Public Participation in Tobacco Control Policy-making in Georgia

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Scientific environment

This research was conducted in the Department of Health Promotion and Development, Faculty of Psychology, at the Graduate School of Human Interaction and Growth. The collaborating agencies in Georgia were the Georgian Health Promotion and Education Foundation and the Framework Convention on Tobacco Control Implementation and Monitoring Center in Georgia.

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Dedication

This work is dedicated to the memory of my father, David Bakhturidze (1947-2011), who would have been very proud to witness the defence of this dissertation. One of the main reasons he passed away so early in life was smoking. He survived laryngeal cancer at age 37, but he was subsequently unable to give up smoking and suffered from various serious illnesses throughout his life, including heart attacks. He finally passed away from a stroke at age 63. His experience is the main reason I began to fight against smoking and to help others avoid premature death and illness related to these kinds of habits. During life he fought tobacco addiction but ultimately couldn’t give up smoking due to the severity of his nicotine dependence and complications relating to the operation on his larynx. He was very happy when I began work at the National Tobacco Counter Center in the 1990s and when I created, together with colleagues, both the FCTC Implementation and Monitoring Center in Georgia and the Georgian Health Promotion and Education Foundation. My father was a very kind and friendly person with a great sense of humour. I think about him often, and his memory gives me energy to pursue my personal goal of creating a healthy, smoke-free Georgia. May he rest in peace.
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Abstract

Background

One out of every three people in Georgia smokes cigarettes, and one out of every five people dies from tobacco-related diseases. Though some regulations on smoking and tobacco advertising have been enacted during the past decade, the country still has problems enforcing current regulations and implementing FCTC provisions. Georgia has a high level of tobacco consumption and a very low level of enforcement of existing regulations.

Public opinion could be influential in shaping tobacco policy and the enforcement of regulations, but before this study no public opinion data existed about tobacco control measures in Georgia. There also was not any kind of data about perceptions of tobacco control measures among policy-makers and decision-makers. There is a deficit of research and too little is known about the problem. Our approach to addressing this deficit is to understand perceptions of tobacco control measures in Georgia among policy-makers, decision-makers, and the public, and to find ways to respond appropriately to these challenges.

Aim

This study had two aims: 1) to document the public’s opinion about tobacco control measures, and 2) to understand policy-makers’ perceptions of how public opinion impacts public health policy-making in the area of tobacco control.

Methodology

This dissertation is based on three articles that I created with the help of colleagues. The first two articles are based on quantitative research methods. These quantitative data were taken from a “Population survey on tobacco economy and policy in Georgia” conducted in 2008. After publishing the quantitative articles in 2012 and 2013, it became clear that qualitative method was needed to understand the problem more deeply. A qualitative study was subsequently conducted in 2013.
We used an explanatory model where an initial quantitative phase was conducted to obtain statistical results. In the second phase I gathered qualitative data (e.g., open-ended interviews) to help explain the quantitative results. This type of mixed approach has been important for this study: by merging the results of two quantitative studies with those of a qualitative study we can learn about real policy-making processes and understand the broader picture of tobacco control policy-making, as well as the lack of enforcement of regulations and international obligations.

Results

Overall support for restrictions on tobacco sales is very high and an absolute majority of non-smokers and a majority of smokers support such measures in Georgia. Regulations already exist but are unfortunately not enforced due to the strong influence of the tobacco industry, which obstructs efforts to introduce licensing requirements for tobacco sales. Though strong political will does not currently exist around this issue, non-governmental organisations strongly support and advocate for the enforcement of tobacco sales restrictions and regulations. These organisations often use public opinion surveys and existing public opinion data as advocacy tools.

The situation is similar with other forms of tobacco control such as bans on tobacco advertising and promotional campaigns, bans on smoking in closed public buildings, and increased penalties for violations.

The results show that the majority of policy-makers in Georgia believe that public opinion plays an insignificant role in policy-making in general.

Discussion

The high level of public support for the prohibition of smoking in public spaces and ban of tobacco advertisement is very similar to findings in other parts of the world with different cultural and political contexts.

Georgia has a very low level of enforcement of FCTC requirements. From the international experience we can assume that implementing smoke-free legislation in
Georgia will decrease the number of young people who start smoking and also protect non-smokers from second-hand smoke exposure.

Georgian policy-makers have the following perceptions of the public's opinion about tobacco control legislation:

- Public opinion is not widely appreciated due to the lack of public opinion data.
- The public's opinion does not carry much weight in matters of public health, and regarding tobacco control specifically.
- The tobacco industry has more influence on tobacco control policy-making than does public opinion or public interests.

Strong public support should be focused on adopting new policy. Though the public demands strong administrative measures and higher penalties for violations, there still exists a deficit of the political will needed to initiate changes.

Conclusions

The three articles that compose our study reached the following major findings and conclusions: (i) the public strongly supports all forms of tobacco control, (ii) due to a lack of public opinion data (before now), public support is not widely recognised, (iii) the public's opinion does not seem to carry much weight in public health policy-making and in tobacco control specifically, (iv) other stakeholders such as the tobacco industry are more influential, and (v) it is therefore a high priority to publicize the findings of the present study showing strong public support for tobacco control. Public opinion in a democratic Georgia has the potential to be an effective tool in the fight for tobacco control.
List of publications

Paper 1


Paper 2


Paper 3

Abbreviations:

CSO – Civil Society Organisations  
EU – European Union  
FCTC – Framework Convention on Tobacco Control  
GATS – Global Adults Tobacco Survey  
GCAO – Georgian Code of Administrative Offences  
GLA – Georgian Law on Advertisement  
GLTC – Georgian Law on Tobacco Control  
GYTS – Global Youth Tobacco Survey  
ISSA – Institute for Social Studies and Analyses  
MIA – Ministry of Internal Affairs  
MoF – Ministry of Finance  
MOH (MoH) – Ministry of Health  
MoLHSA – Ministry of Labour, Health and Social Affairs  
MOP – Members of Parliament  
NCD – Non-communicable Diseases  
NCDC – National Center for Disease Control  
NGO – Non-governmental Organisations  
NSOG - National Statistics Office of Georgia  
ORA – Opinion Research Agencies  
TFI – Tobacco Free Initiative  
TFK – Tobacco Free Kids  
TNA – Thematic Network Analysis  
UNICEF – United Nations Children’s Fund  
WHO - World Health Organisation
Chapter 1. Introduction

The global burden of tobacco use

Tobacco use is one of the most serious public health problems in the world. It is the number one risk factor for cancer (lung cancer and others), strokes, heart attacks and other cardiovascular diseases, and chronic obstructive pulmonary disease. It is also associated with infertility, congenital abnormalities, chronic diseases, and other severe health problems (US DHHS, 2014). The cost of treatment of such diseases contributes to the direct economic burden of tobacco, which is very high.

Global tobacco use kills nearly six million people each year, and over 600,000 non-smokers die from exposure to second-hand smoke. Approximately 80% of these deaths involve residents of low and middle-income countries. Half of all smokers die from diseases caused by tobacco use (WHO, 2016).

Around the globe, 1.3 billion people aged 15 years or older are tobacco dependent. The highest smoking prevalence persists in low- and middle-income countries. Globally, tobacco use has taken the lives of 100 million people in the 20th century; tobacco-related deaths will amount to one billion in the 21st century if current smoking patterns continue. If governments do not implement effective policies to prevent tobacco use, the number of deaths caused by tobacco-related diseases will increase by up to eight million people annually by 2030 (WHO, 2008).

Tobacco use and control in Georgia

In Georgia one out of every three people smokes cigarettes and one out of five people dies because of tobacco-related diseases (Bakhturidze, et al., 2008; WHO 2015; ISSA, 2016a). This creates a social-economic burden related to the high-level of tobacco consumption. The country has a “leading” position in the region after Russia, whose smoking rate is 39% (TFK, 2013). Russia adapted strong tobacco control legislation in June 2013, and in March 2015 the Ministry of Health of the Russian Federation reported that the number of smokers in Russia had fallen by approximately 17% since the adoption of strong regulations (WHO/TFI, 2015).
Some regulations on smoking and tobacco advertising were created over the last decade after Georgia became a member of the Framework Convention on Tobacco Control (FCTC) in May 2006 (WHO/FCTC, 2016). But today the country still has a problem enforcing current regulations and implementing FCTC provisions. Georgia has restricted smoking in public places and prohibited smoking in medical, educational, sports, and cultural facilities since 2008. But the level of enforcement is very low. Georgia has a ban on tobacco advertising for TV and radio, but the country should have had a total ban on all forms of tobacco advertising and promotion since May 2011 (WHO/FCTC, 2016). There exist restrictions on selling cigarettes to and by minors, on selling individual cigarettes, and on selling cigarettes within 50 meters of schools, but such regulations are also not enforced (GLTC, 2010).

Georgia has a high level of tobacco consumption and a very low level of enforcement of existing regulations.

After the collapse of the Soviet empire, nearly all of the transnational tobacco companies entered the Georgian market. During the Soviet era Georgia was a tobacco-growing country and today local tobacco manufacturers continue to operate (Shalutashvili et. al, 2007). Intensive advertising and the lack of real restrictions on smoking and selling cigarettes have created a very high level of social acceptability, mostly among Georgia’s younger population (Bakhturidze, et al., 2013). Strong political will does not exist to deal with tobacco control problems (Bakhturidze, et al., 2016). The tobacco industry still has great influence on political processes and lobbies to postpone implementation of the FCTC (Bakhturidze, et al., 2016).

Public opinion could be influential in shaping tobacco policy and enforcement, but before this study no data existed regarding public opinion about tobacco control measures in Georgia. There also did not exist any kind of data about perceptions of tobacco control measures among policy-makers and decision-makers. There is a deficit of research and understanding about this problem. Our approach to addressing this deficit is to understand perceptions of tobacco control measures in Georgia among policy-makers, decision-makers, and the public, and to find ways to respond appropriately to these challenges.
Study aims

This study has two aims: 1) to document the public's opinion about tobacco control measures, and 2) to understand policy-makers' perceptions of how public opinion impacts public health policy-making in the area of tobacco control.

Research questions

Quantitative research questions:

1. What are the public's attitudes toward restrictions on tobacco sales and toward strengthening enforcement of these measures?
2. What are the public's attitudes toward restrictions on smoking in public spaces, on tobacco advertising, and on strengthening enforcement of these measures?

Quantitative research question:

1. How do policy-makers and decision-makers perceive the impact of public opinion on tobacco control processes?

Quantitative / qualitative mixed-method research question:

1. What are the comparable attitudes, opinions, and beliefs about tobacco control in the governmental, non-governmental, and public spheres with respect to smoking?

Methods

There are several ways to approach research about public opinion: quantitative survey methods, qualitative research methods, mixed methods, etc. The most effective way to research the problem is to use a hybrid research method that gives us more opportunities to explore perceptions of this issue among citizens and policy-makers.
Mixed-method research is characterised as research that contains elements of both qualitative and quantitative approaches. Qualitative and quantitative methods are based on different philosophical paradigms (Teddlie and Tashakkori, 2003). A mixed method is an important tool for answering complex questions and it can take many forms. This approach takes time, expertise, resources, management, and publishing experience, but it can also produce strong, unique results (Bryman, 2007).

There are paradigmatic differences between quantitative and qualitative research. Both, for example, employ empirical observations to address research questions (Jonson & Onwuegbuzie, 2004). There exist multiple research paradigms including positivism, postpositivism, interpretivism, and participatory/advocacy perspectives (Teddlie & Tashakkori, 2003; Creswell, et al., 2007; Jonson & Onwuegbuzie, 2004). The advocacy/participatory perspective is particularly relevant to my research. This perspective dictates that research should include an action plan for changing the lives of individuals and participants by influencing the institutions where they live and work. Furthermore, it is characterised by a desire to change actual practice in this field. This study proposes an action plan for change.

The advocacy/participatory model of research often begins by examining the problematic issues in a society and then creating political discussion in order to affect change. Its nature is fundamentally collaborative, as researchers collaborate with participants in their inquiries (Creswell, 2007).

This approach is immediately relevant to the present dissertation, as it merges two sets of quantitative study results with one set of qualitative findings to better understand the bigger picture of tobacco control policy-making, the lack of enforcement of existing regulations, and failures to fulfil international obligations.
Chapter 2. The politics and practice of tobacco control in Georgia

The burden of the tobacco epidemic in Georgia

Tobacco farming developed significantly in Georgia during the 20th century. After the collapse of the Soviet Union, however, tobacco farming ceased development and was replaced with different forms of agricultural production. After Georgia declared independence, the transnational tobacco companies began importing cigarettes and raw materials for local manufacturing. Tobacco use has increased to serious proportions since 1990, largely due to the collapse of the Soviet industrial era and the country’s transition toward a market economy. When transnational tobacco companies arrived in Georgia they initiated expensive promotional campaigns and thrived in the absence of legislative restrictions on the tobacco industry (Bakhturidze, et al., 2012; 2013).

The prevalence of smoking among men in 2001 was 53.3% and rose to 59.8% by 2008. The prevalence of smoking among women increased from 6.3% to 14.9% over the same period (Bakhturidze, et al., 2008; Gilmore, et al., 2004). A recent study conducted by the Institute for Social Studies and Analysis (ISSA, 2016a) shows that around 31% of the adult population in Georgia currently smokes cigarettes (65% of men and 10% of women).

Smoking among youth is also a global problem. The Global Youth Tobacco Survey (GYTS) conducted between 2000 and 2007 estimated that 19.2% of young people aged 13-15 years smoked cigarettes in EU countries. In Georgia the proportion is 23.7% (Warren, et al., 2008).

The 2008 Global Youth Tobacco Survey indicated that 62.7% of adolescents live in homes where others smoke in their presence and 74.4% are exposed to tobacco smoke outside their homes. This high percentage of young people aged 13-15 years who are exposed to tobacco smoke indicates that more work is necessary in order to establish smoke-free environments. More than half of the surveyed students reported having seen cigarette advertisements on billboards, and nearly half have
seen tobacco advertisements in newspapers or magazines in the past 30 days. 14.6% of students reported having an object with a cigarette brand logo on it.

One in five Georgians dies from smoking-related diseases, and tobacco is accountable for an estimated 11,000 deaths annually. Tobacco use is causing a serious demographic problem in the country: in addition to mortality, the serious impact of smoking is also seen in terms of lost years of life and decreased working ability and performance caused by disease. These constitute both economic and social losses (G. Bakhturidze, et al., 2008).

To conclude, tobacco use is one of Georgia's most significant public health threats. The country has a leading position among those with high rates of smoking within WHO's European Region.

_Tobacco control efforts in Georgia_

Smoking restrictions in public areas were introduced in Georgia in 2003 when the first Georgian Law on Tobacco Control was adopted (GLTC, 2003). In 2004 changes were made in the Georgian Code of Administrative Offences and penalties for violations of the tobacco control law were established (GCAO, 2016). The Framework Convention on Tobacco Control (FCTC) entered into force in Georgia in May 2006 (WHO/FCTC, 2016). Since that time several changes have been made in Georgian tobacco control law, and the most recent amendments were adopted in 2010 (GLTC, 2010). Current law prohibits tobacco smoking in educational institutions, enclosed sports buildings, medical and pharmacy buildings, and on transport including trains and ships. A partial smoke-free policy has been in place in other types of indoor premises; where designated smoking areas are not possible, a total ban of smoking will apply. Restaurants and bars must designate smoking areas, and at least 50% of public areas should be smoke-free.

Georgia’s Law of Advertising, adopted in 2003, prohibits the advertisement of tobacco products on radio and TV, and on newspaper and magazine covers. There are also some restrictions on the location of outdoor tobacco advertising: it is not allowed in educational, medical, and sports facilities, and advertising intended to attract minors is banned as well. Advertisements for tobacco products must be
accompanied by a warning about the harmful effects of smoking. Tobacco advertising must include the following text written in large, black letters against a white background: “Health Ministry’s warning: Smoking is harmful to your health.” There are cigarette advertisements on billboards and in newspapers and magazines. Point-of-sale advertisements are quite visible in almost all shops selling tobacco products (GLA, 1998).

Article 10 of the Tobacco Control Law adopted in 2010 prohibits the demonstration of tobacco smoking by the mass media if it is not an accidental recording and/or part of the creative process (GLTC, 2010).

After ratifying the FCTC, Georgia had five years to implement a total ban on tobacco advertisement and promotion, but this deadline expired in May 2011. The ban is still only a partial one, as it permits outdoor advertising and other marketing vehicles (except TV and radio) (Bakhturidze, et al., 2013).

The tobacco control situation in Georgia can be characterised as follows: even though Georgia is a member of the FCTC, the tobacco control regulations that have been adopted are hardly enforced. The main problem is one of lax enforcement, not poor legislative action (FCTC Mission Report, 2013).

To conclude, tobacco control efforts in Georgia are far behind what is called for by the WHO and tobacco control experts.

**Public health system development in Georgia**

After Georgia gained independence in 1991 the government initiated health care reforms. The Georgian health system has moved away from the highly centralised Semashko model, a legacy of the Soviet Union (WHO/Euro, 2009; Gamkrelidze, et al., 2002). Following its declaration of independence, Georgia no longer had resources to provide free health care. The healthcare sector was considered less effective, and the government rapidly reduced an already insufficient budget for healthcare services, which resulted in a complete collapse of the healthcare system (Gzirishvili & Mataradze, 1998; Chanturidze, et al., 2009; Rukhadze, 2013). The government began to pay less attention to preventive services as it did to
therapeutic and clinical services. Unhealthy lifestyles are common in Georgia and the nation’s healthcare system has not responded adequately to this phenomenon (Gamkrelidze, et al., 2002).

In 1996 the Department of Public Health was established and proclaimed health promotion and disease prevention as its main areas of work. A budget for health promotion activities, included smoking prevention, and several other programs to prevent diseases was established (Djibuti, et al., 2010; Gamkrelidze, et al., 2002; Chanturidze, et al., 2009).

In 2003 the Rose Revolution in Georgia resulted in an opportunity to establish a new government. Mikheil Saakashvili, then 36 years old, was elected as the new president in 2004 (Kemoklidze, 2013). Many stakeholders stated that they were not properly consulted about health reforms in the country. Consequently, their limited involvement was thought to be a major problem in decision-making processes. Since then health-related policy-making rhetoric in Georgia has evolved from the Soviet model relying on top-down experts into a model emphasizing transparency and participatory elements. This new orientation is reflected, for example, in the Prime Minister’s 2006 directive to the Ministry of Labour, Health and Social Affairs of Georgia (MoLHSA) to involve all key stakeholders in the policy-making process (Chanturidze, et al., 2009). This directive could be interpreted in many ways, however. Hauschild and Berkhout (2009) provide the only empirical study of this issue conducted in Georgia. Very little is known by government agencies about the level of involvement of non-governmental stakeholders (Bakhturidze, et al., 2013; 2016).

The reorganisation of the Georgian healthcare system resulted in the abolishment of the Department of Public Health, whose functions were transferred to the National Centre for Disease Control and Public Health (NCDC) in 2006. After this transition development of the healthcare system was very slow, with progress occurring mainly through input from non-governmental and international programs. Georgia has several laws and orders from the government and various ministries that regulate issues relating to public health. The existing legal framework addresses health promotion issues including tobacco control, HIV/AIDS prevention, drug misuse, prevention of micronutrient deficiencies, and water and food safety.
Although many necessary public health laws have been adopted, enforcement systems are often absent or very weak (Chanturidze, et al., 2009; Rukhadze, 2013).

Another important document is the National Health Care Strategy for 2011-2015, which was adopted by the government of Georgia with a focus on health promotion. With this strategy the government intended to improve the population’s health and to reduce the burden of diseases and deaths by 2015 (MoLHSA, 2011). This document was designed to inform the public about the planned reforms in order to encourage its involvement in implementing these reforms. Creating supportive environments was a central theme in this strategy as it aimed to inspire people to take care of their own health. The following priority areas were outlined in this strategy: prevention and screening of non-communicable diseases, enhancing the public health system, monitoring the population’s health and conducting health risk assessments, transparency and public involvement, and inter-sector work (MoLHSA, 2011). The document also covers the improvement of social policy, the educational system, access to high-quality health care, urban and regional development, and macroeconomic stability. The strategy emphasised the need to establish and monitor these areas so that they may contribute to the development of health promotion policy in the country (Bakhturidze, et al., 2016).

Following the parliamentary elections on October 1, 2012, the new Georgian government announced that the health of Georgian citizens will be a high priority. According to the literature, governmental efforts in health promotion and disease prevention can have a significant influence on a country’s health status by helping prevent non-communicable diseases and detecting health problems at an early stage (WHO/Euro, 2009; Chanturidze, et al., 2009; Rukhadze, 2013). Even so, there are very few indicators that can be used to assess the success of the national health system in these areas. There is no regular reporting system that uses either routine or population-based data sources (WHO/Euro, 2009; Chanturidze, et. al., 2009; Rukhadze, 2013).

At the systemic level, public health work is hampered by a weak legislative framework, lack of coordination between agencies, lack of funding, and lack of adequately trained public health professionals (Djibuti, et al., 2010; Gamkrelidze, et al., 2002).
Health promotion challenges

The Ministry of Health is not the only government agency responsible for addressing significant health problems. It is the responsibility of the entire government to enact public health policies in all sectors (NCDC, 2010; WHO/Euro, 2009). Unfortunately, there is as of yet no systematic consideration of health across the government agencies (WHO/Euro, 2009; Chanturidze, et. al., 2009). As a result the conditions for health promotion in Georgia today are bleak, characterised by a lack of political will to prioritize health. This issue is complicated by the complexity of multi-sectorial work in a politically challenging environment, the lack of positive attitudes to public health challenges among Georgians, and inadequate human and financial resources for health promotion (Swallow, 2010; NCDC, 2010).

Many public health problems and practices in Georgia have not been fully acknowledged. There is great need for the country to develop a sustainable health promotion system that would take into account local needs, social disparities, and opportunities for health promotion. The task of promoting the health of the Georgian population should be shared among various governmental and non-governmental agencies, but this will require effective coordination between all agencies and organisations that are involved. The latest draft of the Health Promotion Strategy for Georgia addresses inter-sector cooperation and institutional and human resource capacity building, and acknowledges the impact of other policies and cultural change as essential factors in keeping people healthy (Swallow, 2010; NCDC, 2010; Raminashvili, et al., 2014).

The population’s health challenges are related to living conditions and how society is organised. A systematic approach will be needed to address all of these challenges, and not only within the health sector. Since public health is affected by various factors in different fields, inter-sector work with joint responsibility and coordinated resource mobilization is necessary (NCDC, 2010; Raminashvili, et al., 2014).

To summarise, the weak condition of Georgia’s public health system is exacerbated by frequent changes in the government and poor enforcement of laws. The political context for public health has been marred by a rapid succession of governments
since the dissolution of the Soviet Union, as well as a poorly anchored and poorly functioning public health system. As a result, tobacco control laws that have been enacted are not enforced.

**The role of public opinion with respect to tobacco control in Georgia**

Georgia has enacted a tobacco control law, as well as some other legislative acts, that regulate particular elements of the tobacco problem. Despite these restrictions, however, tobacco use is ubiquitous even in places where it is prohibited, due primarily to lax enforcement of laws. To be effective, Georgian tobacco control law must be amended to include enforcement measures. This calls for policy-makers to revisit the current structure of tobacco control (Bakhturidze, et al., 2013).

No systematic data about public opinion regarding tobacco control exists in Georgia. There are, however, very limited data available through general surveys such as the Global Youth Tobacco Survey (GYTS) and the Global Adults Tobacco Survey (GATS). Globally, 82.5% of youth supported a smoking ban in public places in 2008, compared to 76.1% in 2003 (WHO, 2009). No one from the Georgian government uses these data to respond to public demand.

One possible source of pressure to encourage tighter laws and their enforcement could derive from public opinion, as this strategy has made a difference in other countries. The Georgian public's opinion about tobacco control has been largely unknown, however, due to a conspicuous lack of research on the subject.

In the absence of hard data about public opinion, policy-makers might believe that the public does not support tobacco control. This would obviously make the enactment of tougher control and enforcement laws even more difficult to accomplish.
Chapter 3. Literature review

The role of public opinion in making public health policy

Surveys and polls are often used to assess the public’s opinions about specific issues. The public may be not sufficiently informed to express educated, meaningful opinions about complex or highly targeted policy issues (Stein, 2005; Kinder & Sears, 1985; Weakliem, 2003). Contextual factors are also important, and factors such as the president’s popularity and electoral proximity show that policy leadership sources are institutional (Canes-Wrone & Shotts, 2004). But there is reason to believe that state lawmakers are also responsive to public opinion, especially on certain issues. Specific data about public opinion may provide legislators with more precise information about public attitudes than general opinions about a subject (Erikson, 1976; Arceneaux, 2002; Eriskon & Tedin, 2015). There is a deficit of public opinion survey data with regard to tobacco control measures in Georgia, and no evidence exists regarding the responsiveness of policy-makers and decision-makers to public opinion.

On the global level, however, review of the literature shows that there is a high degree of policy responsiveness to public opinion. The main source of data about public opinion, which is important for our study, are organisations, individuals, and social movements that participate in social-political life. Polls can be a significant influence on politicians' behaviour, but they can also be manipulated by policy-makers to pursue their own agendas. Politicians can influence public opinion by focusing public attention on particular social problems, often through speeches. They use media that can change opinion and impact policy-making. Manipulation of public opinion by elites does happen and can reverse policy achievements that accurately reflect the will of the people (Manza, et. al, 2002; Petry & Bastein, 2009; Brooks, 2006). We have no scientific evidence that such manipulations have occurred in the public health policy arena in Georgia.

It is important to examine how special interests influence public policy, as the link between public opinion and policy is often weakened when special interest lobbying efforts are strong. If politicians and legislators pay more attention to special interests
and less attention to public opinion, “policy congruence” will weaken. Public opinion can set the main contours of public policy when lobbying is not present (Gray, et al., 2004).

Public opinion data seem to have played a significant role in influencing tobacco control policy changes in most European countries. These data help shift policymakers’ perceptions of the public’s beliefs and attitudes about tobacco control legislation. Survey data from several countries shows that smoking bans in workplaces, on public transport, and in public spaces such as shopping malls are widely supported by the public (Borland, et. al., 2006; Brooks & Mucci, 2001; Trotter & Mullins, 1996; Lam, et al., 2002; Brenner, et al., 1997). Awareness among the population about smoking plays an important role in supporting smoke-free policies in general. Public health advocacy work supporting smoke-free policies could be helpful in increasing the health awareness of individuals (Lam, et al. 2002). Prior to this study, the deficit of relevant data about Georgia on this subject has been problematic.

A survey of global research reveals that members of the general public, including tobacco users, seem to be aware of the dangers of tobacco and support tobacco control. In Australia, 89% of never-smokers supported a smoking ban in the workplace, compared with 67% of smokers (McAllister, 1995), and only a minority of Australian tobacco users supported smoking in public bars (Trotter & Mullins, 1996). In South Africa, 83% of non-smokers and 70% of smokers supported bans on smoking in public places (Reddy, et al., 1996). In Greece, smokers and non-smokers were equally supportive of bans on tobacco sales to minors (Lazuras, et al., 2009). In Hungary, almost 80% of respondents supported smoking restrictions in closed and outdoor public spaces, workplaces, restaurants and bars (Paulik, et al., 2012). Public support has proven an important tool for promoting changes to tobacco policy internationally, and this can also be true in Georgia.

In a country closer to Georgia, Ukrainian public support for banning smoking in education and health-related buildings exceeded 94% and reached 67.1% for smoking bans in bars (Andreeva, et al., 2010). Russian studies showed that 95% of the public supported a ban on indoor smoking in healthcare areas, and 99% supported a ban in schools (Chuchalin, et al., 2009). Our goal was to assess public
support for different tobacco control measures in different countries and learn how politicians can use public support to change tobacco control policy and promote enforcement.

**Tobacco industry influence on public opinion and decision-makers**

Studies of the tobacco industry's internal documents reveal a strategy of using international scientific consultants to influence public opinion about the environmental effects of tobacco smoke (Muggli, et al., 2003; Saloojee & Dagli, 2000).

Efforts taken by the Ministry of Health and NGOs, and the positions of the prime minister, resulted in the establishment of a special government committee on tobacco control (Governmental Decree N58, 15.03.13) and the adaptation of the Tobacco Control Strategy (Governmental Decree N196, 30.07.13) and Action Plan 2013-2018 (Governmental Decree N304, 29.11.13). Following these actions, however, the influence of the tobacco industry on government officials and politicians has increased significantly. Use of these kinds of tactics by the tobacco industry is well known (Saloojee and Dagli, 2000; Gray, et. al., 2004). They still continued to defend a "half-pregnant" policy and, looking toward the financial interests of the media, sponsored sporting and cultural bodies (Chapman & Wakefield, 2001). Many of these tactics are based on false facts and deceptive theories that are offered as proven science by tobacco groups (Gruning, et al., 2008). The same thing is happening across countries of the former Soviet Union. In Russia, for example, mass media outlets are sometimes blocked by pro–tobacco interest groups that promote activities of the tobacco industry, especially at the federal level (Demin, et al., 2012). Prior to our study the extent of the tobacco industry’s influence on policy-making processes was unknown in Georgia.

**The media’s role in influencing public opinion**

In democratic countries the media can exercise powerful influence on political agendas, and can significantly affect public opinion (Kingdon, 2011; Cook, et. al., 1983). In western countries, the government pays attention to mass media outlets
and listens and reacts to their positions (Kingdon, 2011; Cook, et. al., 1983; Sweanor & Kyle, 2003; Lerberghe & Ferrinho, 2002). Media outlets are more likely to focus on the interests of individuals than on community interests, and this is a major obstacle to making health systems more responsive to societal needs in developing countries (Cassels, 1995). Mass media outlets have little influence on health issues-mostly they are interested in sensational content (Lerberghe & Ferrinho, 2002). Australian researchers concluded that a willingness and capacity to engage with mass media was seen as an essential attribute of successful public health policy (Chapman, et al, 2012).

Media communications play a vital role in shaping how individuals and communities understand tobacco-related issues, opinions, attitudes, and behaviours (Studlar, 2006; WHO/IARC, 2009). Public relations organisations have often been used to manipulate media and public opinion about various aspects of tobacco control and obtain the support of those who oppose government intervention in business and taxation, thereby encouraging antiregulatory and anti-government viewpoints (WHO, 2012).

Public opinion is of particular importance in the promotion of “new public health,” a model that seeks to empower people to take control of their own wellbeing. But it is important to remember that the public is empowered only to the extent that their views are known and respected.
Chapter 4. Theory

Kingdon’s theory

The main theoretical framework for our study is Kingdon’s theory on agenda setting. In this theory interest groups are active in the policy-making process, but primarily as impediments (rather than actors who promote policy changes) or as people whose agendas are considered only after the policy has been established (Kingdon, 2011). Kingdon defines lobbyists as special interest groups that include businesses and industry representatives, professional groups, labour groups, public interest groups, and sometimes government officials. Public interest groups that include consumers, environmentalists, and healthcare professionals sometimes affect policy agenda as well. Academic literature about the structure of the medical care system has markedly affected the thinking of people in the field of health policy. Some researchers and scholars construct “inner-outer” careers in which they travel between academia and government (Kingdon, 2011). Some suggest that groups avoid competition and pursue “niche-seeking behaviour.” Others argue that resource limitations limit both the monitoring behaviour of groups and the extent to which groups can engage and influence policy activity. While there is some consensus that groups tend to specialize, little published research is available which seeks to explain it (Darren, 2011).

Some groups of people such as politicians, journalists, academics, and citizens have interests in current policy-making and its implementation. Think tanks, opinion leaders, and the media can be major influences on policy-making. Government bodies prefer to keep the status quo, but an attentive public that has greater interest in changing the status quo is more likely to pursue new approaches and achieve them (Pross, 1986; Dumitrescu, 2003). Main actors interested in health promotion include CSOs, patient groups, and media organisations. Both governmental and non-governmental organisations, as well as public and private institutions, try to influence policy-making processes and programs aimed at improving the wellbeing of people in society as a whole (WHO, 2013). Pluralist political theorists recognize organised special interest groups as key players. While policy-making is the purview
of the government, and particularly of the executive organs, the realities of modern politics enable groups formed specifically to promote the interests of certain social groups to play a significant role in the process (Howlett & Rmaesh, 2003).

Data on policy reforms gathered from nearly every developing country between 1975-2007 show that insider groups are against reforms because they like to keep the status quo and weaken the government’s commitments to strengthening the regulatory regime, which is similar to the US experience described by Kingdon (Weymouth, 2012; Kingdon, 2011). Evidently, having an interest group advocate a policy goal is not the same as political success (Binderkrantz & Krøyer, 2012). Consumers in developing countries create incentives for policy-makers to promote the adaptation of regulations regarding their rights, which is an instrument for democratic development. The results show, however, that democracy is not a universal way to achieve public good, because the process appears to depend on powerful insiders as well (Weymouth, 2012).

Kingdon’s theory of agenda setting (1995) suggests the potential importance of public opinion survey data in tobacco control. As the policy-making process progresses at the governmental level, the number of actors decreases. Some actors participate in lobbying activities to persuade government officials to adopt their positions. There are two models of public policy decision-making: the rational model and the incremental model. The rational model holds that the main aim of public policy decision-making is to maximize solutions to complex problems. The second model states that public policy decision-making is more a political activity than a technical one. The rational model shows how to make decisions, while the incremental model describes actual decision-making practice (Kingdon, 2003; Howlett & Ramesh, 2003). The public can have influence on policy, even when there is no democratic government, through informal pressure and the risk of disorder (Burstein, 1998; 2010; Johnson, et al. 2005; Weakliem, 2003; Brooks & Manza, 2006). Supporters of the democratic theory assume that political actors should be alerted to changes in public opinion and adjust their behaviour accordingly. If public opinion had little influence, democratic institutions would not be working well (Soroka & Wlezien, 2004; Burstein, 2003; 2006).
Kingdon’s data are based on the experience of the United States democratic system, but they also provide an example for newly democratic states like Georgia. In the populist version of democracy, politicians demonstrate respect for citizens and their expectations regarding policies. Changes in public mood result in almost immediate shifts in policy activity, and in this model, public opinion is paramount. The anticipation of future public opinion impact does not weaken the influence of present opinion (Druckman & Jacobs, 2006; Stimson, et al., 1995). Normative democratic theory addresses the responsiveness of government policy to citizens’ preferences. Many laws on civil rights were adopted only after public support for them increased (Page & Shapiro, 1992). If we look at countries that have strong tobacco control measures in place, there are big differences among them with regard to democratic development.

Kingdon also emphasizes the role of high officials in agenda setting: “Presidents sometimes set the agenda, for instance, then mobilize the public to pass their legislative proposals” (Kingdon, 2011, p. 67). But most important are deliberations outside of government that can happen through direct public involvement, a democratic ideal. Deliberative processes are a new phenomenon in the health care sector. Top-down formal consultation has a political nature and restricts the neutrality of the opinions expressed. This kind of representation, however, does often provide well-argued opinions (Abelson, et al., 2003; Contandriopoulos, 2004).

Politicians pay attention to public interests because they help make political decisions. A responsive public behaves like a thermostat: a departure from favoured policy temperature, which can be changed over time, produces a signal to consequently adapt a policy. When the signal stops, the policy is changed. Government responsiveness is proportional to the public’s desire for change (Wlezien, 1995; Soroka & Wlezien, 2004; Monroe, 1998; Petry & Mendelsohn, 2004). According to Kingdon’s experience, public agendas sometimes have minimal impact on government officials (Kingdon, 2011).

Most health systems lack this democratic approach and include resistance to greater civil society involvement in health issues and healthcare. One of the essential functions of civil society is to help build policies through advocacy and by informing decision-makers and contributing to their choice of priorities. Putting the
interests of groups that have been forgotten or discriminated against on the agenda can be done through advocacy by civil society organisations (CSOs) that give these groups a voice. These groups may include but are not limited to the homeless, refugees, people with AIDS, chronic patients, people that have inadequate healthcare, and people that do not have the money to access strong health infrastructure.

Kingdon’s model includes several independent “streams”—policies, problems, and politics—yet they all intersect at a critical juncture to yield policy changes. Kingdon refers to these critical stages as a “policy window,” a time when external or internal interest groups push an issue to the top of the political agenda. Economic expectations play a significant role in opening and closing policy windows through which policy advocates may operate. When public opinion can illustrate the harmful effects of tobacco use, this helps open a policy window that might not otherwise open. Public opinion favouring or discouraging different tobacco control measures can be expected to have influence on the degree to which tobacco control policy rises or falls in the political agenda (Kingdon, 2003; Howlett & Ramesh, 2003; Baumgartner, 2015; Bakhturidze, et al., 2012).

The lack of democratic processes in the health sector is significant even in countries where representative democracy is well established. This is a result of a fragmented understanding of what civil society is. Civil society organisations contribute to the health systems by offering technical expertise and evidence, as well as institutional and financial resources for health services and public information. Community networks, non-governmental organisations, and other types of CSOs have a long history of participation in health-related causes through both policy advocacy and community service. There is need for a systematic assessment of the most productive forms of legal, political, institutional, financial, and service-related relationships between CSOs and the state to improve health outcomes (Lerberghe & Paulo Ferrinho, 2002).

Health promotion aims to make political, economic, social, cultural, environmental, behavioural, and biological factors favourable by advocating health and wellbeing. Individuals cannot achieve their fullest health potential unless they can take control of those factors that determine their health (WHO, 1986; Cragg, et. al., 2013).
People are engaged with health promotion as individuals, families, and communities over the duration of their entire lives. Professional groups, social groups, and health industry personnel have a major responsibility to mediate between differing interests in society in the pursuit of health (WHO, 1986; Cragg, et. al., 2013).

Health promotion policy requires identifying barriers to the adoption of healthy public policies in all sectors and finding ways of resolve them. The general aim should be to make sure healthy choices are also easy choices for not only the population, but for policy-makers as well. Health promotion works through networking, effective community actions, asset-centered approaches, healthy decision-making, and planning and implementing strategies to achieve better health. The most important part of this process is the empowerment of communities. Community ownership is crucial in guiding their attempts and preferences (WHO, 1986; WHO, 2009; Cragg, et. al., 2013). The involvement of public opinion in processes is an important part of Kindgon’s theory. Public opinion affects preliminary policy drafts more often than final policy decisions or agendas.

The World Health Organization considers participation and empowerment to be hallmarks of health promotion. Participation and empowerment express value orientation in health promotion and can serve as a conceptual framework. One of the most comprehensive and detailed definitions of participation describes it as the process by which members of a community develop the capacity, either individually or collectively, to assume greater responsibility for assessing their health needs. Public participation in decision-making can promote uniting individuals or groups together for passive or active expression of political or civic identity. The public groups plan and then act to implement their solutions, create and maintain organisations in support of these efforts, and evaluate the effects. The evaluation of empowerment and participation is seen as important mainly when they are explicitly part of the program logic. It has become evident that decision-makers frequently do not support the assessment of empowerment and participation because those concepts are usually not considered as important as changes in health or health behaviour. The scepticism among health authorities’ concerning empowerment and participation outcomes may be affected by a lack of acceptance of the favoured qualitative measures (Brandstetter, et al., 2012; Vaidya & Pradhan, 2008; Litva, et al., 2002).
Summary of main points

Kingdon’s theory is a guide to understanding the processes of including public opinion in tobacco control policy-making in Georgia. Through this theory we can find answers about what kind of role public opinion plays in agenda setting and which interest groups have the most influence on policy decisions. Public participation through public opinion studies is an important part of agenda setting processes. Participation is important in strengthening democracy in that it encourages people to take part in both active and passive tobacco control decision-making processes, such as public opinion studies.

Public attitudes are considered during policy-making processes most often in western countries. With regard to health and tobacco control policy-making, there are several cases where consideration of public opinion in setting agendas has opened windows of opportunity and led to changes in policies or laws. There are very few studies of policy-making processes in developing countries where democracy is not as developed and where there is a lack of consideration of public opinion during policy- and decision-making processes. In such places special interest groups such as the tobacco industry often have more power than the public and create barriers for tobacco control policy-making.
Chapter 5. Methods

Table I presents our various research methods and a timeline of when they were used. Our first two articles are based on quantitative research methods. The quantitative data were taken from the “Population Survey on the Tobacco Economy and Policy in Georgia” conducted in 2008. Quantitative articles were published in 2012 and 2013. After publishing two quantitative articles it became clear that qualitative method is needed to be used to study the problem more deeply, and a qualitative study was subsequently conducted in 2013. Explanations of the methods are provided in Table I below.

In the end I opted to use an explanatory model where an initial quantitative phase is conducted to obtain statistical results (Creswell, et al., 2003). In the second phase I gathered qualitative data (open-ended interviews) to help explain the quantitative results. For my thesis a mixed-method approach proved most appropriate as it merged two quantitative studies with one qualitative study to understand real policy-making processes and the broad picture of tobacco control policy.
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<tr>
<td>1</td>
<td>Quantitative study: population survey on the tobacco economy and policy in Georgia. Activities include a sampling of households, sampling design, fieldwork, computer control, data weighting and analysis.</td>
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<td>2</td>
<td>On the basis of the data and methods from the 2008 survey, the authors prepared and published the first quantitative article about public attitudes towards tobacco sales prohibitions in Georgia.</td>
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<td>3</td>
<td>Based on the data and methods from the 2008 survey, the authors prepared and published the second quantitative article about the public’s attitudes towards smoking restrictions and the ban on tobacco advertising in Georgia.</td>
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<td>4</td>
<td>Qualitative study: the influence of public opinion on tobacco control policy-making in Georgia. Activities included study design and sampling, fieldwork, coding, and thematic network analysis.</td>
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<td>5</td>
<td>On the basis of the qualitative study, the authors prepared and published the third article about the influence of public opinion on tobacco control policy-making in Georgia: “Perspectives of Governmental and Non-governmental Stakeholders”</td>
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<td>6</td>
<td>The author analysed the three above articles by using a mixed-method approach</td>
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**Study design for mixed methods**

Table 2 shows procedures that use qualitative data to explain quantitative results. The two articles illustrate strong public support for different tobacco control measures, but we still had no information about policy-makers’ perceptions of public support for tobacco control. For this reason we decided to conduct a qualitative study to explain what’s happening in the policy-making sphere. The table 2 below describes the entire process. Descriptions of the methods used by the articles are shown separately below.

Diagram 1 shows dimensions of mixing. There was gathered quantitative (QUAN) data first and then qualitative (QUAL) data through sequential data gathering method. Component design was used to combine different data at the end for interpretation and conclusions. Purpose of combining data was to explain and find answer on our fourth mixed question: explanatory sequential mixed method design (Creswell, 2014).
Table 2. Mixed methods design

<table>
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<th>Phase one</th>
<th>Phase two</th>
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<td><strong>Quantitative data collection</strong></td>
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<td><strong>Quantitative data analysis</strong></td>
<td><strong>Qualitative data analysis</strong></td>
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<td><strong>Quantitative Results</strong></td>
<td><strong>Overall findings and interpretation</strong></td>
</tr>
<tr>
<td>Pose new question</td>
<td>Procedures: Explain quantitative results through qualitative results</td>
</tr>
</tbody>
</table>

Procedures: Survey N 1588

Procedures: .Factor analyses .Internal consistency

Procedures: .Identification of additional questions

Procedures: In-depth interviews

Procedures: Narrative .Thematic network analyses

Products: .Numerical item scores

Products: .Factor loadings .Cronbach alpha coefficients

Products: .List of best items .Description of results

Products: Specify new research question and data collection plans .Not specified


Products: .Discussions of findings

Diagram 1. Mixed method design

Dimensions of mixing

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**Paper I QUAN**

**Paper II QUAN**

**Paper III QUAL**

Dissertation MIXED

segregated  Reporting  integrated
**Article I**

Design and sample

Two-stage stratified sampling was applied. The 2007 census enumeration districts were used for the sampling frame (NSOG, 2012). At the first stage of sampling, 94 enumeration districts were selected out of 16 000 such districts across the whole Georgia. At the next stage, lists of the household addresses were used in each of the selected 94 enumeration districts to further sample households (Bakhturidze, et al., 2008). A household with members aged 13-70 available for interviews was considered a unit of observation: 1655 households were sampled, and 1588 people (one member from each household) were interviewed (Bakhturidze, et al., 2008).

Data collection

Survey data were collected in January through February 2008, sponsored by the Open Society – Georgia Foundation’s grant program (Bakhturidze, et al., 2008). In-house face-to-face interviews used a standard questionnaire. About 80 interviewers and ten regional supervisors from the Department of Statistics of Georgia carried out this survey. Regional supervisors controlled the selection of addresses and the work of interviewers (Bakhturidze, et al., 2008; 2012).

Study outcomes/determinants

The variables considered were as follows: 1. Demographic variables age, gender, marital status, education level and income; 2. Smoking status (daily, occasional, ex and never); 3. Levels of agreement with the implementation of eight tobacco sales prohibitions and violation penalties, coded ‘yes’, ‘no’, ‘don’t know’ and ‘refuse to answer’ (Bakhturidze, et al., 2012).

Data analysis/generalizability

The dimensionality of the attitudes towards smoking restriction scale was examined with correlation analysis and with factor analysis (principal axis factoring). The reliability of the scale was estimated with Cronbach’s alpha. Using these eight variables a single dichotomous variable was constructed indicating the degree of overall support for sales restrictions; those answering ‘yes’ to three or less of the

40
eight restrictions were coded ‘low support’ and those answering yes to 4 or more of the eight sales restrictions were coded ‘high support’. Differences in levels of support by the demographic variables were estimated using the Chi-square test of independence. Associations between demographic factors and smoking, on the one hand, and support for smoking restriction, on the other, were also examined with a binary multiple logistic regression analysis. SPSS versions 19 and 20 were used for all analyses (Pallant, 2007; Field, 2009; Bakhturidze, et al., 2012).

Article II

Study design and methods

Survey data were collected in January and February 2008 in the whole country. The primary sampling units were households and one member aged between 13 and 70 was selected for the interview. The sample size was determined with the objective to ensure the high statistical reliability of the estimates of key indicators: the 95% CI should not exceed 10–15% of a key indicator estimate. According to this criterion, the sample size was determined to be 1655. Using stratification and a two-stage procedure carried out the sampling.

In-house face-to-face interviews used a standard questionnaire. In households with more than one age-eligible person available for selection, selection of the respondent was carried out at random.

Data analysis/ generalizability

The dimensionality of the attitudes towards the scale of smoking prohibition and tobacco ad ban was examined with correlation analysis and with factor analysis (principal axis factoring). The reliability (i.e., internal consistency) of the scale was estimated with Cronbach’s α. A simple, additive sum score was constructed based on all eight dichotomised attitude items. This sum score indicates the degree of overall support for smoking restrictions and tobacco ad bans. The sum score was recoded into a single dichotomous variable with high support for smoking restrictions as one category (agreement with at least 4 of the eight restrictions) and low support as the other. Support for smoking restrictions was analysed against
demographic variables with the $\chi^2$ statistic. Associations between demographic factors and smoking status, and support for smoking prohibition and tobacco ad bans, were also examined with bivariate as well as multiple logistic regression analysis. SPSS V19 and V20 were used for all analyses. Analyses were also carried out in Mplus with the weighted least squares—mean adjusted and variance adjusted estimator, and all items were defined as categorical. The Mplus results, which are not reported here, supported the results of the principal components analysis that are reported here.

**Article III**

Study Design and Sampling

This study used a collective case study methodology (Creswell, 2007).

Methods and interview process

The data were obtained through 12 semi-structured interviews during the period from April to May 2013, with three respondents each from the Georgian Ministry of Labour, Health and Social Affairs (MOH case), the Parliament of Georgia (MOP case), Opinion Research Agencies (ORA case) and Non-Governmental Organisations (NGO case). Face-to-face, one-on-one interviews were conducted in Georgian by the first author. They were audio recorded.

Thematic Network Analysis and Coding

Thematic network analysis (TNA) was used to analyse the interview data (Attride-Stirling, 2001). The TNA was undertaken by using the Georgian transcripts. The Basic Themes were grouped and summarised into Organizing Themes. These were further abstracted in Georgian into superordinate Global Themes. In coding the transcripts, basic, organising and global themes were identified without regard to the sources of the data. The authors then constructed a graphical network depiction of the theme structure. Only after this stage in the analysis were the themes cross-identified with the cases, to ascertain which cases contributed information to which themes. Selected quoted material was then translated into English (the transcripts themselves were not translated into English). All authors then discussed the
Georgian-English translations and agreed that close/literal translations resulted in close to unintelligible English. The decision was then taken to paraphrase the Georgian quotes in English, to avoid giving the impression of precise translation. Therefore, material obtained from the interviewees as reported in this paper appears without quotation marks, and in paraphrased form only.

The role of the researcher

Many authors believe that the role of the researcher is central to the effectiveness of a study, but this can lead to ethical, personal, and strategic complications in qualitative research practice. As the principal researcher in this study, I have relied on knowledge, skills, and experience in health promotion and policy-making that I have accumulated over 18 years of advocacy and research work.

Most participants represent an elite group that requires a specific approach to the interview process. They regard the researcher as a colleague, and this was helpful to maintain neutrality. Information was obtained from the participants’ offices and there was a possibility that the researchers were biased. But the qualitative research methods used in this study were designed to reinforce my objectivity as the author. For example, I asked a diverse set of questions about public health, of which only one was related to tobacco control. As a researcher I am strongly interested scientifically in tobacco control policy-making processes inside government and the real role played by public opinion. It is vital for us to understand such processes in order to find solutions. The desire for objective results informed our decision to use only scientific methods in our research.
Chapter 6. Results

Paper I

77.3% of all respondents had agreed to all eight items, while no agreement (or missing answer) on all items was found for 12.5%. The association between a simple, additive sum score based on the eight sales restrictions attitude items and the dichotomy described in the methods section (high versus low support for sales restrictions) was 0.98. The lowest level of approval was 50.4% among respondents aged 13-25 for ‘sales of cigarettes must be only from stores that have a license to sell tobacco products’. The highest level of approval was 98.4% among respondents aged 56-70 for ‘sales prohibition to children under 18’. There was a statistically significant age gradient for all eight restrictions, with older respondents having the highest approval rates.

Regarding demographic education segments, approval of each of the eight restrictions for all education segments was in the range 81.1%-90.1%; nevertheless, there was a statistically significant education gradient, with higher educated respondents having the highest approval rates. Comparison across tobacco use status segments revealed that approval of each of the eight restrictions ranged from 92.1% to 97.9% among ex- and never-smokers, and from 51.2% to 84.2% among less than daily and daily smokers. The lowest approval rates were observed among less than daily smokers, ranging from 51.2% to 54.6%. All the smoking status gradients were statistically significant, with ex and never-smokers having the highest approval rates and less than daily smokers have the lowest approval rates.

In the sample segments aged 36-70 for males and females alike, high approval of restrictions was expressed by 93.4-98.7% of respondents. In the age segment 13-25, only 55.7% of respondents indicated high approval of restrictions. The age differences in level of support for restrictions were statistically significant. Among never or ex-smokers, high approval of restrictions was indicated by 94.3% to 97.9% of respondents. Occasional smokers were less supportive of restrictions than were current smokers. These differences in approval were statistically significant. The
results of the multivariate binary logistic regression analysis roughly confirm the associations with age and smoking behaviour described above. However, after controlling for age, ex-smokers are no longer different from daily smokers, and the association with education is no longer significant.

Approval levels were lowest among occasional smokers. Perhaps the most noteworthy data pertain to smokers’ approval of restrictions, with levels of 71% among women and 87% among men. Data shows no education differences between males and females in levels of approval for restrictions. The result shows high levels of approval for restrictions for income level for both women and men, but lower levels of approval among those who did not provide income data.

**Paper II**

The lowest level of approval was 47.5% among respondents aged 13–25 for the ‘prohibition of indoor smoking in restaurants, bars and nightclubs’. The highest level of approval was 98.2% among respondents aged 56–70 for the ‘prohibition of indoor smoking in medical, educational, sport and cultural facilities’. There was a statistically significant age gradient for all eight restrictions, with older respondents having the highest approval rates.

Approval of each of the eight prohibitions ranged from 88.6% to 98.9% among ex-smokers and never smokers, from 73% to 82% among daily smokers and from 47.1% to 53.9% among less-than-daily smokers. Across all items, the average support for smoking restrictions and tobacco advertisement bans was 84.9%. All eight smoking status gradients were statistically significant, with ex-smokers and never smokers having the highest approval rates, and less-than-daily smokers having the lowest approval rates. Daily smokers had higher approval rates than occasional smokers but lower than ex-smokers and never-smokers.

When we examine the dichotomised sum score, it turns out that among never smokers and ex-smokers, high approval of restrictions was indicated by 94.2–97.7% of respondents. Occasional smokers were less supportive of restrictions than the daily smokers. These differences in approval were statistically significant.
There were no statistically significant differences in the levels of support for restrictions by gender and household income. The bivariate association between the highest completed education and support for restrictions was significant. This significance is due to the difference between the level of support among those who have college-level education (82.7%) and those who have a university level education (87.9%). When compared with the daily smokers (reference group), the occasional smokers were significantly less supportive of restrictive measures (OR=0.63) and never smokers are significantly more supportive (OR=5.80).

The multiple logistic regression analysis produced results that were similar to the results of the bivariate analyses, although some relationships became insignificant (overall association with highest completed education and contrast between daily smokers and ex-smokers) and one surfaced (are between lowest education and college-level education).

**Paper III**

The global theme driving the Thematic Network Analise (TNA) is the public’s role in public health policy making as perceived by the respondents. The TNA revealed three organising themes: A) The public has an opinion; B) Public opinion is ignored or manipulated; C) Public opinion not influential in tobacco control and 13 basic themes.

Organizing Theme A is labelled ‘The public does, indeed, have opinions’.

Basic Theme 1 arises from respondents’ claims that public opinion related to illicit drugs has always been strongly negative. Basic Theme 2 follows from respondents’ comments about sex education and family planning that there is strong public opinion against contraception and sex education hindered policy-makers’ intentions to address these sensitive issues. Basic Theme 3 is stimulated by the changing public stance on road safety relevant to almost everyone. Respondents remembered that public opinion on the compulsory use of seat belts was not supportive before legislation was enacted in 2010. But public support increased after enforcement became a reality. Basic Theme 4 arose out of expressions connected to drinking water quality. Several respondents remarked that the public
attitude is united in calling for safe water, sewerage systems, proper waste management, and permanent supplies of quality drinking water.

Taken together, these basic themes suggest that Georgian policy-makers have some awareness of public opinion on a range of health issues. That conclusion ties in with Organizing Theme B: is public opinion perceived to matter in policy-making processes, or is it ignored, or is it manipulated? The respondents perceive that public opinion is ignored rather than regarded in policy processes.

Basic Theme 5 arises from respondents' reports that during Shevardnadze's leadership (1992-2003), public opinion was not monitored via polls or other means polls, even if the public was presumably informed by the relatively free mass media. During Saakashvili's leadership (2004-2012), public participation in policy-making processes did not increase, and nor has it since. All respondents mentioned in one way or another that there is no political will to involve the public in policy-making. Basic Theme 6 shows, that most of the respondents believed that government should be more willing to consider public opinion in policy formation. NGO respondents underlined the potential for better policy-making if the public were to be involved. ORA representatives underlined potential importance of public opinion polls in policy-making. MOP and MOH group respondents assumed that national mood is important in decision-making when it supports the decisions preferred by the elite. Basic Theme 7 suggests that one reason public opinion may be ignored is that it is considered to be dangerously ill-informed. MOP and MOH respondents declared that sometimes public opinion on a particular issue is ill-informed and is against the course of action that is best (as seen by 'experts'). Basic Theme 8 illuminates the opinion of some respondents that beyond simply ignoring public opinion, the public mood is sometimes studied and then used for manipulation. Respondents believed that during the era of Saakashvili, knowledge about public opinion was used to enhance success during election periods, but was otherwise used to manipulate the public in the direction of policy preferences of the dominant political regime. Basic Theme 9 is closely related to Basic Theme 8: its focus is the perception that the mass media has been an important mechanism in public opinion manipulation. Sometimes the mass media is seen to distort critical facts or omit vital stories or details, to manipulate the public.
Basic Theme 10 is based on respondents' recollection that during the Saakashvili era, public opinion data were collected periodically to manipulate policy outcomes, even if not to inform decision-making processes. At the time of the interviews, NGO, MOH and ORA respondents felt there was no real interest to conduct public opinion research, for any purpose whatsoever.

Turning to Organizing Theme C, tobacco control comes into focus. The basic themes illuminate a dissonance between two perceptions: the public is known to support tobacco control, and this should count, but the public’s opinion about tobacco control is ignored.

Basic Theme 11 is addressed by MOH and NGO respondents, who underlined the importance of public opinion when considering tobacco control policy. ORA, NGO and MOH representatives remarked that public opinion regarding tobacco control is supportive, but the Government does not take it into account in its policy-making. This is due in part, some respondents remarked, to the tobacco industry providing opposite and misleading information to the Government, suggesting that there is a negative public mood towards strong measures like a total ban of smoking in public places, a tobacco tax increase, ad bans, and so forth. NGO and MOH respondents addressed the powerful influence of commercial interests against tobacco control and remarked that Government officials are the lobbyists for the tobacco industry.

Basic Theme 12 is not focused on the public itself but on Donors’ support for tobacco control, which is seen by respondents to be in synchrony with Georgian public opinion. Basic Theme 13 raises for the first time the influence of Georgian tobacco users. MOP representatives expressed a widely held view that smokers’ reaction will be strongly negative to tobacco control measures and thus outweigh public opinion favouring tobacco control. The industry, respondents say, tries to oppose tobacco control efforts in all possible ways. Policy-makers are aware that public opinion favours tobacco control and enforcement, but politicians are resistant; they support business including the tobacco industry and ignore public opinion.

NGO and MOH respondents mentioned that even the weak tobacco control policies in place during Saakashvili period were not enforced. The NGO respondents remarked that public health interest was ignored, and planning and strategy development occurred without public involvement.
The fourth study question: what are the comparable attitudes, opinions, and beliefs about tobacco control in the governmental, non-governmental, and public spheres with respect to smoking?

Overall support for tobacco sales restrictions is very high in Georgia, where an absolute majority of non-smokers and a majority of smokers support such measures. Policy has been officially implemented—regulations now exist—but these regulations are not enforced because of strong interference from the tobacco industry. The tobacco industry creates barriers against restoring the system of licensing required to produce and sell tobacco. Though strong political will is lacking, non-governmental organisations strongly support and advocate for the enforcement of restrictions on tobacco sales. These organisations sometimes conduct public opinion surveys or use existing public opinion data as advocacy tools.

The circumstances are similar with other forms of tobacco control such as bans on tobacco advertising and promotion, prohibitions on smoking in closed buildings, and increased penalties for violations.

The majority of policy-makers perceive that consideration of public opinion in policy-making is very low. This is due to the under-developed nature of democratic institutions, the lack of political will to include the public in policy-making processes, political and business influence on the media, and the fact that the tobacco industry has more influence than those actors seeking to promote public health.
Chapter 7. Discussion

Public support for tobacco control measures

On average, more than 78% of the Georgian population supports tobacco sales restrictions and strong administrative measures. These include a prohibition on the sale of tobacco to and by children under 18; a prohibition on the sale of cigarettes as single units; a prohibition on the sale of cigarettes in schools and youth organisations; a prohibition on the sale of tobacco in health care settings; a prohibition on the sale of tobacco with children’s clothes and toys; increased penalties for violations of the law prohibiting sales to minors and single unit sales; and a prohibition on the sale of cigarettes from stores that do not have a license to sell tobacco products. A high level of support was found among smokers (71% of women, 87% of men) for prohibiting tobacco sales to minors and in schools and hospitals, for increasing penalties and for establishing licenses to sell tobacco. More than half of occasional smokers (54% of women, 55% of men) support all of the proposed prohibitions on tobacco sales. An absolute majority of ex-smokers and never-smokers express high-level support (94% or more) for the above-mentioned measures (Bakhturidze, et al., 2012).

On average, 85% of the Georgian population supports the following smoking prohibitions and administrative measures: prohibitions on smoking promotional campaigns (including free promotional items, such as t-shirts and free samples); prohibitions on the advertisement of tobacco and tobacco companies in mass media and through sponsorship; prohibitions on smoking inside government buildings and offices, in schools, and in youth organisations; prohibitions on smoking inside medical, educational, sport, and cultural facilities; prohibitions on smoking inside private workplaces; prohibitions on smoking inside restaurants, bars, and night clubs; and the introduction of more restrictions on smoking and increased penalties for violations (Bakhturidze, et al., 2013).

These data show that public support for some tobacco control measures is very strong. They also indicate that the public wants to see changes in tobacco policy with the goal of creating a smoke-free environment in Georgia.
It is useful to compare the public opinion data from Georgia with those of other countries with regard to sales restrictions, prohibitions on smoking in public places, bans on tobacco advertising, and increased penalties for violations.

The high level of public support for the prohibition of smoking in workplaces and in public spaces is very similar to findings in other parts of the world with different cultural and political contexts. For example, 76% of Australian non-smokers support a ban on smoking in public spaces, and 81.8% of urban residents in China support the same ban. In South Africa, 83% of non-smokers and 70% of smokers agree with smoking bans. Approximately 80% of Hungarians support smoking restrictions in closed and outdoor public spaces (McAllister, 1995; Perlstadt & Holmes, 1987; Yang, et al., 2010; Reddy, et al., 1996; Paulik, et al., 2012).

With regard to Georgia’s neighbours, 95% of Russians agree that indoor smoking should be prohibited in healthcare facilities, 99% support a ban in schools, and more than half believe that smoking should be prohibited in restaurants and cafes (GATS-Russia, 2009; Danishevski, et al., 2008). In Ukraine in 2009, public support for banning smoking in education and health facilities was more than 94%, and 67.1% of those surveyed want smoking to be banned in bars (GATS-Ukraine, 2010).

Somewhat counter-intuitively, young occasional smokers in Georgia were sometimes less supportive of restrictions than daily smokers. We were not able to find comparable analyses on this subject, and can therefore only speculate about the reasons for this finding. It may be that the occasional smokers in this study perceive themselves to be in control of their tobacco use, and therefore do not feel the need for external restrictions. Nevertheless, approximately one half of occasional smokers indicated support for four or more of the restrictions. This puzzling finding does not detract from the overall conclusion that even tobacco users are generally in favour of restrictions.

The most recent study in Georgia shows that 89-92% of the population supports prohibiting smoking in public spaces and banning tobacco advertising (ISSA, 2016a). Support for banning all smoking in the hospitality sector (bars, restaurants, hotels, etc.) has also increased from 76% in 2008 to 79.1% in 2016 (ISSA, 2016a;
Bakhturidze, et al., 2013). These levels of support suggest that Georgian public opinion about tobacco control issues is in line with global public opinion.

Georgia has very a low level of enforcement of FCTC Article 8, which requires parties to prohibit smoking in public places (WHO, 2005; Bakhturidze, et al., 2016). From the international experience we can assume that implementing smoke-free legislation in Georgia will decrease the number of young people who start smoking and also protect non-smokers from second-hand smoke exposure. A total ban on smoking in public spaces will also decrease cigarette consumption, mostly among young people, and will promote the growth of non-smoking as a social norm in the country (Anderson & Hughes, 2000; Eriksen & Carak, 2008; Reid, et al.; Wakefield, et al.).

It should be mentioned that most challenging part of the smoking ban in public places relates to the prohibition in restaurants and bars. In 2009 the Georgian government argued that it is not possible for restaurants to designate a space for non-smokers and purchase ventilation devices. They also argued that if the government prohibits smoking in bars and restaurants, they will lose money. Public support for these regulations is very high (76% on average), even among smokers (73.0%). Today this support is even higher at approximately 79% (ISSA, 2016a). Studies from different countries show that partial smoking restrictions are not effective and that total bans on smoking in bars and restaurants do not have a negative economic impact. On the contrary, they often have a positive influence on local businesses (Eriksen & Chaloupka, 2007). A study conducted in Georgia in April 2016 showed that 17.3% of respondents expected the number of visitors to increase if Georgia prohibits smoking in restaurants and bars, while only 9.8% expected the number to decrease (ISSA, 2016a). This suggests that such measures would have a positive impact on the profitability of bars and restaurants in Georgia.

Georgia is interested in becoming a full member of the European Union and should implement appropriate regulations and follow the examples set by EU member states. The Baltic countries are a good example for Georgia to follow in implementing tobacco control legislation, including bans on tobacco advertising (Joossens & Raw, 2007). Another excellent example is Norway, which banned smoking in all public spaces, including restaurants and bars, and has a
comprehensive ban on all forms of tobacco advertising, promotion, and sponsorship. The Norwegian experience can be used as a model for countries like Georgia to analyse patterns of smoking risk factors under various market conditions (Braverman & Aarø, 2004).

Our study also showed high support (81-83% of respondents) from the public for a total ban on tobacco sponsorship and advertising in Georgia. The most recent study shows even higher support: 92% (ISSA, 2016a). Together these results confirm that an absolute majority of the Georgian population supports a total ban of tobacco advertisement and promotion.

Georgia currently has a partial ban of tobacco advertising, including TV and radio, but still there exist advertisements in print media, on billboards, and at points of sale (including on the Internet), as well as promotional campaigns. While comprehensive bans on tobacco advertising causes a 6.7% decline in per capita consumption, limited bans have no substantial impact on consumption. Changes in income have a greater impact on consumption in the developing world than in developed countries, and this is also a significant factor in Georgia (Jha & Chaloupka, 2000; Harris et al., 2003).

Due to aggressive tobacco advertising and promotional activities, smoking rates have increased most among the younger population in Georgia, and particularly among young women. Significantly, the frequency of adverse pregnancy outcomes including perinatal loss, low birth weight, birth abnormalities, and miscarriage rises proportionately with increasing rates of smoking among women (Bakhturidze, et al., 2008).

Tobacco advertising causes increased smoking rates, and increased smoking rates correspond to poorer public health (Saffer & Chaloupka, 2000). The group most vulnerable to advertising is the younger population, whose attitudes and intentions regarding tobacco use, as well as their choice of products, are in a state of formation compared with the more established behavioural choices of adults. Tobacco companies exploit the vulnerability of youth through tobacco advertising and promotions (Saffer & Chaloupka, 2000; Cornwell, 1997; Arborgast, 1986; DiFranza, et al., 2006; Moodie, et al., 2008; Braverman & Aarø, 2004). Given how
harmful tobacco use is to one’s health and the particular susceptibility of younger generations to advertising, there is a public health imperative in Georgia to fully implement FCTC Article 13, which has strong support from the Georgian public.

Georgia was supposed to implement these regulations before May 15, 2011, but they are still under discussion by the government. Civil society organisations have been trying to promote changes in the Law on Advertisement since 2008, but these initiatives have been largely ignored. A prohibition on advertising was proposed in the amendments prepared in 2013, but it only passed in the Parliament in June 2016. The draft law is still under consideration in the Parliament of Georgia. The tobacco industry and its lobbyists in the Georgian Parliament are against any ban on tobacco advertising and promotion. They argue that international brands are already known and that local production needs advertising (Bakhturidze, et al., 2013; Parliament of Georgia, 2016).

The Institute for Social Studies and Analyses (2016b) conducted focus-group discussions among youth from 8-12 years of age. The results showed that children and young people are under considerable influence from tobacco advertising and promotional campaigns. In everyday life they see billboards, light boxes, and cigarette displays in front of shops and at points of sale. They also report seeing smoking on most TV programs, specifically in the most popular Georgian TV series.

The design of cigarette packs is also attractive for children, who often remember meeting promo-girls in the shops and know about the lotteries offering gifts that are also appropriate for teenagers. The results of those studies, together with our quantitative data has become a tool for NGOs to use in advocating for a total ban on tobacco advertising and sponsorship in the Parliament of Georgia (ISSA, 2016a; 2016b; Bakhturidze, 2012; 2013). These efforts are gaining momentum and there is a window of opportunity to convince policy-makers of the importance of protecting Georgia’s young population from the harmful influence of tobacco advertising.

After strong effort from civil society organisations, the Georgian Parliament initiated new amendments to the Law on Advertisement on June 13, 2016, that will prohibit all forms of tobacco advertising and promotion, including at points of sale. There is hope that Parliament will take into account the strong support of the public for these
measures and adopt new laws to discourage children and young people from
starting smoking (ISSA, 2016a; 2016b; Bakhturidze, 2012; 2013).

Regarding sales restrictions, our results are similar to those studies indicating that
never-smokers are more likely to support tobacco control measures than smokers
(Ashley, et al., 2000; Lafarge, et al., 1998; Pederson, et al., 1987). The majority of
the Georgian population strongly supports a ban on tobacco sales to minors as well
as related measures aimed at limiting youth access to smoking. But in spite the high
level of public support (even among smokers) for enforcing already existing tobacco
sales prohibitions, the level of enforcement remains very low.

Since May 15, 2006, the WHO Framework Convention on Tobacco Control (FCTC)
entered into force for Georgia, where Article 16 prohibits the sale of tobacco to and
by minors (WHO/FCTC, 2016; WHO, 2005). Since Georgia ratified the FCTC,
however, enforcement has been weak due to a lack of political and administrative
will to deal effectively with those who violate the law (Bakhturidze, et al., 2013;
2016).

Since 2003 Georgian tobacco control laws, for example, have prohibited tobacco
sales to and by minors, within 50 meters of schools, in medical facilities, and as
single cigarettes (GLTC, 2010). Georgian administrative bodies, however, have no
political will to do their duty and fine those who violate the law. There is also strong
influence from the tobacco industry, which has blocked the initiative to require
licensing for the sale and production of cigarettes (Bakhturidze, et al., 2016).

In keeping with Kingdon’s theory we have identified the important role of tobacco
sales restrictions in agenda-setting in Georgia. First, we described tobacco
company tactics that target youth. Second, we compared the international and
Georgian experiences in this area. Third, we categorised problems relating to the
implementation and enforcement of exiting regulations on tobacco sales. Our
research results, which showed very high public support for the enforcement of
tobacco sales prohibitions, is an opportunity for advocates to draw attention to this

There are several cases that illustrate the tobacco industry’s efforts to influence
worldwide public opinion. One of them is the Environmental Tobacco Smoke
Program. This program was simply another “product” designed to influence public opinion and was used by the industry in specific markets throughout the world. Scientists were hired primarily for their influence and contacts within their regions and for their ability to influence decisions about proposed smoking restrictions. The industry deployed these consultants to oppose local tobacco control efforts and, in one instance, exploited the dual role of a scientist who served as an industry consultant and presidential advisor (Muggli, et al., 2003).

Howlett and Ramesh state that the public agenda is primarily an agenda for discussion, while institutional agendas are designed for action (Howlett & Ramesh, 2003). Agenda setting in developing countries depends on the level of democratic development and active advocacy efforts aimed at persuading, encouraging, and sometimes coercing holders of public office. In a democracy where politicians ignore public demands at their peril, waning attention to public opinion would result in a cyclical pattern of agenda setting and public policy-making (Howlett & Ramesh, 2003). As mentioned previously, there is strong interest from the tobacco industry to covertly decrease attention to public opinion through lobbyists influencing the government. The most important messaging on this issue comes from advocates who seek to defend public participation, thereby creating a safe and healthy environment for future generations.

The body of relevant academic literature suggests that public opinion may play a major role in public policy-making in communities where public opinion carries weight in political processes. Though our research shows that the majority of Georgians support stronger tobacco control, this support continues to carry no significant weight in political decision-making processes in Georgia compared to the influence of the tobacco industry. It seems likely that Georgian policy-makers are not aware of the public’s overwhelming support for stronger tobacco control, even among most smokers (Bakhturidze, et al., 2012; 2013). The recent and compelling evidence on this topic may heighten policy-makers’ awareness of the actual state of public opinion, and that might increase their motivation to adjust tobacco policy in directions favoured by the majority of citizens. While this may be cause for optimism, it will be essential for public health advocates to convince policy-makers of the public’s desire for change (Bakhturidze, et al, 2016).
How policy-makers’ perceptions of public opinion influence tobacco regulation

Georgian policy-makers have the following perceptions of the public’s opinion about tobacco control legislation:

- Public opinion is not widely appreciated due to the lack of public opinion data.
- The public’s opinion does not carry much weight in matters of public health, and regarding tobacco control specifically.
- The tobacco industry has more influence on tobacco control policy-making than does public opinion or public interests.

Public involvement in health policy-making processes, which is the foundation of the Ottawa Charter (WHO, 1986), remains at a low level in Georgia. In this field, policy-making rhetoric in Georgia has evolved from a Soviet style based on a top-down expert model to a model that is somewhat more receptive to outside views. In 2006, for example, the Prime Minster called for the involvement of all key stakeholders in policy-making, though this could be interpreted in many ways (Chanturidze, et. al., 2009). According to Bishop and Davis’ model, the current level of participation is merely on the “consultation” level (Bishop and Davis, 2002). Hauschild and Berkhout (2009), who have presented the only empirical study of this issue in Georgia, have concluded that very little is actually known about how the government plans to involve stakeholders, how it attempts to involve them, and how the government and the stakeholders perceive the latter’s involvement. Their paper notes that many stakeholders have not been properly consulted about proposed healthcare reforms, and that the decision-making processes lack transparency.

The Ministry of Health is not the only body responsible for addressing major health challenges; it is the responsibility of the entire government to enact healthy public policies in all sectors, as well as health monitoring (NCDC, 2010; WHO, 1986). There is a low level of awareness about the principles of health promotion among the public, and this is further complicated by the fact that to some degree citizens do not think they can contribute to their own health (Chanturidze, et. al., 2009). As a result, the conditions for health promotion in Georgia today are bleak and
characterised by a lack of political will to prioritize health. There is a lack of public involvement in policy-making processes (which is admittedly complex, multi-sector work in a politically difficult environment), as well as inadequate human and financial resources for health promotion (Chanturidze, et. al., 2009; NCDC, 2010; Raminashvili, et al, 2014).

Greater transparency is needed in tobacco control policy-making in Georgia to illuminate and prevent interference from the tobacco industry and increase responsiveness to public opinion. In 2013 WHO Director-General (DG) announced its Endgame policy that aims by 2050 to decrease global tobacco consumption dramatically to a maximum of five per cent. European countries aim to achieve this goal by 2040 (WHO, 2013; Endgame Conference, 2013; WHO/Euro, 2013).

In Georgia, political will must strengthen significantly if the country is to meet international obligations related to the FCTC and the Tobacco Endgame strategy. On a positive note, there is some evidence that policy-makers are now more aware of public support for tobacco control. Georgia’s new Tobacco Control State Strategy, established in Decree N196, 30.07.13, highlights recent evidence indicating the public’s support for tobacco control (the evidence is provided in Bakhturidze, et al., 2012; 2013). There is reason to be cautious, however, as it is one thing to mention such research results in a policy document, but quite another to continue the weak enforcement of current tobacco control regulations and obligations established by the FCTC (Bakhturidze, et al., 2016). In his annual report for 2015, the Georgian Public Defender specifically underlined FCTC obligations and called on the government to effectively implement FCTC provisions (Public Defender Report 2015). The Office of the Public Defender began preparing a special report about this problem in March 2016. We anticipate that this report will include results from our study and others that draw attention to violations of health rights and politicians’ general ignorance about the public’s demand to live in a smoke-free environment.

The public strongly supports tobacco control, but will the democratic imperative to listen to the voice of the people help Georgia move toward more stringent tobacco control policy and enforcement? Democracy in Georgia is young and difficulties remain in increasing public participation and consideration of public opinion in policy-making processes. This is also true of tobacco control policy, where
unfortunately the most influential player is not the public, but the tobacco industry (Bakhturidze, et al., 2016).

A comparison of attitudes, opinions, and beliefs about tobacco control

Created from three articles published over in the scope of this dissertation, Table 3 (below) compares the attitudes, opinions, and beliefs about tobacco control subjects from the perspective of governmental agencies, non-governmental organisations, and the public according to smoking status.

The table clearly shows that overall support for tobacco sales restrictions is very high and an absolute majority of non-smokers and majority of smokers support such measures in Georgia. Policy in this regard is in place (i.e., regulations already exist) but it is not enforced due to strong influence from the tobacco industry and its efforts to block the creation of a system of licensing to sell tobacco. No strong political will exists, but non-governmental organisations strongly support and advocate for the enforcement of tobacco sales restrictions. These organisations sometimes use existing public opinion data as an advocacy tool.

The situation is similar with other forms of tobacco control such as the ban on tobacco advertising and promotion, the ban on smoking in closed buildings, and increased penalties for violations.

To analyse what’s happening at the governmental level with regard to its consideration of public opinion we must examine documents such as Decree N196, 30.07.13, regarding the approval of Georgia’s Tobacco Control State Strategy. This document emphasizes that, “public support is important to provide tobacco control measures effectively.” Though this policy document cites poll data, it also shows the very low level of enforcement of current tobacco control regulations and the lack of improvement of tobacco control legislation with respect to the FCTC (Bakhturidze, et al., 2016).

The majority of our survey respondents confirmed that policy-makers’ consideration of public opinion is very low. This is primarily due to the low level of development among democratic institutions in Georgia, the lack of political will to include the
public in the policy-making process, the control of the media by political and business entities, and the fact that the tobacco industry has more influence on policy-making than public health promoters.

The NGO sector needs more support in order to promote awareness among policy-makers and resist interference by the tobacco industry lobby. Several examples from different countries show that NGOs can play an important role in enforcing FCTC requirements (Sparks, 2012). Civil society organisations should use the opportunity provided by strong support from the public to demand that the government take appropriate actions.

The government and lawmakers must implement FCTC requirements, adopt appropriate regulations, and promote compliance with the rule of law. The degree to which decision-makers and policy-makers consider public demand in their decisions, instead of special interests, which are sometimes linked to corruption, will be a test for democracy in our country.

On June 13, 2016, following strong advocacy efforts from civil society organisations that included the results of our studies and the latest public opinion polls (ISSA 2016a), the Georgian Parliament introduced new amendments to the Tobacco Control Law to prohibit smoking in all enclosed buildings (excluding private houses). Open discussions were held in different committees, most of which supported strong regulations and acknowledged the high level of public support for restrictions. At the same time, interference from the tobacco industry was very high and in the end the government mostly considered the industry’s interests and recommendations. The government required significant changes in the current draft after consultation with the industry, which is in violation of article 5.3 of the FCTC guidelines as well as the above-mentioned governmental decree related to its tobacco control strategy and action plan. The tobacco control strategy says that it is not acceptable to consider input from the tobacco industry during the preparation and implementation of tobacco control policy (Decree N196, 30.07.13). The most recent Parliament of Georgia concluded its work at the end of July, 2016, and the country is now waiting for the results of the parliamentary elections, which were held on October 8, 2016. Using a familiar strategy, the tobacco industry advised the government not to implement strong regulations before the elections because it will decrease political
support among smokers. The use of smokers’ attitudes to manipulate government policy during elections has in the past influenced the ruling party. Following the elections a new window of opportunity opened to use strong public support to promote strong tobacco control policy and enforcement.

The public demands stronger administrative measures and higher penalties for violations, but there is still a deficit of political will to address these problems. The administrative bodies charged with enforcing current tobacco control laws are the Ministry of Internal Affairs (MIA) and the Ministry of Finance (MoF), but neither ministry has the political will to enforce the law, as there are very few documented incidents of violations (during the last three years the MIA has reported zero violations while the MoF has reported less than 100). The active involvement of NGOs is needed to promote greater compliance with existing legislation. Georgia will not meet FCTC obligations or maintain the constitutional right to a healthy environment without comprehensive tobacco control regulations and stringent enforcement. The Georgian Parliament also initiated appropriate amendments to the Administrative Violations Code on June 13, 2016. The two major enforcement agencies—the Ministry of Finance together with the Ministry of Internal Affairs—will increase penalties. Also, decisions about violations will be made by an officer of the Ministry of Finance, and not by a court, which currently deals with such matters. The best solution would be the involvement of NGOs in the enforcement process, or the creation of a special Tobacco Control Agency to manage enforcement activities. But the government is against spending resources on the establishment of new structures. The most important task today is to adopt new amendments. After this, NGOs can continue advocacy work for meeting FCTC obligations, which require member states to create a National Center for Tobacco Control.
Table 3. A comparison of attitudes, opinions and beliefs about tobacco control: The non-smoking public, the smoking public, government, and non-governmental organisations.

<table>
<thead>
<tr>
<th>Tobacco control issue</th>
<th>The public</th>
<th>The policy makers</th>
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<td>The public</td>
<td>The policy makers</td>
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<tr>
<td>Tobacco sales restrictions: Sales prohibition to and by children under 18, in single units, in schools, medical and youth organizations, with children’s clothes and toys; sales of cigarette must be only from stores that have a license to sell tobacco products</td>
<td>Overall support on tobacco sales restrictions is very high (78%). Absolutely majority of non-smokers (94%) supports such measures in Georgia</td>
<td>Majority of smokers (63%) supports such measures in Georgia</td>
</tr>
<tr>
<td>Tobacco Advertisement and promotion ban: Prohibition of tobacco and tobacco companies advertising in the printing media, on the billboards and sponsorship; prohibition of all types of tobacco products advertisement by tobacco companies; prohibition of smoking promotion (including offering free promotional items, such as t-shirts, free samples, etc.)</td>
<td>Overall support on tobacco advertisement and promotion ban is very high (81-83%). Absolutely majority of non-smokers (96%) supports such measures in Georgia</td>
<td>Majority of smokers (67%) supports such measures in Georgia</td>
</tr>
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</table>
Methodological considerations

The methodological strength of this dissertation lies in its mixed-method approach. Quantitative data alone would not be able to answer our general question about the degree of public participation in tobacco control policy-making. Two quantitative studies together give us sufficient data about the strong public support for different tobacco control issues, but this support has not translated into new policy. Qualitative data became the basis for understanding the processes taking place inside the government and the role played by public opinion and civil society in these processes.

The strengths of the quantitative studies are their high response rates. Regarding statistical assessment, the internal consistency of the questions about attitudes towards sales restrictions, smoking prohibitions, and bans on tobacco advertising is very high.

This dissertation is the first attempt to study the role played by public opinion in tobacco-related policy-making processes in Georgia. It offers a scientific framework for understanding the important questions as we move forward in this field. An important part of this study is the involvement of opinion research experts who have considerable experience conducting public opinion surveys and polls. These experts emphasised that it is important to conduct periodic population surveys, in-depth interviews, and focus group discussions with different stakeholders to have a clearer understanding of the subject. One weakness in our methodology is that the number of in-depth interview respondents was not as high as we had hoped it would be. There is need for more comprehensive, periodic studies covering a greater number of stakeholders and experts in order to learn different factors affecting tobacco control processes in the country.

It is possible that there have been shifts in public opinion since the collection and publication of these data in 2008, and these shifts could affect our conclusions. The most recent study (ISSA, 2016a), however, confirms the positive shift in public support for tobacco control regulation. This survey also collected data not reported in our study, such as the level of respondents’ knowledge about the harmful effects of tobacco and their attitudes towards tobacco tax policies. A complete picture of the
findings from this survey will emerge only after completion of further analyses and publication.

Another weakness in our method is that raw quantitative data cannot be directly translated into policy. Each and every constituency grappling with a public health problem such as tobacco that wishes to assess public opinion can only do so within its own constituency. Advocacy based on research about other populations can be expected to be less effective than advocacy based on locally-generated data.

Regarding qualitative data, it should be noted that respondents from governmental organisations and members of Parliament were mostly connected to the ruling political party. They expressed considerable criticism regarding the role of public opinion in policy-making, which increased our confidence in the validity of the interview data. Regarding reliability, we have checked the transcripts to make sure they do not contain obvious mistakes made during transcription. To prevent drifting definitions of codes we always compared independent data and wrote memos about the codes and their definitions. To ensure validity, we conducted follow-up interviews with participants and gathered their comments. The issue of translation from Georgian to English was cause of some concern. Though we always attempted to verify all translations, the tone of many of the respondents' comments could not be communicated well in English in the limited space of a scientific paper.

I created Table 3 to better illustrate the mixed-method approach. The horizontal axis lists smoking statuses and governmental and non-governmental actors, and the vertical axis lists tobacco control issues. The individual cells feature summarised results of public support according to smoking status, and stakeholders' perceptions relating to the influence of public opinion on tobacco control policy-making. This matrix presents an analysis of the combined qualitative and quantitative data. Though using mixed methods plays a central role in this study, this is the first time it has been used in this context and as such it requires further refinement.

Similar studies must be continued in Georgia so that their results can be transferred into advocacy streams aimed at realising the adoption of stronger tobacco-control measures and more effective enforcement mechanisms.
**Ethical clearances**

Ethical clearance for article 1

The ethical committee of the Georgian Health Promotion and Education Foundation approved the study protocol. Informed consent was obtained via signature from all participants. For participants under age 18, parents or guardians confirmed their approval by signature. The survey organisers took the responsibility of protecting confidentiality very seriously during the collection, analysis, and dissemination of data.

Ethical clearance for article 2

Informed consent was obtained via signature from all participants. For participants under age 18, parents or guardians confirmed their approval by signature. The survey organisers took the responsibility of protecting confidentiality very seriously during the collection, analysis, and dissemination of data. The identities of the respondents were not recorded on the interview forms or in any other manner.

Ethics statement for article 3

The ethical committee of the Georgian Health Promotion and Education Foundation approved the study protocol, which complied with the current laws of the country. Signed, informed consent was obtained from all participants. Neither the raw data nor the data analysis files contain information that can identify the respondents.
Chapter 8. Conclusions and implications

Main conclusions

This study reached the following major findings and conclusions: (i) the public strongly supports all forms of tobacco control, (ii) due to the lack of public opinion data prior to this study, this support is not widely appreciated, (iii) in public health generally and in tobacco control specifically, public opinion seems not to carry much weight in policy-making, (iv) other stakeholders such as the tobacco industry carry more weight, and (v) publicising the findings of this study is therefore a high priority. Showing strong public support for tobacco control is important because the public’s opinion in a democratised Georgia will have the potential to carry more weight in the tobacco control arena.

The findings of this study show that prohibiting the sale of tobacco to minors has strong support among the Georgian population, and this can be a tool to urge policymakers to enforce existing regulations on this point. It is of high importance to implement those FCTC obligations agreed to by Georgia in May 2006. To avoid ignoring public opinion we must limit interference from the tobacco industry in decision-making processes. Legislation alone is not sufficient to prevent tobacco sales to minors (Stead & Lancaster, 2008). If effective programs are not developed and implemented soon, future morbidity and mortality rates attributed to tobacco consumption will most likely increase. Nationwide and region-wide tobacco control action plans provide useful frameworks for implementing such a comprehensive approach. They offer a unique opportunity to develop, implement, and evaluate comprehensive tobacco control policy that can be helpful for Georgia.

Additional control measures that must be implemented include taxation, sales prohibitions, bans on advertising, tobacco prevention, and education programs. These measures, which should complement law enforcement efforts, will lead to a decrease in tobacco consumption among the young population in Georgia.

Smoking prohibitions and bans on tobacco advertising and sponsorship also have a high level of public support in Georgia. We interpret this as public demand for the
government to adopt comprehensive smoking prohibitions in all closed public buildings, including restaurants and bars, and to completely ban tobacco advertising and promotional campaigns. We have shown in our review of the literature that conducting research on public opinion is important because the public’s opinion is a factor in political decision-making. Together with our findings, the latest ISSA study results (2016a, 2016b) can be a strong advocacy tool for NGOs to stimulate tobacco control political processes in Georgia. A new comprehensive draft law was initiated in the Georgian Parliament on June 13, 2016.

The process of adapting a new draft law will be a test for democracy and an opportunity to respond to public demand instead of the tobacco industry, which continues to have serious influence on political processes in Georgia.

As an Associate Member of the EU and a member of the FCTC, Georgia must consider the membership requirements and obligations of these organizations. Georgia must follow the Endgame Policy, the Non-Communicable Diseases (NCD) action plan, and other relevant policy documents and recommendations that promote the health of the population, save lives, and contribute to Georgia’s economic development.

**Political and practical implications**

Our study results clearly indicate significant public support for all tobacco control measures, and this has practical implications for policy-making in Georgia. Some policy-makers acknowledge the importance of public opinion concerning public health problems, including tobacco control. Tobacco control questions are easy to understand and easy to take into account during political decision-making and policy-making processes. Unfortunately, there is still a high level of negative influence from the tobacco industry and its lobbyists on government agencies and the Georgian Parliament. The public, medical organisations, and NGOs are simply not strong enough to fully counter such influence. The tobacco industry’s influence is allowed to continue primarily due to the lack of transparency in the relationships between the tobacco industry and governmental officials. Politicians still consider the tobacco industry a “normal” industry like any other that should be supported.
It is critical that we disseminate the results of relevant public opinion studies. Georgia has a very limited number of such studies, and most decision-makers have no information about these data. Most are still afraid of resistance from the smoking electorate. This is a myth created by tobacco industry representatives and spread among policy-makers. Most politicians don’t know the real benefits of public support and participation, and consequently don’t take them into account during policy deliberations.

The media in Georgia is weak in this regard: it has no strong positions and some media outlets continue to receive funding from the tobacco industry, which in turn creates serious barriers for strong media advocacy work. Our study’s conclusions were not surprising: though the public strongly supports anti-smoking measures, the government doesn’t take this support seriously and does not use it to create appropriate policy and legislation. A new window of opportunity opened in 2016 with the creation of a new draft law in the Georgian Parliament. If Parliament passes this law, it will confirm the importance of our conclusions.

**Implications for further research**

This dissertation shows that the Georgian public overwhelmingly supports tobacco control measures. As with many controversial issues in which strong interests are at stake, the media may influence the public perception of these issues. Often only sensational stories and controversial positions qualify as “newsworthy” in Georgian media. This kind of distortion is relevant to the questions at hand: decision-makers are also members of the public, and they may be prone to misjudge public opinion on issues where a loud minority manages to make a lot of news. If smokers, tobacco retailers, or cigarette manufacturers complain in the media about infringement on their freedom due to tobacco control, decision-makers may perceive that support for tobacco control is lower than it actually is. The potential for situations like this only increases the importance of the present study, which relies on relatively unbiased estimates of public support for tobacco control.

The results of our qualitative study show that public opinion has very little influence on decision-making related to public health, and to tobacco control in particular.
Members of Parliament confirm, for example, that economic interests carry more weight than public interest. High officials from the Ministry of Health, however, as well as experts in the field, emphasize the importance of including the public in decision-making processes and listening to public opinion.

This dissertation is essential in the Georgian context because no amount of public opinion results from other countries will have as much impact on Georgian decision-makers as local findings will. Many low-income and middle-income countries in Eastern Europe are struggling with the same forces encouraging tobacco consumption that are at work in Georgia.

We need continued study of public opinion on this matter in Georgia and persistent media attention about study results. As a general strategy we recommend generating data regularly, reporting them to the public, and allowing them to bring pressure on policy-makers so that they will become less indifferent to public opinion and more resistant to the tobacco lobby. Georgia needs on-going surveys of adults and children (school-based surveys) regarding rates of substance use and abuse in society (including tobacco). These surveys should collect data not only about behaviour, but also about knowledge, intentions, and attitudes in this area.

We had no opportunity to develop new mechanisms for calculating the degree of consideration of public opinion in policy-making processes. More observations and interviews are needed alongside periodic collection of relevant data. For this study we only used existing methods and theories.

Finally, we can conclude that while some decision-makers care about public opinion, most are largely ignorant of the public’s support for tobacco control. To address this problem we must develop a public health strategy that ensures the continued collection of public opinion data and includes efforts to educate decision-makers about the findings.

A future tobacco control strategy should use communication and educational campaigns to activate the public in ways that reinforce its fundamental right to a smoke-free environment. This strategy should involve petitions, public awareness-raising campaigns that demand no-smoking policies, social-advertisements,
educational programs in schools, community-based interventions, and on-going public opinion surveys on different tobacco control questions.

Tobacco control advocates should disseminate public opinion data and indications of public support by using direct contact with policy-makers. These findings should also be disseminated through mass-media targeting decision-makers and through capacity-building work for politicians.
Source of data


PAPERS I-III
The public’s attitudes towards tobacco sales prohibitions: Evidence from a nationally representative survey in the former Soviet state of Georgia

George D. Bakhuridze, Nana T. Peikrishvili, Maurice B. Mittelmark, Leif E. Aare

BACKGROUND: In the Caucasus region country of Georgia, no data on public opinion regarding tobacco sales restrictions have been available until now. The aim of the study is to provide data from a nationally representative sample including non-smokers, ex-smokers and current smokers, on their level of support for restricting tobacco sales.

METHODS: 1,588 people aged 13-70 were interviewed at home about their level of agreement with eight possible tobacco sales restrictions, which were combined to create a dichotomous scale indicating low agreement (agree with none to three of eight restrictions) or high agreement (agree with four or more of eight restrictions). Levels of agreement were analyzed by demographic segments defined by age, gender, education, and income and by tobacco use status.

RESULTS: Across all eight forms of tobacco sales restrictions, the average support for tobacco sales restrictions was 85.2% which is a high level of support.

Among smokers, 71% of women and 87% of men indicated a high level of agreement for restricted tobacco sales; among occasional smokers 54% and 55% respectively. Above 95% of female and male ex-smokers and never smokers expressed high level of agreement with sales restrictions.

After adjustment for other predictors, agreement was significantly associated with age (more agreement with higher age) and smoking status (more agreement among never-smokers, less in current smokers), while there were no significant differences in agreement by gender, education, and income.

DISCUSSION: It is of high importance for Georgia to fully implement the Framework Convention on Tobacco Control, including strong sales restrictions, and there is good evidence of public support for doing so.

CONCLUSION: The present findings indicate to Georgian public health authorities that the support for tightened tobacco sales restrictions is high.

KEYWORDS: tobacco; tobacco control; tobacco control policy; public attitude; sales restrictions; tobacco sales restriction; youth access; law; FCTC.

Распространение общественности о запрете продажи табака: данные национально-репрезентативного опроса в Грузии

George D. Bakhuridze, Nana T. Peikrishvili, Maurice B. Mittelmark, Leif E. Aare

УДК 303.425:339.1:663.97(479.22)

АКТУАЛЬНОСТЬ: В странах Карабахского региона Грузии до настоящего времени не было результатов исследований об отношении общественности к ограничению продаж табачных изделий. Цель данного исследования является получение сведений о национально-репрезентативной выборке, включающей некуриющих, бывших курильщиков и нынешних курильщиков, об уровне поддержки ограничений продажи табака.

МЕТОДЫ: 1588 человек в возрасте 13-70 лет были опрошены у них дома об их согласии с восьмыми возможными ограничениями продаж, эти ответы затем были скомбинированы для получения дихотомической переменной, противовставляющей низкий уровень согласия (от нуля до трех восьмьих ограничений) и высокий уровень (согласие с четырьмя и более восьмыми ограничениями). Уровень согласия сопоставлен по демографическим группам, определяемым возрастом, полом, образованием и уровнем дохода, а также в зависимости от курительного статуса.

РЕЗУЛЬТАТЫ: Средний уровень согласия при сравнении восьми вариантов ограничений продажи табака составил 85.2%, что составляет высокий уровень поддержки.

Среди курильщиков 71% женщин и 87% мужчин обозначили высокий уровень поддержки ограничений продаж, среди некуриющих курильщиков 54% и 55% соответственно. Среди бывших курильщиков и некурящих более 95% респондентов сообщили о высоком уровне поддержки ограничения продаж табака.
INTRODUCTION
The World Health Organization (WHO) terms tobacco consumption and related health burden ‘the 20th century’s epidemic’; even after decades of public health work to reduce tobacco use, it remains the number one cause of avoidable deaths worldwide (WHO, 2012). Nevertheless, health promotion strategies combining public education and healthy public policy are effective in reducing tobacco use as experienced in the USA, Canada, and Australia (Ashley, et al., 2000; Borland, 2006; Brooks, 2001; Lafarge, et al., 1998). The Framework Convention on Tobacco Control (FCTC) emphasizes the importance of combining tobacco demand reduction strategies with tobacco supply reduction ones (WHO, 2005).

Experience of countries that have done well in reducing tobacco consumption shows that key policy elements in a comprehensive approach to the tobacco problem include specific actions to increase tobacco prices and taxes, to protect smokers and non-smokers from exposure to tobacco smoke, to restrict advertising, promotion and sponsorship, to restrict sales to minors, and to conduct of education, communication, and public awareness campaigns (Borland, 2006; Brooks, 2001; Lafarge, et al., 1998; WHO, 2005).

Tobacco use in Georgia and tobacco control policies
Tobacco use in the former Soviet state of Georgia has increased to alarming proportions since 1990, mostly due to transition toward a market economy and the arrival of the international tobacco industry, whose costly promotional campaigns have thrived in the absence of legislative restrictions on tobacco industry behavior. In 2001, the prevalence of tobacco use among men was 53.3% and rose to 59.8% in 2008. Among women, the prevalence increased from 6.3% to 14.9% in the same period (Bakhturidze, et al., 2008; Gilmore, et al., 2004).

The tobacco use trend among youth is also worrying. The Global Youth Tobacco Survey conducted in 2000-2007 estimated that 19.2% of youth aged 13-15 years smoked cigarettes in European countries, while the prevalence was 23.7% in Georgia (Warren, et al., 2008). Thus, the trend in Georgia is opposite to that in countries with long-running comprehensive approaches to tobacco control. Ban of tobacco sales to minors and other tobacco control measures have been recently enacted but not enforced (Bakhturidze, et al., 2008).

The influence of public opinion on policy-making
From the public health perspective, Georgia is in need of better tobacco control legislation with effective enforcement. Such legislation may be enacted as a result of policy decision-making, which is the subject of several theories in the literature on public policy-making (Anderson, 2006). Factors that are hypothesized to be of importance to collective decision-making are values at different levels (organizational, professional, personal, public interest, ideological), political party affiliation, constituency interests, deference to others, decision rules and public opinion, amongst other factors (Anderson, 2006; Kingdom, 2003; Stein, et al., 2005).

In this context, public opinion is defined as “those public perspectives or viewpoints on policy issues that public officials consider or take into account in making decisions” (Anderson, 2006, p. 133). Public opinion may be expressed in many ways, amongst which surveys and polls are used to elicit public opinion on specific issues. However, the public may be not sufficiently informed about an issue to express a meaningful opinion about it, and hence surveys and polls may not be able to illuminate public opinion in a comprehensive way (Stein, et al., 2005; Kinder & Sears, 1985).

The potential importance of public opinion survey data for tobacco control is suggested by Kingdom’s (1995) theory of agenda setting. Based on his research in California in the USA, Kingdom described the...
policy-making process as an ongoing one, where streams of policies, problems, and politics constantly mingle together in a primeval soup. His model attempts to capture the organic, constantly changing nature of political agenda-setting (Kingdon, 2003).

Kingdon’s model presents streams of policies, problems, and politics as largely independent of one another, yet coupled at critical junctures to yield policy change. The term Kingdon used for these critical junctures is ‘policy window’, a moment when external or internal forces push an issue to the top of the political agenda.

In theory, at least, convincing claims about public opinion can illuminate problems, like that of the harm tobacco does to health, sufficiently that they help to open a policy window that might otherwise not open. Thus, with regard to tobacco control policy-making, public opinion favoring or not favoring certain control measures may be expected to have some influence on the degree to which tobacco control rises or falls on the political agenda, interacting with the host of other factors that have impact on political agenda-setting.

In the arena of tobacco control, public opinion data do seem to have played a significant role in many countries in helping to shift policy-makers’ perceptions about the public’s normative beliefs and attitudes towards tightened tobacco control legislation. Survey data from the USA, Canada, the UK, and Australia indicate that even smokers supported bans on smoking in restaurants and bars if they lived in places with such bans, and many studies show that bans in workplaces, public transport and in public spaces such as shopping malls are widely supported by the public as well (Brooks, 2001; Trotter & Mullins, 1996; Lam, et al., 2002; Brenner, et al., 1997). Support for tobacco control is evident among smokers and non-smokers across various age groups from students to the adult population (Regotti, et al., 2003; Trotter & Mullins, 1996). Similarly, data from Canada shows that smokers demonstrate high compliance with smoking bans even if non-smokers were less optimistic (Ashley, et al., 2000; Pederson, et al., 1987). Newer types of bans (e.g., in homes and in vehicles carrying children) were supported by up to 77% of respondents in an opinion poll in New South Wales, Australia (Walsh, et al., 2002).

However, it is a truism that ‘all politics are local’, and no amount of public opinion data from outside Georgia can be expected to have significant influence on health policy-making in Georgia. Furthermore, while the general thrust of evidence from Anglo-Saxon countries suggests strongly that citizens support legislation restricting the use of tobacco, as reviewed above, there are no similar studies in the former Soviet Union, at least so far. One cannot guess what public opinion about tobacco control exists in today’s Georgia. This situation prompted the design of the present study aiming to provide unique data on the Georgian public’s attitudes towards a range of tobacco sales restrictions options.

**Aim**

In Georgia, no data on public opinion regarding tobacco sales restrictions have been available until now, and public opinion has therefore played a minor role in policy development processes. This situation is the background for the present report, which aims to provide data from a nationally representative sample including non-smokers, ex-smokers and current smokers, on their level of support for restricting sales to minors, restricting sales outlets, and increasing penalties for sales restrictions violations.

With this report in hand, public health agencies in Georgia get empirical evidence on the degree to which Georgians support, or do not support tobacco sales restrictions. This report can also be valuable for other countries making the transition to market economies, providing a means to compare levels of public support for tobacco sales prohibitions, and a guide to analyze data on public opinion regarding such prohibitions.

**METHODS**

**Sample**

Survey data were collected in January through February, 2008, sponsored by the Open Society – Georgia Foundation’s grant program (Bakhtrudize, et al., 2008). Two-stage stratified sampling was applied. The 2007 census enumeration districts were used for the sampling frame (National Statistics Office of Georgia, 2012). Each region was divided into homogenous strata consisting of urban/rural and mountainous/lowland settlements.

At the first stage of sampling, 94 enumeration districts were selected out of 16 000 such districts across the whole Georgia. At the next stage, lists of the household addresses were used in each of the selected 94 enumeration districts to further sample households (Bakhtrudize, et al., 2008). A household with members aged 13-70 available for interviews was considered a unit of observation: 1655 households were sampled and 1588 people (one member from each household) were actually interviewed (Bakhtrudize, et al., 2008).
Data Collection
In-house face-to-face interviews used a standard questionnaire. About 80 interviewers and 10 regional supervisors from the Department of Statistics of Georgia carried out this survey. Regional supervisors controlled the selection of addresses and the work of interviewers.

Study outcomes/determinants
The variables considered in the present report were as follows:

1. Demographic variables age, gender, marital status, education level and income;
2. Smoking status (daily, occasional, ex and never);
3. Levels of agreement with the implementation of eight tobacco sales prohibitions and violation penalties, coded ‘yes’, ‘no’, ‘don’t know’ and ‘refuse to answer’: (1) sales prohibition to children under 18, (2) prohibition of sales by children under 18, (3) prohibition of sales of single cigarettes, (4) prohibition of sales in schools and youth organizations and within 50 meters around these facilities, (5) prohibition of sales in health care settings, (6) prohibition of sales along with children’s clothes and toys, (7) increased penalties for violations of the law prohibiting sales to minors and single cigarette sales, and (8) sales of cigarettes only from stores licensed to sell tobacco products.

The denominators equaled numbers of all respondents, including those who refused to answer. For the whole sample (n=1588), the number of study participants who did not answer individual sales restrictions attitude items ranged from 17 to 31 (1.1-2.0%). The numerators were all respondents who indicated ‘yes’ when asked to consider each sales restriction.

Data analysis
The dimensionality of the attitudes towards smoking restriction scale was examined with correlation analysis and with factor analysis (principal axis factoring). The reliability of the scale was estimated with Cronbach’s alpha. Using these eight variables a single dichotomous variable was constructed indicating degree of overall support for sales restrictions; those answering ‘yes’ to three or less of the eight restrictions were coded ‘low support’ and those answering yes to 4 or more of the eight sales restrictions were coded ‘high support’. Differences in levels of support by the demographic variables were estimated using the Chi-square test of independence. Associations between demographic factors and smoking, on the one hand, and support for smoking restriction, on the other, were also examined with a binary multiple logistic regression analysis. SPSS versions 19 and 20 were used for all analyses (Pallant, et al., 2007).

Ethical clearance
The Georgian Health Promotion and Education Foundation Ethical Committee approved the study protocol. Signed informed consent was obtained from all participants. For participants under age 18, parents or guardians confirmed by signature their approval of the minor’s participation. The survey organizers took responsibility with regard to the protection of confidentiality during the collecting, analysis and dissemination of data.

RESULTS
Intercorrelations between the sales restrictions attitude items ranged from 0.79 to 0.95. Factor analysis (principal axis factoring) showed that the first unrotated factor had an eigenvalue as low as 0.32. This strongly supports the assumption that the scale is unidimensional and can be reduced to one single index. Cronbach’s alpha turned out to be as high as 0.98. A simple, additive sumscore based on the eight attitude items was constructed (range 0-8). As much as 77.3% of all respondents had agreed to all eight items, while no agreement (or missing answer) on all items was found for 12.5%. The association between a simple, additive sumscore based on the eight sales restrictions attitude items and the dichotomy described in the methods section (high versus low support for sales restrictions) was 0.98.

The lowest level of approval was 50.4% among respondents aged 13-25 for ‘sales of cigarettes must be only from stores that have a license to sell tobacco products’. The highest level of approval was 98.4% among respondents aged 56-70 for ‘sales prohibition to children under 18’. There was a statistically significant age gradient for all eight restrictions, with older respondents having the highest approval rates (Table 1).

No statistically significant gender differences or differences by income level were observed with regard to any of the sales restrictions items. Regarding demographic education segments, approval of each of the eight restrictions for all education segments was in the range 81.1%-90.1%; nevertheless, there was a statistically significant education gradient, with higher educated respondents having the highest approval rates.

Comparison across tobacco use status segments revealed that approval of each of the eight restrictions ranged from 92.1% to 97.9% among ex- and never-smokers, and...
Table 1. Tobacco sales restrictions 1-8 by demography and smoking status, bivariate analysis; (n = 1588)

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<tr>
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<td>84.6</td>
<td>85.6</td>
<td>84.8</td>
<td>85.2</td>
<td>84.1</td>
<td>85.7</td>
<td>81.9</td>
<td>83.1</td>
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<tr>
<td><strong>Smoking status</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>225.3</td>
<td>222.4</td>
<td>231.2</td>
<td>199.5</td>
<td>214.7</td>
<td>213.1</td>
<td>213.4</td>
<td>219.0</td>
</tr>
<tr>
<td>p</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
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<tr>
<td>Ex-smoker</td>
<td>95.8</td>
<td>97.9</td>
<td>96.9</td>
<td>93.8</td>
<td>94.8</td>
<td>96.9</td>
<td>97.9</td>
<td>94.8</td>
</tr>
<tr>
<td>Never smoker</td>
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<td>93.7</td>
<td>93.9</td>
<td>92.8</td>
<td>93.0</td>
<td>93.3</td>
<td>92.1</td>
<td>92.4</td>
</tr>
</tbody>
</table>

### Notes:
- 19 study participants did not report income.
- 1. Agree to sales prohibition to children under 18
- 2. Agree to prohibition of sales by children under 18
- 3. Agree to prohibition of sales of cigarettes in single units
- 4. Agree on sales prohibition in schools and youth organisations
- 5. Agree to prohibition of sales in health care settings
- 6. Agree to prohibition of sales with children’s clothes and toys
- 7. Agree it is important to increase penalties for violations of the law prohibiting sales to minors and single unit sales
- 8. Sales of cigarette must be only from stores that have a license to sell tobacco products
- from 51.2% to 84.2% among daily and less than daily smokers. The lowest approval rates were observed among less than daily smokers, ranging from 51.2% to 54.6%.
- All smoking status gradients were statistically significant, with ex- and never-smokers having the highest approval rates and less than daily smokers have the lowest approval rates.
- Approval rates across all demographic segments and across the eight restrictions were very high for all restrictions.

In the sample segments aged 36-70 for males and females alike, high approval of restrictions was expressed by 93.4-98.7% of respondents. In the age segment 13-25, only 55.7% of respondents indicated high approval of restrictions (Table 2). The age differences in...
## Table 2. Support for tobacco sales prohibitions by the demographic factors

<table>
<thead>
<tr>
<th>Age</th>
<th>N total</th>
<th>High support %</th>
<th>Odds ratio</th>
<th>CI95%</th>
<th>Sign. P</th>
<th>Odds ratio</th>
<th>CI95%</th>
<th>Sign. P</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-25</td>
<td>264</td>
<td>55.7</td>
<td>1.00</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
<td>1.00</td>
<td></td>
<td>&lt;.001</td>
</tr>
<tr>
<td>26-35</td>
<td>307</td>
<td>79.2</td>
<td>3.02</td>
<td>2.09-4.36</td>
<td>&lt;.001</td>
<td>2.85</td>
<td>1.81-4.47</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>36-45</td>
<td>334</td>
<td>93.4</td>
<td>11.29</td>
<td>6.88-18.53</td>
<td>&lt;.001</td>
<td>9.94</td>
<td>5.68-17.40</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>46-55</td>
<td>298</td>
<td>80.0</td>
<td>38.74</td>
<td>16.66-90.09</td>
<td>&lt;.001</td>
<td>28.32</td>
<td>11.72-68.43</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>56-70</td>
<td>385</td>
<td>98.7</td>
<td>60.49</td>
<td>24.23-151.04</td>
<td>&lt;.001</td>
<td>43.87</td>
<td>16.41-117.26</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>923</td>
<td>86.6</td>
<td>1.00</td>
<td>&lt;.01</td>
<td>&lt;.05</td>
<td>1.00</td>
<td></td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Male</td>
<td>665</td>
<td>86.5</td>
<td>0.99</td>
<td>0.74-1.33</td>
<td>&lt;.05</td>
<td>0.97</td>
<td>0.81-1.76</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Highest completed education</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary or secondary school</td>
<td>494</td>
<td>85.4</td>
<td>1.00</td>
<td>&lt;.01</td>
<td>&lt;.05</td>
<td>1.00</td>
<td></td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Middle college</td>
<td>571</td>
<td>83.9</td>
<td>0.89</td>
<td>0.64-1.24</td>
<td>&lt;.05</td>
<td>0.90</td>
<td>0.62-1.34</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>University, post graduate degree</td>
<td>523</td>
<td>90.4</td>
<td>1.61</td>
<td>1.10-2.37</td>
<td>&lt;.05</td>
<td>0.97</td>
<td>0.63-1.53</td>
<td>&lt;.05</td>
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<tr>
<td>Household income last month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (100-400 Gel., about 50-200 Euro)</td>
<td>458</td>
<td>86.7</td>
<td>1.00</td>
<td>&lt;.01</td>
<td>&lt;.05</td>
<td>1.00</td>
<td></td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Middle (401-800 Gel., about 201-400 Euro)</td>
<td>571</td>
<td>87.4</td>
<td>1.07</td>
<td>0.74-1.54</td>
<td>&lt;.05</td>
<td>0.79</td>
<td>0.53-1.18</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>High (401+ EURO)</td>
<td>540</td>
<td>85.9</td>
<td>0.94</td>
<td>0.65-1.35</td>
<td>&lt;.05</td>
<td>0.73</td>
<td>0.57-1.01</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Not applicable</td>
<td>19</td>
<td>73.7</td>
<td>0.43</td>
<td>0.15-1.24</td>
<td>&lt;.05</td>
<td>0.18</td>
<td>0.07-0.51</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Tobacco use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke daily</td>
<td>449</td>
<td>84.2</td>
<td>1.00</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
<td>1.00</td>
<td></td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Smoke less than daily</td>
<td>205</td>
<td>54.6</td>
<td>0.23</td>
<td>0.16-0.35</td>
<td>&lt;.001</td>
<td>0.38</td>
<td>0.13-1.02</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Smoked cigarettes regularly in the past</td>
<td>96</td>
<td>97.9</td>
<td>8.83</td>
<td>2.13-36.64</td>
<td>&lt;.01</td>
<td>1.85</td>
<td>0.40-8.63</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Never smoker</td>
<td>838</td>
<td>94.3</td>
<td>3.09</td>
<td>2.10-4.55</td>
<td>&lt;.001</td>
<td>4.18</td>
<td>2.63-6.63</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Percentages from crosstabs (bivariate analyses) and results from binary multiple logistic regression. Low support is agreement with three or fewer of eight types of sales prohibitions. High support is agreement with four or more sales prohibitions.
level of support for restrictions were statistically significant, as shown in the Table 2.
Among never- or ex-smokers, high approval of restrictions was indicated by 94.3% to 97.9% of respondents. Occasional smokers were less supportive of restrictions than were current smokers. These differences in approval were statistically significant, as shown in the Table 2. Bivariate analysis showed that support for restrictions was significantly higher among those with university or post-graduate degree. There were no statistically significant differences in levels of support for restrictions by gender and household income level.

The results of the multivariate binary logistic regression analysis roughly confirms the associations with age and smoking behavior described above. However, after controlling for age, ex-smokers are no longer different from daily smokers, and the association with education is no longer significant (Table 2).

Figures 1-4 provide a further breakdown of the composite measure of approval of restrictions, with age by gender tabulations given in Figure 1, showing no gender differences by age. As shown in Figure 2, approval levels were lowest among occasional smokers. Perhaps the most noteworthy data in Figure 2 pertain to smokers’ approval of restrictions, with levels of 71% among women and 87% among men. Figure 3 shows no education differences between males and females in levels of approval for restrictions. Figure 4 shows similarly high levels of approval for restrictions for income level for both women and men, but lower levels of approval among those who did not provide income data.
This study presents new data suggesting that a majority of the Georgian population strongly supports restrictions to prevent youth access to tobacco. In fact, such restrictions already exist in Georgia de jure, but there is a very low level of implementation and enforcement. This is deplorable, since restrictive youth access laws are most effective when administered in a comprehensive manner. Restricted accessibility of tobacco products is particularly important to prevent an eventual first use of tobacco (Ashley, et al., 2000).

The point has been made that beyond sales restrictions, it is also important to prevent adolescents from acquiring cigarettes through noncommercial sources (Laforge, et al., 1998). Yet the importance of commercial restrictions cannot be overemphasized. Global Youth Tobacco Survey data analyses show that 61.7% of youth aged 13-15 who smoke cigarettes usually purchase their cigarettes in stores. In European countries, seventy percent of youth who attempted to purchase cigarettes in a store were not refused a purchase because of their age, during the month preceding the survey (Warren, et al., 2008).

According to the WHO, the World Bank and several relevant studies, raising taxes and sales restrictions on tobacco products are among the measures aimed to reduce tobacco consumption (Pederson, et al., 1987; Andreeva, 2005; Rimpela & Auro, 1993; Castrucci, et al., 2002; WHO, 2004; Jha & Chaloupka, 2000). Turning to the situation in Georgia, since May 15, 2006, the WHO Framework Convention on Tobacco Control (FCTC) entered into force in the country, with Article 16 prohibiting sales of tobacco to and by minors, and other related measures (WHO, 2005; WHO, 2012). However, after six years since Georgian ratification of the FCTC, enforcement has been poor due to little political and administrative will to deal effectively with those who violate the law (WHO, 2007; WHO/Euro, 2007).

Summing up the situation in Georgia, it seems evident that the political environment is ripe for renewed advocacy to penalize sales of tobacco to minors. Yet as mentioned in the introduction, the tobacco industry and their lobbyists present a huge barrier to the successful implementation of tobacco control regulations in Georgia; the industry works actively to hinder the enforcement of laws and regulations dealing with tobacco sales prohibitions, in part by efforts to influence public opinion in many countries (Muggli, et al., 2003). They hope to turn public opinion to their side, to counter public health’s concentrated assault on youth access to tobacco products (Forster & Wolfson, 1998).

The potential relevance of this study’s findings for policy processes in Georgia can be probed by considering Kingdon’s ideas about policy windows (Kingdon, 2003); does the unique information about public opinion presented in this paper have the potential to open a policy window for tightened regulation and enforcement of sales restrictions to protect youth? Realistically, that will depend on the effectiveness of health advocates’ efforts to translate a research publication into advocacy material that can reach the ears, minds and hearts of decision-makers.

Yet there is one aspect that should not be overlooked – there may be few public issues, indeed, in which a strong majority of the public expresses such uniform support, as is found in the present data. Guessing cautiously, one might have expected strong support for some restrictions, modest support for others and low support for yet other restrictions. But that is not the case; pick any restriction and the large majority in this study supports it. Beyond that they support virtually all of the restrictions, and there is evidence that very high levels of public support can have rather direct impact on the enactment of legislation restricting youth access to tobacco (Howlett & Ramesh, 2003).
Strengths and limitations
Strengths of this study that are worth noting are the representativeness of the sample and the high response rate. Regarding measurement, the internal consistency of the items regarding attitudes towards sales restrictions is very high, the advantages of which have already been mentioned. On the other hand, the attitude items have not been used in previous research, nor were their psychometric properties tested in a pilot study. Whether the high internal consistency observed in this study would be replicated in other populations is therefore a matter for speculation that only future research could illuminate.

Further research
This study shows that the normative attitude in Georgia supports tobacco sales restrictions, almost overwhelmingly. However, for many controversial issues in which strong vested interests are at stake, communication via the media may help twist the public’s perceptions about what is normative and what is not. That is because the media emphasise ‘news’, and what is news is often uncommon experiences and controversial positions on issues. For example, even if the majority of users of a particular hospital are quite satisfied with the level and quality of medical service, media stories about just a few instances of bad treatment in the hospital may give readers the impression that the level of satisfaction with the service is lower – perhaps much lower – than it actually is. Similarly, media reports of serious crime in a community may give the public the impression that crime is a much more serious problem than it actually is.

The relevance of this kind of norm distortion to tobacco control generally, and to attitudes toward tobacco sales restrictions in particular, is that decision-makers are also members of the public, and they may be prone to misjudge public opinion about issues in which a loud minority manage to make a lot of news. If some smokers, or tobacco retailers, or cigarette manufacturers complain in the media about abuses of their freedoms due to tobacco control, decision-makers may perceive that support for tobacco control is lower than it actually is. That would enhance the importance of studies like this one, which report relatively unbiased estimates of public support for tobacco control.

However, in the case of Georgian decision-makers, no research on their perceptions about public opinion regarding tobacco control has been undertaken, as far as we are aware. To explore this issue it would be useful to complement studies like this one with studies of decision-makers’ perceptions about public opinion. One can only speculate what the findings would be, but if there is a large disconnect between what the public supports and what decision-makers think they support, that be news-worthy, indeed.

CONCLUSION
The findings of this study show that all eight tobacco sales restrictions have a high level of public support in Georgia. We interpret this as public demand for the government to enforce the already existing restrictions and regulations, to establish new restrictions on tobacco sale at non-licensed outlets, and increase penalties for violations of restrictions.
ABSTRACT

Objectives: This study aims to provide data on a public level of support for restricting smoking in public places and banning tobacco advertisements.

Design: A nationally representative multistage sampling design, with sampling strata defined by region (sampling quotas proportionate to size) and substrata defined by urban/rural and mountainous/lowland settlement, within which census enumeration districts were randomly sampled, within which households were randomly sampled, within which a randomly selected respondent was interviewed.

Setting: The country of Georgia, population 4.7 million, located in the Caucasus region of Eurasia.

Participants: One household member aged between 15 and 70 was selected as interviewee. In households with more than one age-eligible person, selection was carried out at random. Of 1508 persons selected, 14 refused to participate and interviews were conducted with 915 women and 659 men.

Outcome measures: Respondents were interviewed about their level of agreement with eight possible smoking restrictions/bans, used to calculate a single dichotomous (agree/do not agree) opinion indicator. The level of agreement with restrictions was analysed in bivariate and multivariable analyses by age, gender, education, income and tobacco use status.

Results: Overall, 84% of respondents indicated support for smoking restrictions and tobacco advertisement bans. In all demographic segments, including tobacco users, the majority of respondents indicated agreement with restrictions, ranging from a low of 51% in the 15–24 age group to a high of 98% in the 56–70 age group. Logistic regression with all demographic variables entered showed that agreement with restrictions was higher with age, and was significantly higher among never smokers as compared to daily smokers.

Conclusions: Georgian public opinion is normatively supportive of more stringent tobacco-control measures in the form of smoking restrictions and tobacco advertisement bans.

BACKGROUND

The WHO Framework Convention on Tobacco Control (FCTC) emphasises the importance of combining tobacco demand reduction with tobacco supply restrictions. Article 8 of the FCTC addresses the need for protection from exposure to tobacco smoke and recognises the scientific evidence that exposure to tobacco smoke causes death, disease and disability. Article 13 calls for a comprehensive ban on advertising, promotion and sponsorship to stimulate reduction in the consumption of tobacco products.

Evidence from countries that have carried out well in reducing tobacco consumption suggests that a comprehensive approach to tobacco control should include: (1) increased tobacco prices and taxes; (2) bans on tobacco advertising, promotion and sponsorship; (3) no sales to minors; and (4) the conduct of public awareness campaigns.

In addition, clean indoor-air laws have been the focus of many of the tobacco-control efforts in North America, Western Europe and Australia, the lessons of which are instructive to those drafting tobacco-control policies in low-income and middle-income countries.

Regarding tobacco advertisement and promotional activities, a special concern is their influence on adolescent behaviour. Partial bans on tobacco advertisement are not effective, and WHO analyses suggest that comprehensive control programmes, including comprehensive advertising bans, are required to reduce cigarette consumption.

Tobacco use in Georgia and tobacco-control policies

Tobacco use in the former Soviet state of Georgia has increased to alarming proportions.
since 1990, mostly due to the transition towards market economy and the arrival of the international tobacco industry. In 2001, the prevalence of tobacco use among men was 33.8% and rose to 50.8% in 2006. Among women, the prevalence increased from 6.3% to 14.9% in the same period (ibid). The tobacco use trend among youth is also worrying. The Global Youth Tobacco Survey conducted in 2000-2007 estimated that 12.8% of south aged 13–15 years smoked cigarettes in European countries, while the prevalence was 25.7% in Georgia. Smoking rates in schools and workplaces were implemented in Georgia in 2003, when the first Georgian Law on Tobacco Control was enacted. In 2004, changes in the Georgian Code of Administrative Offences established penalties for violations of tobacco-control law measures. Since May 2006, the FCTC entered into force in Georgia. Following which several changes have been made to the Georgian tobacco-control law. As of this writing, the law prohibits tobacco smoking in educational institutions, enclosed sports buildings, in medical and pharmaceutical buildings and in public transport. In working places where smoking is restricted, smoking-allowed zones may be created. Regarding tobacco advertisement regulation, the 1999 Georgian Law on Advertisement only bans tobacco ads on TV and radio. After entering into the FCTC, Georgia had 5 years to achieve full implementation of a total ban on tobacco advertisement and promotion. However, as of this writing, the ban is still only a partial one, with outdoor advertising and other advertising forms (except TV and radio) still being permitted. Despite the existing restrictions, tobacco use is ubiquitous even in places where it is prohibited, due to tax enforcement of the law. Thus, Georgian tobacco-control law requires revision to emphasise enforcement measures. This calls for policymakers to revisit the present structure of tobacco-control law. In this context, public opinion about the appropriateness of tobacco-control measures may have an important role to play in influencing the policy-making process.

Influence of public opinion on policy-making

'Public opinion' refers to citizen's attitudes, perspectives and viewpoints on policy issues that decision makers may take into account in policymaking processes. Policymakers are influenced by public opinion through a range of 'barometers' including election results, what elected officials sense that people want, what powerful constituencies have to say, how the media reflect public sentiment, public demonstrations, public opinion polls and survey research. In democracies, a key factor that determines the power of the public opinion’s political influence is how close the coming election is. That public policy is responsive to public opinion is a core expectation of democratic theory, under the principle that political actors should be alert to changes in public opinion and adjust their behaviour accordingly. However, public opinion influences policy even where there is no democracy, through informal pressure from dissatisfied publics. Indeed, there is some concern that policymakers may pay too much attention to the public’s opinion, and that policy researchers underestimate this source of influence because the study of public opinion is emphasised less than other policy determinants. Worried that public opinion has too much influence, Brooks and Manza point out that the wishes and preferences of the public are often not sufficiently informed to express meaningful opinions. Regardless, research shows that the impact of public opinion on policy is substantial, and remains strong even when the influence of organised interests is taken into account. Not only is the broad shape of policy responsive to public opinion but can also be the proximal cause of a policy. The relationship between public opinion and policymaking may often operate as a self-reinforcing system, the way a thermostat interacts with a machine to keep it within operating temperature. Public opinion sends signals to policymakers that can help in fine-tuning policy, and policy sends signals to the public, which can help shape public opinion. Public’s support for tobacco control

Data from several countries indicate that smoking bans in workplaces, public transport and in public spaces such as shopping malls are widely supported by the public. Significant support for tobacco control is evident even among smokers. An opinion poll in New South Wales, Australia, showed that 89% supports smoke-free policy for children’s playgrounds, 77% for sports facilities, 72% for bars, 69% for pubs, 55% for beaches and 77% for autos carrying children. Perhaps the highest ever levels of support for tobacco bans were reported in a study in Lausanne, Switzerland, with 87% supporting smoking bans in public places. Some studies about internal tobacco industry documents revealed a strategy using international scientific consultants to influence public opinion on environmental tobacco smoke. In summary, there is good evidence from Anglo-Saxon countries that the public supports legislation restricting the use of tobacco, and that public opinion matters in tobacco policy-making. However, there are no similar studies in Georgia. This prompted the present study, which aimed to collect, analyse and disseminate data on the Georgian public’s attitudes towards smoking restrictions and tobacco advertisement bans. The precise degree to which public opinion influences decision-making cannot be ascertained, since there is no method to separate this source of influence from many other sources of influence (eg, lobbying, scientific...
evidence and Government white papers). Therefore, this study is limited in documenting the state of public opinion, and cannot make valid and reliable estimates of the degree to which public opinion has affected actual tobacco-control decision-making in Georgia.

**STUDY AIM AND METHODOLOGY**

**Aim**

This study aims to provide data from a nationally representative sample including non-smokers, ex-smokers and current smokers on their level of support for restricting smoking in public places, banning tobacco advertisement, and increasing penalties for violations of restrictions and bans.

**Study design and methods**

Survey data were collected in January and February 2008 in the whole country. The primary sampling units were households and one member aged between 15 and 70 was selected for the interview. The sampling frame was formed on the basis of the national census, covering the non-institutionalised population. Households located at the sampled addresses were observed. The sample size was determined with the objective to ensure high statistical reliability of the estimates of key indicators: the 95% CI should not exceed 10-15% of a key indicator estimate. According to this criterion, the sample size was determined to be 1655. The sampling was carried out by using stratification and a two-stage procedure. At the first stage, a sample of primary sampling units (enumeration districts) was drawn. In accordance with the sampling design, the country was divided into 10 comparatively homogeneous regions. Each region was divided into homogeneous strata according to urban/rural and mountainous/lowland settlements. Regional sampling quotas were proportional to their size. Primary sampling units were selected in each stratum by random sampling (with the probability proportional to size) from the frame of enumeration districts. At the first stage of sampling, from 16,000 enumeration districts 94 districts were selected. At the second stage, lists of the household addresses in the selected districts were compiled. Then, using systematic sampling, addresses were selected from those lists according to the sampling quotas.

In-house face-to-face interviews used a standard questionnaire. In households with more than one age-eligible person available for selection, selection of the respondent was carried out at random. About 50 interviewers and 10 regional supervisors from the Department of Statistics of Georgia carried out this survey. Regional supervisors controlled the selection of addresses and the work of the interviewers. Sample weights were calculated using estimation, determined as the inverse \(1/p\) (i) of its probability \(p\) (i) to be selected.99

**Study outcomes/determinants**

The variables considered in the present report were as follows:

A. Demographic variables age, gender, education level and income;
B. Smoking status (daily, occasional, ex-smoker and never smoker);
C. Levels of agreement with the implementation of eight tobacco smoking prohibitions and tobacco advertisement/promotion ban, and increased penalties on violations, coded 'yes', 'no', 'don’t know' and 'refuse to answer':
   1. Prohibition of smoking promotion (including offering free promotional items, such as exhibit, free samples, etc);
   2. Prohibition of tobacco and tobacco company advertising in the printing media, on the billboards and sponsorship;
   3. Prohibition of all tobacco and tobacco company advertising;
   4. Prohibition of indoor smoking in government buildings/offices, schools and youth organisations;
   5. Prohibition of indoor smoking in medical, educational, sport and cultural facilities;
   6. Prohibition of indoor smoking private workplaces;
   7. Prohibition of indoor smoking in restaurants bars and nightclubs;
   8. Increased penalties for violations of restrictions/prohibitions.

In calculating agreement rates, the denominators included those who refused to answer, such that the two coded response categories were 'agree' and 'disagree or no answer'. This was intended to create a conservative bias in estimating the level of agreement with restrictions.

**Data analysis**

The dimensionality of the attitudes towards the scale of smoking prohibitions and tobacco ad bans was examined with correlation analysis and with factor analysis (principal axis factoring). The reliability (i.e., internal consistency) of the scale was estimated with Cronbach’s α. A simple, additive sum score was constructed based on all eight dichotomised attitude items. This sum score indicates the degree of overall support for smoking restrictions and tobacco ad bans. The sum score was recoded into a single dichotomous variable with high support for smoking restrictions in one category (agreement with at least 4 of the 8 restrictions) and low support as the other. Support for smoking restrictions was analysed against demographic variables with the \(\chi^2\) statistic. Associations between demographic factors and smoking status, and support for smoking prohibition and tobacco ad bans, were also examined with bivariate as well as multiple logistic regression analysis. SFSS V19 and V20 were used for all analyses. Analyses were also carried out in Mplus with the weighted least squares—mean adjusted and variance adjusted estimator, and all items
were defined as categorical. The Mplus results, which are not reported here, supported the results of the principal components analysis that are reported here.

**Ethical clearance**

Signed informed consent was obtained from all participants. For participants under age 18, parents or guardians confirmed, by signature, their approval of the minor’s participation. The survey organizers took responsibility with regard to the protection of confidentiality during the collection, analysis and dissemination of data. No respondent’s identity was recorded on the interview forms or in any other manner.

**RESULTS**

Of the 1655 households selected, interviews could not be conducted in 67 households due to no age-appropriate residents present (n=5), refusal to participate (n=13) and no response/no one home (n=49). Interviews were conducted with 1588 respondents (response rate of 96%). The number of study participants who were interviewed but refused to answer one or more questions about restrictions ranged from 14 to 76 (9.5-4.8%). Fourteen respondents who had missing responses on half or more of the eight restrictions questions were not included in the analysis, reducing the analysis sample size to 1574 (response rate 96%).

Inter correlations between the smoking prohibition and tobacco ads/promotion ban attitude items ranged from 0.81 to 0.95. Factor analysis (principal axis factoring) showed that the first unrotated factor had an eigenvalue of 6.41 while the second unrotated factor had an eigenvalue of 0.56. This supports the assumption that the scale is unidimensional and can be reduced to one index, for which Cronbach’s α is 0.96. An unweighted sum score was calculated using all eight attitude items.

The lowest level of approval was 47.5% among respondents aged 13-25 for the ‘prohibition of indoor smoking in restaurants, bars and night clubs’. The highest level of approval was 58.8% among respondents aged 56-70 for the ‘prohibition of indoor smoking in medical, educational, sport and cultural facilities’. There was a statistically significant age gradient for all eight restrictions, with older respondents having the highest approval rates (table 1).

No statistically significant gender differences or differences by income and educational level were observed with regard to any of the smoking prohibition and tobacco ad ban items.

Approval of each of the eight prohibitions ranged from 88.6% to 98.9% among ex-smokers and never smokers, from 78% to 82% among daily smokers and from 47.1% to 58.9% among less-than-daily smokers (table 1). Across all items, the average support for smoking restrictions and tobacco advertisement bans was 84.9%. All eight smoking status gradients were statistically significant, with ex-smokers and never smokers having the highest approval rates, and less-than-daily smokers having the lowest approval rates. Daily smokers had higher approval rates than occasional smokers but lower than ex-smokers and never smokers.

When we examine the dichotomised sum score, it turns out that among never smokers and ex-smokers, high approval of restrictions was indicated by 94.3-97.7% of respondents. Occasional smokers were less supportive of restrictions than the daily smokers. These differences in approval were statistically significant, as shown in table 2.

There were no statistically significant differences in the levels of support for restrictions by gender and household income. The bivariate association between the highest completed education and support for restrictions was significant. This significance is due to the difference between the level of support among those who have college-level education (92.7%) and those who have a university level education (87.9%).

The bivariate relationships between the attitude scale and each of the sociodemographic/tobacco-use variables also described with logistic regression are shown in table 2 (in the columns under bivariate logistic regression). The associations are identical to the ones described with percentages above.

Results of a multiple logistic regression analysis are shown in the last four columns of table 2. Support for restrictive measures increased with age from the youngest age group (13-25) to the second oldest (46-55), with OR values similar to the bivariate ones. There were no significant associations with gender and household income. The overall association between the highest completed level of education and support for restrictions was no longer significant, but the difference between those with the lowest level of education (reference group) and those with college-level education (OR=0.992) was significant at the p<0.05 level. When compared with the daily smokers (reference group), the occasional smokers were significantly less supportive of restrictive measures (OR=0.65) and never smokers are significantly more supportive (OR=1.89).

The multiple logistic regression analysis produced results that were similar to the results of the bivariate analyses, although some relationships became insignificant (overall association with highest completed education and contrast between daily smokers and ex-smokers) and one surfaced (contrast between lowest education and college-level education).

**DISCUSSION**

The study sampling design and the 96% response rate give reason for confidence in the representativeness of the findings, and we surmise therefore that the majority of the Georgian population supports smoking prohibitions in public places and a total ban on tobacco advertisement and promotion. The high level of public support to prohibit smoking in public places and work
<table>
<thead>
<tr>
<th>Table 1</th>
<th>Smoking restrictions and tobacco sale ban* (%) by demographic and smoking status (proportion analyses); see footnote 1a to key to specific content of each restriction (*p &lt; 0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Percentage of yes</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>15-25</td>
<td>51.9</td>
</tr>
<tr>
<td>26-35</td>
<td>54.9</td>
</tr>
<tr>
<td>36-45</td>
<td>56.5</td>
</tr>
<tr>
<td>46-55</td>
<td>59.6</td>
</tr>
<tr>
<td>56-65</td>
<td>62.6</td>
</tr>
<tr>
<td>Income</td>
<td>0.04, 0.660</td>
</tr>
<tr>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>81.4</td>
</tr>
<tr>
<td>Female</td>
<td>82.2</td>
</tr>
<tr>
<td>Education</td>
<td>3.26, 3.000</td>
</tr>
<tr>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>52.6</td>
</tr>
<tr>
<td>Middle</td>
<td>57.6</td>
</tr>
<tr>
<td>High</td>
<td>55.4</td>
</tr>
<tr>
<td>Income</td>
<td>4.81, 11.10</td>
</tr>
<tr>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>51.5</td>
</tr>
<tr>
<td>Middle</td>
<td>56.5</td>
</tr>
<tr>
<td>High</td>
<td>55.9</td>
</tr>
<tr>
<td>Smoking</td>
<td>324.33, 5.000</td>
</tr>
<tr>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>77.1</td>
</tr>
<tr>
<td>Less than</td>
<td>46.5</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>65.7</td>
</tr>
<tr>
<td>Former</td>
<td>30.7</td>
</tr>
</tbody>
</table>

A. Agreement to provisions of smoking prevention (including allowing designated smoking areas) in shopping malls, swimming pools, child care centers, etc. B. Agreement to provisions of all types of tobacco products and advertising to tobacco consumers. C. Agreement to provisions of tobacco smoking in restaurants, bars, hotels, and other hospitality establishments. D. Agreement to provisions of tobacco smoking in health care facilities and schools. E. Agreement to provisions of tobacco smoking in public works and transportation facilities. F. Agreement to provisions of tobacco smoking in government offices and public buildings. G. Agreement to provisions of tobacco smoking in private workplaces. H. Agreement to provisions of tobacco smoking in schools and local government offices. I. Agreement to provisions of tobacco smoking on city streets and public places. J. Agreement to provisions of tobacco smoking in health care facilities. K. Agreement to provisions of tobacco smoking in residential or residential areas. L. Agreement to provisions of tobacco smoking in parks and public recreation areas. M. Agreement to provisions of tobacco smoking in religious institutions. N. Agreement to provisions of tobacco smoking in post offices and other public facilities. O. Agreement to provisions of tobacco smoking in schools and local government offices. P. Agreement to provisions of tobacco smoking in public works and transportation facilities. Q. Agreement to provisions of tobacco smoking in government offices and public buildings. R. Agreement to provisions of tobacco smoking in private workplaces. S. Agreement to provisions of tobacco smoking in residential or residential areas. T. Agreement to provisions of tobacco smoking on city streets and public places. U. Agreement to provisions of tobacco smoking in health care facilities. V. Agreement to provisions of tobacco smoking in public works and transportation facilities. W. Agreement to provisions of tobacco smoking in government offices and public buildings. X. Agreement to provisions of tobacco smoking in private workplaces. Y. Agreement to provisions of tobacco smoking in residential or residential areas. Z. Agreement to provisions of tobacco smoking on city streets and public places.
Table 2. Support for smoking restrictions and tobacco ads ban by demography

<table>
<thead>
<tr>
<th></th>
<th>High support (%)</th>
<th>OR (95% CI for Exp(B))</th>
<th>p Value</th>
<th>OR (95% CI for Exp(B))</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13–25 (ref)</td>
<td>263 (21.3)</td>
<td>1.00</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>26–35</td>
<td>305 (27.0)</td>
<td>3.16 (1.13, 8.77)</td>
<td>1.00</td>
<td>0.34 (0.24, 5.60)</td>
<td>0.000</td>
</tr>
<tr>
<td>36–45</td>
<td>323 (29.1)</td>
<td>1.75 (0.16, 19.05)</td>
<td>0.000</td>
<td>1.21 (0.62, 19.28)</td>
<td>0.000</td>
</tr>
<tr>
<td>46–55</td>
<td>258 (27.7)</td>
<td>4.19 (0.70, 56.82)</td>
<td>0.000</td>
<td>0.83 (0.28, 2.57)</td>
<td>0.000</td>
</tr>
<tr>
<td>56–70</td>
<td>203 (25.8)</td>
<td>4.69 (0.09, 98.96)</td>
<td>0.000</td>
<td>0.07 (0.01, 0.48)</td>
<td>0.000</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (ref)</td>
<td>915 (84.9)</td>
<td>1.00</td>
<td>0.000</td>
<td>1.00</td>
<td>0.000</td>
</tr>
<tr>
<td>Male</td>
<td>659 (84.8)</td>
<td>0.95 (0.75, 1.21)</td>
<td>0.000</td>
<td>1.32 (0.90, 1.95)</td>
<td>0.164</td>
</tr>
<tr>
<td>Highest compulsory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary or secondary</td>
<td>104 (84.2)</td>
<td>1.00</td>
<td>0.000</td>
<td>1.00</td>
<td>0.000</td>
</tr>
<tr>
<td>school (ref)</td>
<td>566 (82.7)</td>
<td>0.90 (0.65, 1.25)</td>
<td>0.523</td>
<td>0.62 (0.40, 0.98)</td>
<td>0.041</td>
</tr>
<tr>
<td>Middle college</td>
<td>522 (87.9)</td>
<td>1.27 (0.99, 1.63)</td>
<td>0.084</td>
<td>0.73 (0.43, 1.21)</td>
<td>0.222</td>
</tr>
<tr>
<td>University</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postgraduate/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>graduation degree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income</td>
<td>485 (85.8)</td>
<td>1.00</td>
<td>0.538</td>
<td>0.773</td>
<td></td>
</tr>
<tr>
<td>Low (ref)</td>
<td>568 (84.9)</td>
<td>0.92 (0.65, 1.31)</td>
<td>0.849</td>
<td>0.98 (0.64, 1.51)</td>
<td>0.930</td>
</tr>
<tr>
<td>Middle</td>
<td>353 (84.6)</td>
<td>0.90 (0.63, 1.28)</td>
<td>0.552</td>
<td>1.20 (0.77, 1.96)</td>
<td>0.421</td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco use</td>
<td>446 (80.9)</td>
<td>1.00</td>
<td>0.000</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Daily (ref)</td>
<td>206 (50.0)</td>
<td>0.24 (0.16, 0.34)</td>
<td>0.000</td>
<td>0.63 (0.40, 0.98)</td>
<td>0.042</td>
</tr>
<tr>
<td>Less than daily</td>
<td>203 (69.7)</td>
<td>1.08 (0.90, 1.30)</td>
<td>0.000</td>
<td>2.74 (0.81, 12.42)</td>
<td>0.190</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>628 (94.2)</td>
<td>1.94 (1.04, 3.61)</td>
<td>0.000</td>
<td>1.90 (0.76, 5.18)</td>
<td>0.000</td>
</tr>
</tbody>
</table>

*Percentages from crossaedes (Bivariate analysis) and results from binary multiple logistic regression. Low support is agreement with three or fewer of eight types of smoking prohibition and tobacco ads ban. High support is agreement with four or more prohibitions.*

sites is consistent with observations in other parts of the world with different cultural and political contexts, although there are exceptions. In Australia 90% of non-smokers reported supporting a total ban, among Chinese urban residents 81.8% supported banning smoking in public places; in South Africa 83% of non-smokers and 79% of smokers; non-smokers were more supportive in this regard than current smokers.49-51 Nine in 10 Hungarian respondents supported a ban on smoking in healthcare facilities and almost 80% supported smoking restrictions in closed and outdoor public places, work places, restaurants and bars.52,53

These prevalence rates suggest that Georgian public opinion about tobacco control is in line with global public opinion generally. Closely to home, nearly all adults in two Russian studies agreed that indoor smoking should be prohibited in healthcare facilities (95%) and schools (99%), more than half thought smoking should be prohibited in restaurants and cafes, and almost a third supported a total ban of smoking in bars and restaurants.54,55 Public support for banning smoking in educational and health facilities exceeded 94% and reached 67.1% for bars in荞村 in 2009.56

This pattern supports the validity of the present findings, which might otherwise be suspected as resulting from a possible ‘acquiescence’ bias, in a public that not too long ago was a part of the Soviet Union.

Yet important exceptions to the overall pattern do exist. A survey conducted in nine former Soviet countries during 2010-2011 observed that only 56.6% of adults supported a total ban of smoking in restaurants, bars and cafes in Russia. In the same study, the corresponding figure was 38.2% in Ukraine and 50% in Georgia.56 It is well known that the exact form of question wording in survey research can have a significant influence on findings, and this is sometimes exploited by pollsters who are affiliated with candidates, campaigns and causes. Questions wording, however, is but one source of survey research bias among many sources. It is beyond the scope of this report to analyse and speculate about the large discrepancy just noted. We simply note that the many estimates cited in the paragraphs above are close to the estimate we provide for Georgia.

There is a strong discord between public opinion as documented in this study and tobacco control as
practiced in Georgia today. Georgia has a partial ban on tobacco ads. While there is evidence for the effectiveness of total advertising bans in reducing per capita tobacco consumption, no such evidence exists for partial bans and restrictions. Accordingly, limited bans cannot be assumed to have important impact on consumption. Tobacco advertising causes increased smoking and increased smoking translates into poorer public health. The population segment most vulnerable to ads are the youth, whose attitudes and intentions regarding possible tobacco use and choice of products are in a state of formation, compared with the more established behavioural choices of adults. The vulnerability of youth is exacerbated by targeted tobacco advertising and promotions. Given the damage to health attributable to tobacco use and the special vulnerability of youth to advertising, there is a public health imperative in Georgia to fully implement the FCTC prohibitions, with strong support from the Georgian public. Furthermore, recent successes have the Baltic States and Norway in implementing FCTC prohibitions—among a number of other European countries—are nearly examples that full implementation is feasible. A counter-intuitive finding in the present study was that occasional and young age smokers were less supportive of restrictions than daily smokers. A search of the literature to find comparable analyses was unsuccessful, and we can only speculate about the reason for this finding. It may be that occasional smokers in this study perceived themselves to be in control of their tobacco use, and therefore not in need of externally imposed restrictions. They may have generalised this perception to tobacco users in general. Nevertheless, fully half of occasional smokers indicated support for four or more of the restrictions. This finding does not detract from the overall conclusion that even tobacco users are generally in favour of restrictions.

Strengths and limitations
It seems evident from this study that supportive public opinion makes the time ripe for renewed advocacy to fully implement the FCTC and its smoking restrictions. Strengths of this study that are worth noting are the national representativeness of the sample and the high response rate of 95%. Regarding measurement, the internal consistency of attitudes towards smoking prohibition and tobacco ads ban was very high in this study. On the other hand, the attitude items have not been used in previous research, and comparative studies are not available. Whether the high internal consistency observed in this study would be replicated in other populations is therefore a matter for speculation that only future research could illuminate. In the period since the data of this study were collected and in this publication, it is possible that there have been shifts in public opinion that might affect our conclusions. Regarding the study data, this report focuses on one issue, the state of public opinion regarding tobacco-control measures. The survey also collected data not reported here, such as the level of respondents' knowledge of the harmful health effects of tobacco and their attitudes towards tobacco tax policies. Thus, a complete picture of the findings from the survey will only emerge after completion of more analyses and publication.

Further research
This study provides a model, a methodology and an instrument for the assessment of national public opinion about tobacco control. As we remarked in the Background section, this study is essential in the Georgian context, because no amount of public opinion findings from other countries has as much currency with Georgian decision-makers as findings from Georgia. Many low-income and middle-income countries in Eastern Europe (mostly former Soviet Republics) are struggling with the same negative forces for increased tobacco consumption that are at work in Georgia. We have described and demonstrated a method for gathering good quality data on national public opinion regarding tobacco control. The study's findings have relevance in Georgia, while the study's methodology has relevance not only in Georgia, but also in other former Soviet Republics that are facing the same tobacco-related public health threat that Georgia faces.

Public opinion data have a special standing in public health research. Questions about the generalisability of findings are restricted to constituencies defined by political boundaries. Each and every constituency, that is, grappling with a public health problem like tobacco use, and that wishes to document public opinion relevant in controlling the problem, has to do so within the constituency. Advocacy based on research in other constituencies can always be expected to be less effective than advocacy based on locally generated data and findings.

Conclusion/recommendation
The findings of this study show that all eight smoking prohibition and tobacco ads/sponsorship bans have a high level of public support in Georgia. We interpret this as public demand for the government to enforce the already existing smoking prohibitions and regulations, to establish total prohibitions in any other public places including restaurants/bars, and to totally ban tobacco advertisement, direct and indirect, and to ban tobacco promotion in any form. We have shown in our review of literature that there is a good reason to conduct research on public opinion, because the public's opinion is a factor in political decision-making.

High quality public opinion data can be gathered using a methodology accessible to researchers in former Soviet Republics, where the threats to the health of people consuming tobacco are in many cases rising.

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Conflicts of interest: GRB participated in the planning and data collection phases of the study and in formulating the study objectives. He was the lead statistical analyst and the lead writer of the article. MBM participated in formulating the study objectives, the identification of variables, and the analysis plan. The other authors (LEA, AM, and JRA) participated in the statistical analyses and contributed to the drafting of the statistical parts of the article. KBP participated in the planning and data collection phases of the study and also edited the academic papers. He also contributed to the drafting of the study.

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Competing interests: The Eurasia Program, administered by the Norwegian Center for International Cooperation in Higher Education and the Norwegian Ministry of Foreign Affairs, provided financial support for GRB in the study’s data analysis and report writing phase.

Ethical approval: The Georgian Health Protection and Education Foundation Ethical Committee approved the study protocol.

Provenance and peer review: Fast turnaround, external peer reviewed.

Data sharing statement: The study data are available by emailing the corresponding author.

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The influence of public opinion on tobacco control policy-making in Georgia: Perspectives of governmental and non-governmental stakeholders

George Bakhturidze*, Nana Peikrishvil*, Maurice Mittelmark*

* FCTC Implementation and Monitoring Center in Georgia
* Georgian Health Promotion and Education Foundation, Georgia

ABSTRACT

INTRODUCTION: Georgia has one of the highest smoking rates (36%) in Europe. This may be due partly to the fact that the present Georgian tobacco control regulations are weakly enforced. It is unclear if the authorities are aware that they would have majority public support for tighter enforcement of tobacco control regulations. The study aimed to fill a knowledge gap by addressing these research questions: (1) To what degree are policy makers aware of the Georgian public’s opinions about tobacco control and enforcement? (2) To what degree do policy makers take Georgian public opinion into account in their decision-making, including tobacco control and enforcement?

METHODOLOGY: This study used a collective case study methodology. The data were obtained through 12 semi-structured interviews during the period from April to May 2013, with three respondents each from the Ministry of Health, the Parliament of Georgia, Opinion Research Agencies and Non-Governmental Organizations. Thematic Network Analysis was used to analyze the interview data.

RESULTS: Policy makers are aware that public opinion favors tobacco control and enforcement. However, Georgian politicians do not take public opinion into account during policy making. Tobacco industry influence is very strong in the Georgian policy-making arena. Some policy makers are themselves lobbyists for the tobacco industry, and ignore public opinion. Public health planning and strategy development occur without public involvement.

CONCLUSIONS: Georgia faces a challenge in increasing the influence of public opinion in health policy making generally, and in tobacco control in particular.

Keywords: Public health, tobacco control, Public policy, public opinion, policy-making, public participation
male smokers approving strict tobacco control. Given
the strong level of public support for tobacco control,
from a public health standpoint the main challenge in
Georgia is to stiffen the enforcement of existing
controls. On the face of it, strong public opinion favoring
tobacco control should create an atmosphere supporting
strong enforcement. As reviewed below, research in
many countries indicates that public opinion has a
meaningful role to play in the degree to which tobacco
control is pursued as a public health priority.

With Georgian public opinion research showing
strong support for enforcement, yet with enforcement
being lax, two questions arise that this article
addresses: Are Georgian health policy makers and
authorities sensitive to public opinion about tobacco
control and enforcement? If they are, what is their level
of understanding of the Georgian public’s support for
tobacco control enforcement? Answers to these
questions should help to identify the next steps to
strengthen Georgian tobacco control. If the authorities
tend to discount or ignore public opinion in this context,
advances in tobacco control will first require a
strengthening of the responsiveness of authorities to
public opinion. If, on the other hand, the problem is a
lack of awareness of public opinion, educational efforts
are needed to inform the authorities about the actual
state of public support for tobacco legislation
enforcement. Combined strategies will be required to
the extent that both these scenarios are evident.

The challenges to tobacco control described above are,
of course, not unique to Georgia. Poor enforcement of
tobacco control policies and the interference of the
industry is commonplace in Eastern Europe,
derunning in tobacco control. Positive
attitudes from the public without effective enforcement
do not translate into compliance with the law.[9, 10] For
example, full protection from second-hand smoke is only
achieved when compliance with smoking bans is high.
Compliance is related to public support but also
knowledge of second hand smoke hazards,[11] both
influenced by media campaigns and by advocacy efforts.
[11]

Public opinion in policy-making processes

Methods to ascertain public opinion include
referenda, elections, public demonstrations and electoral
research. Public opinion polls, especially, are rapid
barometers by which policy makers detect public
preferences.[12, 13, 14] There is evidence that public
opinion can translate into policy in significant ways, at
least in some arenas. For example, much of civil rights
legislation in the USA was enacted only after public
support was expressed repeatedly and forcefully in the
American mass media.[15] There is some controversy
about the relative impact on policy makers of public
opinion versus interest group pressure versus research
on policy makers.[16] But Birkins’s (2010A)
[17]summary of the public policy literature concludes
that public opinion is a significant force for policy
change, in the USA and in other Anglo – Saxon
countries. This is also evident in cultures as disparate as
those of Western and Eastern Europe.[14, 16, 18 -21]

In the study of policy responsiveness to public
opinion, perhaps the most influential theorist is Kingdon
(2011). [22] His theory of political agenda setting
includes consideration of the role of public opinion and
he provides a framework within which to study the
public’s influence. Kingdon’s core idea is that three
distinct influence ‘streams’ – policies, problems, and
politics – sometimes intertwine at ‘policy windows’,
moments when external or internal forces push an issue
up to the top of the political agenda. [22, 23] These forces
include public opinion and other interests arising from
business and industry, professional associations, civil
servants, labor groups, welfare advocates, lobbyists and
the mass media:

“Health officials know, for instance, that the
nation’s bill for medical care could be lowered
considerably by a change in such health habits as
smoking, drinking, and reckless driving. But they feel
keenly the limits on government action in this area”.
Kingdon (2011, p. 65).[22]

An illuminating example of the policy window
concept is the experience with tobacco control in the
USA. The US Surgeon General’s report in 1964 clearly
opened a policy window for taking major steps towards
comprehensive tobacco control, [24] contributing to the enactment of landmark control policies and now in force in many USA States.

Indeed, research worldwide reveals that the public everywhere, including tobacco users, seem to be aware of the dangers of tobacco and support tobacco control. In Australian research, 89% of never-smokers reported supporting a workplace-smoking ban, compared with 67% smokers,[25] and only a minority of Australian tobacco users reported support for smoking in public bars.[26] In South Africa, 83% of non-smokers and 70% of smokers supported bans on smoking in public places,[27] In Greece, smokers and non-smokers were equally supportive of bans on tobacco sales to minors.[28] In Hungary, almost 80% supported smoking restrictions in closed and outdoor public places, work places, restaurants and bars.[29]

Closer to Georgia, Ukrainian public support for banning smoking in educational and health premises exceeded 94% and reached 67.1% for drinking bars. [30] Russian studies showed that 95% of the public supported a ban on indoor smoking in healthcare premises, and 99% supported a ban in schools.[31]

In view of the above, the present study aimed to fill a knowledge gap by addressing these research questions:

1. To what degree are policy makers aware of the Georgian public opinion about tobacco control and enforcement?
2. To what degree do policy makers (and those who try to influence policy makers) take Georgian public opinion into account in their decision making regarding key public health issues, including tobacco control and enforcement?

**METHODS**

**Study Design and Sampling**

This study used a collective case study methodology. [32]

**Methods and interview process**

The data were obtained through 12 semi-structured interviews during the period from April to May 2013, with three respondents each from the Georgian Ministry of Labor, Health and Social Affairs (MOH case), the Parliament of Georgia (MOP case), Opinion Research Agencies (ORA case) and Non-Governmental Organizations (NGO case). Respondents were selected based on their having extensive public health portfolios within their respective organizations. Face-to-face, one-on-one interviews were conducted in Georgian by the first author. They were audio recorded.

**Thematic Network Analysis and Coding**

The second author prior to further data analysis listened to all the recordings. The second author then transcribed the tapes in Georgian. All tapes were transcribed before analysis began. Thematic network analysis (TNA) was used to analyze the interview data.

[33] The TNA was undertaken by the second author using the Georgian transcripts. The intent to have the second author undertake the analysis was to distance the allegiances of the first author and his interview context-experience. TNA is a hermeneutic approach to extracting the lowest-order of meaning, referred to as Basic Themes. This was done in Georgian. The Basic Themes were grouped and summarized into Organizing Themes, also done in Georgian. These were further abstracted in Georgian into super-ordinate Global Themes.

In coding the transcripts, basic, organizing and global themes were identified without regard to the sources of the data, with the second author having no access to the identities of the interviewees (beyond what might be guessed/surmised by the content of an interview). The first and second authors then constructed a graphical network depiction of the theme structure. Only after this stage in analysis were the themes cross-identified with the cases, to ascertain which cases contributed information to which themes.

The first and second authors then returned to the transcripts to search for case-specific data to illustrate the evidence for the themes. Selected quoted material was then translated to English (the transcripts themselves were not translated into English). All authors then discussed the Georgian-English translations and agreed that close/literal translations resulted in close to
The influence of public opinion on tobacco control policy-making in Georgia: Perspectives of Governmental and non-governmental stakeholders

unintelligible English. This stemmed in good part from the interviewees’ frequent use of jargon and phraseology commonly used in the Georgian policymaking and public administrative arena, but having obscure meaning in everyday Georgian.

The decision was then taken to paraphrase the Georgian quotes in English, to avoid giving the impression of precise translation. Therefore, material obtained from the interviewees as reported in this paper appears without quotation marks, and in paraphrased form only. The Georgian transcripts are available from the first author, which permits an independent analysis.

Ethics statement
The Georgian Health Promotion and Education Foundation Ethical Committee approved the study protocol, which complied with the current laws of the country. Signed informed consent was obtained from all participants. Neither the raw data nor the data analysis files contain information that can identify the respondents.

RESULTS

Before presenting the results, we can underline that all respondents were collaborative, and none refused to participate in our study.

The global theme driving the TNA is the public’s role in public health policy making as perceived by the respondents. The TNA revealed three organizing themes: A) The public has an opinion; B) Public opinion is ignored or manipulated; C) Public opinion not influential in tobacco control and 13 basic themes as shown in Figure 1. The basic and organizing themes on the role of public opinion in public health policy making are presented in Table 1. As shown, a “+” sign is assigned to similar responses of all respondents from the appropriate stakeholder group (case representatives). In most cases there are similar positions from the different stakeholder groups.

Organizing Theme A is labelled ‘The public does, indeed, have opinions’. That, at least, is how the respondents perceived it. They had no trouble describing their perceptions of public stances on a variety of health issues that were probed by the interviewer. The four basic themes supporting this interpretation cover a range of health topics.

Basic Theme 1 arises from respondents’ claims that public opinion related to illicit drugs has always been strongly negative. Only a small minority of the public is seen to support marijuana decriminalization, and according to NPO respondents, this minority can and should be ignored.

Basic Theme 2 follows from respondents’ comments about sex education and family planning. In general family planning and sex education is stigmatized in Georgian society. NGO, NPO and ORA respondents indicated that giving public opinion against contraception and sex education hindered policy-makers’ intentions to address these sensitive issues. As an ORA respondent put it, “the main hindering force [for family planning policy] was public opinion”.

Basic Theme 3 is stimulated by the changing public stance on an issue relevant to almost everyone: the requirement to use seat belts in moving vehicles. Respondents remembered that public opinion on the compulsory use of seat belts was not supportive before legislation was enacted in 2010. Yet, as the majority of respondents remarked, public support increased after enforcement became a reality.

Basic Theme 4 arose out of expressions connected to drinking water quality. Despite the fact that Georgia is rich in water resources, there are still problems with water supply and water quality. Several respondents remarked that the public attitude is united in calling for safe water, sewerage systems, proper waste management, and permanent supplies of quality drinking water. Taken together, these basic themes suggest that Georgian policy makers have some awareness of public opinion on a range of health issues. That conclusion ties in with Organizing Theme B: public opinion perceived to matter in policy-making processes, or is it ignored, or is it manipulated?

The Basic Themes informing Organizing Theme B suggest that the respondents perceive that public opinion is ignored rather than regarded in policy processes.
Basic Theme 5 arises from respondents' reports that during Shevardnadze's leadership (1992-2003), public opinion was not monitored via polls or other means polls, even if the public was presumably informed by the relatively free mass media. During Saakashvili's leadership (2004-2012), public participation in policy-making processes did not increase, and nor has it since. Most of the respondents simply did not believe that policy-making in Georgia is affected by public opinion. Rather, the perception is that private vested interests always have been a dominant influence. Yet, the MOH respondents believed that the fundamental expression of democracy is when public opinion and public policy interact. Thus, at least at a private level among some policy-makers, there may be a desire for a greater role in policy-making than seems to have been the case. For example, NGO and ORA respondents argued that government should increase the involvement of the public in order to enhance the public's connections with governmental officials. They believed that in general, decisions are made without considering public opinion and policy-making processes are dominated by the elite's interests. All respondents mentioned in one way or another that there is no political will to involve the public in policy-making.

Basic Theme 6 is very closely related to Basic Theme 5; the latter deals with the perception that public opinion is ignored, while the former deals with the conviction that public opinion should count. Most of the respondents believed that government should be more willing to consider public opinion in policy formation. NGO respondents underlined the potential for better policy-making if the public were to be involved. ORA representatives underlined potential importance of public opinion polls in policy-making. MOP and MOH group respondents assumed that national mood is important in decision-making when it supports the decisions preferred by the elite.

Basic Theme 7 suggests that one reason public opinion may be ignored is that it is considered to be dangerously ill-informed. MOP and MOH respondents declared that sometimes public opinion on a particular issue is ill-informed and is against the course of action that is best (as seen by 'experts'). Hence, they ignore such opinions, citing the need to avoid potential danger. This thought was expressed in a general way, and not with reference to particular policy issues.

Basic Theme 8 illuminates the opinion of some respondents that beyond simply ignoring public opinion, the public mood is sometimes studied and then used for manipulation. ORA representatives mentioned that in earlier times, instruments were used to listen to the 'heart beat' of the public. These instruments were research surveys repeated 3-4 and more times a year (during the period 2004-2012). Also used were league tables and other data sources. The data were accumulated in one database, which was used to manipulate the public and steer policy processes including health care policy making. PO respondents believed that during the era of Saakashvili, knowledge about public opinion was used to enhance success during election periods, but was otherwise used to manipulate the public in the direction of policy preferences of the dominant political regime.

Basic Theme 9 is closely related to Basic Theme 8: its focus is the perception that the mass media has been an important mechanism in public opinion manipulation. The mass media are seen as always serving the interests of the elite. Sometimes the mass media is seen to distort critical facts, or omit vital stories or details, in order to manipulate the public. One NGO respondent remarked that today, the mass media are selective, if any pro-tobacco control public event is planned, media coverage is neutral. An ORA respondent claimed that since 2004 the mass media are fully controlled, which has resulted in the total non-support of tobacco control by the media.

Basic Theme 10 is based on respondents' recollection that during the Saakashvili era, public opinion data were collected periodically in order to manipulate policy outcomes, even if not to actually inform decision-making processes. At the time of the interviews, NGO, MOH and ORA respondents felt there was no real interest to conduct public opinion research, for any purpose whatsoever.

Turning to Organizing Theme C, tobacco control comes into focus. The basic themes illuminate a dissonance between two perceptions: the public is
The influence of public opinion on tobacco control policy-making in Georgia: Perspectives of Governmental and non-governmental stakeholders

Table 1. Basic and organizing themes on the role of public opinion in public health policy making

<table>
<thead>
<tr>
<th>Public opinion has very little consideration in policy-making generally</th>
<th>MOH</th>
<th>NGO</th>
<th>ORA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy makers have little interest in involving public in decision-making</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion has very little consideration</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public is considered dangerously uninformed</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion polls have been used for manipulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media have been used for manipulation</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion data are not regularly collected</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion has little influence on public health policy-making in particular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public opinion to combat illicit drugs is very supportive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public opinion was negative on sex education and family planning from early stages</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion support increased sufficiently after the seat belt regulations entered into force</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public has little interest in quality of drinking water</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Donors have some positive influence on policy-making</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion is not considered in tobacco control policy-making</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>It is important to consider public opinion regarding tobacco control</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is not important to react to public opinion regarding tobacco control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media role is weak on tobacco control</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>No tobacco control policy enforcement</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Tobacco industry influence is strong</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Donors have positive interest in supporting tobacco control</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Public opinion is very supportive for strong tobacco control measures and requests enforcement</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* More minor responses of all respondents from appropriate stakeholder group (n=ea)

Basic Theme 11 is addressed by MOH and NGO respondents who underlined the importance of public opinion when considering tobacco policy. ORA, NGO and MOH representatives remarked that public opinion regarding tobacco control is supportive, but the Government does not take it into account in its policy-making. This is also in part, some respondents remarked, to the tobacco industry providing opposite and misleading information to the Government, suggesting that there is a negative public mood towards strong measures like a total ban of smoking in public places, a tobacco tax increase, ad bans, and so forth. NGO and MOH respondents addressed the powerful influence of commercial interests against tobacco control and the embroilment of the Government, with one remarking that Georgians live in a country where politicians are richer than businessmen, and Government officials are the lobbyists for the tobacco industry.

Basic Theme 12 is not focused on the public itself, but on Donors’ support for tobacco control, which is seen by respondents to be in synchrony with Georgian public opinion. The strong support of the international public health community for tobacco control was remarked on by NGO, MOH and MOH respondents, with one saying that international organizations and donors have ideological and financial influence in the policy formation process, a positive example of which is the World Health Organization’s Framework Convention on Tobacco Control. Donors, NGO respondents said, make ideological contributions, investments and help with policy design. MOH respondents noted that donors are one of main players in policy making and their influence is important. Furthermore, international obligations

were found to be important, such as the motivation to implement EU regulatory regimes.

Basic Theme 13 raises for the first time the influence of Georgian tobacco users. MOP representatives expressed a widely held view that smokers’ reaction will be strongly negative to tobacco control measures, and thus outweigh public opinion favoring tobacco control. This creates inertia for tobacco control, exacerbated by pressure from the tobacco industry. The industry, respondents say, tries to oppose tobacco control efforts in all possible ways. Policy-makers are aware that public opinion favors tobacco control and enforcement, but politicians are resistant; they support business including the tobacco industry, and ignore public opinion. NGO and MOH respondents mentioned that even the weak tobacco control policies in place during Saakashvili period were not enforced. The NGO respondents remarked that public health interest was ignored, and planning and strategy development occurred without public involvement.

DISCUSSION

It is important to recall the reason this study was undertaken, to establish a framework for a discussion of the above findings. Two recently published studies from Georgia revealed strong majority support for tobacco control (more than 80%), including support from tobacco users.[6, 7] The academic literature suggests that public opinion may play an important role in public policy making, in communities where public opinion carries weight in political processes. The majority of Georgians support enhanced tobacco control according to the new research, but can this have weight in Georgian political decision-making processes in the tobacco control arena? We cast the issue in the form of two research questions: (1) To what degree are policy makers aware of the Georgian public opinion about tobacco control and enforcement? (2) To what degree do policy makers (and those who try to influence policy makers) take Georgian public opinion into account in their decision making regarding key public health issues, including tobacco control and enforcement?

The short answers are these: (1) our respondents were of the opinion that many Georgians favor tobacco control (and recent research indicates this is correct), but (2) the public’s opinion carries little weight, especially in comparison to the influence of the tobacco industry. This is a sobering finding. Yet it seems likely that Georgian policymakers are not aware of the overwhelming support of the public for getting tobacco control, nor that most smokers also favor tobacco control. [6,7] The recent and compelling evidence on this may heighten policy-makers awareness of the actual state of public opinion, and that might increase motivation to adjust tobacco policy in directions favored by the majority of the public. There may be grounds for optimism, but it will be essential that public health advocates find ways to illuminate the recent findings about public opinion so that policy-makers are confronted emphatically with the facts of the matter.

The barriers are formidable. Grass-roots involvement and participation, which is the Ottawa Charter’s basis, [3, 4] is not sufficiently practiced in health policy-making processes in Georgia. The health policy-making rhetoric in Georgia has evolved from a Soviet focus based on a top-down expert model. For example, in 2006 the Prime Minister called for the involvement of all key stakeholders in policy-making. [35] However, the instruction ‘to involve’ stakeholders could be interpreted in many ways. Using the Bishop and Davis’ model, the current situation in Georgia is that participation is merely on the ‘consultation’ level. [20] The paper by Haaschke and Bankhout [36] is the only empirical study of this issue from Georgia, and it concludes that very little is actually known about how the government plans to involve stakeholders, how they actually attempt to involve them, and how the government and the stakeholders perceive their involvement.

"Many stakeholders (the general public, health professionals, health insurance companies, donors and non-government organizations (NGOs)) stated that they have not been properly consulted about proposed reforms; decision-making processes lack transparency..."
In theory, the Ministry of Health is not the only responsible body addressing major health challenges; it is the task of the entire government, which should enact healthy public policies in all sectors and health monitoring.[37, 34] Citizens generally lack the awareness of the principles of health promotion and to some extent do not believe that they can contribute to their own health.36 Thus, the conditions for health promotion in Georgia today are bleak, characterised by a lack of political will to prioritize health, lack of public involvement in policy-making processes, the complexity of multi-sectoral work in a politically difficult environment and inadequate human and financial resources for health promotion.[37-39]

It should be noted that the respondents from governmental organizations and the members of Parliament were mostly connected to the ruling political party. Yet they did express considerable critical comments regarding the role of public opinion in policy-making engendering confidence in the validity of the interview data. Of more concern is the issue of translation from Georgian to English. We attempted close translation using the translation-retranslation method, but the tone of the respondents' comments could not be communicated well in English in the limited space of a scientific paper. We therefore elected to take a conservative approach, using paraphrasing as explained in the Methods. However, the complete Georgian transcripts of the interviews are available for independent analysis.

CONCLUSIONS

Greater transparency is needed in tobacco control policy-making in Georgia, to illuminate and prevent tobacco industry interference, and increase responsiveness to public opinion. WHO DG announced in 2013 the End Game policy, which aims to decrease tobacco consumption dramatically, to a maximum of five percent tobacco use prevalence globally by 2050; European countries aim to achieve this goal by 2040.[40, 41] In Georgia, political will must strengthen significantly if the country is to implement international obligations connected to the FCTC and the Tobacco End Game strategy. On a positive note, there is some evidence that policy-makers are now more aware of public support for tobacco control. The new Georgian State Strategy was set in Resolution N196,[42] 30.07.15, and the Resolution highlights recent evidence on the public’s support for tobacco control.[6, 7] The Resolution acknowledges that “public support is important to provide tobacco control measures effectively”. Yet there is reason for skepticism. It is one side of the issue to mention such research results in a policy document, but quite another side is the continued very low level of enforcement of current tobacco control regulations. The public strongly supports tobacco control; will the democratic imperative to listen to the voice of the people propel Georgia to an ever more stringent tobacco control policy, and rigorous enforcement? Georgian democracy is new. There remain challenges to increasing public participation and consultation of public opinion in policy-making processes generally. This is also true in the tobacco control policy arena, where the most important player is still the tobacco industry and not the public interest.

Declaration of competing interests

The authors have no conflicts of interest to disclose.

Declaration of funding sources

The Eurasia Program, administered by the Norwegian Center for International Cooperation in Higher Education and the Norwegian Ministry of Foreign Affairs, provided financial support for first author in the study’s data analysis and report writing phase.

REFERENCES

The influence of public opinion on tobacco control policy-making in Georgia: Perspectives of Governmental and non-governmental stakeholders

https://www.gov.ge/sites/1316


APPENDIX

Extract from questionnaire for tobacco sales restrictions:

A. GENERAL INFORMATION
A1. Name __________________________
A3. How old are you?
AGE OF RESPONDENT IN YEARS: ____ ____ IF THE AGE OF THE RESPONDENT IS NOT
13-70 YEARS, STOP THE INTERVIEW
A4. Gender: 1. Female; 2. Male;
A5. What is your marital status?
1. Married, living with a spouse; 2. Other ___________; 99. Refuse to answer
A6. What is your highest completed education?
1. Low (Primary or Secondary school completed); 2. Middle (College completed);
3. High (University/postgraduate degree completed)
88. Don’t know; 99. Refuse to Answer
A7. Last month what was your household income in GEL
1. Low (100-400 GEL, equal to about 50-200 EURO); 2. Middle (401-800 GEL, equal to about 201-
400 EURO); 3. High (801 and more GEL, equal to about 401 and more EURO); 88. Don’t know; 99.
Refuse to Answer
A10. Would you say that in general your health is
1. Good; 2. Poor; 88. Don’t know; 99. Refuse to answer

B. SMOKING STATUS

Now I will ask you several questions regarding your smoking. As I mentioned before, this
questionnaire is
anonymous, so please answer the questions sincerely, to the best of your knowledge.
B1. Do you currently smoke cigarettes on a daily basis, less than daily, or not at all?
1. Daily; 2. Less than daily (occasional); 3. Not at all; 4. Ex-smoker; 88. Don’t know; 99. Refuse to answer
B2. IF CURRENTLY Less than daily SMOKER: How many days of the week do you smoke on a
TYPICAL
week? _______________
H. RESTRICTION ON SMOKING & ATTITUDES

H1. Are you agree to be implemented the following tobacco sale’s prohibitions:

READ THE RESPONSES, CIRCLE ALL MENTIONED

H1.1. Sale of tobacco products to children under 18
1. Yes; 2. No; 88. Don’t Know; 99. Refuse to answer

H1.2. Sale of tobacco products by children under 18

H1.3. Sale of tobacco products by stick

H1.4. Sale of tobacco products in schools and organizations for children under 18, and around their territories on 50 m. distance

H1.5. Sale of tobacco products in medical organizations

H1.6. Sale of tobacco products with the toys and clothes for children

H3. Do you think that the current policy should include more restrictions on smoking and increase the penalties for violations?
1. Yes; 2. No; 3. Don’t know details about the current law; 88. Don’t know/Hard to say; 99. Refuse to answer

Extract from questionnaire for smoking prohibition and tobacco advertisement ban

A. GENERAL INFORMATION

A1. Name ____________________________

A3. How old are you?

AGE OF RESPONDENT IN YEARS: ___ ___ IF THE AGE OF THE RESPONDENT IS NOT 13-70 YEARS, STOP THE INTERVIEW

A4. Gender: 1. Female; 2. Male;

A5. What is your marital status?
1. Married, living with a spouse; 2. Other ____________; 99. Refuse to answer

A6. What is your highest completed education?
1. Low (Primary or Secondary school completed); 2. Middle (College completed);
3. High (University/postgraduate degree completed)
88. Don’t know; 99. Refuse to Answer
A7. Last month what was your household income in GEL

1. Low (100-400 GEL, equal to about 50-200 EURO); 2. Middle (401-800 GEL, equal to about 201-400 EURO); 3. High (801 and more GEL, equal to about 401 and more EURO); 88. Don't know; 99. Refuse to Answer

A10. Would you say that in general your health is

1. Good; 2. Poor; 88. Don't know; 99. Refuse to answer

B. SMOKING STATUS

Now I will ask you several questions regarding your smoking. As I mentioned before, this questionnaire is anonymous, so please answer the questions sincerely, to the best of your knowledge.

B1. Do you currently smoke cigarettes on a daily basis, less than daily, or not at all?

1. Daily; 2. Less than daily (occasional); 3. Not at all; 4. Ex-smoker; 88. Don't know; 99. Refuse to answer

B2. IF CURRENTLY Less than daily SMOKER: How many days of the week do you smoke on a TYPICAL week? ____________

E. MEDIA (Ask everyone)
Now let’s talk about your knowledge, attitude and experience regarding advertising of tobacco products.

E2. Tobacco companies should not be allowed to offer promotional items (such as t-shirts, free samples of cigarettes, etc.)

1-Strongly agree;
2- Agree;
3-Neither agree nor disagree;
4- Disagree;
5- Strongly disagree

E3. Tobacco and tobacco company advertising in the printing media, on the billboards, sponsorship of sports and cultural events by tobacco companies should be banned

1-Strongly agree;
2- Agree;
3-Neither agree nor disagree;
4- Disagree;
5- Strongly disagree

E4. All tobacco and tobacco company advertising should be banned

1-Strongly agree;
2- Agree;
3-Neither agree nor disagree;
4- Disagree;
5- Strongly disagree

H. RESTRICTION ON SMOKING & ATTITUDES

H2. Please tell me if you think indoor smoking should be allowed in following public places.

H2.1. Government buildings/offices

1. Smoking should not be allowed in any indoor areas;
2. Smoking should be allowed only in some indoor areas;
3. Should not have any rules or restrictions on indoor smoking
H2.2. Medical, educational, sport and cultural facilities
1. Smoking should not be allowed in any indoor areas;
2. Smoking should be allowed only in some indoor areas;
3. Should not have any rules or restrictions on indoor smoking

H2.3. Private workplaces
1. Smoking should not be allowed in any indoor areas;
2. Smoking should be allowed only in some indoor areas;
3. Should not have any rules or restrictions on indoor smoking

H2.4. Restaurants bars and night clubs
1. Smoking should not be allowed in any indoor areas;
2. Smoking should be allowed only in some indoor areas;
3. Should not have any rules or restrictions on indoor smoking

H3. Do you think that the current policy should include more restrictions on smoking and increase the penalties for violations?
1. Yes;
2. No;
3. Don’t know details about the current law;
88. Don’t know/Hard to say;
99. Refuse to answer

Interview guide for in-depth interviews with policy-makers

“As an expert on health policy, can you please tell me what are the main forces that shape public health policy in Georgia?” Then go on:

Please think about how your professional staff members assist you in public health policy making. Are there certain health policy issues wherein staff contributions to policy making are particularly helpful to you, or less helpful? influential or not particularly influential? What are the particular health concerns where staff input really helps you to decide your position? Thank you! Can you please say some more about that?

Please think about how lobbyists assist you in public health policy making. Are there certain health policy issues wherein lobbyists are particularly helpful or less helpful? influential or not particularly influential? What are the particular health concerns where lobbyists’ input really helps you to decide your position? Thank you! Can you please say some more about that?

Please think about how doctors and other health professionals assist you in policy making. Are there certain health policy issues wherein they are particularly helpful or less helpful? influential or not particularly influential? What are the particular health concerns where their input really helps you to decide your position? Thank you! Can you please say some about that?

Please think about how patients’ special interest groups assist in policy making. Are there certain health policy issues wherein they are particularly helpful or less helpful? influential or not particularly influential? What are the particular health concerns where their input really helps you to decide your position? Thank you! Can you please say some about that?

Please think about how medical equipment manufacturers and drug companies assist in policy making. Are there certain health policy issues wherein they are particularly helpful or less helpful? influential or not particularly influential? What are the particular health concerns where their input really helps you to decide your position? Thank you! Can you please say some about that?

Please think about how public opinion, for example as measured in opinion polls, assists you in policy making. Are there certain health policy issues wherein public opinion is particularly helpful or less helpful? influential or not particularly influential? What are the particular health concerns where
their public opinion really helps you to decide your position? Thank you! Can you please say some about that?

Please think about how newspapers, radio and TV inform you about public health policy issues. Are there certain health policy issues wherein mass media news is particularly helpful to you, or less helpful? influential or not particularly influential? What are the particular health concerns where information in the mass media really helps you to decide your position? Thank you! Can you please say some more about that?

Thank you, I am very near the end, I realise you are quite busy! Just these last few questions... In your expert view, how much do the ideas, beliefs, opinions and political influence of these groups influence health policy making in Georgia?

*Family planning?* [staff, lobbyists, health professionals, patient interest groups, manufacturers and drug companies, public opinion, media]

*Restricting harm due to tobacco?* [staff, lobbyists, health professionals, patient interest groups, manufacturers and drug companies, public opinion, media]

*Traffic safety?* [staff, lobbyists, health professionals, patient interest groups, manufacturers and drug companies, public opinion, media]

*Safe water supply and public sanitation?* [staff, lobbyists, health professionals, patient interest groups, manufacturers and drug companies, public opinion, media]

*Control of illegal drugs?* [staff, lobbyists, health professionals, patient interest groups, manufacturers and drug companies, public opinion, media]

Now, I have just about come to the end, but I must ask you... are there any important questions I should have asked you, to gain a better understanding of how public health policy making happens in Georgia? And if so, what answers are you able to provide?
Ethical committee decisions

05.11.2007

Ethics Committee Approval Letter

To: Dr George Bakhturidze (PI)
FCTC Implementation and Monitoring Center in Georgia

Dear Dr Bakhturidze,

The Ethics Committee (EC) of the Georgian Health Promotion and Education Foundation reviewed and discussed your application and documents (dated: 12.10.2007) to conduct the survey entitled: Population Survey on Tobacco Economy and Policy in Georgia on 5th November 2007.

We approve the survey to be conducted in presented form.

The Ethics Committee expects to be informed about progress of the study, any changes in the study protocol and participants consent form should be notified to EC.

Please provide a final study report to the EC at the end.

We confirm that none of your study staff member was present during the decision-making/voting procedures of this meeting.

Yours sincerely,

Gela Kobkashvidze
EC Chairman
Ethics Committee Approval Letter

To: Dr George Bakhturidze (PI)
FCTC Implementation and Monitoring Center in Georgia

Dear Dr Bakhturidze,

The Ethics Committee (EC) of the Georgian Health Promotion and Education Foundation reviewed and discussed your application and documents (dated: 02.03.2013) to conduct the qualitative study entitled: The nature of the relationship between public opinion and policy-making in the public health arena: Experience of Georgian policy-makers, bureaucrats and advocates on 17th March 2013.

We approve the study to be conducted in presented form.

The Ethics Committee expects to be informed about progress of the study, any changes in the study protocol and participants consent form should be notified to EC.

Please provide a final study report to the EC at the end.

We confirm that none of your study staff member was present during the decision-making/voting procedures of this meeting.

Yours sincerely,

Simon Gabrichidze
EC Chairman