The Great Tobacco Conspiracy

EXPOSED!

Tobacco Kills

Don't be duped

World Health Organization
South-East Asia Region


FREEDOM FROM TOBACCO

Message from Dr Uton Muchtar Rafei, Regional Director WHO South-East Asia Region

Tobacco is the only consumer product that kills when used as intended by the manufacturer. Currently, tobacco kills 4 million people a year globally. By 2020, tobacco is predicted to become the leading cause of death and disability, killing 10 million people every year, 70% of them in developing countries. Tobacco-related mortality and disease burden in the WHO South-East Asia Region are already unacceptably high. Unless systematic and sustained action is taken now, the situation is bound to get aggravated.

The good news is that reliable and effective measures to reduce tobacco use are available. The bad news is that these measures are only partially adopted and implemented in SEAR countries. The tobacco industry seems to have influenced many governments to believe that effective control measures will be detrimental to their economies. This deception must be exposed.

Tobacco is a socioeconomic and developmental issue and, as such, should not be left to health professionals alone. Tobacco control encompasses many areas, including law, economics, environment, as well as the media. A large-scale collaborative effort is urgently needed to address the problem. Multi-sectoral collaboration and integrated strategies are imperative. Sectors, including the government, NGOs, and the private sector, should realize that tobacco control ultimately benefits all substantially.

Many professionals, have key roles to play in tobacco control. Mediapersons should realize how the tobacco industry used them to create misconceptions. They must expose the ploys of the tobacco industry to delay effective action to reduce tobacco consumption and, at the same time, highlight the magnitude of tobacco-related harm. Economists should present the benefits of tobacco control measures on government revenue, employment, productivity and the cost of health care. Legal experts should actively lobby for effective legislation and implementation of existing laws that protect all individuals. Together, we should act to save the millions of children who are today the main target of the tobacco industry.

This information package highlights the magnitude and dimensions of the problem, the strategies that can be adopted to address them and some of the obstacles to effective tobacco control. Most of all, it provides information for advocacy and action by countries to help stem the epidemic caused by tobacco consumption before it is too late.

Industry efforts to expand tobacco aggravates health problems

Global patterns

Of the nearly 1.15 billion smokers in the world today, low and middle-income countries account for 82% of all smokers. While smoking prevalence is declining steadily in most high income countries, the tobacco epidemic is expanding in developing countries.

Tobacco use presently causes four million deaths everywhere, worldwide - around 11,000 deaths every day. The number of deaths in the next three decades are projected at 10 million annually. 70% of these will occur in developing countries.

Patterns in WHO South-East Asia Region

Tobacco consumption

The South-East Asia Region has consistently had the second highest (2.8%) annual growth rate in adult per capita cigarette consumption among the six WHO Regions.

India and Indonesia rank third and seventh respectively among the leading producers of unmanufactured tobacco in the world. Indonesia has the fourth largest number of smokers in the world, while in India and Thailand it has been estimated that there are approximately 240 million and 11 million tobacco users respectively. In Bangladesh there are an estimated 20 million smokers, 5 million of them women.

In the Region, tobacco is used in many forms and in a variety of social and cultural contexts. Cigarettes account for less than one-third of the total tobacco consumption in the Region. Also consumed are *bidis*, *keeyos*, cigars, cheroots, *chutta*, *hookahs*, *pan*, *pan-masala*, *mawa*, creamy stuff, *gundi*, *mishri*, *gudhaku*, betel-quid, and snuff, among others.

Disease burden

Nicotine levels of up to 3.2 mg and tar levels of up to 50 mg have been reported in tobacco products (eg. *bidis, kreteks* and white cigarettes) in the Region. In many developed countries, the accepted levels are less than 1.4 mg of nicotine and 15 mg of tar. Consequently tobacco causes more damage to smokers in the Region.

Tobacco-related illnesses such as cancer, cardiovascular diseases and respiratory diseases are already major problems in most countries. There are an estimated 12 million cases of preventable tobacco related illnesses each year in India. Approximately half of all cancers in men in India are tobacco related, while over 60% of those suffering from heart disease below the age of 40 years are smokers. In Sri Lanka, it is estimated that over 43% of reported cancers are tobacco related. Oral cancer is the most prevalent form of cancer in Sri Lanka and cardio-vascular disease is the leading cause of death.Thailand reports 10,000 cases of tobacco related lung cancers each year, while 70% of those treated for acute heart attack in Bangladesh are smokers.

In India, tobacco attributable mortality has been estimated to be around 600,000 per year while in Indonesia, it was estimated to be 192,000 in 1992. Tuberculosis, already widely prevalent in the Region, has been shown to be further exacerbated by tobacco use.

Countries in the Region are already coping with a double burden of disease – both communicable and noncommunicable. The projected increase in tobacco related illnesses will mean that the already overstretched health care systems of countries will have to handle an ever increasing disease burden, which may affect the efficiency of the health services.

Targeting Youth

The tobacco industry has been targeting youth for decades. In the words of a Philip Morris executive: **"hitting the youth can be more efficient even though the cost to reach them is higher, because they are willing to experiment, they have more influence over others in their age group than they will later in life, and they are far more loyal to their starting brand."**

The search for new, young smokers was not only conducted by Philip Morris. The tobacco industry is aware that to maintain and increase their sales, they need to ensure that more people start smoking. The industry needs to lure new smokers to replace the ones who die due to tobacco use. 11,000 new tobacco users are needed each day, to replace those that die, to keep the sales of the tobacco industry intact.

The younger the age when smoking begins, the longer the smoking cycle. Young persons are also more vulnerable because they are likely to be less aware of the addictive nature of nicotine and the harmful effects of tobacco consumption.

In most developing countries, including countries of WHO South-East Asia Region, a significant percentage of the population belongs to the adolescent and younger age groups. It is established that almost all tobacco users commence use before the age of 18 years. Therefore the young in developing countries are now increasingly being targeted by the tobacco industry to increase sales, in order to offset their losses in the developed countries.

The number of adolescents using tobacco in the Region is already a cause for concern.

- India reports 5 million child smokers with 55,000 children starting regular tobacco use every year.
- Thailand reports 52,000 of those less than 20 years starting to smoke every year.

- In Indonesia, a 1995 survey showed one-third of school children between the ages of 15 and 19 years smoke. Based on this trend it has been estimated that 2.5 million out of the 8.5 million children in Indonesia will become regular smokers.
- In Myanmar, a survey in 1993 found that 44.6% of urban school children consumed tobacco.
- In 1997, a survey among school children in Bangladesh showed that 23% of those in the 15-16 year age group smoked.
- In Sri Lanka, a survey in 1992 found that over 15% of those who smoked some time in their lives, had their first smoke by the age of 11 years.

By the time young persons become young adults and realize that they have become dependent on tobacco, it is already too late.

Many children are conditioned to perceive smoking as glamourous, sophisticated, an adult habit, a status symbol and a sign of rebelliousness through tobacco advertising and sponsorships.

A study carried out in India showed that despite a high level of knowledge about the adverse effects of tobacco, cricket sponsorship by tobacco companies increased children's likelihood of experimentation with tobacco, creating false impressions between smoking and sport.

Many marketing strategies that target young people have been prohibited in developed countries. But, the industry keeps on targeting children in developing countries.

Only powerful advocacy combined with appropriate and effective policies and legislation can protect our vulnerable youth against the huge onslaught of tobacco advertisIng and promotion.

Deception by the tobacco industry

The tobacco industry has known of the dangers of tobacco for a long time. Yet they have consistently denied this. Over the years the tobacco industry has built up a powerful lobby in most countries that has influenced all efforts to curb tobacco use. The disparity between what they knew, what they said and what they did is deplorable.

1. What they said: "Health effects of tobacco are not proven"

What they knew:
An internal document from as far back as 1953 states:
"Studies of clinical data tend to confirm the relationship between heavy and prolonged tobacco smoking and incidence of cancer of the lung."

C. Teague. RJ Reynolds. Survey of Cancer Research with Emphasis Upon Possible Carcinogens from Tobacco. 1953. 2 February (Source: Action on Smoking and Health. Tobacco Explained. The truth about the tobacco industry in its own words. ASH, UK 1998)

2. What they said: "Tobacco is not addictive"

What they knew:
"Nicotine is addictive. We are, then, in the business of selling nicotine, an addictive drug."
Addison Yeaman from Brown and Williamson, 1963

A. Yeaman, Implications of Battelle Hippo 1 & 11 and the Griffith Filter, 1963, 17 July, Memo (1802.05) (Source: Action on Smoking and Health. Tobacco Explained. The truth about the tobacco industry in its own words. ASH, UK 1998)

3. What they said: "Smoking is an adult choice and freedom of choice should be respected"

What they knew:
A Former scientist of British American Tobacco indicates:
"It has been suggested that cigarette smoking is the most addictive drug. Certainly large numbers of people will continue to smoke because they can't give it up. If they could they would do so. They can no longer be said to make an adult choice."

Dr S J Green, Transcript of Note By SJ Green, 1980, 1 January [Pollock 129] (Source: Action on Smoking and Health. Tobacco Explained. The truth about the tobacco industry in its own words. ASH, UK 1998)

4. What they said: "Advertising does not increase consumption"

Emerson Foote, former Chairman of McCann-Erickson, which handled US$20m of tobacco industry advertising accounts asserts:

" I am always amused by the suggestion that advertising, a function that has been shown to increase consumption of virtually every other product, somehow miraculously fails to work for tobacco products."

L. Heise, Unhealthy Alliance, World Watch, 1988, October, p20. (Source: Action on Smoking and Health. Tobacco Explained. The truth about the tobacco industry in its own words. ASH, UK 1998)

5. What they said: "We do not market our products to children"

What they did:
Dave Goerlitz, lead model for RJ Reynolds for seven years, says his marketing brief was to:

"attract young smokers to replace the older ones who were dying or quitting ...I was part of a scam, selling an image to young boys. My job was to get half a million kids to smoke by 1995".

J. di Giovanni, Cancer Country - Who's Lucky Now?, The Sunday Times, 1992, 2 August, p12 (C 7.5) (Source: Action on Smoking and Health. Tobacco Explained. The truth about the tobacco industry in its own words. ASH, UK 1998)

Terence Sullivan, a sales representative in Florida for RJ Reynolds, laments:
"We were targeting kids, and I said at the time it was unethical and maybe illegal, but I was told it was just company policy."

PJ Hilts, Smokescreen - The Truth Behind the Tobacco Industry Cover-Up, 1996, Adison Wesley, 96-8 (Source: Action on Smoking and Health. Tobacco Explained. The truth about the tobacco industry in their own workds. ASH, UK 1998)

Policy makers can make a judgement on the tobacco industry by looking at the industry's own documents and statements from those who worked for the industry.

Debunking the tobacco industry's economic arguments

The tobacco industry has argued for decades that curtailing its growth, production and sale would be detrimental to national economies. These are all lies, and the industry knows it. Consider the real facts:

The tobacco industry argues that it brings substantial revenues to governments:
Econometric studies undertaken by the World Bank have established that tobacco is a net loss to almost all economies. While the money that the governments collect on excise and taxes may be substantial, the direct and indirect losses caused by tobacco consumption are, indeed, much larger.

Consider the high direct costs of medical care for tobacco related illnesses, absenteeism from work, loss of productivity and related income loss, premature deaths, and the perpetuation of poverty.

Then there are other substantial costs. These include the cost of reduced quality of life for smokers, and all those affected by second hand smoke, as well as the suffering of those who have to face the loss of a loved one in the prime of their lives.

The cost to economies:
In India, the cost of major diseases due to tobacco use such as cancers, heart disease and respiratory diseases in 1999 was estimated to be US$ 6.5 billion. This was more than the sales value of all tobacco products in the country, and considerably more than the tobacco taxes.

The cost to individuals and families:
It is estimated that in some countries of the South-East Asia Region, persons of the low socioeconomic group may spend as much as a third of their income on tobacco products. This accentuates other consequences of poverty such as lack of education, basic sanitary facilities and malnutrition.

The industry argues that increasing taxes on tobacco will reduce government revenue.

On the contrary, increased tobacco taxes can, in fact result in:

- Increase in government revenue.
- Significant decrease in smoking by poorer socio-economic groups.
- Significant decrease in smoking among young people.
- Delayed onset of smoking by young people.
- Reduced consumption by current smokers.
- Decrease in the number of ex-smokers restarting use.

The tobacco industry claims that measures to control tobacco consumption will reduce the number of jobs in a country:

There is no correlation between cigarette production and the employment generated. As has been demonstrated in several European countries, if the number of jobs in the tobacco industry decreases in the near future, it will be more because of mechanization and increased productivity rather than effective tobacco control measures.

Econometric studies have also shown that even if the tobacco industry was totally eliminated, there would be hardly any negative impact on a country's economy. This is because the money spent on tobacco will be spent instead on other products and services, which will generate a greater demand for those products and services, which, in turn, will generate more employment. A study in Bangladesh estimated that there would be a net increase of 18.7% in the number of jobs if all tobacco consumption was eliminated in that country.

The tobacco industry claims that increase in cigarette prices will increase smuggling:

The issue of smuggling is used by the industry to stop governments from increasing tobacco prices. However it has been demonstrated that the magnitude of smuggling to a country does not depend on the level of taxation alone. In some countries with high taxes, smuggling is rare, while in some countries with low taxes smuggling is common. In some cases, manufacturers themselves encourage smuggling because smuggled cigarettes are cheaper than taxed ones and they can, thus, realise higher profits.

Tobacco industry does not spare the ecology, either.

A healthy environment is a pre-requisite for healthy lives. Factors that threaten the environment and bio-diversity in fact, threaten the lives of all living beings. The environment should be considered an asset by countries. Even if countries in the Region are poor economically, they are still wealthy in terms of nature and natural resources. Therefore, environmental consequences of tobacco should be taken seriously to prevent further losses to the natural riches of the countries.

The cost of tobacco should not only be measured in terms of human lives lost or affected. **Other losses are due to deforestation, soil erosion, and the direct and indirect effects of chemicals used for tobacco cultivation.**

It has been documented that globally an estimated 200,000 hectares of forests and woodlands are destroyed by tobacco production each year. Unfortunately, deforestation due to tobacco mainly occurs in developing countries.

It is estimated that every year, 7000 billion tonnes of paper is used for wrapping cigarettes. However, according to the tobacco industry's reports, this accounts for only 16% of the industry's overall use of forest resources.

Curing accounts for the major portion of the tobacco industry's exploitation of wood, with 69% of wood being consumed as fuel wood used for curing, and 15% used for construction of curing barns.

Studies from various regions show that more than 10 kg of wood is needed to cure I kg of virginia tobacco. For countries in WHO's South-East Asia Region, the fuel wood-deficits are estimated to be very high. The situation is aggravated by the increasing production of tobacco, leading to severe deforestation with serious ecological consequences such as loss of bio-diversity and soil erosion.

In Bangladesh, the use of wood for tobacco production alone is estimated to be responsible for over 30% of the annual deforestation.

Tobacco depletes soil nutrients faster than other crops, particularly where soils are characterized by their low nutrient content. This should be an important consideration in countries of this Region. When tobacco is cultivated on the same land repeatedly with minimal rotation, there is a tendency for soil to become exhausted, and for crop pests to become endemic. These are some of the reasons why tobacco cultivation requires high inputs of hazardous pesticides and chemical fertilizers.

The large workforce of women and children engaged in tobacco cultivation in the Region are not equipped to be protected from occupational health hazards arising from exposure to pesticides. Exposure in early life can lead to a range of problems including mental impairment, damage to the nervous system, reproductive defects and cancer. In addition, these chemicals remain in the water table and are hazardous to the health of rural populations.

Moving away from tobacco farming

Though there are many who may argue that diversification from tobacco farming is not viable, pilot projects on alternative crops have been successful. A Tobacco crop-substitution programme was launched in Bangladesh by the Bangladesh Cancer Society to reduce local dependence on tobacco cultivation as a means of livelihood. It was also used as a key strategy for the primary prevention of tobacco-related cancers. It started with a modest project in a rural community of 15,000 people in Kushtia district where tobacco cultivation was widespread, and three quarters of adults were tobacco users.

Three years later, in 1992, studies indicated that the prevalence of tobacco use had fallen dramatically from baseline levels. The crop substitution programme too had been successful and the new crops were yielding better profits. In addition, new employment opportunities had also been generated. So, there are viable options for alternative livelihoods.

Tobacco industry strategies to lure women

Women are being increasingly targeted by the tobacco industry in their effort to shore up their declining sales graphs, particularly in developing countries. Sophisticated marketing strategies are being used by the tobacco industry targeted at women. Even in the West, trends show that while tobacco use is actually declining among men, it is steadily increasing among women. The industry promotes "female" brands, and tries to tempt younger women.

A journal of the tobacco trade, *Tobacco Reporter*, gave its vision of the future, in 1982:

" ... Women smokers are likely to increase as a percentage of the total. Women are adopting more dominant roles in society: they have increased spending power, they live longer than men. And as a recent official report showed, they seem to be less influenced by the anti-smoking campaigns than their male counterparts.

The tobacco industry has long been researching on how best to use advertising imagery to market to women. An RJ Reynolds study showed that

"With the exceptions of career women and single women who work to support themselves, all female segments in the present study reacted positively to advertising imagery associated with the following dimensions: intimacy and closeness, tenderness and gentleness, loving, caring, sharing. .... Career women reacted most positively to imagery associated with elegance and success."

Compared to other WHO Regions, the prevalence of tobacco use among females may seem relatively low in percentage terms, but in actual terms, these low rates translate into millions of users.

- In Bangladesh it is reported that over 5 million women smoke. Between 1980 and 1993, smoking prevalence among men decreased from 67% to 60%, but the prevalence among women increased fifteen fold
- In India it is estimated that 45 million women use tobacco.

- In Nepal, a 1988 study showed that 71.7% of the women in a high mountain area (Jumla), and 58.9% of the women in the plains (Terai), smoked.
- The incidence of lung cancer in women in the northern part of Thailand is among the highest in the world. A link with tobacco smoking is suggested by similarly raised rates in women, of cancers of the larynx and pancreas.
- According to a 1997 national survey in Maldives 29.4% of females over 16 years of age smoked.
- Sri Lanka and Indonesia report relatively low levels of tobacco use among women.

In addition to these tobacco related problems that both men and women suffer from, women suffer from gender-specific problems:

Tobacco use puts women at greater risk of breast cancer and cervical cancer. Women are also more prone to premature menopause, unsuccessful pregnancy and impaired fertility. Oral contraceptives combined with smoking also increases the risk of heart disease and stroke in relatively younger women. Female smokers are more susceptible to osteoporosis or "brittle bones". In India, where betel quid chewing is widespread among women, oral cancer is more common among women than breast-cancer, and tobacco-related cancers account for one-fourth of cancers among women.

Women who smoke during pregnancy also expose their unborn child to the effects of nicotine and other constituents of cigarettes. Cigarette smoking is a leading cause of underweight newborns. Maternal smoking during pregnancy may also adversely affect the child's long term growth, intellectual development and behavioural characteristics.

Preventing any further increase in cigarette consumption and reducing tobacco use among women could be one of the most cost-effective means to alleviate the burden of noncommunicable diseases and poor reproductive health outcomes among women in the WHO South-East Asia Region, now and in the future.

Actions that can reduce tobacco use and tobacco-related harm

Despite the grim picture of the current status of tobacco use and tobacco-related harm in the Region, there is good news. This relates to the tried and tested measures that reduce tobacco consumption and tobacco-related harm. Some tobacco control measures that have been implemented in the countries of the South-East Asia Region include:

- Bangladesh has banned tobacco advertising in most media.
- Bhutan has declared seven of its districts tobacco free.
- In India, tobacco advertising is banned in state controlled media and health warnings are mandatory. The capital territory of Delhi has banned cigarette sales to minors and smoking in public places and in government buildings.
- Tobacco advertising is banned in Maldives with several islands declared tobacco free.
- In Myanmar, tobacco advertising in electronic media is not permitted and health warnings are mandatory.
- Nepal has designated a part of the tobacco tax collected to health promotion including tobacco control activities. There is also a ban on tobacco advertising in the electronic media, and health warnings are mandatory.
- No-smoking flights on both domestic and international flights have been introduced in some countries including India, Indonesia and Thailand.
- Both government and nongovernmental organizations are actively involved in demand reduction programmes at the community level in some countries.

Unfortunately, the impact of these measures have been limited. **A range of measures implemented in tandem, within a comprehensive tobacco control policy to reduce tobacco consumption backed by legislation, is imperative. Two countries of the Region, Thailand and Sri Lanka have adopted comprehensive tobacco control policies.** There is an urgent need for other countries also to adopt a comprehensive national strategy for tobacco control.

The strategy should include, among others, the following:

1. Setting up a National Multisectoral body

Implementation of action on tobacco control should not be considered the responsibility of a single or a few government agencies. A multisectoral body which could provide direction and mobilize necessary support and resources of other sectors for tobacco control should be set up to coordinate and facilitate tobacco control action at the country level.

2. Health promotion and health education

Tobacco control measures require strong public support for effective implementation. Therefore education on issues related to tobacco is essential to create social environments supportive of the adoption of comprehensive tobacco control policies, supported by relevant cessation programmes.

3. Adopting appropriate fiscal measures

Tax increases will reduce smoking in the poorer socio-economic groups who bear a heavier disease burden, reduce smoking among the young, delay the onset of smoking by the young, reduce consumption by current smokers, and reduce the number of ex-smokers restarting use. Regular increase of taxes will reduce the affordability of all types of tobacco products.

4. Setting up a Health Promotion Fund, based on a levy on tobacco products

A specific tax on the sale price of tobacco products should be instituted to ensure the financial sustainability of tobacco control programmes. In our Region, Nepal imposed such a health promotion tax several years ago. Thailand has also taken steps to initiate such a fund.

5. Discontinuation of advertising, promotions and sponsorships

All direct and indirect advertising, promotions and sponsorships used to attract young smokers, increase consumption of those already consuming tobacco and delay cessation of use should be banned. Evaluations indicate that significant and sustained reductions in smoking occur following such restrictions.

6. Restricting availability and accessibility of tobacco products

Restricting the availability and accessibility of tobacco products is an approach to lower the rates of initiation to tobacco use. This means disallowing sales of tobacco products in and around venues meant primarily for young people, restricting vending machines that dispense tobacco products and banning production and sale of specific tobacco products. A minimal age for smoking should also be strictly implemented, evaluated and strengthened.

7. Adopting measures for consumer protection

Serious attention needs to be paid to providing prominent, precise consumer protection information on tobacco products. Other information such as tar and nicotine levels, disclosure of ingredients and additives should also be made mandatory.

8. Protecting health of non-users

Prolonged exposure to environmental tobacco smoke (ETS) causes tobacco-related diseases in children and non-smoking adults. Tobacco-free environments should therefore be created in public places, in public transport, at work places and in homes.

9. Providing support for tobacco users to quit

If even a small proportion of the hundreds of millions of current users cease tobacco use, substantial short and long-term health and economic benefits will accrue. Therefore, cessation of tobacco use is one of the most important areas that need to be addressed.

10. Addressing smuggling and illicit production

Smuggling and illicit production are issues that needs to be addressed by individual countries as well as by countries in the Region as a group.

11. Continuing research

Operational research including quantification of the magnitude of consumption, and consequences of tobacco use, environmental consequences, monitoring trends in consumption, research on behavioural pathways, assessing the impact on vulnerable groups, advocacy research and evaluation of tobacco control interventions, should be given priority.

12. Supporting the Framework Convention on tobacco control

Member Countries should actively participate in the development and negotiation of the WHO Framework Convention on Tobacco Control and related protocols, and its subsequent implementation.

13. Provision of alternative livelihoods

Governments must plan for agricultural diversification and diversification from agriculture to other livelihoods in the long term, to address fears of long or short-term loss of jobs.

Tobacco use can be reduced only by adopting and implementing a comprehensive range of measures concurrently.

Environmental tobacco smoke endangers nonsmokers also

There is growing evidence that connects exposure to smoking with a higher risk of mortality. Scientists have found over the past two decades that Environmental Tobacco Smoke (ETS) effects the health of non-smokers living or working around people who smoke. So the tobacco industry's quest to recruit more smokers will cause many more deaths of people other than tobacco users. ETS is made up of toxic and carcinogenic agents which are emitted primarily from the burning end of a tobacco product as the smoker waits to take the next puff. This is called side-stream smoke. ETS also consists of mainstream smoke, which is exhaled by the smoker.

WHO estimates that about 700 million children, almost half of all children worldwide, live in a home where one parent is a smoker. The tragic impact of ETS on child health translates into a huge burden as:

Children exposed to environmental tobacco smoke:

- Suffer more coughs and colds and from more lower respiratory tract infections such as bronchitis and pneumonia
- have an increased chance of developing asthma, triggering off or making existing asthma worse
- have an increased risk of developing middle-ear infections which can lead to reduced hearing
- are at increased risk of lymphoma (cancer of white blood cells) and brain tumors during childhood

Smoking during pregnancy significantly increases the chances of:

- the infant dying of sudden infant death syndrome
- spontaneous abortions
- delivering a pre-term baby
- delivering a low birth-weight baby
- impairing the child's long term growth and intellectual development.

In Nepal, the high incidence of respiratory tract infection among children under five years is linked with smoke from cigarettes and cooking in enclosed areas. Environmental tobacco smoke and maternal smoking compromises the health of children even before they are born, of growing children living among a constant cloud of smoke in their environment, and of adults exposed to ETS in their living or working environment.

Studies carried out in 25 different worksites in the USA in 1997 concluded that non-smokers working in ETS choked environments have a double risk of developing lung cancers and heart diseases than their non -smoking counterparts who are not exposed to ETS.

The US Environment Protection Agency concludes that ETS is a Class A carcinogen. It estimates that ETS is responsible for 3000 lung cancers annually among non-smokers in USA, whilst contributing up to 300,000 cases annually of respiratory illness in infants and children younger than 18 months. Currently, an estimated 45,000 deaths each year due to heart diseases among non-smokers are attributed to passive smoking.

- The USA spends US$ 1 billion every year for ETS-related health problems.
- In the South-East Asia Region, the nicotine and tar levels of cigarettes, *bidis*, and *kreteks* are high.
- Laws banning smoking in public places are not well enforced.
- There is a general lack of laws prohibiting smoking in overcrowded and enclosed working and dwelling spaces.
- The knowledge and awareness of the harmful effects of environmental tobacco and cooking smoke is sparse.

All these factors put non-smokers at higher risk of tobacco-related diseases.

There is therefore an urgent need to highlight strong public policies to protect non-smokers and children from exposure to tobacco smoke.

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