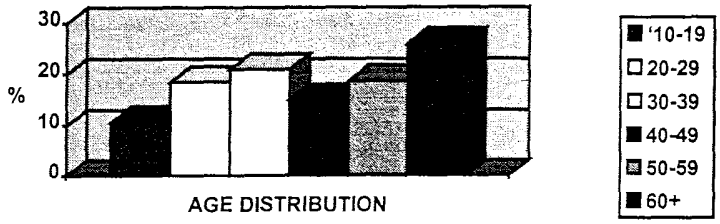
FIGURE 2: PREVALENCE OF SMOKING BY ETHNIC GROUPS 1979 & 1997



Source: 1979 Tobacco or Health global status report
1997 National Nutritional Survey

Data from the 1997 survey also showed that 10.7% of smokers are aged between 10-19 years, the secondary school going age. Many of the students who smoke begin their habit while in the primary schools.

FIGURE 3: PREVALENCE OF SMOKING BY AGE GROUPS 1997



Source: 1997 National Nutritional Survey

The age group 60 years and over represent the largest group of smokers. These are the smokers who had been smoking for a long time and have difficulty in quitting (figure 3).

In the 1950s and 1960s smoking was considered socially acceptable. It was common practice then to offer cigarettes to guests at social functions such as 'tahlil prayers' or a wedding. Whether such practice was responsible for the larger number of males and females' smokers is unclear. Obviously, there were other reasons for people on those days to take up smoking. One often cited reason is the habit of taking a smoke when one needed to go the bathroom. Smoking was one way to rid the mosquitoes and the kill the smell in the bathroom. The influence of the cigarette advertisements and peer pressure would certainly play important role in initiating and maintaining cigarettes smoking.

Today, worldwide one in three adults smoke. If the trend continues, death due to smoking will increase from the present one in ten adults to one in six, or 10 million deaths per year by the year 2030 – more than any single cause. It will cause more death than HIV, tuberculosis, automobile accidents, homicide and suicide combined. While, the prevalent of smoking in many western countries are declining, increased prevalence is shifting to the developing countries. It is estimated that by 2020, seven of every 10 people killed by smoking will be in the low and middle-income countries (World Bank, 1999).

The health consequences of smoking are well recognized and many nations are taking action to control smoking. Notable successes in controlling tobacco consumption are seen in countries such as US, Canada, United Kingdom, Australia and Singapore indicated by declining prevalence of smoking and

smoke related diseases. Their successes are characterized by strong government participation and leadership, comprehensive tobacco control programmes with strong emphasis on key areas for action such as legislation to restrict the advertising, sale and use of tobacco products; taxation; health promotion and cessation services. One of the reasons cited for failure in many countries is governments' reluctance to take strong action to control smoking because of concerns that their interventions might have harmful consequences on their economics

Health Consequences

The first health consequence is the addiction to nicotine, where a smoker can quickly become addicted. Nicotine is so addictive that smokers who attempt to quit have low success rate if they do it alone without assistance of cessation programmes. Over 90 percent start the habit again within a year.

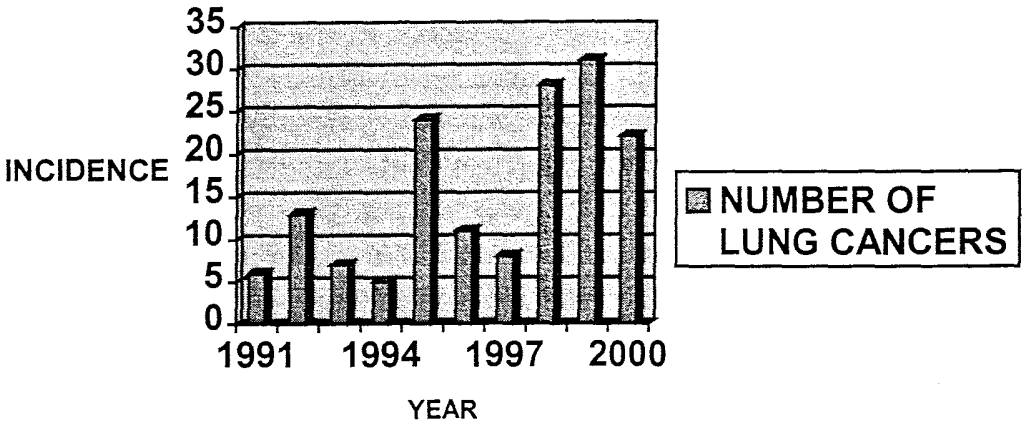
Fatal and disabling diseases caused by smoking include lung cancers, cancers of other organs, ischaemic heart disease and other circulatory diseases, and respiratory diseases which include emphysema.

Cancers related to smoking

Data kept by the Pathology Laboratory of Raja Isteri Pengiran Anak Saleha Hospital shows that during the ten year period from 1991-2000, 155 cancers of the lung were detected (Appendix 1). These are histologically proven carcinomas of the lung. The 155 lung cancer cases may represent a conservative figure as advanced inoperable cancers are diagnosed radiologically and are not included in the statistics.

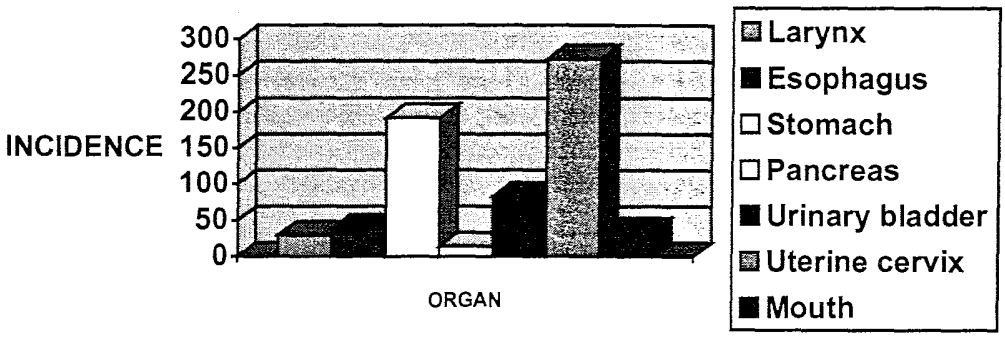
Nearly 90% of the cancers cases were aged 50 years and over. The male to female ratio is 1.3:1 (89 males to 66 females). 90% of the affected people were smokers or ex-smokers. Brunei Darussalam has a young population where those aged 15 – 49 years represent 56.6 % (183, 200) of the population, and yet to reach the "cancer age". The implication is clear. If the present trend of smoking is not abated it can be postulated that the number of people who will die from smoking related lung cancers might increase by at least four folds. The incidences of lung cancers are much higher in 1998 to 2000 (figure 3). The incidence of other cancers related to smoking in Brunei Darussalam over the period 1991 – 2000 is shown in figure 4.

FIGURE 3: TOTAL NUMBER OF LUNG CANCERS BY YEAR (1991-2000)



Source: Dr P U Telesinghe, Pathology Laboratory, RIPAS Hospital

FIGURE 4: INCIDENCE OF OTHER CANCERS RELATED TO SMOKING, 1991 - 2000



Source: Dr P U Telesinghe, Pathology Laboratory, RIPAS Hospital

Smoking usually starts in adolescence or early adulthood. These groups lack information with regards to the health consequences of smoking. Even if they are given information they may not be able to make sound decisions, and as a result underestimate the future cost of their smoking habit. It is this weakness that the tobacco companies are exploiting, and are now targeting children and youth. By using advertisements that appeal to the children and youth,

cigarettes companies are able to recruit more smokers from these vulnerable groups. It is imperative tobacco control programmes must be aimed at preventing children and youth from taking up smoking and to encourage those who smoke to quit. These programmes should include measures to restrict access to cigarettes in addition to improving their education and that of their parents.

Measures to reduce the demand for tobacco

Raising Taxes

Experiences from countries, which have successfully control tobacco show that price increases on cigarettes, are highly effective in reducing demand. High taxes prevent individuals, especially children, from taking up smoking, and induce some smokers to quit. Such measure also reduces the number of ex-smokers to return to cigarettes and for smokers to reduce their consumption.

Brunei Darussalam imposed a 200 % tax on tobacco in 1991. However, the price of cigarettes are still relatively cheap, where the most expensive cigarettes sells for $3.00 for a pack of 20, and the cheapest sells for $1.80. These prices are still within the purchasing power of some of the school children and adolescence. Increasing the prices further will deter them from buying the cigarettes.

Non-price measures to reduce demand

Other measures found to be effective to reduce demand include comprehensive bans on advertising and promotion of tobacco, health information measures, prominent health warning labels and prohibitions of smoking in work and public places. Comprehensive bans on advertising and promotion have been shown to reduce demand by 7 percents. Prohibition of smoking prevents non-smokers from being exposed to second hand smoke.

The ongoing health information and promotion activities on health consequences of smoking by the Ministry of Health and the prohibition of smoking in government building have certainly brought positive results. Smoking in offices and work places are now viewed by most as offensive, and it is now rare to see smokers smoke in office buildings. Voluntary bans on smoking in public places by private organizations, notably by Royal Brunei Airlines, private organizations, cinemas, supermarkets, are also encouraging. However, there is still a need to have a comprehensive ban on smoking in all enclosed public places. For this to succeed a strong legislation will be in order. There is also a need for legislation or administrative order to ban all forms of advertising and promotion of cigarettes or tobacco products. The

cigarettes companies are notoriously clever in circumventing advertising ban by sponsoring sporting and cultural events. Unfortunately, these practices are still taking place in Brunei Darussalam. FIFA's successful staging of World Cup in Korea and Japan free from any form of cigarettes sponsorship and advertising should offer a good lesson to us. Sporting events can be organized without potential harmful consequences of Tobacco Company's sponsorship.

Smoke Free School Initiative

Ministry of Education's recent implementation of smoke free school initiative, as part of 'Health Promoting School Initatives', addresses one of the important elements in tobacco control, that of discouraging school children from taking up smoking and to encourage those who smoke to stop. The initiative includes on-going health education, stringent surveillance on smoking in school premises, counseling to those who are caught smoking and to mete out disciplinary action to repeated offenders. The parents are also to be involved in this initiative. Close collaboration between the school community and the parents increases the chance of success in controlling smoking in school children. Additionally, the initiative also encourages the parents who smoke to reduce or stop smoking, or at least not to subject their children to second hand smoke.

Data collected by the Department of Schools on government secondary school students caught smoking in schools in 1999, 2000 and 2001 is shown in table 2. These figures do not accurately reflect the number of secondary students who smoke as some students who smoke are not caught or else, they smoke outside the schools. However, the figures do illustrate that significant number of schoolchildren smoke and some of them smoke in schools. 2.3% of Government Secondary students are caught smoking in schools in 1999, 1.6% in 2000 and 1.4% in 2001. Increasing number of female students smoke from 6.3% of all student smokers in 1999 to 10% in 2000 and 9.2% in 2001.

Table 2: Percentage of Secondary School Student Smokers in all government schools – Brunei Darussalam 1999 - 2001

YEAR	% of student smokers	% male	% female
1999	2.3	93.7	6.3
2000	1.6	90	10
2001	1.4	90.8	9.2

Cigarettes are easily available from the numerous provision shops some of which are strategically located around schools. These shops have attractive cigarette advertisements, which may appeal to the students. In the absence of

laws against minor buying cigarettes, students can easily buy cigarettes from these provision shops.

Nicotine replacement therapies

Studies have shown that NRT increases the success of those who want to stop smoking. NRT is not yet available in Brunei Darussalam. This is a necessary intervention to enhance the success of tobacco control in the country. Ministry of Health is conducting a smoking cessation workshop for its health workers with a view of equipping these health workers with the knowledge and skill to counsel and help smokers to quit smoking.

Measures to reduce supply of tobacco

The extreme measure of prohibiting tobacco is unwarranted on economic grounds as well as unrealistic and likely to fail (World Bank, 1999). But country and cultural specific prohibition on tobacco may be successful in a country like Brunei Darussalam. Brunei Darussalam neither grow nor manufacture cigarettes, hence economically Brunei Darussalam does not lose from any prohibition of tobacco initiative. In fact, prohibition of tobacco in a similar line with the present prohibition on alcohol will bring more positive outcomes than negative ones.

One possible outcome of tobacco control is increase in smuggling. However, with effective measures, which include aggressive enforcement and consistent application of tough penalties will deter would-be smugglers.

Comprehensive control on tobacco is necessary and should bring enormous benefits in term of healthy life saved; reduce costs to the government, society, the family and the individuals. In considering these control measures several issues need to be addressed. These are:

- Comprehensive ban in all form of advertising and promotion of tobacco or tobacco products
- Effective health education and health promotion programmes aimed at smoking prevention and cessation of smoking
- Effective protection from second hand smoke
- Comprehensive prohibition of smoking in all enclosed areas, public eating places, work and recreational places
- Appropriately high tobacco taxes
- Restriction of access and prohibition of tobacco product to young people
- Strong and varied warning on cigarettes packages
- Curb and strong action against smuggling

- Legal instruments to carry the above mentioned measures
- Available smoke cessation therapy
- Close regional and international cooperation in tobacco control measures – the Framework Convention on Tobacco Control for ASEAN
- Mechanism for monitoring trends in smoking and other forms of tobacco use, tobacco related diseases and effectiveness of national smoking control measures.

Brunei Darussalam is committed to tobacco control and has instituted tobacco control programmes, which have a positive impact to public health. However, more comprehensive and strong tobacco control measures are necessary for sustainable long-term successes. Brunei Darussalam is poised to institute these comprehensive tobacco control measures.

Brunei Darussalam's comprehensive tobacco control measures must target at stopping children from taking up smoking, to encourage non-smokers not to start smoking and to assist smokers to give up smoking.

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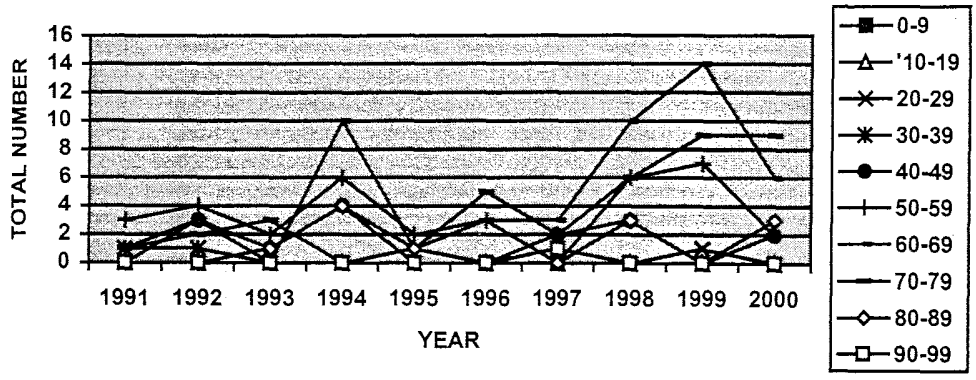
APPENDIX 1: TABLE SHOWING TOTAL NUMBER OF LUNG CANCERS BY AGE (1991- 2000)

AGE	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	TOTAL
0-9	0	0	0	0	0	0	0	0	0	0	0
10-19	0	0	0	0	0	0	0	0	0	0	0
20-29	0	0	0	0	0	0	0	0	1	0	1
30-39	1	1	0	0	0	0	0	0	0	0	2
40-49	0	3	1	4	0	0	2	3	0	2	15
50-59	3	4	2	6	2	3	0	6	7	2	35
60-69	1	3	0	10	1	3	3	10	14	6	51
70-79	1	2	3	0	1	5	2	6	9	9	38
80-89	0	0	1	4	1	0	0	3	0	3	12
90-99	0	0	0	0	0	0	1	0	0	0	1
TOTAL	6	13	7	24	5	11	8	28	31	22	155

Source: Dr P U Telesinghe, Pathology Laboratory, RIPAS Hospital

APPENDIX 2: CHART SHOWING TOTAL NUMBER OF LUNG CANCERS BY AGE (1991- 2000)



Source: Dr P U Telesinghe, Pathology Laboratory, RIPAS Hospital

APPENDIX 3: PREVALENCE OF SMOKING BY SEX, 1979 and 1997

SEX	1979	1997
MALE	40%	30.9%
FEMALE	14	5.2

Source: 1979 Tobacco or Health global status report
1997 National Nutritional Survey

APPENDIX 4: PREVALENCE OF SMOKING BY ETHNIC GROUPS, 1979 and 1997

	1979	1997
MALAY	61.3%	70.2%
OTHER INDIGENOUS GROUPS	2.3	9.0
CHINESE	36.4	20.8

Source: 1979 Tobacco or Health global status report
1997 National Nutritional Survey

APPENDIX 5 : PREVALENCE OF SMOKING BY AGE GROUP 1997

AGE	1997
10-19	10.7%
20-29	18.5
30-39	20.9
40-49	15.0
50-59	18.7
60+	25.9

Source: 1979 Tobacco or Health global status report
1997 National Nutritional Survey

APPENDIX 6 : TOTAL NUMBER OF LUNG CANCERS BY YEAR 1991 – 2000

1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
6	13	7	5	24	11	8	28	31	22

Source: Dr P U Telesinghe, Pathology Laboratory, RIPAS Hospital

APPENDIX 7 : INCIDENCE OF OTHER CANCERS RELATED TO SMOKING IN BRUNEI-DARUSSALAM

ORGAN	NUMBER (1991-2000)
Larynx	29
Esophagus	38
Stomach	192
Pancreas	14
Urinary bladder	83
Uterine cervix	273
Mouth	34

Source: Dr P U Telesinghe, Pathology Laboratory, RIPAS Hospital