eurocare

European Alcohol Policy Alliance

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The European Alcohol Policy Alliance (EUROCARE) is an alliance of non-governmental and public health and well-being organisations. It advocates the prevention and reduction of alcohol related harm in Europe through effective and evidence based alcohol policy. www.eurocare.org

EUROCARE

The European Alcohol Policy Alliance

EUROCARE

Eurocare is an alliance of non-governmental and public health and well-being organisations with around 50 member organisations across 21 European countries. Eurocare is not affiliated and does not receive any funding from the alcohol industry or any of its social aspect organisations.

Member organisations are involved in research and advocacy, as well as in the provision of information to the public; education and training of voluntary and professional community care workers; the provision of workplace and school based programmes; counselling services, residential support and alcohol-free clubs for problem drinkers; and research and advocacy institutes.

VISION

Eurocare's vision is a Europe where alcohol related harm is no longer one of the leading risk factors for ill-health and premature death. A Europe where innocents no longer suffer from the drinking of others and where the European Union and its Member States recognise the harm done by alcohol and apply effective and comprehensive policies to tackle it.

MISSION

Eurocare's mission is to prevent and reduce alcohol related harm in Europe. To that end, Eurocare seeks to:

- Monitor all EU policy developments that have an impact on national alcohol policies
- Promote the development and implementation of policies that are effective and evidence-based
- Engage in dialogue with decision makers to ensure that the harms caused by alcohol (social, health and economic burden) are taken into consideration in all relevant policy discussions
- Facilitate the collection, collation, analysis, dissemination and utilization of data on alcohol consumption and related harm within the EU and other countries
- Create and nurture alliances between organisations concerned with alcohol related harm

RECOMMENDATION

There is a mass of evidence that the levels of alcohol related harm in any population are correlated with the overall level of alcohol consumption: higher per capita consumption tends to be associated with higher levels of harm, lower consumption with lower levels of harm .

Eurocare recommends that the target for the EU should be reduction of total alcohol consumption in Europe by 2020, from an average of 12.5 litres to 9 litres per adult per year.

Alcohol is no ordinary commodity - less is better

JOIN US

New members are always welcome to join Eurocare. Send us an email to get more information

info@eurocare.org

A Cause for Action

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Alcohol is the 3rd leading cause of ill-health and death in the EU

Alcohol is one of the world's leading health risks

- Europe is the heaviest drinking region of the world.
- Consumption levels in some European countries are around 2.5 times higher than the global average.
- Alcohol is one of the top 4 risk factors for non-communicable diseases (NCDs), and
- The World Economic Forum's 2010 Global Risks Report identifies NCDs as the second most severe threat to the global economy in terms of likelihood and potential economic loss.

Alcohol harms you

- Alcohol is one of the 4 top risk factors for developing NCDs such as cancer and cardiovascular disease.
- Alcohol is a toxic substance in terms of its direct and indirect effects on a wide range of body organs and systems and a cause of some 60 diseases.
- 23 million people in the EU are dependent on alcohol.
- Use of alcohol is especially harmful for younger age groups.

Alcohol harms others

- 9 million children and young people in the EU living with at least one parent addicted to alcohol.
- Approximately 30 000 Europeans are killed on the roads yearly. Around one accident in four can be linked to alcohol consumption, and at least 10,000 people are killed in alcohol-related road accidents in the EU each year.
- Drinking alcohol during pregnancy can lead to birth defects and developmental disorders. It may cause the unborn child physical, behavioural and learning disabilities.
- There is a strong link between alcohol and violence. In some countries, as much as 80% of violent crimes committed by adolescents are associated with alcohol use.

Alcohol harms society

- Alcohol is the world's number one risk for ill-health and premature death for the core of the working age population (25-59 year).
- A 13% increase in work absence can be expected with an increase in consumption of 1 liter pure alcohol.
- NCDs are estimated to cause a €25 trillion global economic output loss over the period 2005-2030.
- The social cost attributable to alcohol is 155,8 billion Euro yearly.

Conclusions of the EU Roundtable on an Integrated Approach to Alcohol Related Harm

Three EU Roundtable meetings on an Integrated Approach to Addressing Alcohol Related Harm were held in Brussels in November 2011, May 2012 and January 2013, and MEP Nessa Childers (S&D, IE) chaired the third Roundtable. The concept of the Roundtable was initiated during discussions with the European Commission and other stakeholders active in this area (including physicians, patients and families affected by alcohol related harm) with the aim of bringing together likeminded stakeholders for an exchange of views on alcohol consumption, alcohol use disorders (AUDs), and the policy measures needed to reduce alcohol related harm. The EU Roundtables on an Integrated Approach to Alcohol Related Harm were facilitated by Lundbeck.

SIGNED (IN ALPHABETICAL ORDER)

Alcohol Concern
Making Sense of Alcohol

www.alcoholconcern.org.uk

EASL
EUROPEAN ASSOCIATION FOR THE STUDY OF THE LIVER

www.easl.eu

European Liver Patients Association
ELPA

www.elpa-info.org

emna

www.emna.org

EUFAMI
EU years

www.eufami.org

eurocare
European Alcohol Policy Alliance

www.eurocare.org

Lundbeck

www.lundbeck.com

Conclusions of the EU Roundtable on an Integrated Approach to Alcohol Related Harm

ALL THE SIGNATORIES OF THESE CONCLUSIONS:

Support the renewal of the EU alcohol strategy and believe that it should encompass an integrated approach to addressing alcohol related harm for Europe, which would entail provisions to encourage the prevention, early diagnosis and treatment of alcohol use disorders (AUDs) and support the individuals and families suffering from the harmful effects of excessive alcohol consumption.

Although National Alcohol Strategies and the EU Alcohol Strategy[i] have made progress in addressing alcohol related harm, the problem of excessive alcohol consumption and the negative effect it has on those suffering from AUDs, on their families and to society as a whole, remains an overwhelming public health challenge that should be tackled through targeted, evidence-based policy measures.

In light of:

- The overwhelming social stigma of people suffering from AUDs and related harm, which results in extremely worrying levels of under recognition, detection and treatment of AUDs;
- New data published in 2012 on alcohol consumption and the value to society and individuals of reducing alcohol consumption to address the burden caused by alcohol in Europe[ii];
- Data on prevention[iii];
- Data on the low diagnosis[iv] and treatment rates[v] of alcohol dependence in Europe;
- Available data which estimates the social costs attributable to alcohol at €155.8 billion in Europe in 2010[ii];
- Scientific evidence showing that alcohol is a small molecule that easily penetrates the brain[vi] and affects the individuals' motivational / reward system in a way that can lead to dependence[vii viii ix];
- The Global status report on alcohol and health[x] that shows that alcohol is also a major risk factor for more than 60 major types of diseases and injuries and a component cause in 200 others, including alcoholic liver disease (ALD), neuropsychiatric disorders and AUDs such as alcohol dependence, cardiovascular diseases (CVDs), Fetal Alcohol Spectrum Disorders (FASD), cancer, diabetes;

All signatories agree that an integrated policy approach to addressing alcohol related harm should include the following components:

DATA COLLECTION

An integrated and comprehensive approach to alcohol policy interventions rests on sound evidence. Data on alcohol consumption, its burden and the related direct and indirect costs across the EU must therefore be improved. There is a need for standardised condition coding and data collection systems in order to improve the ability to compare, disseminate and replicate studies across the EU[xi xii xiii]. In addition, effective monitoring systems to assess the impact of existing policies are needed.

PREVENTION

There is a clear need to increase efforts to prevent excessive alcohol consumption as it is the second leading risk factor for disease burden in Europe[v], and AUDs are the leading cause of disability in men[xiv]. Evidence also suggests that the earlier people start drinking the higher the risk of developing AUDs[xv]. Policies should therefore aim to "delay" the drinking starting age.

TAXATION AND PRICING: Taxation on alcohol products and other pricing measures, in particular minimum unit pricing (MUP), should be supported and encouraged as they serve to deter the consumption of alcohol, and therefore reduce rates of consumption[xvi].

ADVERTISING: The monitoring of the alcohol industry's advertising practices (including displays in private settings such as night clubs, online advertising and in social media) and compliance with relevant national codes of conduct applying to the alcohol industry should be closely monitored. A total ban on advertising and sponsorship of alcohol brands (i.e. sport events and festivals) should be implemented.

SALE RESTRICTIONS: Measures to restrict alcohol sales, such as age limits (i.e. 18 years old) and controlled opening hours, need to be better implemented and enforced[xi].

ALCOHOL LABELLING: Warning labels help establish a social understanding that alcohol is a hazardous commodity. Moreover, they have shown to be effective in raising awareness amongst the general public about the health message that they contain[xvii], and visual labelling on products must change regularly to have continuing impact. Alcohol labelling should therefore be improved and extended as effective means to prevent excessive alcohol consumption.

AWARENESS RAISING: The Commission has led a number of successful awareness campaigns in the area of health in the past. A targeted EU initiative focused on the negative effects of excessive alcohol consumption for individuals, families and the society should be considered. Awareness initiatives should aim to:

- reduce stigmatisation of people with an AUD and their families;
- raise awareness of the risks associated to alcohol consumption;
- support services available and how to access them.

Such initiatives also play an important role in supporting national governments' awareness initiatives with adequate expertise and tailored materials, especially those facing financial constraints in the current economic context. In addition, as civil society organisations working directly with alcohol problems, patient and medical organisations have a key role in awareness raising efforts. Greater support should be provided to them to develop consistent and effective media (including social media) strategies.

VULNERABLE GROUPS: Selected interventions for vulnerable groups, such as the children of people with alcohol related problems and people with mental health disorders, should be researched, implemented and evaluated, with best practice shared across Europe.

DIAGNOSIS, TREATMENT AND CONTINUOUS SUPPORT

There is an urgent need to ensure the early diagnosis and improved access to tailored support, counselling services and treatment for AUDs[ii]. Early detection and access to adequate support services and treatment could save thousands of lives[ii]. Evidence shows that there is a need for a Europe-wide monitoring system to evaluate the prevalence of AUDs and the impact of early detection, treatment and counselling services[iii].

EDUCATION, TRAINING AND GUIDELINES FOR HEALTHCARE PROFESSIONALS: Healthcare professional education is crucial to ensure quality diagnosis and management of AUDs. This should include measures to develop and update relevant guidelines on AUDs, increase healthcare professionals' knowledge and implementation of brief interventions and quality follow up support for people suffering from AUDs and their families.

SCREENING AND EARLY INTERVENTION: Access to reliable screening and diagnostic tools should be available and consistently used by primary healthcare professionals (General Practitioners and other healthcare staff), to help them identify people with alcohol related problems, according to adequate protocols and codes of conduct.

Screening and early detection should be part of continuous care and support to patients. Primary healthcare professionals need to continuously assess alcohol use in patients and refer to appropriate services as appropriate, such as alcohol treatment services and/or mutual aid associations.

Family education programmes are essential to ensure early detection of AUDs. Targeted education programmes should focus on the nature of AUDs, risks, symptoms, and how to communicate and support people with AUDs.

National governments need to:

- strengthen General Practitioners' incentives schemes to screen people who are at risk of having an AUD;
- ensure and support the establishment of standardised screening including a mandatory liver enzymes test (GPT (ALT) for patients between 20 – 60 years old, and recollection of the patient's case history;
- support the implementation of brief interventions beyond the healthcare sector (e.g. education of social services staff, drink-driving interventions by law enforcement officers, etc).

COUNSELLING, SUPPORT AND TREATMENT SERVICES: National governments should prioritise action and resources to ensure improved access to counselling and treatment services in order to successfully address AUDs and meet patients' needs. These should range from brief interventions, primary care, to specialised treatment methods and centres[iii]. There is a need to follow-up and continue to have a support system in place for people living with AUDs and their families, as well as those who have taken part in treatment. Long term recovery and relapse prevention support should be consistently provided to people with alcohol related problems and their families.

INTEGRATED POLICIES

Policy measures in different relevant areas, such as healthcare, employment, justice and education, should be shaped in a consistent and integrated manner. This should include the integration of outcomes from relevant research projects as well as targeted measures for specific settings such as the workplace. Exchange of best practices schemes, including the establishment of a database, should be further developed and implemented in order to inform and support effective policy development and implementation.

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Pan American Network on Alcohol and Public Health (PANNAPH)

First Regional Meeting, Mexico City, Mexico August 21–23, 2012

Summary Report and Recommendations

Pan American Health Organization
Regional Office of the World Health Organization

110 1902 - 2012

PANNAPH
Pan American Network for Alcohol and Public Health

Maristela Monteiro Carlos Tena Tamayo

Background

The Pan American Health Organization (PAHO) has accelerated its efforts in recent years to increase awareness of the harm from alcohol consumption and support member countries' responses to reduce alcohol related problems. In 2005, it organized the first Pan American Conference on Alcohol and Public Policies, with the support of the Government of Brazil; 26 countries participated. PAHO subsequently prepared a technical report entitled "Alcohol and Public Health in the Americas: A Case for Action," which summarized the situation in the Region, described which policies are most effective, and proposed ten areas for national and regional action. PAHO translated, adapted, and/or disseminated several publications into Spanish to assist countries in implementing effective national response to alcohol problems. PAHO, also supported research on nonfatal injuries in emergency rooms and alcohol and gender issues, with a focus on intra-family violence. To that end, it published the book *Unhappy Hours: Alcohol and Partner Aggression in the Americas.* Finally, PAHO provided technical cooperation on alcohol policy issues and brief interventions in primary care to several countries in the Region.

In 2010, the Ministers of Health of the Member States of the World Health Organization (WHO) approved by consensus a global strategy to reduce alcohol-related problems. In February 2011, the WHO organized the first meeting between countries in Geneva, Switzerland, to discuss mechanisms and priorities for implementing the global strategy. Over 100 countries participated in the meeting, including 23 countries from the region of the Americas. Those 23 participating countries formed the Pan-American Network on Alcohol and Public Health (PANNAPH), led by Mexico and vice-chaired by Brazil. In 2011, Member States adopted a regional plan of action at the 51st Directing Council titled "Plan of Action to Reduce the Harmful Use of Alcohol," the plan calls for the implementation of the WHOGlobal Strategy to Reduce Harmful Use of Alcohol and promotes a public health and human rights approach aimed at lowering the levels of per capita alcohol consumption in the population, as well as reducing alcohol related harm in the Americas and Caribbean. The plan of action proposed that PAHO's role be to coordinate the regional response and to strengthen its technical cooperation for national activities based on the ten target policy areas proposed by the global strategy, for a period of ten years (2012 – 2021).

The plan of action contains five main objectives and describes both regional and national activities under each objective. The five main objectives are: (1) to raise awareness and political commitment; (2) to improve the knowledge base on the magnitude of problems and on effectiveness of intervention disaggregated by sex and ethnic group; (3) to increase technical support to Member States; (4) to strengthen partnerships and; (5) to improve monitoring and surveillance systems and dissemination of information for advocacy, policy development, and evaluation.

In order to facilitate communication with regional partners in the network, PAHO created a listserv, a logo for the group, a system for exchanging information, and continued to promote research collaboration and advocacy. A regional meeting was proposed by Mexico and the country provided logistical, technical and financial support. The 1st Meeting of the Pan American Network on Alcohol and Public Health took place in Mexico City, Mexico, from August 21 to 23, 2012.

Thirty countries participated in the meeting. In addition, thirteen regional and national PAHO advisors, three collaborating centers, six non-governmental organizations, a WHO representative, and Mexican and international experts participated in the meeting.

Objectives

The three main objectives of the meeting were to:

1) Update all partners on global and regional processes in place, such as the global strategy adopted in 2010 by the WHO and the regional action plan, the role of the collaborating centers, NGOs, and civil society, as well as to discuss the contributions of others.
2) Present scientific evidence regarding the policies that were adopted in the global strategy and the regional plan, and discuss ways in which regional countries have implemented these strategies and barriers encountered.
3) Discuss and agree on the highest priority areas for cooperation, according to needs, with PAHO and WHO. PAHO understands there are regional, national and subnational needs and can provide the necessary tools and training, seek resources, promote technical cooperation between countries, promote multi-country research, and share knowledge.

Topics Discussed

Three plenary conferences opened the meeting, covering the burden of alcohol in Mexico, an overview of the evidence on the effectiveness of various alcohol policies globally, and a review of the global developments since the approval of the WHO global strategy for reducing alcohol problems.

The rest of the meeting was organized through eleven panels of discussion. Each panel topic began with a lead presenter followed by commentaries by three countries. A question and answer session followed the presentations. The eleven topic areas are summarized below.

Panel 1: Implementing Policies to Control Availability

Among the policies used to control availability, panelists mentioned restricting alcohol outlet density, restricting the types of alcohol beverages that can be sold or packaged, especially those types of products that appeal to youth (i.e. alcopops), and restricting hours and days of sales. The importance of community groups and youth in advocating and supporting restrictions were mentioned as key factors in encouraging public officials in implementing and enforcing polices to control availability.

Panel 2: Implementing Policies on Price and Taxation

Numerous studies have shown that increased alcohol taxes and prices are related to reductions in alcohol-related problems, including crime, traffic crashes, and mortality rates. Panelists encouraged network members to consider pricing and/or taxation of alcoholic beverages based on their alcohol content and to consider dedicating a portion of alcohol tax revenues to the prevention and treatment of alcohol-related problems.

Panel 3: Implementing Polices on Traffic Safety and Alcohol

Statistics show that in the Americas, the majority of alcohol-related traffic deaths are associated with drivers with medium and low levels of alcohol in their system. Panelists encouraged network members to establish and enforce a low legal maximum-blood alcohol concentration level for drinking and driving (.05 g/dL for many countries in the region). In the region, efforts that combine a public information campaign in conjunction with enforcement actions have shown reductions in alcohol-related traffic crashes and deaths.

Panel 4: What Works to Reduce Youth Drinking?

Establishing and enforcing a minimum legal drinking age for the purchase of alcohol is an important policy in reducing youth drinking. Panelists mentioned the need to combine campaigns seeking to influence social norms around youth drinking with policies that limit availability, increase alcohol prices, and encourage health care professionals to discuss alcohol issues with youth.

Panel 5: Alcohol and Violence

Alcohol use is related to intentional and non-intentional injuries, intra-familiar and interpersonal violence, child abuse, suicide, homicide and traffic crashes. Alcohol use is seen in domestic violence situations, where women are more likely to be physically and sexually assaulted by their partners and these issues have been seen in urban, rural and indigenous populations. Panelists mentioned the need to link gender equity policies and policies for the primary prevention of violence with those to reduce harmful use of alcohol at the population level , as well as to improve and strengthen treatment and care services to all those involved in alcohol-related violence.

Panel 6: Regulation of Alcohol Marketing and Sponsorship

The alcohol industry constantly promotes positive images of alcohol consumption and has increasingly sponsored community projects, sports teams, and prevention projects. The alcohol industry relies on self-regulating their own practices but, as has been constantly demonstrated, the alcohol industry frequently violates its own codes without any consequence. Panelists stressed the need for statutory regulations to restrict or ban, as appropriate, the marketing of alcoholic beverages, particularly to youth, and to establish a government agency to be responsible for monitoring and enforcing of alcohol marketing regulations. Several countries expressed concern with the pressure the alcohol industry and the International Federation of Association Football (FIFA for its French acronym) has put on Brazil to change the law prohibiting alcohol sales in soccer stadiums, as such change would influence policy decisions in their own countries, which look up to Brazil as a model. Several countries discussed the need for a code and guidelines on how to interact with the alcohol industry and discussed having PAHO take a lead role in developing such guidance to countries.

Panel 7: Law Enforcement

Public health should partner with law enforcement agencies to promote the proactive enforcement of alcohol laws to prevent alcohol-related harm. Multiple law enforcement strategies that can be used were described and an emphasis on building public awareness and support for law enforcement strategies was encouraged.

Panel 8: Unrecorded Alcohol Consumption

Unrecorded alcohol consumption includes alcoholic beverages that are produced legally but are not registered (taxes are not paid), alcohol that is not produced for human consumption, and alcohol that is produced illegally. Illegally produced alcohol may have increased risk because there is no standard alcohol level, it's cheap, and often contains toxic substances. Strategies to reduce unrecorded alcohol include abolishing the use of methanol to denature alcohol, treating certain products with bittering agents to make alcohol undrinkable (for alcohol that is not produced for human consumption), controlling medicinal alcohol sales, and testing illegally produced but available products. Countries expressed a need to have a regional laboratory which could analyze samples in a standardized and unbiased way, as currently such efforts are

Thomas Babor

Marline Elizabeth Paz Castillo Ralph Hingson Ethel Veronica Villalta de Rodriguez

only done through studies sponsored by the alcohol industry, which has a vested interest in such analyses and results.

Panel 9: Implementing Programs for Early Intervention and Treatment

The goal of early intervention programs is to delay the initial use of alcohol. These programs establish strong networks of community groups and schools to promote prevention programs with youth but they also establish a system through which screenings, brief interventions, and treatment referrals can be made. Panelists called for strengthening the capacity of health care systems to integrate and provide screening, brief interventions and treatment, centered in primary health care services, as well as in collaboration with schools, community groups, self-help groups and work-places. Furthermore, it is necessary to update both the undergraduate and graduate academic training of health professionals to facilitate and accelerate the creation and improvement of commu-nity-based services, instead of psychiatric hospitals, as promoted in the region since the Declara-tion of Caracas.

Panel 10: The Role of Civil Society, Collaborating Centers and Non-Governmental Organizations

In order for civil society to have a large impact on reducing alcohol-related problems, society should recognize the autonomy of these associations, these groups should not take funds from the alcohol industry, and their policies should be evidence-based. Panelists encouraged network members to not only talk about the problems and solutions but to train and assist civil society on how to best implement solutions.

Panel 11: The Influence of the Alcohol Industry in Public Policies to Reduce Harmful Alcohol Consumption: How Can We Manage Conflict of Interest?

The alcohol industry promotes and supports groups and studies that encourage prevention policies that have little or no effect on reducing alcohol consumption or alcohol-related problems. They present false evidence to create confusion about the three most effective strategies (taxes, restrictions on physical availability, and restrictions on alcohol marketing). In addition to counter-advertising campaigns, panelists recommended PAHO's assistance on developing clear guidelines on interactions with the alcohol industry and conflicts of interest with public health.

Claudina Cayetano

Where We Are

In addition to the adoption of the "Plan of Action to Reduce the Harmful Use of Alcohol", network members are collaborating on several new research projects. Below is a list of current projects and participant countries:

- New studies on nonfatal injuries in Emergency Rooms: Costa Rica, Peru, and Belize.
- New general population studies based on the GENACIS (Gender, Alcohol and Culture: An International Study (GENACIS) questionnaire: Belize and Brazil.
- New STEP Survey participants: Colombia and Suriname.
- Grand Challenges in Mental Health Canada: Belize and Guyana.
- New proposals under development to International Development Research Centre (IDRC): Brazil, Peru, St Kitts and Nevis, Argentina and Uruguay.

Maria Elena Medina-Mora Icaza

Mexico Recommendations

The participants of the 1st Meeting of the Pan American Network on Alcohol and Public Health (PANNAPH) in Mexico City, Mexico, August 21-23, 2012 recommend that:

- As the leading risk for the burden of diseases in the Americas, alcohol needs to be considered a top priority in national and regional efforts aimed at improving public health. Alcohol is a causal factor to over 60 disease conditions, including intentional and non-intentional injuries, cancers, heart disease, neuropsychiatric conditions, in both men and women and across the life cycle.
- Effective policies need to be integrated into a national alcohol policy which brings the various sector of the government together with the goal of protecting and promoting public health.

There are a number of effective alcohol policies which are cost effective and have a population impact. These include taxes, restrictions on physical availability, and restrictions on alcohol marketing.

- PANNAPH represent the views of over 30 countries in the Region and the network should continue as a unified group with a unified technical voice.
- Brazil acts as Chair and Belize as Vice-Chair of the network from 2012 until the next meeting of the group.
- Actions be coordinated with other sectors of the government and within the Ministries of Health to ensure that evidence-based policies are promoted.
- Adult Per Capita consumption be the only feasible and technically sound indicator for the Non-Communicable Disease strategy at global and regional levels and should not be replaced by others indicators such as prevalence of heavy drinking.
- Actions of the network should be coordinated with the Global Coordinating Council through the national counterparts of each country and that they be the same as those participating in the Global Network.
- PAHO assist in the development of clear guidance on interactions with the alcohol industry and conflicts of interest with public health such as developing procedures and rules of engagement (who, with whom and how).
- PAHO assist in the development of a universal code of principles for the regulation of marketing of alcohol that is public health-oriented and that can be used by governments, regardless of self-regulatory codes (where they exist, these have been found to be insufficient).
- PAHO provide complete information to Ministers of Health and other relevant stakeholders about research being undertaken with the support of the alcohol industry in the Region.
- PAHO cooperate with collaborating centers, research institutions, and individual researchers to create and promote a Regional Network of Alcohol Policy Researchers, independent of the influence of the alcohol industry.
- PAHO cooperate with non-governmental organizations for alcohol policy advocacy, promoting the creation of a regional network and linking it with the Global Alcohol Policy Alliance (GAPA) and other relevant networks internationally.

- PAHO assist member countries in preparing case studies related to alcohol policy implementation and disseminating these studies at regional and global levels.
- PANNAPH write a letter to the government of Brazil, indicating its support for maintaining a ban on alcohol sales in stadiums during the 2014 FIFA World Cup.
- PAHO support a sub-regional meeting on alcohol policy with Caribbean countries.
- PAHO assist Member States in developing a definition of a standard alcoholic drink that is compatible with WHO recommendations and can improve the comparability of information across the Region.
- New members be integrated into the network.
- A regional laboratory for analysis of alcohol beverages be established.
- PAHO continue to support technical cooperation between countries.
- PAHO assist in building the capacity for alcohol policy through virtual courses and dissemination of information in English and Spanish to network members and others interested in public health.

Participating Countries

Argentina
Antigua and Barbuda
Bahamas
Barbados
Belize
Bolivia
Brazil
Canada
Colombia
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
El Salvador
Grenada
Guatemala
Guyana
Honduras
Mexico
Nicaragua
Panama
Paraguay
Peru
St. Kitts and Nevis
St. Lucia
Suriname
Trinidad and Tobago
United States of America
Uruguay
Venezuela

www.paho.org
Area of Sustainable Development and Environmental Health (SDE)
Pan American Health Organization
Regional Office of the World Health Organization
110 1902 - 2012
PANNAPH
Pan American Network for Alcohol and Public Health

PROTOCOL

TO ELIMINATE ILLICIT TRADE IN TOBACCO PRODUCTS

AN INTRODUCTION

FCTC

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

ABOUT THE PROTOCOL TO ELIMINATE ILLICIT TRADE IN TOBACCO PRODUCTS

What is the Protocol?

The Protocol to Eliminate Illicit Trade in Tobacco Products is the first protocol to the WHO Framework Convention on Tobacco Control (WHO FCTC) and a new international treaty in its own right.

It builds upon and complements Article 15 of the Convention (Illicit trade in tobacco products), with the objective of eliminating all forms of illicit trade in tobacco products.

The Protocol was adopted on 12 November 2012 by the Conference of the Parties (COP) to the WHO FCTC at its fifth session in Seoul, Republic of Korea, after four years of negotiations by the Intergovernmental Negotiating Body that was established by the COP in 2007.

Why is it so important to prevent the illicit trade in tobacco products?

The growing international illicit trade in tobacco products poses a serious threat to public health globally. Illicit trade increases the accessibility and affordability of tobacco products, thus fuelling the tobacco epidemic and undermining tobacco control policies. It also causes substantial losses in government revenues, and at the same time contributes to the funding of transnational criminal activities.

The World Customs Organization (WCO) reports that a total of 1.9 billion illicit cigarettes were seized in 2011, across 64 of its Member States. According to recent studies, between 9% and 11% of the global cigarette market is illicit. However, this percentage is significantly higher in low- and middle-income countries, reaching 50% or more in some cases. Estimates show that if the illicit trade were eliminated globally, governments would gain at least US$ 30 billion annually in tax revenue, and one million premature deaths would be avoided every six years due to higher average cigarette prices and lower consumption.

What are the key provisions of the Protocol?

The Protocol aims to control the **supply chain** in tobacco products (Articles 6-13): this has often been referred to as the "heart" of the Protocol. It requires the establishment of a global tracking and tracing regime within five years of entry into force of the Protocol, comprising national and/or regional tracking and tracing systems and a global information sharing point located in the Convention Secretariat. The global tracking and tracing regime will mean that if tobacco products are found on the illegal market, the authorities would be able to determine which company produced them, where and when they were produced, and the intended market of sale, shipment route and the point of diversion.

Other provisions to ensure control of the supply chain cover licensing, due diligence, record keeping and security and preventive measures. In particular, strict requirements are imposed on the licensing of manufacture, import and export of tobacco products and manufacturing equipment, and on the monitoring of sales to ensure that the quantities are commensurate with the actual demand. Transactions regarding tobacco products in free zones, international transit and duty free sales as well as through the Internet and other telecommunication modes will be subject to the same comprehensive regulations as other sales.

The Protocol also covers important matters concerning **offences** (Articles 14-19), with provisions on liability, prosecutions and sanctions, seizure payments and special investigative techniques, as well as the disposal and destruction of confiscated products. The Protocol contains a catalogue of conduct, which each Party shall include in its national legislation as unlawful, for example producing or selling cigarettes without a licence, or smuggling cigarettes. Each Party shall also decide which unlawful conduct constitutes a criminal offence.

Another key group of substantive articles addresses **international cooperation** (Articles 20-31), with measures on information sharing, technical and law-enforcement cooperation, protection of sovereignty, jurisdiction, mutual legal and administrative assistance and extradition. For example, Parties have the obligation to exchange information necessary to detect or investigate illicit trade in tobacco products, including records of investigations and prosecutions and details of seizures of tobacco products. This enhanced cooperation will have a deterrent effect. Parties also agreed to afford one another mutual legal assistance and to cooperate in providing technical assistance in order to achieve the objectives of the Protocol.

The Protocol establishes the **reporting** obligations of the Parties linked to the reporting system of the WHO FCTC (Article 32), as well as the institutional and financial arrangements (Articles 33-36) necessary for its implementation.

The Protocol will require a **multisectoral approach** by governments, with cooperation among health, finance, customs, law enforcement, trade and other relevant sectors.

Governance of the Protocol

The Protocol establishes in its Article 33 the Meeting of the Parties (MOP) as its governing body. The MOP will comprise all Parties to the Protocol.

Sessions of the MOP shall be convened immediately before or immediately after the sessions of the COP, including the first session following entry into force of the Protocol. Entry into force will take place 90 days after the deposit of the 40th instrument of ratification. The Rules of Procedure and the Financial Rules of the COP apply, *mutatis mutandis*, to the MOP, unless the MOP decides otherwise.

The Secretariat of the WHO FCTC is also the Secretariat of the Protocol (Article 34).

Protection from the interests of the tobacco industry

Like the WHO FCTC, the Protocol refers to the necessity for Parties to protect their public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry. In addition, the Protocol specifically stipulates that obligations assigned to a Party shall not be performed by or delegated to the tobacco industry. In Article 8, the Protocol requires Parties to ensure that their competent authorities, in participating in the tracking and tracing regime, interact with the tobacco industry and those representing the interests of the tobacco industry only to the extent strictly necessary in the implementation of that Article.

Where to find the text of the Protocol?

The text of the Protocol is available in all six official languages of the COP at: http://www.who.int/fctc/protocol/illicit_trade/

BECOMING A PARTY TO THE PROTOCOL

Who can become a Party to the Protocol?

According to Article 33 of the WHO FCTC, Parties to the Convention may be parties to a protocol.

Signature and ratification

The Secretary-General of the United Nations is the Depositary for the Protocol (Article 46). In accordance with its Article 43, the Protocol was opened for signature at the World Health Organization Headquarters in Geneva on 10 and 11 January 2013, and thereafter at the United Nations Headquarters in New York until 9 January 2014.

Full powers are required to sign the Protocol (except for Heads of State, Heads of Government or Ministers for Foreign Affairs who are empowered, by virtue of their functions, to sign the Protocol on behalf of the State) and should be submitted to the Treaty Section of the United Nations Secretariat in New York.

A model instrument of full powers is available for download at:
http://www.who.int/fctc/protocol/protocol_sign/en/index.html

Pursuant to its Article 44, the Protocol is subject to ratification, acceptance, approval or accession by States and to formal confirmation or accession by regional economic integration organizations that are Party to the WHO FCTC. Ratification, acceptance and approval are international acts by which States that have already signed the Protocol establish on the international level their consent to be bound by it. Formal confirmation is the equivalent of ratification for international organizations, such as regional economic integration organizations.

A model instrument of ratification of the Protocol is available at:
http://www.who.int/fctc/protocol/protocol_sign/en/index.html

Accession

The Protocol will be open for accession from the day after the date on which it is closed for signature. Accession is an international act by which a State or an international organization, which has not signed a treaty, establishes on the international level its consent to be bound by it.

RESOURCES AND ASSISTANCE

Preparing the entry into force of the Protocol

The Secretariat will carry out activities to raise awareness of the Protocol and to provide assistance to Parties, upon request, in the process leading up to entry into force. The preparatory work will include, in particular, establishing coordination with international organizations that have expertise in Protocol-related matters; conducting a study of the basic requirements of the tracking and tracing regime and the global information sharing focal point, including relevant experiences available in Parties; and developing a self-assessment checklist for use by Parties in assessing their legal, regulatory and policy frameworks in view of the requirements of the Protocol and in order to scope Parties' technical assistance and capacity building needs.

How will the implementation of the Protocol be funded?

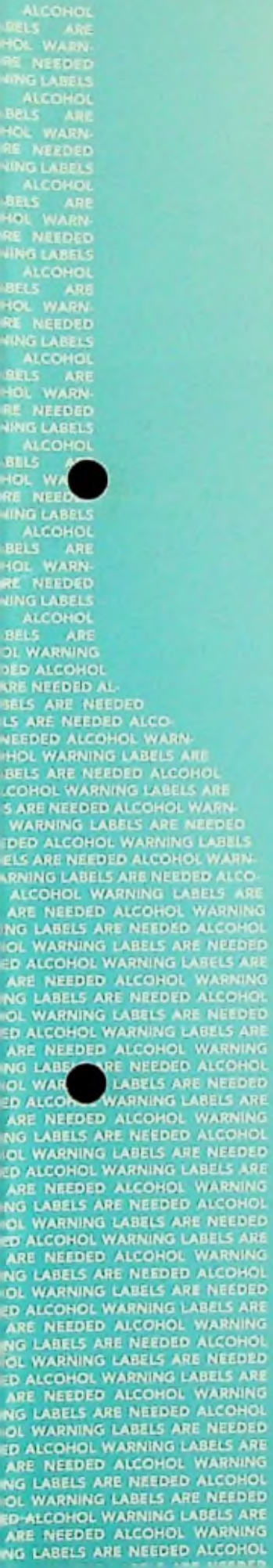
At the national level, each Party shall provide financial support in respect of its national activities intended to achieve the objective of the Protocol, in accordance with its national plans, priorities and programmes (Article 36). The Secretariat shall advise lower-resource Parties, upon request, on available sources of funding.

At the international level, once the Protocol has entered into force, the MOP shall decide on the scale and mechanism of the voluntary assessed contributions from the Parties to the Protocol and other possible resources for its implementation (Article 33). The Protocol also requires Parties to promote the utilization of bilateral and multilateral channels to provide funding. Prior to entry into force, the Convention Secretariat will raise funds in order to carry out the activities required for preparing entry into force, in line with the preparatory work endorsed by the COP.

Contact

For information and assistance, please contact the Convention Secretariat at:
protocolfctc@who.int

Convention Secretariat
WHO Framework Convention on Tobacco Control
World Health Organization
Avenue Appia 20, 1211 Geneva 27 Switzerland
Tel. +41 22 791 50 43 Fax: +41 22 791 58 30
Email: fctcsecretariat@who.int
Web: www.who.int/fctc



eurocare

European Alcohol Policy Alliance

Library of ALCOHOL HEALTH WARNING LABELS

eurocare

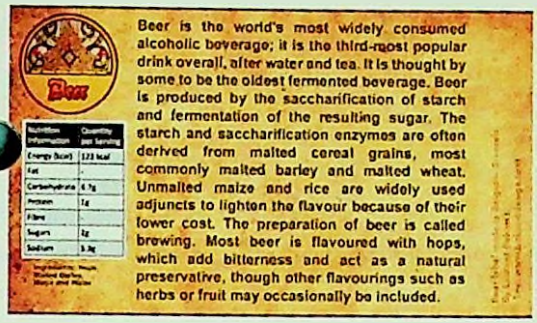
European Alcohol Policy Alliance

The European Alcohol Policy Alliance (EUROCARE) is an alliance of non- governmental and public health organisations with around 51 member organisations across 23 European countries advocating the prevention and reduction of alcohol related harm in Europe. Member organisations are involved in advocacy and research, as well as in the provision of information and training on alcohol issues and the service for people whose lives are affected by alcohol problems.

The mission of Eurocare is to promote policies to prevent and reduce alcohol related harm. **The message, in regard to alcohol consumption is "less is better"**

Publication name: Eurocare library of health warning labels
Publication year: 2012
Produced by: European Alcohol Policy Alliance

EXAMPLE OF ALCOHOL HEALTH WARNING LABEL



Introduction

Eurocare proudly presents the second library of alcohol health warning labels. It is Eurocare's wish that this proposal will serve as a starting point for much needed discussion around labelling of alcoholic beverages in the European Union (EU).

Over the last years Eurocare has been advocating for introduction of health warning messages.
The Eurocare report: 'What's not on the bottle? Brief overview of state of play in the alcohol labelling' (December 2011) gives an overview of the different initiatives taken in this area around the world and summarises the main research findings on effectiveness of warning labels.

In the long term, it is Eurocare's hope that a library of health warning messages will be prepared at the EU level by the European Commission. Moreover, it should be made available to all EU Member States and alcohol producers.

In this document Eurocare would like to present its recommendations and ideas for such a library. It is hoped that they will be a constructive starting point for preparation of library of health warning labels at the EU level, similar to that which has already been developed for tobacco products.

Rationale

Product labels can serve a number of purposes, providing information about the product to the consumer, enticing the consumer to buy the product and warning consumers of dangers and health risks from the product.

Promoting consumers rights, prosperity and wellbeing are core values of the European Union (EU) and this is reflected in its laws. Consequently, the Directive on General Product Safety obliges producers 'to provide consumers with relevant information to enable them to assess the risks inherent in a product (...) where such risks are not immediately obvious without adequate warnings'[1]

[1] DIRECTIVE 2001/95/EC; http://eur-lex europa.eu/LexUriServ/LexUriServ.do?uri=O-J:L:2002:011:0004:0004:EN:PDF

France is the only EU Member State which has introduced mandatory health warning labels which inform about the dangers of drinking alcohol while pregnant. Eurocare would like this initiative expanded across all Member States and across other areas of alcohol related harm.

Alcohol is a cause in some 60 diseases and conditions however public awareness about the risks associated with alcohol consumption remains relatively low. For instance, despite the research dating back to 1987 that conclusively points out to the carcinogenicity of all alcoholic beverages[2], the connection between alcohol and cancer is not well known by the consumers. The 2010 Eurobarometer report found that 1 in 10 European citizens do not know that there is a connection and what is especially alarming, is that 1 in 5 do not believe the connection[3].

There is a clear public health obligation to inform consumers of the dangers and health risks associated with the consumption of alcohol and this is backed up with substantial public support. The Eurobarometer 2010 reports that overwhelming majority of the European Union population (79%) would agree with putting warnings on alcohol labels to warn pregnant women and drivers of the dangers of drinking alcohol.

Warning labels can increase knowledge and change in the perception of risks associated with alcohol consumption. Studies show that warning labels are noticed by most drinkers, especially by young and high risk drinkers and prompt target groups to discuss health effects of drinking (especially early after their introduction)[4]. Evidence also suggests that the recall of warning labels was associated with being less likely to report having engaged in drunk driving[5].

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[2] International Agency for Research on Cancer (1987) Monographs on the Evaluation of Carcinogenic Risks to Humans
Volume 44: Alcohol Drinking. http://monographs.iarc.fr/ENG/Monographs/vol44/volume44.pdf

[3] Eurobarometer (2010) EU citizens' attitudes towards alcohol http://ec.europa.eu/public_opinion/archives/ebs/ebs_331_en.pdf

[4] Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht N., Hill L., Holder H , Homel R., Osterberg E., Rehm J. ,Room R. and Rossow I. (2003) Alcohol: No ordinary commodity – research and public policy Oxford: Oxford University Press
Greenfield T. (1997) Warning Labels: Evidence on harm reduction from long-term American surveys. In Plant M., Single E. and Stockwell T. (Eds) Alcohol: Minimizing the harm. London: Free Association Books

[5] Greenfield T. (1997) Warning Labels: Evidence on harm reduction from long-term American surveys In: Plant M., Single E. and Stockwell T. (Eds.) Alcohol: Minimizing the harm. London: Free Association Books

The studies from the US, note that warning labels have prompted discussions about the dangers of drinking and there is evidence of increased support for alcohol labeling by the US public following its introduction[6] [7]
In addition, a 'dose-response' effect was found showing when people were frequently exposed to warnings (on adverts at point of-sale, in magazines and on containers) the more likely they were to have discussed the issue[8].

In France it has been found that there has been somewhat of a change in the social norm surrounding alcohol during pregnancy. This is thought to be related to the introduction of the health warning labels in 2006[9].
Alcohol warning labels have also been found to deter others from driving under the influence of alcohol[10]. This further illustrated how health warnings may play a role in changing social norms and public acceptability.

It could plausibly be argued that where relatively strict warning label regulations have been used, there has indeed been a shift towards regarding alcohol as more problematic and heavier drinking as less 'normalised'[11].

As a single measure, it is unlikely that warning labels will, result in a substantial reduction in hazardous alcohol consumption or specific risk behaviours such as drinking and driving.

Labels need to be regarded as an opportunity for impact over time and as a part of a comprehensive strategy, rather than expecting that they will affect behavioural change immediately.

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[6] Greenfield (1997) in Stockwell T. (2006) A Review of Research Into The Impacts of Alcohol warning Labels On Attitudes And Behaviour. University of Victoria, Canada.
[7] (Kaskutas and Greenfield 1992). In Stockwell T. (2006) A Review of Research Into The Impacts of Alcohol warning Labels On Attitudes And Behaviour. University of Victoria, Canada.
[8] Ibid
[9] Guillemont J. (2009) Labelling on alcoholic drinks packaging: The French experience. Presentation to the CNAPA meeting, February 2009 retrieved from: http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/ev_20090217_co08_en.pdf
[10] Tam, W. T. Et al (2010) Do Alcohol Warning Labels Influence Men's and Women's Attempts to Deter Others from Driving When Intoxicated?. Human factors and Ergonomics in Manufacturing Service Industries, 20 (6), 538-546
[11] Wilkinson C. and Room R. (2009) Warnings on alcohol containers and advertisements: International experience and evidence on effects. Drug and Alcohol Review, 28, 426-435

Introduction of health warning messages on alcohol labels throughout the EU would prove a cost effective measure, to significantly raise public awareness about the risks associated with alcohol consumption.

HEALTH WARNINGS ON ALCOHOLIC BEVERAGES SHOULD:

- Be placed in a standard location on the container
- Be parallel to the base of the container
- Be clearly separate from other information of the label i.e. be placed in boxes with thick red borders
- Size should be determined by a minimum percentage of the size of the container
- Be written in capital letters and bold type
- Appear on a contrasting background (red bold type on white) warnings printed in red compared to black lead to improved noticeability
- Be rotating and with sufficient vividness and strength to attract consumers
- Use images that are informational in style and taken from other ongoing education campaigns, this would enhance their effectiveness
- Be in the official language of the country in which the products is sold
- Be determined by the European Institution/ Agency or Ministers of Health (public body not private agency)

LIBRARY OF HEALTH WARNING MESSAGES

Health warnings on alcoholic beverages should be clear messages about the harm to the individual and others. These messages should cover all relevant health issues like, liver cirrhosis, cancers, mental health as well as risk of injuries and violence. In addition, specific messages should warn of the dangers of consuming alcohol during pregnancy, when driving, operating machinery or taking certain medication.

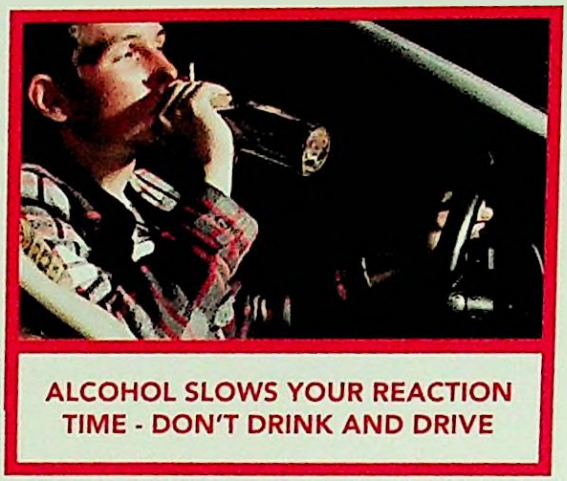
Health warning messages should be accompanied by a recommendation for action.

For example:
'If you are concerned about your alcohol consumption, call [appropriate help line and phone number] or visit [appropriate website].

This message could be in smaller font than the health message. Pictogram should be accompanied with a health warning messages corresponding to it.

ALCOHOL MAY HARM THE UNBORN BABY

ALCOHOL SLOWS YOUR REACTION TIME - DON'T DRINK AND DRIVE



ALCOHOL SLOWS YOUR REACTION TIME - DON'T DRINK AND DRIVE

DON'T SERVE ALCOHOL TO MINORS

DON'T SERVE ALCOHOL TO MINORS

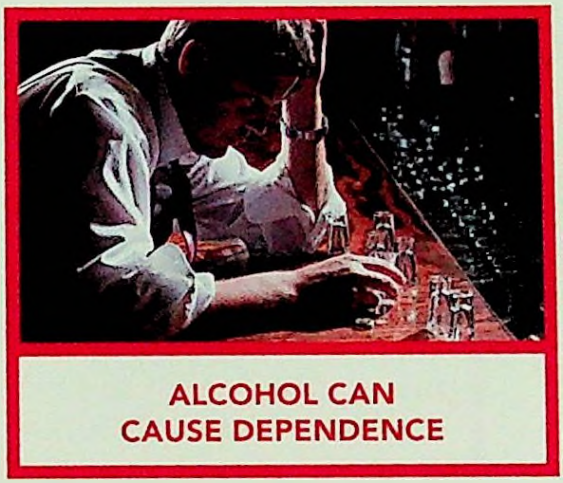
DON'T DRINK WHILE OPERATING MACHINERY

DON'T DRINK WHILE OPERATING MACHINERY

ALCOHOL INCREASES THE RISK OF ACCIDENTS AND INJURIES

ALCOHOL INCREASES THE RISK OF ACCIDENTS AND INJURIES

ALCOHOL CAN CAUSE DEPENDENCE

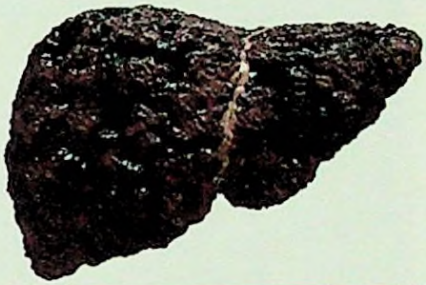


ALCOHOL CAN CAUSE DEPENDENCE

ALCOHOL CAN CAUSE MENTAL HEALTH PROBLEMS

ALCOHOL CAN CAUSE MENTAL HEALTH PROBLEMS

ALCOHOL CAN CAUSE
LIVER CIRRHOSIS



ALCOHOL CAN CAUSE
LIVER CIRRHOSIS

DON'T DRINK
WHEN TAKING MEDICINE

DON'T DRINK
WHEN TAKING MEDICINE

ALCOHOL CAN CAUSE CANCER

ALCOHOL CAN CAUSE CANCER

A Cause for Action

Alcohol is the 3rd leading cause of ill-health and death in the EU

Alcohol is one of the world's leading health risks

- Europe is the heaviest drinking region of the world
- Consumption levels in some European countries are around 2.5 times higher than the global average
- Alcohol is one of the top 4 risk factors for non- communicable diseases (NCDs) such as cancer and cardiovascular disease.
- Alcohol is a toxic substance in terms of its direct and indirect effects on a wide range of body organs and systems and a cause of some 60 diseases
- 23 million people in the EU are dependent on alcohol

Use of alcohol is especially harmful for young people

- 43% among 15-16 year old Europeans student report heavy binge drinking
- Alcohol is the biggest cause of death among young men of age 16 to 24
- 9 million children and young people in the EU live with at least one parent addicted to alcohol

Alcohol harms the society

- Around 1 accident in 4 can be linked to alcohol consumption, and at least 10 000 people are killed in alcohol related road accidents in the EU each year.
- NCDs to which alcohol is one of the top risk factors, are estimated to cause a €25 trillion global economic output loss over the period of 2005-2030
- The social cost attributable to alcohol is 155,8 billion EUR yearly
- Alcohol is the world's number 1 risk for ill health and premature death for 25-59 year old age group- core of the working age population

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European Alcohol Policy Alliance

EUROCARE RECOMMENDATIONS FOR A FUTURE EU ALCOHOL STRATEGY

June 2012

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The European Alcohol Policy Alliance (EUROCARE)

The European Alcohol Policy Alliance (EUROCARE) is an alliance of non-governemental and public health and well-being organisations with around 50 member organisations across 21 European countries advocating the prevention and reduction of alcohol related harm in Europe. Member organisations are involved in research and advocacy, as well as in the provision of information to the public; education and training of voluntary and professional community care workers; the provision of workplace and school based programmes; counselling services, residential support and alcohol-free clubs for problem drinkers; and research and advocacy institutes.

The mission of Eurocare is to promote policies to prevent and reduce alcohol related harm, through advocacy in Europe. The message, in regard to alcohol consumption is "less is better".

Contents

Foreword by President Tiziana Codenotti

At the time when European Commission is evaluating the current European Union strategy to support Member States in reducing alcohol related harm1 the European Alcohol Policy Alliance (Eurocare) wishes to present its view and recommendations for of a comprehensive alcohol policy in the European Union (EU) 2013 - 2020.

Eurocare was created in 1990, as concerns grew over the impact of the single market on national alcohol policies. As the recognition of the importance of health issues has moved forward on the European political agenda, it gradually allowed emphasising issue of alcohol related harm. Eurocare grew over the last twenty years, from few enthusiasts to a network of around 50 organisations from 21 countries. Eurocare recognises the progress that has been achieved over the past years, from the first mention in 1986 of a need to tackle the problems related to harmful and hazardous consumption of alcohol in the Council Resolution, through 2006 EU Alcohol Strategy, to 2010 adoption of WHO Global Alcohol Strategy. Despite all the progress achieved over last years, our work to tackle alcohol related harm and raise it on the political agenda is by no means finished. Europe is still the heaviest drinking region in the world and harm caused by alcohol to the individual and society at large is too high.
In the current context of economic crisis keeping the focus on public health is crucial. Eurocare would like to take this opportunity to emphasise the need to place the health and social well being of European citizens above purely economic interests.

As a public health partner of Directorate General for Health and Consumer Protection (DS SANCO), Eurocare, and its broader civil society network, would like to appeal to all DGs of the European Commission to commit to prioritising health issues.
Eurocare is dedicated to working together towards reduction of harm caused by alcohol, to the individual, others and the society. We hope that European Commission and decision makers at both national and European level will find this document as a valuable source of inspiration.

Tiziana Codenotti , Eurocare President

[1] European Commission (2006) *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol related harm.* Brussels, Commission of the European Communities COM(2006) 625 Retrieved from: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2006:0625:FIN:EN:PDF

Summary

Eurocare strongly supports continuation of efforts at the EU level to address alcohol related harm; to that end it believes that the European Commission should develop a comprehensive EU alcohol strategy 2013-2020.

Alcohol is the world's number one risk for ill-health and premature death amongst the 25-59 year old age group, a core of the working age population. Europe is the heaviest drinking region of the world. Consumption levels in some countries are around 2.5 times higher than the global average[2].

Due to the size of the problem and the universal impact, alcohol requires focused approach and commitment for action from policy and decisions makers at the European and national levels.

Eurocare believes that a number of policy tools can be implemented to address crucial areas such as:

- Regulation of marketing
- Increase in price of alcoholic beverages
- Smarter regulation of availability of alcohol
- Provision of information to consumers- labelling
- Reduction of drink driving
- Creation of safer drinking environments
- Raised awareness of dangers from drinking during pregnancy
- Protection of family and children
- Prevention with special focus on prevention in the workplace
- Treatment and early interventions
- Better monitoring of data, development and maintenance of common evidence base

There is a mass of evidence that the levels of alcohol related harm in any population are correlated with the overall level of alcohol consumption: higher per capita consumption tends to be associated with higher levels of harm, lower consumption with lower levels of harm[3].

Eurocare recommends that the target for the EU should be reduction of total alcohol consumption in Europe by 2020, from an average of 12.5 litres to 9 litres per adult per year

[2] WHO Europe (2012) *Alcohol in the European Union*
[3] *Ibid*

Introduction

Eurocare's vision is a Europe where alcohol related harm is no longer one of the leading risk factors for ill-health and pre-mature death, Europe where innocents no longer suffer from the drinking of others and where the European Union and its Member States recognize the harm done by alcohol and apply effective and comprehensive policies to tackle it.

This report is based on "Eurocare Overview and Recommendations for a Sustainable EU alcohol Strategy" September 2009. At the time Eurocare consulted its member organizations, the Alcohol Policy Network (APN), the European Public Health Alliance (EPHA) alcohol working group and the AMPHORA research network regarding their assessment of the progress so far with the EU Alcohol Strategy.

Eurocare members were then as today concerned about the role of the alcohol industry in the implementation of the Strategy and the opportunities the industry is being given to obstruct and to divert attention to what the scientific evidence suggests are unproductive areas of activity.

Addressing the issue of alcohol related harm through effective policies will offer measurable health system savings and enhance the growth and productivity agenda for Europe 2020.

Alcohol – a cause for action

Alcohol is one of the world's leading health risks; use of alcohol is especially harmful for younger age groups. Europe is the heaviest drinking region of the world. Consumption levels in some countries are around 2.5 times higher than the global average[4]. Alcohol harm is disproportionately high among young people (115 000 deaths per year) alarmingly 43% among 15-16 year old European students reported heavy binge drinking during the past 30 days and alcohol is the single biggest cause of death among young men of age 16 to 24[5].

The World Economic Forum's 2010 Global Risks Report identifies non-communicable diseases (NCDs) as the second most severe threat to the global economy in terms of likelihood and potential economic loss. NCDs are a global risk equal in cost to the current global financial crisis[6]. The World Economic Forum and Harvard School of Public Health estimate that NCDs will cause a €25 trillion global economic output loss over the period 2005-2030.

Alcohol is one of the 4 risk factors for developing NCDs such as cancer (1 in 3 Europeans will get cancer in the coming years) and cardiovascular disease[7]. It is important to address alcohol in this context and give it the attention needed. By decreasing the level of alcohol consumption, as well as being physically active and having a healthy diet:

- 75% of deaths from cardiovascular disease could be avoided[8]
- 30-40 % of cancers could be avoided[9]

Accurate European wide data on the impact of alcohol at workplace is not sufficiently gathered and not comprehensive in its scope. However, the figures from individual countries suggest that the problem might be bigger than expected.

- UK estimates that approximate loss in productivity amounts to 6.4 bn GBP; this includes alcohol related absence, reduced employment, and premature death
- International Labour Organisation estimated that globally up to 5% of average work force is alcohol dependent and up to 25% drink heavily to the risk of becoming addicted

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[4] WHO Europe (2012) *Alcohol in the European Union*
[5] ESPAD (2011) *ESPAD Report: Substance Use Among Students in 36 European Countries*
[6] World Economic Forum (2010) *Global risks 2010.* Geneva, Retrieved from: http://www.weforum.org/en/initiatives/globalrisk/Reports/index.htm
[7] WHO (2009) *Global Health Risks: Mortality and burden of disease attributable to selected major risks*
[8] O'Flaherty & Capewell S. *Recent levelling of CHD mortality rates among young adults in Scotland may reflect major social inequalities.* BMJ 2009; 339: b2613
[9] World Cancer Research Fund (2008) *Recommendations for Cancer Prevention*

- A 13% increase in work absence can be expected with an increase in consumption of 1 liter pure alcohol[10]

Due to the size of the problem and the universal impact, alcohol requires a comprehensive, coordinated response from policy and decisions makers at the European and national levels.

Eurocare recognizes the difficulty of reconciling public health and commercial objectives in regard to alcohol products. However, there are a number of policy areas where the European Commission is perfectly placed to enhance actions and deliver measureable achievements to form a coherent approach to reducing alcohol related harm in the EU. Eurocare believes that the goal should be to work towards setting clear and specific targets for reduction in the harmful consumption of alcohol and in levels of harm.

This document aims to contribute to a constructive and action oriented discussion on the future Alcohol Strategy for the EU (2013-2020). It will focus on the main policy areas accompanied with Eurocare recommendations and followed by suggestions on the methods of implementation.

With this in mind, Eurocare calls on the Ministers of Health and Social Affairs in Europe and the European Commission to support the development of comprehensive Alcohol Strategy for the European Union with clear and targeted measures.

[10] Science Group of the Alcohol and Health Forum (2011) *Alcohol, Work and Productivity: Scientific Opinion of the Science Group of the European Alcohol and Health Forum* Retrieved from: http://ec.europa.eu/health/alcohol/docs/science_02_en.pdf

Main policy areas

Eurocare believes that a combination of policy tools and interventions is needed to reduce alcohol related harm, to the benefit of society. It should be our common goal to create an environment that supports lower risk drinking.

Population wide approaches are of significance as they facilitate the reduction of aggregate level of alcohol consumed. Moreover, such approaches might reduce the numbers of people who start drinking at harmful and hazardous levels.

Alcohol causes harm to the individuals, others and society at large. It is a multilayered issue which diversified and evolved over time into a major health threat. This complex problem needs to be solved by a comprehensive strategy employing a number of policy options, some of which are presented below.

2.1. Regulation of marketing

Despite being a key health determinant alcohol is still one of the most heavily marketed products and young people are a very important target group for the alcohol industry[11]. They are exposed to sophisticated marketing aimed at creating positive expectations and beliefs not just about the product itself but how it will make them feel. Alcohol marketing ranges from mass media advertising to sponsorship of events, product placement, internet, merchandise, usage of other products connected with alcohol brands, social networks etc. In 2009, the Science Group of the European Alcohol and Health Forum produced a report[12] which reviewed a number of studies regarding impact of marketing on the volume and patterns of drinking alcohol. It concluded that alcohol marketing increases the likelihood that young people will start to drink alcohol, and that among those who have started to drink, marketing increases the their drinking levels in terms of both amount and frequency.

Eurocare firmly believes that this is one of the central policy areas that needs to be addressed in the coming years. A level playing field for commercial communications should be implemented across Europe, building on existing regulations in Member States, with an incremental long-term development.

[11] Eurocare defines marketing as a mix of sophisticated, integrated strategies, grouped around four main elements: the product, its price, its place (distribution) and its promotion.

[12] Science Group of the Alcohol and Health Forum (2009) *Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?* Retrieved from: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf

Furthermore, Eurocare believes that the existing French 'Loi Evin[13] provides a framework to the regulation of alcohol marketing which could be accepted as the minimum standard across the EU. Volume and content of marketing, online marketing, sponsorship as well as product placement are vital to address in a regulatory framework. Crucially, in light of technological advances and the increased role of social media in society today, particular focus needs to be placed on regulation of the alcohol marketing in the online environment.

RECOMMENDATIONS
Alcohol advertising should only be permitted under precise conditions defined by statutory regulation
When alcohol advertising is permitted, its content should be controlled: • Messages and images should refer only to information of the products such as degree, origin, composition and means of production • A health message must be included on each advertisement • Messages should not mention or link to sexual, social and sports related images
Therefore, we recommend: • No alcohol advertising on television or in cinemas • No alcohol advertising on internet except at points of sale • No alcohol sponsorship of cultural or sport events • No alcohol advertising should be targeted at young people
Regulations on product placement of alcohol products i.e. films and programs portraying drinking classified as for 18 certificate
A complete removal of intrusive[14] and interstitial[15] marketing tools such as: social media, apps on mobile phones
A complete removal of alcohol advertising outdoors and in public premises (i.e. athletes' shirts, bus stops, lorries etc.)
A complete removal of sales promotions such as Happy Hours and Open Bars/Girls Night etc.

2.2. Price and taxation

A number of studies have found that increasing the price of alcohol reduces immediate and chronic harm related to drinking among people of all ages. All consumers, including heavy and problematic drinkers, respond to changes in alcohol prices[16]. Moreover, increase in prices of alcoholic beverages would reduce consumption by young people, and also have more impact on frequent and heavier drinkers than on lighter drinkers.

The affordability of alcoholic beverages has increased in Europe over the last 12 years. The real value of excise duty rates for most alcoholic beverages has gone down since 1996 and consequently alcohol has been much more affordable. There has been a decline in the EU minimum excise duty rate in real terms

[13] Included in the French Act of Public Health
[14] Intrusive here defined as behaviour ad that targets your habits and based on your profile using social net, your own emails, cookies, geolocalisation etc, or brings you to change web page by replacing ads by others.
[15] Interstitial here defined as movable ads that appears between two web pages in a plain screen or when you start apps on your smartphone
[16] Babor TF et al (2010) *Alcohol: no ordinary commodity. Research and public policy*, 2nd ed. Oxford, Oxford University Press.

for alcoholic beverages since 1992 as they have not been adjusted for inflation. There is also a trend towards more off-trade alcohol consumption, which tends to be cheaper than alcohol sold on-trade[17].

Current excise duties vary for different alcoholic products; this means duty does not always relate directly to the amount of alcohol in the product; in addition an increase in the duty levied does not necessarily translate into a price increase- retailer or producers may absorb the cost.

Pricing and other economic measures would be an important part of an effective policy mix to tackle harmful and hazardous alcohol consumption. Several Member States are discussing minimum pricing policies and the support from the European Commission for these initiatives is crucial.

Moreover, restrictions on sales below cost and on sales promotions such as 'two for one' and 'happy hour'; would also have a positive impact on addressing excessive alcohol consumption.

Eurocare acknowledges the difficulties in tackling this issue on the European level, however believes that a European strategy should encourage Members States to introduce policy options like minimum pricing and increased taxes.

RECOMMENDATIONS
Minimum alcohol tax rates should be at least proportional to the content alcohol for all alcoholic beverages
Tax on wine should rise in line with alcoholic strength
Minimum tax rates should be increased in line with inflation
Member States should have the flexibility to limit individual cross-border purchases so as not to diminish the impact of their current tax policies
Member States should retain the flexibility to use taxes to deal with specific problems

2.3. Consumer protection: provision of comprehensive information

Product labels can serve a number of purposes, providing information about the product to the consumer, enticing the consumer to buy the product and warning consumers of dangers and health risks from the product.

Listing the ingredients contained in a particular beverage alerts the consumer to the presence of any potentially harmful or problematic substances. Even more importantly, providing the nutritional information such as calorie content allows consumer to monitor their diets better and makes it easier to

[17] RAND (2009) *The affordability of alcoholic beverages in the European Union, Understanding the link between alcohol affordability, consumption and harms.* Cambridge

keep a healthy lifestyle. Unfortunately, today sulphite is the only allergen required to be listed compulsorily although many other allergens can be present.

Allowing the alcohol industry not to provide full information on the labels of their products is yet another missed opportunity for reducing alcohol related harm. Eurocare believes that alcohol producers should provide information not only on ingredients, but also about the risks associated with alcohol consumption: damages to health (liver cirrhosis, cancers) risk of dependence, dangers associated with drinking alcohol during pregnancy, when driving, operating machinery and when taking certain medication. These messages would be, at a low cost to public budgets, easy to implement at EU level- important reminder that alcohol is a hazardous product.

European Commission is best positioned to coordinate efforts to protect consumers from side effects of products which are sold in the internal market of the EU. Eurocare believes labelling should be part of a comprehensive strategy to provide information and educate consumers about alcohol and should be part of integrated policies and programmes to reduce the harm done by alcohol.

RECOMMENDATIONS
Introduction of health warning labels on containers of alcoholic beverages determined by state/ public bodies.
Containers of alcoholic products should be required to provide the following information about the product to consumers: • their ingredients • substances with allergenic effect • relevant nutrition information (energy value kcal) • alcoholic strength • include health warnings

2.4. Public safety and harm to others

2.4.1. Drink Driving

In 2010, nearly 31,000 Europeans were killed on the roads the main causes of fatal accidents in the EU are speeding, drink driving and non-use of a seat belt[18]. Progress in reducing the number of deaths on the road has been decreasing over the period between 2001 and 2007. In 2007, the percentage of reduction of fatalities was 0% for the EU. Traffic accidents related to alcohol consumption therefore remain a major cause for concern. Around one accident in four can be linked to alcohol consumption, and at least 10,000 people are killed in alcohol-related road accidents in the EU each year.

It has been estimated that a Blood Alcohol Concentration (BAC) of 0,8g/l increases the crash risk of a driver 2,7 times compared to a zero BAC. When a driver has a BAC of 1,5g/l the injury crash rate is 22 times that of a sober driver. Not only the crash rate grows rapidly with increasing BAC but the crash also becomes more severe. With a BAC of 1,5g/l the crash rate for fatal crashes is about 200 times that of sober drivers[19].

RECOMMENDATIONS
Zero tolerance for drink driving in all Member States for all drivers[20]
Adequate enforcement is needed within Member States (e.g.; police checks, random breath testing etc)
A harmonised penalty system with license suspension should be implemented across the EU
Information on drink driving, the harm which results from drinking and driving and the penalties should be included in driving lessons, driving tests and in published driving codes
Ban on sale of alcoholic beverages at petrol stations
Introduce alcohol interlocks for professional drivers and in a first phase to repeat offenders
Introduce mandatory labelling on alcohol products on drink driving

2.4.2. Safer drinking environments

Harm done by alcohol to third parties is a significant burden on society. It causes a number of deaths. Accidents harm individuals' families, communities and society at large. There is a strong link between alcohol and violence (e.g.80% of violent crimes committed by adolescents in Estonia are associated with alcohol use). Alcohol is attributable factor in 40% of all homicides throughout the EU[21]. Effort should be made to create an environment that supports lower- risk drinking. Drinking settings such as pubs, bars, nightclubs are key areas for interventions, for improvements in the way alcohol is served and consumed.

[18] ETSC (2012) Drink Driving: Towards Zero Tolerance
http://www.etsc.eu/documents/Drink_Driving_Towards_Zero_Tolerance.pdf
[19] *Ibid*
[20] A technical enforcement tolerance level could be set at 0,1 or 0,2 g/l BAC but the message to drivers should always be clear: no drink and drive
[21] WHO Europe (2012) *Alcohol in the European Union*

Key features of dangerous venues include a permissive atmosphere, crowding, low levels of comfort, inadequately trained staff, cheap drinks promotions[22]. Thoroughly implemented interventions can enhance prevention of risky behaviour, protect the health of individuals and care for broader impact of hazardous alcohol consumption on communities (i.e. vandalism)

RECOMMENDATIONS
Minimum legal age for purchasing 18 years (while respecting MS with higher minimum age of purchase and stricter implementation policy)
Stricter opening hours for commerce selling alcohol (with special emphasis on night shops)
Reduced density of alcohol outlets, especially around areas where young people are more likely to be present e.g. schools, sport centres, cultural centres, stadiums, play grounds etc.
Mandatory and independently evaluated professional training for employees handling alcohol (serving, selling)

2.4.3. Alcohol and pregnancy

Drinking alcohol during pregnancy can lead to birth defects and developmental disorders. It may cause the unborn child physical, behavioural and learning disabilities. Alcohol can damage the baby throughout the entire pregnancy. During the first trimester of pregnancy, exposure to alcohol can cause abnormalities in the physical structure of the foetus. During the third trimester, the baby's length and weight increase dramatically and exposure to alcohol can impair the growth. The brain develops and is vulnerable to damage during the entire pregnancy. The damage to the brain, which may result in behaviour problems and cognitive deficits, is the most debilitating of the effects of prenatal alcohol exposure. FASD is an umbrella term describing the range of effect that can occur in person whose mother drank during pregnancy. It affects nearly 5 million people and is 100% preventable. Although many women give up alcohol when pregnant there are a substantial number of women in all the EU Member States who continue to drink.

[22] Hughes et al (2011) *Environmental factors in drinking venues and alcohol-related harm: the evidence base for European intervention* Addiction 106(S1):36-46

RECOMMENDATIONS
Containers of alcoholic products should carry a warning message determined by public health bodies describing the harmful effects of drinking during pregnancy
Introduction of comprehensive and permanent awareness-raising campaigns and educational programmes for the public at large
Programmes to enhance knowledge of health care professionals
Provision of services for diagnosis and treatment for children with foetal alcohol syndrome (FAS/FASD)
Implementation of modules promoting health prevention and awareness-rising as compulsory modules in the curriculum for medical degrees
Inclusion of FASD diagnosis by social and judicial services

2.4.4. Family and Children

Whilst million of families within the EU are affected by the problem it is difficult to find an accurate assessment of its size. Perceptions on alcohol problems vary from culture to culture and, among those affected, it can often take the 'character of a shameful secret'. It is being estimated that 23 million people in the EU are dependent on alcohol, which consequently results in 9 million children and young people in the EU living with at least one parent addicted to alcohol[23]. Many of these children are raised in families with alcohol addiction and are exposed to risk behaviour of their parents. Two thirds of the reported victims of domestic violence had been attacked by a person using alcohol, and 16% of cases of child abuse and neglect involve alcohol[24]. Children living with families affected by alcohol related harm tend to have lower school attendance and worse health.

RECOMMENDATIONS
More support for rehabilitation centres for alcohol dependence
Support for educational centres for children of alcohol dependent parents
Awareness raising campaigns on protection of children from alcohol related harm.

2.5. Social inclusion and equality in health

Social inclusion is important both as prevention and as rehabilitation. In order to keep people in the workforce and out of treatment, care and social support, programs to socially integrate and rehabilitate people with alcohol problems are a priority. It would benefit the individual, its family and community and the economy as well as reducing inequalities in health. This could be achieved by integration of alcohol harm related dimension in programs aiming at reducing inequalities in health and social exclusion. Furthermore, effective programs should be supported, such as self- help groups and early intervention programs as well as effective treatment.

[23] Anderson P, Baumberg B (2006) *Alcohol in Europe: a public health perspective.* London Institute of Alcohol Studies
[24] *Ibid*

The adverse effects of alcohol are exacerbated among those from lower socioeconomic groups; this is especially the case for dependency, which is often accompanied by poor diet and general lack of money. People in lower socioeconomic groups who drink heavily cannot protect themselves as well as those in more affluent groups, who can purchase social and spatial buffering of their behaviour. Low socioeconomic status renders a pattern of drinking more visible and makes the drinker more vulnerable to marginalisation and stigma.

RECOMMENDATIONS
Implementation of health objectives in all policies
Impact assessments of other Directorate Generals policies and decisions on alcohol policy.

2.6. Prevention with special focus on prevention at workplace

Prevention cannot remain a responsibility of the Member States alone, Europe, as a market place, a cultural space and communication area must address prevention. Equally the local level is where people conduct their daily lives. Therefore, prevention should therefore span across the European and local level. Community based prevention must be supported by a European wide program in a comprehensive, coordinated, long- term manner.

Harmful and hazardous alcohol consumption is one of the main causes of premature death and avoidable disease and furthermore has a negative impact on working capacity. Alcohol-related absenteeism or drinking during working hours have a negative impact on work performance, competitiveness and productivity. Often forgotten is the impact of drinkers on the productivity of people other than the drinker. Moreover, about 20 to 25% of all accidents at work involve intoxicated people injuring themselves and other victims, including co-workers[25].

RECOMMENDATIONS
Implementation of alcohol policies within the workplace to focus on health promotion and on different lifestyles rather than on the disease and punitive sanctions
More comprehensive data collection on impact of alcohol related problems on economy and within the workplace
Enforcement and where not existent introduction of zero tolerance policies for BAC levels in industries where alcohol increases the danger of accidents and injuries
Implementation of awareness raising campaigns at work about alcohol related harm

[25] Science Group of the Alcohol and Health Forum (2011) *Alcohol, Work and Productivity: Scientific Opinion of the Science Group of the European Alcohol and Health Forum* Retrieved from: http://ec.europa.eu/health/alcohol/docs/science_02_en.pdf

2.7. Treatment and early interventions

Treatment and early interventions is a vital component of the total response to alcohol problems, and must be included in a comprehensive approach to alcohol policy. As some studies indicate in primary health care settings, commonly less than 10% of the population at risk of becoming hazardous and harmful drinkers are identified and less than 5% of those who could benefit are offered brief interventions[26]. There is consistent evidence that early interventions reduce alcohol related harm and are cost effective. Moreover, organisational factors increase the implementation and effectiveness of these programmes.

RECOMMENDATIONS
Support given to Member States in exchange of information in area of brief interventions (including interventions designed for non- dependent high drinker, specialised treatment for persons with alcohol dependence)
Recognition and support for informal groups of mutual self help

2.8. Monitoring of data, developing and maintaining common evidence base

It is crucial to appropriately monitor alcohol policy developments in the EU, with a set of common indicators and definitions, in order to ensure that comparable data across EU is available. Consequently, this consistency will provide tools to assess the policy actions undertaken. There is a need for better data on alcohol in Europe. The European Commission and Member States should regularly obtain comparable information on alcohol consumption, on drinking patterns, on the social and health effects of alcohol; and information on the impact of alcohol policy measures and of alcohol consumption on productivity and economic development.

The European Commission should monitor and follow the developments in Member States to see if targets are reached.

RECOMMENDATIONS
A European Alcohol Monitoring centre with country based counterparts, should be established and financed
When new legislation is adopted at regional, national and the European level standardised evaluation should be performed.
Alcohol related targets should be included in European Commission work on prevention of chronic disease
European Commission defining and tracking a common set of indicators and policy responses and interventions in the framework of Open Method of Coordination

[26] WHO Europe (2012) *Alcohol in the European Union*

Way forward: how to address alcohol related harm?

Compared to the current EU alcohol strategy there is a strong need for future policies to have specific and clear targets, whilst also working harder at promoting a coherent approach through health in other policies.

3.1. Enhanced cooperation between Member States

One way forward to provide a more structured approach would be for the new EU alcohol strategy to include:

- Fixing guidelines and timetables for achieving short, medium and long-term goals
- Establishing quantitative and qualitative indicators and benchmarks, tailored to the needs of Member States and sectors involved, as a means of comparing best practices
- Translating European guidelines into national and regional policies, by setting specific measures and targets
- Periodic monitoring and evaluation of the progress achieved in order to put in place mutual learning processes between Member States

Eurocare suggests having a 3 step period; 2013 – 2015, 2016- 2018, 2019-2020 that would be expected to produce the following outcomes:

- Enhanced mutual learning and peer review
- Identification of good practices and of their conditions for transferability
- Development of joint policy initiatives among several Member States and regions
- Identification of areas where Community initiatives could reinforce actions at Member State level.

3.2. Alcohol in all policies

European Union regulations, such as those governing the internal market, trade, competition and agriculture, have in practice an enormous impact on national and local health policies.

Eurocare is concerned that alcohol related harm does not seem to be taken into account when issues like cross border trade, taxes and agricultural support are discussed and regulated by Directorates of the Commission which are not directly working on health. The efforts of the health community and all stakeholders involved could be counterproductive if the issue is not being addressed.

This has been recognised over the years by the EU legislature and as mentioned in Art. 168(5) TFEU, it *(...) may adopt incentives measure designed to protect and improve human health (...) and measures*

which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol.

Alcohol is no ordinary commodity and should not be treated as such. Free trade rules and competition paradigm should not take precedence over the protection of public health and social wellbeing in Europe. European Commission with other partners should start reflecting on future exemption of alcohol from free trade agreements as it is a harmful substance with detrimental effect to health and society.

CONCLUSIONS: Let us all think about alcohol differently

What's drinking?

A mere pause from thinking!

~George Gordon, Lord Byron

Alcohol is not a neutral substance. Neither to the individual, as it is an addictive and harmful product, nor to the society, as one person's freedom to drink might hinder other's person freedom to safety.

As physical borders disappear and trade within and beyond the EU is made easier and faster, we are faced with new challenges in terms of alcohol policy. Combination of interventions is needed to reduce alcohol-related harm to the benefit of society as a whole.

Preventing harm in the first place and promoting healthy lifestyles are a cost effective measure for fighting diseases- it is an investment in the future saving. We should strive to continuously achieve small milestones towards the final outcome of a healthier society.

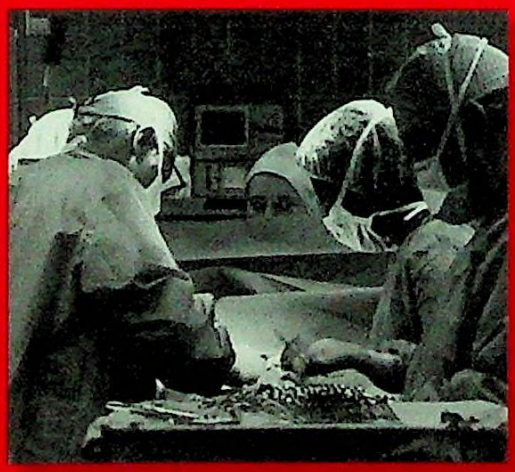
As we are faced with new austerity measures and an aggressive drive for increased alcohol sales, the protection of consumers and citizen's welfare should not be sidetracked. Otherwise, it is almost certain that our public systems will be faced with tangible consequences of inaction.

Eurocare believes that the European Commission and Member States have much to learn from sharing experience of national policies in areas of common interest. This can help them to improve the design and implementation of their own policies, to develop coordinated or joint initiatives on issues of transnational interest and to identify areas where Community initiatives could reinforce national actions.

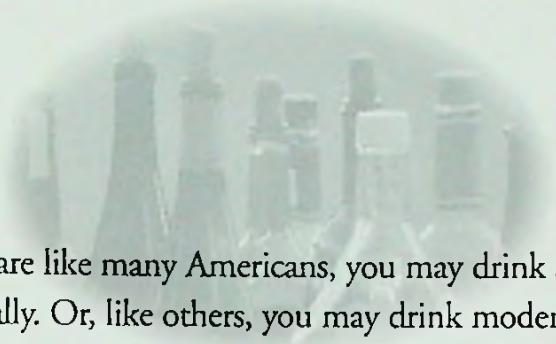
Over the last years policies such as awareness rising have become widespread, whereas policies that would have a greater impact such as increasing alcohol price and regulating marketing tended to be forgotten. There is thus a great area for improvement to reduce the burden of alcohol on individuals and societies over the coming years.

ALCOHOL

What You Don't Know Can Harm You



National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health



If you are like many Americans, you may drink alcohol occasionally. Or, like others, you may drink moderate amounts of alcohol on a more regular basis. If you are a woman or someone over the age of 65, this means that you have no more than one drink per day; if you are a man, this means that you have no more than two drinks per day. Drinking at these levels usually is not associated with health risks and can help to prevent certain forms of heart disease.

But did you know that even moderate drinking, under certain circumstances, is not risk free? And that if you drink at more than moderate levels, you may be putting yourself at risk for serious problems with your health and problems with family, friends, and coworkers? This booklet explains some of the consequences of drinking that you may not have considered.

What Is a Drink?

A standard drink is:

- One 12-ounce bottle of beer* or wine cooler
- One 5-ounce glass of wine
- 1.5 ounces of 80-proof distilled spirits.

*Beer ranges considerably in its alcohol content, with malt liquor being higher in its alcohol content than most other brewed beverages.

Drinking and Driving

It may surprise you to learn that you don't need to drink much alcohol before your ability to drive becomes impaired. For example, certain driving skills—such as steering a car while, at the same time, responding to changes in traffic—can be impaired by blood alcohol concentrations (BACs) as low as 0.02 percent. (The BAC refers to the amount of alcohol in the blood.) A 160-pound man will have a BAC of about 0.04 percent 1 hour after consuming two 12-ounce beers or two other standard drinks on an empty stomach (see the box, "What Is a Drink?"). And the more alcohol you consume, the more impaired your driving skills will be. Although most States set the BAC limit for adults who drive after drinking at 0.08 to 0.10 percent, impairment of driving skills begins at much lower levels.

Interactions With Medications

Alcohol interacts negatively with more than 150 medications. For example, if you are taking antihistamines for a cold or allergy and drink alcohol, the alcohol will increase the drowsiness that the medication alone can cause, making driving or operating machinery even more hazardous. And if you are taking large doses of the painkiller acetaminophen and drinking alcohol, you are risking serious liver damage. Check with your doctor or pharmacist before drinking any amount of alcohol if you are taking any over-the-counter or prescription medications.

Interpersonal Problems

The more heavily you drink, the greater the potential for problems at home, at work, with friends, and even with strangers. These problems may include:

- Arguments with or estrangement from your spouse and other family members;
- Strained relationships with coworkers;
- Absence from or lateness to work with increasing frequency;
- Loss of employment due to decreased productivity: and
- Committing or being the victim of violence.

Alcohol-Related Birth Defects

If you are a pregnant woman or one who is trying to conceive, you can prevent alcohol-related birth defects by not drinking alcohol during your pregnancy. Alcohol can cause a range of birth defects, the most serious being fetal alcohol syndrome (FAS). Children born with alcohol-related birth defects can have lifelong learning and behavior problems. Those born with FAS have physical abnormalities, mental impairment, and behavior problems. Because scientists do not know exactly how much alcohol it takes to cause alcohol-related birth defects, it is best not to drink any alcohol during this time.

Long-Term Health Problems

Some problems, like those mentioned above, can occur after drinking over a relatively short period of time. But other problems—such as liver disease, heart disease, certain forms of cancer, and pancreatitis—often develop more gradually and may become evident only after long-term heavy drinking. Women may develop alcohol-related health problems after consuming less alcohol than men do over a shorter period of time. Because alcohol affects many organs in the body, long-term heavy drinking puts you at risk for developing serious health problems, some of which are described below.

Alcohol-related liver disease. More than 2 million Americans suffer from alcohol-related liver disease. Some drinkers develop alcoholic hepatitis, or inflammation of the liver, as a result of long-term heavy drinking. Its symptoms include fever, jaundice (abnormal yellowing of the skin, eyeballs, and urine), and abdominal pain. Alcoholic hepatitis can cause death if drinking continues. If drinking stops, this condition often is reversible. About 10 to 20 percent of heavy drinkers develop alcoholic cirrhosis, or scarring of the liver. Alcoholic cirrhosis can cause death if drinking continues. Although cirrhosis is not reversible, if drinking stops, one's chances of survival improve considerably. Those with cirrhosis often feel better, and the functioning of their liver may improve, if they stop drinking. Although liver transplantation may be needed as a last resort, many people with cirrhosis who abstain from alcohol may never need

liver transplantation. In addition, treatment for the complications of cirrhosis is available

Heart disease. Moderate drinking can have beneficial effects on the heart, especially among those at greatest risk for heart attacks, such as men over the age of 45 and women after menopause. But long-term heavy drinking increases the risk for high blood pressure, heart disease, and some kinds of stroke.

Cancer. Long-term heavy drinking increases the risk of developing certain forms of cancer, especially cancer of the esophagus, mouth, throat, and voice box. Women are at slightly increased risk of developing breast cancer if they drink two or more drinks per day. Drinking may also increase the risk for developing cancer of the colon and rectum.

Pancreatitis. The pancreas helps to regulate the body's blood sugar levels by producing insulin. The pancreas also has a role in digesting the food we eat. Long-term heavy drinking can lead to pancreatitis, or inflammation of the pancreas. This condition is associated with severe abdominal pain and weight loss and can be fatal.

If you or someone you know has been drinking heavily, there is a risk of developing serious health problems. Because some of these health problems are both reversible and treatable, it is important to see your doctor for help. Your doctor will be able to advise you about both your health and your drinking.

Research Directions

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health, supports about 90 percent of the Nation's research on alcohol use and related consequences. Through this research, NIAAA and the researchers it supports make an implicit promise—that alcohol research will yield practical applications that will help those who suffer as a result of alcohol abuse and alcoholism. Today, alcohol researchers are working on the cutting edge of medical science to answer questions such as:

- Who is at risk for alcohol-related problems?
- How does alcohol affect the body, including the brain?
- How is the risk for alcoholism inherited?
- What are the health benefits and risks of moderate drinking?
- What therapies, including medications, show promise for treating alcohol dependence more effectively?

Each new discovery made by alcohol researchers provides a piece of the answer to the ages old question of how to prevent and treat the alcohol-related troubles that plague individuals, families, and society. We see the future of alcohol research both as a challenge and as a reward: A challenge, because with more answers come more questions,

and we still have far to go. A reward, because the answers we find ultimately will help diminish a public health threat that has existed for far too long.

If you or someone you know needs help or more information, contact:

➢**Al-Anon Family Group Headquarters**
1600 Corporate Landing Parkway
Virginia Beach, VA 23454–5617
Internet address: http://www.al-anon.alateen.org

Makes referrals to local Al-Anon groups, which are support groups for spouses and other significant adults in an alcoholic person's life. Also makes referrals to Alateen groups, which offer support to children of alcoholics.

➢ Locations of Al-Anon or Alateen meetings worldwide can be obtained by calling 1–888–4AL–ANON Monday through Friday, 8 a.m.–6 p.m. (e.s.t.).
➢ Free informational materials can be obtained by calling the toll-free numbers (operating 7 days per week, 24 hours per day):
➢U.S.: (800) 356–9996
➢Canada: (800) 714–7498

➢**Alcoholics Anonymous (AA) World Services**
475 Riverside Drive, 11th Floor
New York, NY 10115
(212) 870–3400
Internet address: http://www.alcoholics-anonymous.org

Makes referrals to local AA groups and provides informational materials on the AA program. Many cities and towns also have a local AA office listed in the telephone book.

➢**National Council on Alcoholism and Drug Dependence (NCADD)**
12 West 21st Street
New York, NY 10010
(800) NCA–CALL
Internet address: http://www.ncadd.org

Provides telephone numbers of local NCADD affiliates (who can provide information on local treatment resources) and educational materials on alcoholism via the above toll-free number.

➢**National Institute on Alcohol Abuse and Alcoholism**
Scientific Communications Branch
6000 Executive Boulevard, Suite 409
Bethesda, MD 20892–7003
(301) 443–3860
Internet address: http://www.niaaa.nih.gov

Makes available free publications on all aspects of alcohol abuse and alcoholism. Many are available in Spanish. Call, write, or search the World Wide Web site for a list of publications and ordering information.

NIAAA
National Institute on Alcohol Abuse and Alcoholism

NIH Publication No. 99–4323
Printed 1999

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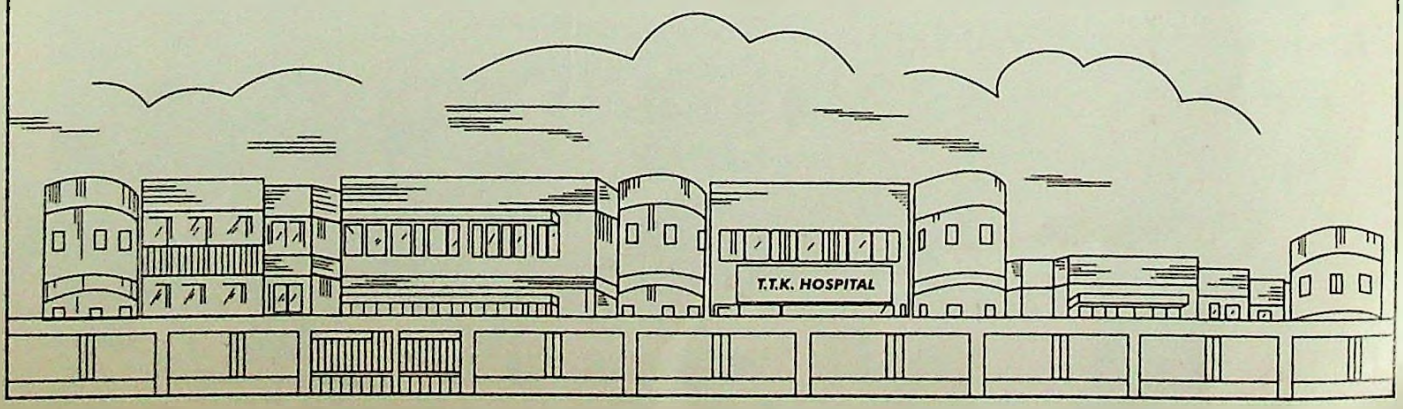
Let everyone lead a happy life

Treatment and Rehabilitation Centre for Alcoholism and Drug Dependency

T T RANGANATHAN CLINICAL RESEARCH FOUNDATION

TTK HOSPITAL



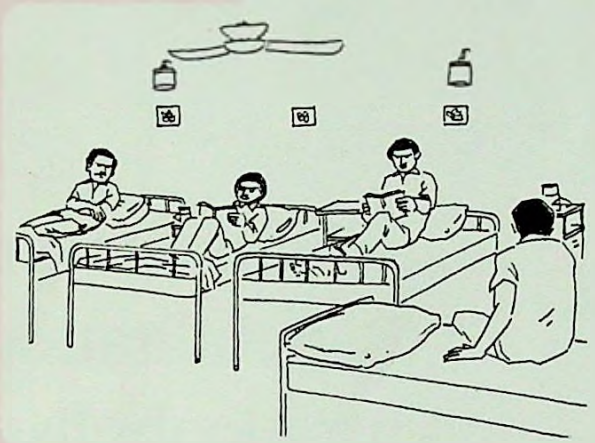
TTK Hospital

TTK Hospital / TT Ranganathan Clinical Research Foundation is a voluntary, non-profit organisation dedicated to the treatment and rehabilitation of persons addicted to alcohol and drugs.

60 Bed Premier Hospital run by a Team of Committed Professionals

Established in 1980, the hospital has 60 beds. A team of qualified professionals, deeply committed to the mission, provide the patients with both medical and psychological treatment.

The facilities offered at the Hospital include :



- detoxification unit
- emergency ward
- general wards
- special rooms
- family ward
- therapy centre
- counselling units
- family therapy centre
- recreation centre
- canteen
- pharmacy

Addiction is a Disease. It requires Treatment

Alcoholism or drug dependency is a disease. A chronic and progressive disease that leads to severe physical. emotional and social problems.

Our authentic experience in having treated over 11,000 patients during the last 20 years, has strengthened our belief that addicts, when provided timely treatment and support, can lead qualitative lives free of alcohol and drugs.

Treatment aims at Total Abstinence and Improved Quality of Life

The objective of the treatment is to achieve the twin goals of

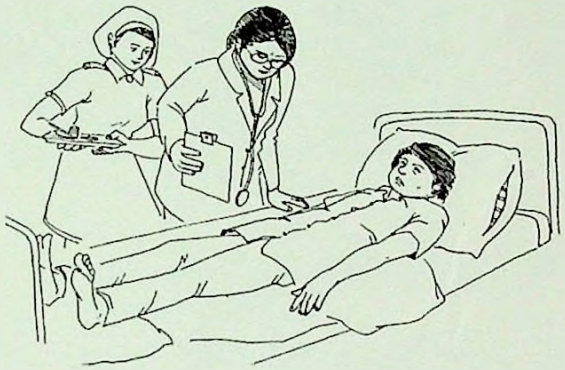
- Total abstinence from alcohol and drugs for life and
- Positive changes towards enhancing the quality of his life.

In-patient Treatment

The treatment programme is a residential, multi-disciplinary therapeutic programme, conducted by a team of psychiatrists, physicians, psychologists, social workers, counsellors and nursing staff. The duration of the treatment programme is 4 to 6 weeks.

Detox facilities to mitigate withdrawal problems

Patients are admitted to the detoxification unit where the required medical treatment is given. Withdrawal symptoms due to sudden stoppage of drug usage and health problems associated with addiction are dealt with.



When the physical condition of the patient stabilises, he is transferred to the psychological therapy wing.

Psychological Therapy

Psychological therapy comprises individual counselling, lectures, group therapy and relaxation techniques. Individual care and attention are given to patients.

Free Follow-up

Follow-up forms an important part of the treatment and is maintained for a period of five years. Patients are encouraged to meet the Doctor and their Counsellors regularly to seek medical advice and report on their progress.

Support groups - AA and Al-Anon

Patients and family members are encouraged to attend Alcoholics Anonymous (AA) and Al-Anon meetings. Meetings are also held at the hospital premises.

Helping the family towards leading a qualitative life

Addiction is an illness that affects not only the addicted individual, but also his family members.

The family is provided with emotional support to manage the stress caused by the behaviour of the addict. Guidelines to help the patient in his recovery form part of this two week programme.

The programme includes lecture sessions, group therapy, and participation in Al-Anon.

Social support programme

The Social Support Programme aims at exploring the possible support, the recovering patients can receive from the society in which they live and utilising it towards their recovery.

The support persons are usually family members - other than the spouse - or co-workers or friends. Contact with the support persons helps in stabilising recovery and ensuring regular follow-up.

After Care Centre

For patients who need extended help, a special after care programme is available. The programme is for a period of 3 months. This centre has 20 beds.

How do I get admitted

For admission, contact the Intake Counsellor either over telephone or in person. It may not be possible to get admission without advance reservation.

For additional information contact: Ms. Thirumagal.

TTK HOSPITAL

IV Main Road, Indira Nagar, Chennai 600 020.

Phone : 4912948 / 4918461 / 416458 E-mail : ttrcrf@md2.vsnl.net.in

Treatment and Rehabilitation Centre for
Drug Dependency and Alcoholism

T.T. Ranganathan
Clinical Research Foundation

AFTER CARE CENTRE

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Let everyone lead a happy life

AFTER CARE CENTRE

20 Bedded half way home run by a team of committed professionals

After Care Centre - TT Ranganathan Clinical Research Foundation is a voluntary, non-profit organisation dedicated to the treatment and rehabilitation of persons addicted to drugs and alcohol.

Established in 1989, the Centre has 20 beds. A team of qualified professionals, deeply committed to the mission, provide the patients both medical and psychological treatment.

The facilities offered at the centre include:

- Therapy centre
- Counselling units
- Family therapy centre
- Recreation centre
- Yoga

Addiction is a Disease It requires Treatment

Drug dependency is a disease. A chronic and progressive disease that leads to severe physical, emotional and social problems.

Our experience in having treated over 700 patients during the last 10 years, has strengthened our belief that addicts, when provided timely treatment and support, can lead qualitative lives free of drugs / alcohol.

Treatment aims at total abstinence and improved quality of life

The objective of the treatment is to achieve:

- Total abstinence from drugs for life
- Positive changes towards enhancing the quality of life

AFTER CARE CENTRE

In-patient Treatment

The treatment programme is a residential, multi disciplinary therapeutic programme, conducted by a team of psychologists, social workers, counsellors and Doctor. The duration of the treatment programme is 12 weeks.

Psychological Therapy

Psychological therapy comprises of individual counselling, lectures, group therapy and relaxation techniques. Individual care and attention are given to patients.

Free Follow-up

Follow-up forms an important part of the treatment and it is maintained for a period of five years. Patients are encouraged to meet the Doctor and their Counsellors regularly to seek medical advice and report on their progress.

Support groups - NA, AA and A1-Anon

Patients and family members are encouraged to attend Narcotic Anonymous (NA), Alcoholics Anonymous (AA) and A1-Anon meetings. Meetings are also held at the hospital premises.

All dormitory { Treatment cost + food Rs. 5000 p.m. x 3 mths. Rs 15,000

Personal expenses - extra

Helping the family towards leading a qualitative life

Addiction is an illness that affects not only the addicted individual, but also his family members.

The family is provided with emotional support to manage the stress caused by the behaviour of the addict. Guidelines to help the patient in his recovery form a part of this 12 week programme.

The programme includes lecture sessions individual therapy, group therapy and participation in Al-Anon.

Social support programme

The Social Support Programme aims at exploring the possible support, the recovering patients can receive from the society in which they live and utilise it towards their recovery.

The support persons are usually family members - other than the spouse - or co-worker or friends. Contact with the support persons helps in stabilising recovery and ensuring regular follow-ups.

How do I get admitted

For admission, contact the Centre either over telephone or in person. It may not be possible to get admission without prior consultation.

For additional information contact :

AFTER CARE CENTRE

IV Main road, Indira Nagar, Chennai - 600 020. Tel: 4424314.

4912948 / 4918461

T T RANGANATHAN CLINICAL RESEARCH FOUNDATION (Regd)
"TTK HOSPITAL"
17, IV Main Road, Indira Nagar, Chennai 600 020

TREATMENT CHARGES

The facilities offered and charges for the Wards are listed below:

GENERAL WARDS 'B' WARDS Dormitory

Detoxification is done in a Common Ward consisting of 12 beds. The patient is admitted here for about 4 days. He is then shifted to the Therapy Wards for the remaining period of 21 days.

There are 6 Wards. Each Ward has 7 beds. Toilets are provided outside the Wards.

Detoxification and Therapy Charges		1,500.00
Bed Charges during Detoxification & Therapy for 25 days at the rate of Rs. 125.00 per day		3,125.00
	Rs.	4,625.00

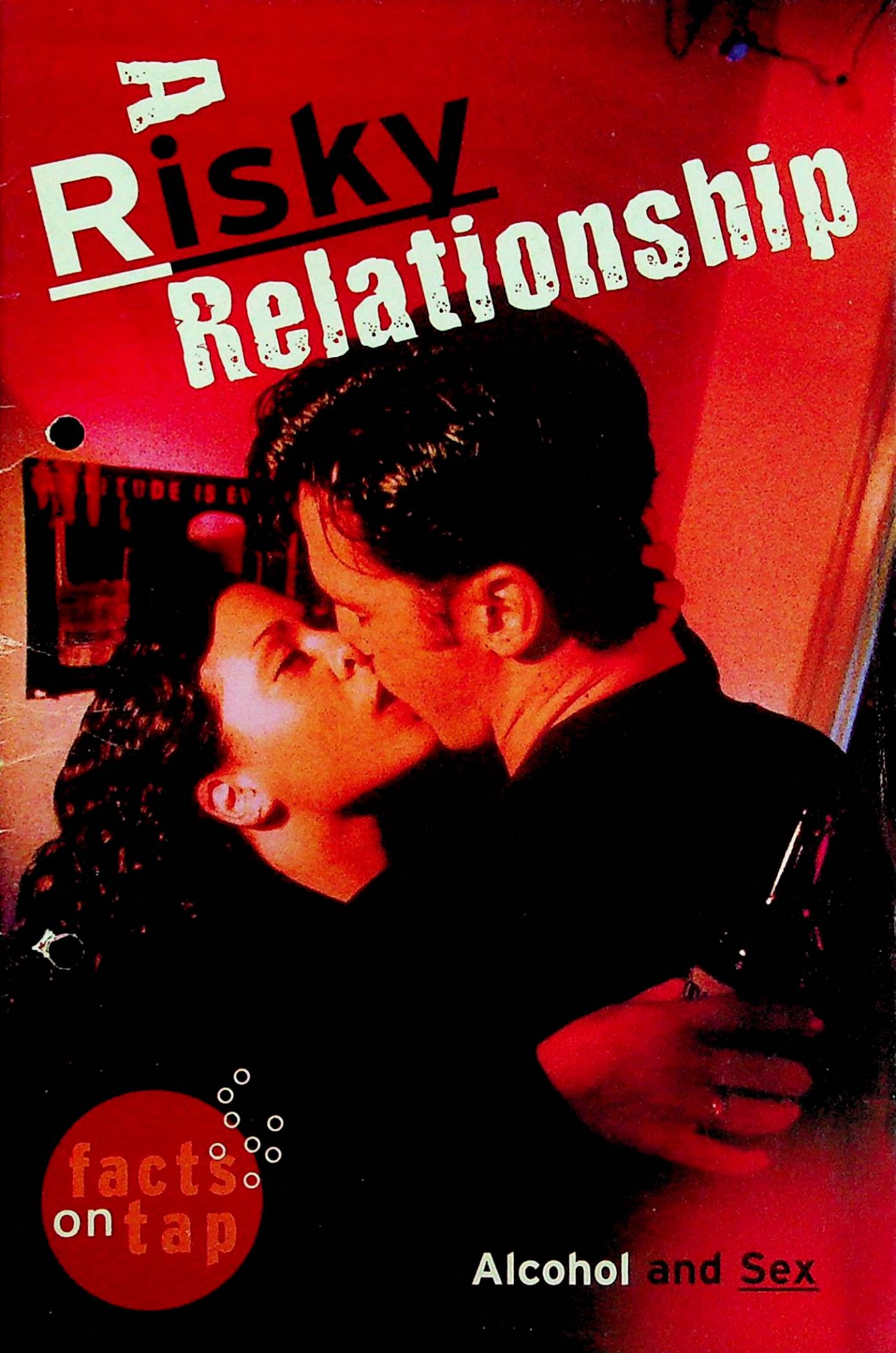
1 month 08

FAMILY WARD (FOR WOMEN)

Rs. 6000/- food + medicines for 1 Month

Family members accompanying patients staying in 'B' Wards can avail of the accommodation provided in the Family Ward. The Ward can accommodate 10 people. The charge is Rs. 20/- per day.

A Risky Relationship



facts on tap

Alcohol and Sex

You know that alcohol lowers your inhibitions and interferes with decision-making, which **makes for some potentially dangerous sexual situations.** At best, deciding to sleep with someone while you're under the influence can put you in an embarrassing predicament the next morning. **At worst, it can cause you to be the victim of sexual assault or leave you with a deadly disease like AIDS.** That's why you need to have a plan, to prevent yourself from getting into sexual jeopardy when you drink.

Dangerous (Drunken) Liaisons

In this brochure, you'll find:

- **Real-life stories** from students who've been in drunken sexual situations they've regretted—and that have changed their lives forever
- **The facts** about how alcohol has different effects on men and women
- **Scary but true statistics** about the sexual danger that alcohol can put you in
- **How to respond** when you're being pressured into having sex while under the influence
- **Where to get help** if you've been sexually assaulted
- **Danger signals** to watch out for when you're drinking with potential romantic partners
- **Whether you can have sex legally** with someone who is drunk
- **Assault prevention** including the basic facts about "date rape drugs" Rohypnol and GHB
- **A quiz** that will help you determine if your relationship depends too heavily on alcohol

Here, six students who learned the hard way that mixing alcohol and sex have serious consequences:

Jon "This guy I really liked asked me to go to a party with him. We were having fun, and I guess we were getting pretty drunk. We decided to go back to my room to be alone. We were kissing and fooling around, and I was okay with it. Then he started to go further than I wanted to go. I told him that I didn't want to, but I guess he thought I was into it. **I don't even think he realizes that he raped me.**"

Jon "I was at a party at a friend's apartment right before Thanksgiving break. I got pretty tanked playing drinking games, and suddenly I was outside on this fire escape with a guy I'd met an hour earlier. I was doing something to him I'd rather not talk about. The next morning I woke up and couldn't even remember his name. **I felt disgusted.** To make matters worse—either someone saw us or he bragged to his friends about what happened, because after I got back from the break, a friend of mine told me I had a new nickname. I still haven't lived it down, and I feel like I'm this big joke."

Jon "Karen was the first girl I'd gone out with since I'd come out [of the closet], and I was really psyched. On our second date, we went out for dinner and somehow managed to drink two bottles of wine. Then we headed back to my dorm room, where we started making out. I wasn't ready to have sex yet, because everything was so new to me and I wanted my first time with a woman to be really special. **After all that wine, I guess my judgement was off, and I had sex with her anyway.** I didn't even remember most of it. Even though part of me really liked her, I felt so embarrassed after that. Since then it's been really hard for me to get close to anyone."

Jon "At the end of the semester I was at a party. It was late and everyone was really trashed. We were all just hanging out when my friend's girlfriend decided to sit on my lap. I didn't think it was any big deal, since we were pals, but suddenly she started kissing me. I was so out of it I didn't stop her. This was right in front of everyone we knew. Someone finally said to us, 'What do you guys think you're doing?' and we stopped, but of course it got back to my buddy. He flipped. **Our friendship was totally destroyed by this stupid, drunken incident.** I think he felt I'd broken a code of trust, which, in a way, I guess I had. We don't even talk anymore."

"I've been openly gay for two years, and active in our campus gay support organization. This fall, after a meeting, I invited the group over to my house for a party. I was excited to be back on campus, and I guess I celebrated a little bit too much—I kept drinking more even though I knew I was already pretty drunk. As everyone was getting ready to leave, a guy who I'd been talking to for most of the night asked if he could hang out for a while longer. **We had sex—which I would not have done if I had been sober.** I don't believe in sleeping with people on the first date. I think he regrets it too, because we haven't spoken since."

"One Thursday night I was out with my friends, kicking off the weekend. This girl challenged me to a drinking contest, so I took her up on it and we got really drunk. She came back to my room after last call. We hung out, drank a few more beers, and I guess I passed out. I don't know how much time had passed, but I woke up to her on top of me. Apparently my body was in the mood to have sex, even though I wasn't mentally interested at all. She had already gotten going before I managed to push her off me. There was no protection involved. **I know it's hard to believe that a guy can be raped,** but I really felt violated. I did not want to have sex with her. To make things worse, about a month later I realized I'd contracted herpes."

How Alcohol Discriminates

Unfortunately, alcohol isn't up with the times when it comes to treating men and women equally. Check out this chart to see how drinking affects you, based on whether you're male or female.

	Women	Men
Ability to Dilute Alcohol	Average Total Body Water: 52%	Average Total Body Water: 61%
Ability to Metabolize Alcohol	Women have a smaller quantity of dehydrogenase, an enzyme that breaks down alcohol.	Men have a larger quantity of dehydrogenase, which allows them to break down the alcohol they take in more quickly.
Hormonal Factors	Premenstrual hormonal changes cause intoxication to set in faster during the days right before a woman gets her period. Alcohol increases estrogen levels. Birth control pills or other medicine with estrogen increase intoxication.	Their susceptibility to getting drunk does not fluctuate dramatically at certain times of the month. Alcohol also increases estrogen levels in men. Chronic alcoholism has been associated with loss of body hair and muscle mass, development of swollen breasts and shrunken testicles, and impotence.

Just the Frightening Facts, Ma'am

Here are some stone-cold sobering statistics about the college sex-and-alcohol cocktail:

- As many as 70% of college students admit to having engaged in sexual activity primarily as a result of being under the influence of alcohol, or to having sex they wouldn't have had if they had been sober.
- At least one out of five college students abandons safe sex practices when they're drunk, even if they do protect themselves when they're sober.
- 90% of all campus rapes occur when alcohol has been used by either the assailant or the victim.
- One in twelve college males admit to having committed acts that meet the legal definition of rape or acquaintance rape.

- 55% of female students and 75% of male students involved in acquaintance rape admit to having been drinking or using drugs when the incident occurred.
- 60% of college women who are infected with STDs, including genital herpes and AIDS, report that they were under the influence of alcohol at the time they had intercourse with the infected person.
- Female college freshman are at the highest risk for sexual assault between the first day of school and Thanksgiving break.
- According to the Center for Disease Control, 1 in 1500 college students is HIV positive, and the fastest-growing populations of American people infected with HIV are teenagers and young adults.

Dos & Don'ts for Defusing a Sexual Advance

The following tips can be used whether the person who's crossing the line is drunk or not. But before you start drinking, ingrain them in your memory so you can put them into action if you need to. Keep in mind that sometimes, no matter what you do, you cannot avoid an assault.

Do say, "No!" Say it with certainty. Let there be no doubt in the person's mind that you have no intention of having sex with him or her.

Don't smile or worry about being friendly or polite. Your own physical safety is your main concern, not whether you hurt this person's feelings. After all, you're being pressured–it's already obvious that he or she doesn't care about your feelings.

Do use the word "rape." Saying something like, "You know you'll be raping me if you get your way, don't you?" may give the drunk person a sobering wake-up call and stop them in their tracks.

Don't hesitate to lie to get out of a situation. If you're in a room together but you'd like this person to leave, tell him or her you have an STD or that your roommate is going to be home any minute.

Do act quickly. Assess the situation:

- Are there people around to help you? If so, get someone's attention by making eye contact to let him or her know you're in trouble.
- If no one is around, but you think you might be heard if you screamed, then go ahead and yell, "Fire!" People are more likely to respond to this alarm than if you were to yell for help, because people don't like to get involved in what they perceive to be a lover's quarrel.
- If you are in a deserted area, try to determine an escape route. Distract your assailant by looking off in the opposite direction, as though you hear someone approaching. Since the person is drunk, this tactic should buy you a few moments to make a run for it.

Where to Go for Help

What to Do If You Are Raped or Sexually Assaulted

Whether or not you were drunk when the assault occurred, remember that it is not your fault. If the incident occurred within the last 24-72 hours:

- Call the police and file a report. You may need to go in to the station to do this, or you may be directed to go to the hospital emergency room for an examination.
- If possible, do not shower, bathe, eat or drink before you are examined. Bring a change of clothes with you to the hospital because the police will need to keep the clothes you were wearing during the assault as evidence.
- Ask to speak to rape crisis counselor or social worker, who will inform you about counseling services that are available to you.
- Even if you decide not to press charges, it is still extremely important that you be examined by a doctor. You may have contracted a sexually transmitted disease from your attacker for which you should receive immediate treatment.

If the incident occurred recently or long ago, you can still get help.

- Ask a school counselor about support groups on campus for survivors of sexual assault.
- If you're not comfortable seeking help on campus, look in your telephone directory to find other support groups in your area. You can also call RAINN (Rape and Incest National Network) at 800-656-4673 for a victims services office near you.

What to Do If You Are in An Abusive Relationship

Whether it has to do with your partner's alcohol abuse or not, here's where to turn:

- We know it's easier said than done, but get out. You don't have to tolerate abuse of any kind.
- Seek on-campus help by visiting a school counselor and learning about support groups.
- Call the National Domestic Violence Hotline at 800-799-SAFE.
- You can also call the Covenant House 9-line for a crisis intervention services in your area. 800-999-9999.

When a Date = Danger Zone

The following is a checklist of behaviors that should set off alarms in your head whether you're drinking or not. Don't let your politeness or intoxication put you in a threatening situation. If a person you're with at a party or a bar displays any of these behaviors, stay alert enough to call a friend and ask him or her to help you get home safely.

Do not get into a car or go home with a person who shows any of these signs:

- Not listening to you, interrupting you, or ignoring you.
- Disregarding your space boundaries and touching you without your consent.
- Trying to make you feel guilty if you won't do something sexual or using red flag words like "uptight," "prude," or "tease."
- Acting possessive, jealous, or paranoid and becoming upset if anyone else looks at or talks to you.
- Drinking heavily.

Protect Yourself

Here are some tactics to use to avoid getting involved in a dangerous sexual situation.

Avoid drinking too much. Alcohol impairs your ability to make smart choices.

Talk to your date beforehand to make sure you are on the same page about where the night is going.

Don't go back to someone's room or leave a party with someone you don't know well.

Trust your gut. If you feel at all uncomfortable, get out of the situation.

When going on a date with someone new, **make sure to tell a friend** what your plans are so that someone knows where you will be.

Take a self defense class. That way, you will know what to do if things get too physical.

What Does It Mean to Be "Consenting Adults?"

Legally speaking, for two people to have sex, you've both got to agree to it. That's called consent: a voluntary, verbal, positive affirmation that you both want to have sex. Problem is, things get hazy if either you or your partner is drunk. So keep these points in mind if you're drunk and horny, or you may find yourself sober and jailed:

Consent is not just the absence of the word "no." So ask your partner if he or she wants to have sex. No answer means "no."

Even if you hear the word, "yes," explicit consent may not be considered legally established. If you've been drinking, any sexual activity will still be considered assault in some states.

Remember you or your partner can change "yes" to "no" at any time.

If someone is passed out, he or she can't give his or her consent. If you have sex with this person, you will be committing sexual assault. Period.

Don't think you can claim you were drunk and didn't know what you were doing if you commit an act of sexual assault. You will be held accountable for your conduct.

Date Rape Drugs:

What You Need to Know

You've heard about them on the news—young women being sexually assaulted after drugs have been slipped into their drinks. What exactly are "Roofies" and GHB? And how can you protect yourself?

What are they? Rohypnol, known on the street as "Roofies," and Gamma hydroxy butryic acid, known as GHB or liquid ecstasy, are depressants that can cause dizziness, disorientation, loss of inhibition, memory blackouts, and loss of consciousness when mixed with alcohol. Both are odorless, colorless, and tasteless, so you may not even realize it if someone slips one of these substances into your drink. Because they may cause you to pass out, ingesting them may put you at risk for sexual assault.

How can you protect yourself?

Don't put your drink down. If your drink is out of sight, even for a few minutes, don't finish it. Get yourself a new one.

Don't accept an open drink from anyone. If you order a drink in a bar, make sure you watch the bartender open the bottle or mix your drink.

Avoid punch bowls. With Roofies and GHB in circulation, you can't be sure what's in the punch, so think twice before you partake.

Make a pact with your friends to watch out for each other, and spread the word about these "date-rape drugs" to everyone you know.

If you think you may have been given Roofies or GHB, immediately go to the emergency room and ask for a urine screening test. Though traces of the drug may still appear up to 72 hours after ingestion (depending on dosage, and individual metabolism) the chances of getting proof are best when the sample is obtained quickly. Therefore, in the event that you are sexually assaulted after you were unknowingly given one of these drugs, the results of this test could provide incriminating evidence against your attacker.

Quiz: Do You Have An Alcohol-based Relationship?

Is beer, wine or liquor the elixir of love that brought you and your significant other together? Take this quiz to find out.

1 When you met your current love, which of the following most closely characterized your state of mind?
a) Stone-cold sober
b) Completely intoxicated
c) Buzzing

2 When you two hang out together, how often is the consumption of alcohol **not** involved?
a) About half of the time—you like to party, but you spend down time together too.
b) Almost always—you're not big drinkers.
c) Almost never—you're pretty much consuming some concoction whenever you're together.

3 Has there ever been a time when you've gotten into a fight with your partner while you were both drunk?
a) No
b) Yes, you've gotten into drunken spats from time to time.
c) Yes, you've been known to get into nasty fights when you've both been drinking. The next day, you usually have only sketchy memories of what the argument was about.

4 Since you met your honey, you've been under alcohol's influence:
a) More often than before you met
b) Less often than before you met
c) Equally as often as before you met

5 Have you ever been drinking together and done something wild that you know you wouldn't normally have done on your own?
a) Yes, this happens often.
b) Yes, but only once or twice
c) No, never

6 When you and your significant other are feeling romantic, the first thing you do is:
a) Decide whether you'll go out or stay in
b) Kiss
c) Share a six-pack or a bottle of wine

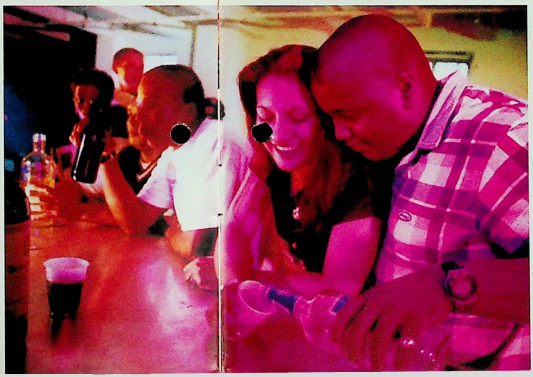
Read on to see if your relationship has a solid or a liquid foundation.

Scoring:
1. a-1, b-3, c-2
2. a-2, b-1, c-3
3. a-3, b-2, c-3
4. a-3, b-1, c-2
5. a-3, b-2, c-1
6. a-2, b-1, c-3

6-9 points
Alcohol Dependency Rating: **Low**
You've got many memories that haven't involved beer, wine, or liquor, and that means there's a good chance your relationship is built on true mutual affection. **Congratulations, you've got a solid foundation.**

10-14 points
Alcohol Dependency Rating: **Medium**
You and your partner like to drink together pretty frequently, but you throw some non-partying time into the mix too. To keep from tipping the bottle too much, **try taking a vacation from drinking. A full month on the wagon will tell you if your relationship is solid,** or if it's been alcohol-dependent all along.

15-18 points
Alcohol Dependency Rating: **High**
Since you and your significant other have both got a buzz on whenever you're together, neither of you realizes that your relationship may be on the rocks. If you have a hard time relating without the help of cocktails, it means you aren't getting to know each other. If you really want to make a go of things, **start spending alcohol-free time together.** But if losing the alcohol means your love is headed down the drain, get out of this liquid-based relationship before it drowns you both.



Call 800-DRUGHELP

24-hour confidential information and how to get help for yourself or a friend.

www.drughelp.org

Visit www.factsontap.org

Also in this series:

- The Non-Alcoholic Hangover: When Someone Else's Drinking Gives You a Headache
- The Naked Truth: Alcohol and Your Body
- The College Experience?: Alcohol and Student Life

Also part of Facts on Tap, the Options Program includes:

- Do you ever? – a brochure that talks about parental substance abuse and its impact on students.
- Life Lessons – a detailed handbook for students from substance abusing families.
- Wallet Card – a handy pocket reminder for those stressful trips home to families affected by substance abuse.

Made possible by a generous grant from
Metropolitan Life Foundation

ACDE
American Council for Drug Education
An Affiliate of Phoenix House
800-488-DRUG

Global Tobacco Treaty Action Guide:

Protecting National Health Policies from International Tobacco Industry Interference

September 2005

CORPORATE ACCOUNTABILITY INTERNATIONAL
CHALLENGING ABUSE, PROTECTING PEOPLE

formerly **Infact**

Corporate Accountability International (formerly Infact) is a membership organization that protects people by waging and winning campaigns challenging irresponsible and dangerous corporate actions around the world. For over 25 years, Corporate Accountability International and its members have scored major victories that protect people and save lives. Corporate Accountability International is an NGO in official relations with the World Health Organization (WHO) and a founding member of NATT.

NATT

The Network for Accountability of Tobacco Transnationals (NATT) consists of more than 100 consumer, human rights, environmental, faith-based and corporate accountability NGOs in 50 countries. NATT was formed in the spring of 1999 to ensure a strong, unified voice for a Framework Convention on Tobacco Control (FCTC) that will:

- Institute effective controls over tobacco transnationals that are spreading tobacco addiction, disease and death; and
- Contribute to the establishment of broad global standards that hold corporations accountable for policies, practices and products that endanger human health and the environment.

Credits: A special thank-you to the many people around the world who contributed to this *Global Tobacco Treaty Action Guide* by sharing their stories and lending their insight. Thank you to all of the FCTC campaigners, including members of NATT, who are working toward FCTC ratification and implementation and to expose and challenge tobacco industry interference in health policy.

Thank you in particular to: Tjandra Yoga Aditama, Indonesian Smoking Control Foundation; Issah Ali, Action for Integrated Development, Ghana; Joaquín Barnoya, InterAmerican Heart Foundation; Rafael Camacho Solís, Founding Member, Alianza Contra el Tabaco (ATCA); Tânia Maria Cavalcante, National Cancer Institute of Brazil (INCA); Beatriz Marcet Champagne, InterAmerican Heart Foundation; Hatai Chitanondh, Thailand Health Promotion Institute; Muyunda Hilonga, Zambia Consumers Association; Patricia Lambert, Head of the South African Delegation to the FCTC; Akinbode Oluwafemi, Environmental Rights Action, Nigeria

Corporate Accountability International's campaigning toward the ratification and implementation of the global tobacco treaty is made possible through the commitment of thousands of our members. We would like to say a special thank you to: Jamey Aebersold, AHS Foundation, Edie Allen, Martha Alworth, Christine Andersen, Big Cat Foundation, Mig Boyle, Helen Boyle, Lee Carpenter, Judith Davidson, Delight and Paul Dodyk, David Dunning, Neva Goodwin, Diane and Don Hewat, Betty Jenney, Chris Lloyd, Robin Lloyd, Henry Lord, Cindy Marshall and Kathy Pillsbury, Betty Morningstar, Catherene Morton, Ostara Fund, Pettus Foundation, Deborah Rose, Kathleen Ruff, Sisters of Charity of the Blessed Virgin Mary, Sisters of Charity of the Incarnate Word, Ted and Jennifer Stanley, Alice Zea, and every member of our Ida Tarbell Society.

Table of Contents

This document is a complement to the *Handbook for FCTC Ratification Campaigns*, published in 2004 by Corporate Accountability International and NATT.

How to Use This Action Guide: A Message from Corporate Accountability International's Executive Director

After more than a decade of arduous campaigning by many, we now have a tool that has the capacity to protect public health in an unprecedented way: the WHO Framework Convention on Tobacco Control (FCTC), the first global public health treaty. The FCTC, a milestone in the history of corporate accountability, is considered one of the most rapidly embraced United Nations treaties of all time. Presently ratified in more than 70 countries, the FCTC is already protecting almost half of the world's population. On 27 February 2005, the treaty went into force after the initial 40 countries ratified it through their domestic processes.

But this significant progress is under threat from interference by the international tobacco industry. Transnational tobacco corporations—Philip Morris/Altria, British American Tobacco (BAT), and Japan Tobacco International (JTI)—often have annual revenues greater than the Gross Domestic Product (GDP) of the countries in which they operate. With tremendous wealth and power, these giant corporations pose the greatest risk to effective, meaningful tobacco control measures around the world.

While these victories continue to inspire and empower more countries to protect their citizens from tobacco, this success has also strengthened the tobacco industry's resolve to interfere.

From the treaty's initial negotiations to today, the international tobacco industry has attempted persistently to stop, weaken and delay it. Now that the fight for people's lives is in the hands of individual countries, the tobacco industry is working at the country level to undermine the treaty's progress. The good news is, you can help stop transnational corporate influence over the national health policies in your country.

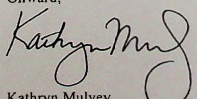
As the ratification numbers reflect, the movement challenging the tobacco industry's interference in health policy is strong and growing. As part of our commitment to protecting people around the world, our network wants to share success stories, tips and tactics for challenging the tobacco industry in your country. We created this action guide to help public health advocates, non-governmental organizations, government officials and concerned citizens stop the tobacco industry's attempts to use their money and influence to manipulate the debate over FCTC ratification.

As you work to protect people by campaigning for your country to ratify and implement the FCTC, please share news of your activities — and the tobacco industry's tactics — with allies, including Corporate Accountability International. If you are a member of the Network for Accountability of Tobacco Transnationals (NATT), please share your news with that listserve as well.

Together we are challenging some of the most powerful and dangerous corporations in the world and making incredible progress. Our hope is that this Action Guide will strengthen and advance our collective work.

For electronic versions of this *Global Tobacco Treaty Action Guide*, the *Handbook for FCTC Ratification Campaigns* and other valuable tools for protecting people from dangerous and irresponsible corporate actions, visit www.stopcorporateabuse.org.

Onward,



Kathryn Mulvey
Corporate Accountability International Executive Director

The Tobacco Industry Does NOT Have the Right To Participate in the Development of Public Health Policy

Tobacco corporations have an inherent conflict of interest with effective tobacco control legislation. The World Health Organization (WHO) and governments around the world have been very clear: Philip Morris/Altria and the rest of the tobacco industry do NOT have a right to participate in the development of public health policy. The tobacco industry and its allies continue their attempts to influence tobacco control at both the domestic and international level, but WHO resolutions and the FCTC exclude industry participation:

World Health Assembly resolution 54.18 finds that *"the tobacco industry has operated for years with the expressed intention of subverting the role of governments and of WHO in implementing public health policies to combat the tobacco epidemic,"* and urges governments to ensure the integrity of health policy development.

The **Preamble of the FCTC** recognizes *"the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts."*

In **Article 5.3**, the FCTC obligates parties to *"protect these [public health] policies from commercial and other vested interests of the tobacco industry."* The treaty also affirms the importance of civil society participation in achieving its objectives, while restricting such involvement, in **Article 12(e)**, to "*nongovernmental organizations not affiliated with the tobacco industry.*"

The FCTC and WHO resolutions on tobacco control provide governments with the support of the international community to stand up to the tobacco industry and its attempts to influence policy. In Article 20.4(c), the FCTC also requires parties to collect and disseminate information on tobacco industry activities that have an impact on the treaty or national policies.

While the tobacco industry may try to pressure governments to include "all stakeholders" in the discussions around tobacco control legislation, the FCTC clearly excludes the industry from participating. **For this reason, any tobacco industry inclusion in public health policymaking violates both the spirit and the letter of the FCTC.**

Tobacco Industry Interference in Public Health Policy

The tobacco industry uses its political influence to weaken, delay and defeat tobacco control legislation around the world—and tobacco corporations have attempted to derail the FCTC process from the beginning. According to *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization,* a July 2000 report by a committee of experts on tobacco industry documents, the "tobacco companies have operated for many years with the deliberate purpose of subverting the efforts of the World Health Organization to address tobacco issues. The attempted subversion has been elaborate, well-financed, sophisticated, and usually invisible." In order to ensure that the FCTC protects people around the world from the tobacco industry, the public health community must be vigilant in identifying, exposing and ultimately defeating tobacco industry attempts to interfere.

Stories from around the world show that the tobacco industry is taking a country-by-country approach, but the industry favors four strategies for thwarting FCTC ratification and public health policy in general. Transnational tobacco corporations Philip Morris/Altria, BAT and JTI—with combined annual revenues greater than the GDPs of Costa Rica, Kenya, Nicaragua, Uganda, Honduras and Lebanon combined—set the pace.

Please help us track tobacco industry use of these four strategies by filling out the form on pages 19-22.

1) Spreading Misinformation About the Legal Process

The tobacco industry has been misinforming country governments and civil society organizations about the ratification process—asserting that countries need to pass domestic tobacco control legislation before they can ratify the FCTC. This is not true. After ratifying the FCTC, countries will be given a reasonable amount of time, depending on their individual circumstances and in consultation with the Conference of the Parties, to implement the FCTC.

2) Asking for a Seat at the Table

The tobacco industry has an inherent conflict of interest and should therefore be disqualified from having a role in the development of public health policy. Furthermore, the FCTC clearly excludes the industry from participating. Yet corporations like Philip Morris/Altria and BAT still attempt to derail ratification and implementation by not always articulating their opposition, faking "support" for the treaty, and trying to win a seat at the table. While tobacco corporations like Philip Morris/Altria claim to support the treaty, they oppose its central provisions, such as the ban on tobacco advertising, promotion and sponsorship.

3) Demanding Voluntary Self-Regulation

The tobacco industry has a long history of proposing voluntary regulation as a strategy to fight effective and enforceable protections. However, voluntary codes are non-binding, lack independent oversight and often do not include consequences; in practice they have proven ineffective at curbing the tobacco industry's most successful forms of spreading tobacco addiction.

Through the FCTC process, a majority of the world's countries came together to reject the industry's calls for voluntary regulation and instead set aggressive, binding global limits on how the industry operates. This hard-fought victory will seriously limit the ability of Philip Morris/Altria, BAT and JTI to spread addiction, disease and death with images like the Marlboro Man and a host of other tactics. Nevertheless, in countries around the world, the tobacco industry continues to pressure governments to take no direct action and to let the industry regulate itself through voluntary measures.

Here is an example:
In Mexico, BAT and Philip Morris joined forces to undermine Mexico's health policy. According to a 1992 internal memo from Philip Morris International, the corporation was "evaluating the possibility of developing with BAT an industry self-regulating advertising and promotional code" in Latin America. The intent was to "help improve the industry's image and reduce the chances of government restrictions."

Unfortunately, it seems the industry has succeeded with these plans. Just three weeks after Mexico ratified the FCTC, the government signed a voluntary agreement with Philip Morris and BAT. Mexico's voluntary agreement with Philip Morris and BAT is a clear example of voluntary self-regulation that could distract the government from implementing effective and meaningful health laws. This example should alert us to the ever-present danger of industry interference.

4) Slick PR Campaigns

Corporate Social Responsibility describes the inclusion of social and environmental concerns into a corporation's business practices with actions to back up the words. With the tobacco industry, however, Corporate Social Responsibility is part of a slick PR campaign to try to re-brand its deadly image. British American Tobacco (BAT) and Philip Morris/Altria spend millions annually in an attempt to brand themselves as "socially responsible" corporations. This allows them to hide behind glossy image makeovers while continuing to promote tobacco addiction to children and adults around the world.

While the tobacco industry claims to have changed and evolved, internal documents show their corporate social responsibility initiatives are merely part of a coordinated attempt to improve their image and gain access to politicians.

Help Us Track Emerging Efforts by the Tobacco Giants to Interfere in Health Policy!

According to survey data from NGOs and government officials in more than 20 countries, the tobacco industry attempts to influence public health policy in many ways. No country escapes. Many countries that have become parties to the FCTC continue to face pressure from the tobacco industry. In Kenya, which has ratified the FCTC, BAT sponsored a beach holiday for members of Parliament, just days before they were set to discuss the implementing legislation for the treaty.

Ongoing monitoring and exposure of tobacco industry tactics are a key component of FCTC implementation. In addition to the four major strategies described previously, be on alert for the following:

- *Giving campaign contributions* to political parties in order to influence their decision making;
- *Organizing roundtable discussions* on the FCTC's implementation or other "social issues";
- *Providing government officials* with recommendations or a sample health policy;
- *Funding government health initiatives* like malaria control and HIV/AIDS treatment programs;
- *Sponsoring* major sporting and cultural events;
- *Conducting* purposefully ineffective "youth smoking prevention" programs;
- *Supporting environmental* protection and tree-planting programs;
- *Funding* "smokers' rights" groups;
- *Drawing attention* to the alleged economic benefits of tobacco addiction;
- *Funding university research* on health issues;
- *Providing scholarships* to journalism students;
- *Recruiting public relations* spies to infiltrate health groups; and,
- *Setting up fake NGOs* to gain access to health policy or other meetings.

Case Studies & Success Stories: Three Stories Illustrating Tobacco Industry Interference and How Activists Are Pushing Back

Guatemala: Ratifying the FCTC Despite Philip Morris' Slick PR & Lobbying

In response to activist pressure at the Philip Morris/Altria annual shareholders' meeting in April 2005, CEO Louis Camilleri declared that the corporation is working with Ministries of Health and Ministries of Education in countries around the world. This is not only alarming, but in countries that have ratified, it violates the spirit and letter of Articles 5.3 and 20.4(c) of the FCTC.

The tactics being used by Tabacalera Centroamerica S.A., the Philip Morris/Altria subsidiary in Central America, reflect those of its parent company. In the media, the CEO of Tabacalera Centroamericana in Guatemala publicly declared his support for the FCTC. Months later, the corporation sent Guatemalan legislators a letter, referencing the FCTC but detailing the regulations it would support that fell far short of the regulations the FCTC mandate. Not surprisingly, in its letter to Guatemalan legislators the corporation called for regulations that are significantly weaker than the FCTC. Philip Morris fought against key FCTC protections, such as the ban on tobacco advertising, promotion and sponsorship and the promotion of a higher tobacco tax.

This is an increasingly common tobacco industry tactic: publicly claiming support for the tobacco treaty then pressing for implementing legislation that is significantly weaker than the treaty itself. With this approach, tobacco corporations try to cultivate positive public recognition for supporting the treaty, while working behind closed doors to undermine its most central provisions.

At the same time in Guatemala, Philip Morris/Altria employed one of the most insidious tobacco industry tricks: a so-called youth anti-smoking campaign. According to historical internal industry documents, Philip Morris discussed expanding this type of program to other countries in Latin America to "strengthen relationships with governments and community."

As the ratification process progresses in Guatemala and the Senate begins the process of drafting implementation legislation, activists will remain vigilant and ensure the Senate dismisses the tobacco industry's weak recommendations. The progress of public health advocates in the face of a powerful industry is an inspiring example for activists around the world that it is possible to protect people from one of the deadliest industries. ■

Nigeria: Taking on British American Tobacco's Bribes and Lies

As Africa's most populous country, Nigeria is a prime target for the tobacco industry to market its deadly products. British American Tobacco (BAT), which controls 75 percent of Nigeria's cigarette market, is notorious for using its financial resources and government contacts to ensure steady profits and weak tobacco control legislation. A short list of BAT's tactics to prevent positive health policy in Nigeria includes attempting to bribe the media and giving expensive gifts to regulatory agencies and government officials.

In Nigeria, BAT depends on a misinformed public and easily influenced government, so the media is a top target. In an orchestrated campaign to buy the media in Nigeria, the corporation hosts expensive meals for media owners and editors, sponsors journalist association meetings, syndicates articles favoring the company and tobacco products and leverages its advertising power to stop the publication of critical articles.

The corporation's "British American Tobacco Industry Reporter of the Year Award" rewards reporters who write favorable stories about the company with a new laptop and 100,000 Nigerian Naira (US$750). Between January 2003 and January 2005, BAT sponsored three meetings between media executives and BAT executives at the prestigious Lagos Sheraton Hotel and awarded attending journalists with gifts for participating. The tobacco giant has a track record of cultivating journalists to write pro-BAT articles that attack the FCTC. Uncovered evidence showed that a reporter, John Ozeze-Langley—who recently wrote an article in the *Daily Independent* titled "BAT: Not the Enemy to Fear" and pleaded to "please let the tobacco companies be!"—was given the information to write the article by the tobacco company.

Political gifts and lobbying are also a major tactic. Operating from its "Political Liaison Office" in Nigeria's capital, BAT's dirty lobbying activities include expensive holidays and gifts. The corporation's lobbying tactics are so extreme that during the tobacco advertising bill debate, a member of Parliament openly accused the tobacco transnational of employing tactics to stop passage of the bill.

Specific examples include donating three sport utility vehicles to the Standards Organization of Nigeria, the government agency charged with ensuring products (like cigarettes) do not endanger consumers. BAT also donated three SUVs to the enforcement unit of the Nigerian Custom Service.

These donations to regulatory bodies in Nigeria demonstrate a conflict of interest that puts people at risk. Unfortunately, BAT's activities are being replicated around the world in order to weaken the implementation and enforcement of laws protecting people from the tobacco industry.

Activists in Nigeria have worked to expose and denounce these instances of dirty politics. By organizing press conferences and rallies and meeting directly with key government officials, Environmental Rights Action and a range of organizations in Nigeria are building critical support for FCTC ratification and strong, effective implementation, even in the face of BAT's heavy-handed influence. ■

Costa Rica: Overcoming the Tobacco Industry's Influence over Legislators

The FCTC calls for strong, enforceable protections from tobacco products. Considering the tobacco industry's dependence on weak regulation for its expansion, it's no surprise they're working against an enforceable treaty that protects people. And since Costa Rica is a political leader in the region and home to British American Tobacco's (BAT) Central American headquarters, the country is a high priority for public health advocates and the tobacco industry. While Costa Rica signed the FCTC on 3 July 2003, it has not yet ratified the treaty.

In June 2005, an international coalition of public health advocates met in Costa Rica to call on Costa Rica's government to ratify the FCTC swiftly. The delegation joined AMBIO-ALERTA, a NATT member based in Costa Rica, to meet with Representatives of Congress and talk to the media about why the FCTC needed Costa Rica's ratification.

In a related event, at a June 2005 forum on national tobacco control policy convened at the National Assembly by health advocates, BAT used a slick PowerPoint presentation to push its own regulatory agenda. Presenting itself as a "responsible" tobacco corporation and legitimate "partner," BAT advocates for policies that would do more to protect its bottom line than public health.

This is a tactic that the tobacco industry has used for years to thwart effective regulation. In response the countries of the world have been clear: the tobacco industry shall play no role in public health policy making. They unanimously adopted Article 5.3 of the treaty that obligates parties to *"protect these [public health] policies from commercial and other vested interests of the tobacco industry."*

AMBIO-ALERTA and IAFA, the leading public health advocates, are resisting. At the June 2005 public forum, they laid out a clear case for why BAT's proposals won't work and why a ratified and implemented FCTC is best for reducing the burden of tobacco-related death and disease. As the battle in Costa Rica continues, NGOs and the public will continue to pressure the government to stand up to the tobacco industry and protect people by ratifying and implementing the global tobacco treaty. ■

Profiles of the Biggest Tobacco Transnationals

In many countries Philip Morris/Altria, British American Tobacco and Japan Tobacco International are more commonly known by a local subsidiary name. Many times, the local tobacco company is owned by one of these transnational corporations.

Philip Morris/Altria

Chair and CEO: Louis Camilleri
Headquarters Address:
120 Park Ave.
New York, NY 10017
USA

International Subsidiary:
Philip Morris International
President and CEO: André Calantzopoulos

Address:
Avenue de Cour 107
Casa Postale 1171
1171 Lausanne, CH-1001
Switzerland

2004

Philip Morris/Altria
Revenues: **$64 billion**

Philip Morris International
Revenues: **$17.58 billion**

Philip Morris/Altria
Profits: **$9.4 billion**

Notable Facts:

- Largest and most profitable tobacco corporation in the world
- Created the Marlboro Man—one of the most effective promotional images globally—with strong appeal to young people
- Claims to support FCTC but opposes central provisions like ban on advertising, promotion and sponsorship

British American Tobacco (BAT)

CEO: Paul Adams

Headquarters Address:
Globe House, 4 Temple Place
London
WC2R 2PG
United Kingdom

2004	
Revenues:	$60.1 billion
Profits:	$2.1 billion

Notable Facts:

- Second-largest tobacco corporation in the world
- Maintained highly visible lobbying presence throughout FCTC negotiations, including representation by BAT's Director of International Political Affairs, Manager of International Regulatory Affairs, and Manager of Legal Division

Japan Tobacco Inc. (JT)

President and CEO: Katsuhiko Honda

Headquarters Address:
2-1, Toranomon 2-chome, Minato-ku
Tokyo, 105-8422
Japan

2004	
Revenues:	$43.8 billion
Profits:	$72 million

Notable Facts:

- 50% owned by Japanese government
- Throughout FCTC negotiations, Japan attempted to block progress toward the comprehensive ban on advertising, promotion and sponsorship. Japan's opposition to effective treaty provisions was not surprising, given the heavy industry representation on its delegation, including the Finance Ministry, which controls the country's stake in JT.

Exposing and Defeating Tobacco Industry Interference: Take Action!

As you uncover tactics that Philip Morris/Altria, BAT and JTI are employing in your country, there are several simple things you can do to challenge their dirty tricks. Please share your findings and stories via email to natt@list.stopcorporateabusenow.org or mrising@stopcorporateabuse.org if you are not a NATT member.

1. Involve key allies

- Distribute this *Global Tobacco Treaty Action Guide* to Parliamentarians, Ministry of Health officials, NGOs and the media.
- Encourage allies and members of Parliament to challenge tobacco industry involvement and interference in FCTC ratification and implementation.
- Ask government allies about what the tobacco industry is doing to interfere in policy. Use the report form in this *Global Tobacco Treaty Action Guide* to collect their stories, track and share evidence of industry activity in your country.

2. Media

- Build relationships with reporters and ask them to write stories on the FCTC and to expose tobacco transnational attempts to interfere.

3. Challenge the tobacco industry face-to-face

- Stand up in a meeting to challenge the tobacco corporations' presence and rhetoric. The tobacco industry is working very hard to gain access to government decisionmakers and you may be in a meeting where a representative from a tobacco corporation is also present. It is important to identify this person and remind participants that the FCTC obligates decisionmakers to protect health policy from tobacco industry interference.

4. Draw international attention

- Let other FCTC campaigners know about this interference. Share what is happening in your country with domestic and international allies. If you are a NATT member, use the NATT listserve to draw international attention to the problems.

5. Promote legislation to keep the tobacco industry out of policy development

- Pass legislation for implementing Article 5.3 of the FCTC so that keeping the tobacco industry out of health policy is included in your national law. Send copies of the sample legislation found on pages 17-18 of this *Global Tobacco Treaty Action Guide* to all legislators urging them to include it as a part of your tobacco control bill.

Talking Points

Why should the tobacco industry be excluded from public health policymaking?

- Tobacco is a product that causes addiction, disease and death, and therefore places an unwarranted financial burden on existing resources for health.
- The tobacco industry attempted to water down the FCTC from its inception.
- The tobacco industry's primary concern is maintaining or increasing its enormous profits and sharing that wealth with rich shareholders in the North—not protecting public health.
- After decades of deception and deceit, tobacco corporations should simply never have been allowed to participate in public health policymaking.
- Internal corporate documents outline a well-funded, highly coordinated, covert campaign to thwart protections for public health.
- While the industry claims to have changed its ways, it continues its attempts to use sophisticated methods to undermine meaningful tobacco control legislation around the world.
- There are many ways that tobacco corporations such as Philip Morris/Altria use their economic and political muscle to influence public policy—including by hiding behind subsidiaries like Kraft Foods and public relations campaigns like Corporate Social Responsibility.
- The WHO and governments around the world have come together to pass provisions clearly excluding the industry from participation in the formation of public health policymaking.

Note: It is important that limits on political activities include activities by subsidiaries of the tobacco corporations, such as Philip Morris/Altria's Kraft Foods. Internal documents and the Committee of Experts Report, *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization,* demonstrate how Philip Morris/Altria has tried to influence national and international policy through Kraft. According to industry analysts, Philip Morris/Altria is likely to spin-off Kraft by early 2006. This separation will be a major step toward reducing the wealth, power and influence of the world's largest tobacco corporation.

FCTC Preamble Statement, Articles 5.3, 12 (e) and 20.4 (c)

The following sections of the FCTC clearly exclude the tobacco industry from participating in public health policymaking and call for the collection and dissemination of information on tobacco industry activities that have an impact on tobacco control.

Preamble

Recognizing the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts;

Article 5 — General Obligations

3. In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.

Article 12 — Education, communication, training and public awareness

Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Towards this end, each party shall adopt and implement effective legislative, executive, administrative or other measures to promote:

(e) awareness and participation of public and private agencies and nongovernmental organizations not affiliated with the tobacco industry in developing and implementing intersectoral programs and strategies for tobacco control.

Article 20 — Research, surveillance and exchange of information

4. The Parties shall, subject to national law, promote and facilitate the exchange of publicly available scientific, technical, socioeconomic, commercial and legal information, as well as information regarding practices of the tobacco industry and the cultivation of tobacco, which is relevant to this Convention, and in so doing shall take into account and address the special needs of developing country Parties and Parties with economies in transition. Each Party shall endeavour to:

(c) cooperate with competent international organizations to progressively establish and maintain a global system to regularly collect and disseminate information on tobacco production, manufacture and the activities of the tobacco industry which have an impact on the Convention or national tobacco control activities.

The following page suggests model legislation for implementing these sections.

Model Legislation to Exclude the Tobacco Industry and Implement the FCTC

The model legislation below suggests ways in which countries can insulate tobacco control policy, as well as their tobacco control legislation, from the influence of the tobacco industry.

Comprehensive, effective model legislation to implement the FCTC has been created by the WHO, PAHO and the International Union for Health Education and Promotion. The purpose of these legislative suggestions below is to provide guidance specifically on industry exclusion. They should be used in tandem with other existing sources of comprehensive model legislation. Many existing sources of model legislation provide guidance on implementation of Article 20.4(c).

Principles/Preamble/Purpose

> *Recognizing the need to safeguard the development, implementation, review and enforcement of tobacco control policies from interference by commercial and other vested interests of the tobacco industry;*

This suggested legislative text would give effect to the concepts contained in the FCTC. While preambles are not necessarily an essential component of any piece of legislation, if they are used, they can give expression to aspects of policy that lie behind the legislation. In doing so, they can educate people about the context for the legislation and also assist the courts in interpreting the law if it is challenged. Including clear language like that given in our example in a preamble to a piece of legislation would help indicate that, if questions of tobacco industry involvement ever arose, the country's law should be interpreted in such a way that it restricts or prevents any industry involvement.

Definitions/Interpretations/Preliminaries

> *"Vested interests of the tobacco industry" means people or groups who stand to benefit, financially or otherwise, from legislation, policies, or programs that promote or protect the interests of the tobacco industry. They include, but are not limited to, people or groups that own shares in a tobacco corporation or any of its subsidiaries, and people or groups that directly participate in tobacco advertising, promotion, or sponsorship.*

Having a definition like the one we have suggested above in a piece of tobacco control legislation provides a clear indication of the types of people or groups whose interests would be in direct or indirect conflict with public health interests. This definition is consistent with existing treaty law, other FCTC provisions and the ordinary meaning and interpretation of the phrase. Articulating a clear definition of this term will help countries to thwart tobacco industry attempts to influence legislation and implementation through subsidiaries and affiliates. Governments should be urged to define this important term in a way that affords maximum protection for domestic tobacco control policies. A broad definition is critical to target actions that may not constitute direct interference by the tobacco industry, and this idea is captured in the phrase "who stand to benefit financially or otherwise."

Administration

Prohibition on tobacco industry participation—*The Minister of Health [or other governing authority] shall implement policies and procedures to prohibit commercial and other vested interests of the tobacco industry, including government agencies and wholly or partially government-owned tobacco companies, from participating in the development, implementation, and review of all policies under this Act. This prohibition shall include, but not be limited to:*

> *(i) The use of tobacco industry-funded research in developing, implementing, and reviewing tobacco control policies;*
>
> *(ii) Consultation with or participation by scientists or other individuals who may have a conflict of interest as defined [in previous sections of this legislation];*
>
> *(iii) The participation of commercial and other vested interests of the tobacco industry, including government agencies and wholly or partially government-owned tobacco companies, in any official proceedings conducted under this Act; and*
>
> *(iv) The use of print, electronic, or other public media by commercial and other vested interests of the tobacco industry, including government agencies and wholly or partially government-owned tobacco companies, regarding any topic covered by this Act.*

This suggested legislative text goes to the heart of excluding the tobacco industry from participation in policymaking. It captures all of the obligations required in FCTC Articles 5.3, and 12.

The inclusion of these three provisions in any domestic tobacco control legislation will ensure that policy, legislation and implementation are all insulated from tobacco industry interference. In addition, they will provide policymakers, legislators, implementers and enforcers with legally binding tools to uphold tobacco control measures and protect them from interference by tobacco corporations, their subsidiaries and affiliates.

Tobacco Industry Interference Reporting Form

Please share your country's stories of activities and interference with allies around the world. Sharing your stories will help FCTC advocates around the world more effectively counter tobacco industry interference. For an online version of the survey visit www.stopcorporateabuse.org/reportform, or

- ► If you are a NATT member, email it to natt@list.stopcorporateabusenow.org.
- ► If you are not a NATT member, email it to mrising@stopcorporateabuse.org.

NAME: _____ TITLE: _____

ORGANIZATION: _____

ADDRESS: _____

CITY/ STATE/ PROVINCE: _____ POSTAL CODE: _____

COUNTRY: _____

PHONE: _____ FAX: _____

EMAIL/WEBSITE: _____

DIRECTIONS:

On pages 6-7, we detailed four of the main strategies giant tobacco corporations are using to undermine health policy. Please use the questions below to share information about the tobacco industry's tactics in your country.

PLEASE USE DETAIL & PROVIDE SOURCES/EVIDENCE WHEREVER POSSIBLE

1. Spreading Misinformation About the Legal Process

The tobacco industry has been misinforming country governments and civil society organizations about the ratification process — asserting that countries need to pass domestic tobacco control legislation before they can ratify the FCTC. This is not true.

A. Which transnational tobacco corporations are active in your country? How would you characterize their presence generally? Do you have specific information on trends, etc.?

B. Has the tobacco industry told government officials or civil society organizations in your country that your government needs to pass domestic tobacco control legislation before ratifying the FCTC? If so, what were the circumstances of the conversation? Who was present?

C. List all companies and organizations (including business groups) currently opposing the FCTC, tobacco control and/or public health legislation in your country. *Note: Tobacco transnationals often use trade unions, advertising agencies, farmers, business councils and chambers to lobby on their behalf.*

2. Asking for a Seat at the Table

The FCTC clearly excludes the industry from participating in public policy. Yet corporations like Philip Morris/Altria still attempt to derail ratification and implementation by not always articulating their opposition, faking "support" for the treaty, and trying to win a seat at the table. While tobacco corporations like Philip Morris/Altria claim to support the treaty, they oppose its central provisions, such as the ban on tobacco advertising, promotion and sponsorship.

A. Has Philip Morris/Altria, BAT or JTI taken a public position on the FCTC in your country? If so, what is it? How have they communicated this position?

B. Is the government holding consultations with the industry or its affiliates? If so, what do these consultations look like? What is the industry saying?

C. Is the tobacco industry organizing meetings of "stakeholders" about tobacco control policies or other topics on your country? If yes, please describe.

3. Demanding Voluntary Self-Regulation

The tobacco industry has a long history of proposing voluntary regulation as a strategy to fight effective and enforceable protections. However, voluntary codes are non-binding, lack independent oversight and often do not include consequences; in practice they have proven ineffective at curbing the tobacco industry's most successful forms of spreading tobacco addiction.

A. Are you aware of any voluntary self-regulation agreement between a tobacco corporation and your government? If yes, please describe in detail. What has the tobacco corporation agreed to do?

B. Are any major tobacco corporations promoting voluntary self-regulation as an alternative to legal, binding regulations? If yes, please provide details.

4. Slick Public Relations

While the tobacco industry claims to have changed and evolved, internal documents show their corporate social responsibility initiatives are merely part of a coordinated attempt to improve their image and gain access to politicians.

A. Does Philip Morris/Altria, or any other tobacco transnational, advertise its philanthropy/ charitable giving or social responsibility (on TV, magazines, other)? If yes, please describe. **Do you have print examples?** Fax or .pdf and email or mail please!

B. Are any of the tobacco transnationals promoting their so-called corporate responsibility? If so, how?

C. Are any of the tobacco transnationals running advertisements or campaigns they say are designed to stop youth smoking, or funding any youth smoking prevention programs in your country? If yes, please describe.

If you prefer to send by mail, please send to • Corporate Accountability International • • c/o Megan Rising • 46 Plympton Street Boston, MA 02118 • USA •

Positive Impact of the FCTC: Story Form

With the global tobacco treaty we are on the road to reversing the global tobacco epidemic. Along the way there are significant victories and milestones that are important to celebrate. From Bangladesh to Palau and from Thailand to South Africa, we have heard many stories of positive policy change, growing civil society momentum and noticeable changes in everyday life because of the FCTC.

In September 2005, the world will celebrate with Thailand as they implement an advertising law that raises the standard for controlling Big Tobacco's marketing.

In Thailand, for example, Philip Morris worked for years to undermine tobacco control legislation. But because of the vigilance of NGOs and officials in the Thai Health Promotion Institute, Thailand has been able to counter this interference effectively and is setting a high standard for tobacco control policy. According to an internal industry document from 1994, Philip Morris developed strategies and an action plan to "mitigate the impact of the Tobacco Control Bill." Despite Philip Morris's plans, public health advocates in Thailand have moved forward with some of the strongest tobacco control legislation in the world.

In September 2005, the world will celebrate with Thailand as they implement an advertising law that raises the standard for controlling Big Tobacco's marketing. It bans all point-of-sale advertising and promotions—outlawing one of the primary ways that tobacco corporations market tobacco.

Philip Morris attempted to stop this point-of-sale advertising ban by lobbying and sending letters to key government decisionmakers, including the Public Health Minister and the Chair of the Senate Health Committee. When this tactic failed, Philip Morris (Thailand) joined BAT (Thailand), JTI and the Thailand tobacco monopoly in threatening to sue the Thai Ministry of Public Health for implementing this law! Public health advocates continue to move forward in the face of this interference and pressure by meeting with key decisionmakers and holding news conferences to assert the importance of this order and ensure its implementation. The Public Health Ministry has declared that all point-of-sale advertising must be removed by 24 September 2005 and retailers are pledging their compliance. Congratulations to all who made this victory happen in Thailand!

We invite you to take a few minutes to reflect on the impact that the FCTC has had on your country, its people and health policy. As your country takes steps toward ratification and implementation, please share this progress with allies around the world, by sending an email to the NATT list at natt@list.stopcorporateabusenow.org or mrising@stopcorporateabuse.org if you are not a NATT member. For an online version of the survey visit www.stopcorporateabuse.org/storyform.

Impact of the FCTC: Question Form

Have you noticed a change in tobacco control in your country or region since the FCTC negotiations began in 2000?

If your country has ratified, has the ban on advertising, promotion and sponsorship passed into law yet? What is the timeline for the ad ban? When will it take effect? Are ads coming down already? What changes have you seen since the FCTC was adopted in May 2003? Examples may include: labels, promotional activities, TV, magazines, etc. Please be as detailed as possible and include specific dates to demonstrate the progress.

What positive impact of the FCTC have you seen in your country? Are there specific practices of tobacco corporations that have changed? Concrete examples will be most helpful.

How do you think ratifying the FCTC will improve the lives of people in your country? What are you most hopeful about for the impact of the FCTC in your country?

For NATT members, how has being part of NATT helped you to be a more effective advocate?

For government officials, how have NGOs in NATT supported you in advancing effective legislation?

Appendix 1: WHO Regional Information

WHO Headquarters
Tobacco Free Initiative
Avenue Appia 20
1211 Geneva 27
Switzerland
Telephone: (+41 22) 791 21 11
Fax: (41 22) 791 3111

Regional Office for Africa
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Congo
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Fax: +242 839 501/+47 241 395018
Email: regafro@whoafr.org
Regional Director: Dr. L. Sambo

Regional Office for Europe
8, Scherfigsvej
DK-2100 Copenhagen 0
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Fax: +45 39 171 818
Email: postmaster@euro.who.int
Regional Director: Marc Danzon

Regional Office for the Western Pacific
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Philippines
Telephone: +63 2 528 8001
Email: postmaster@wpro.who.int
Regional Director: Dr. Shigeru Omi

Regional Office for the Eastern Mediterranean
Abdul Razzak Al Sanhouri Street,
P.O. Box 7608,
Nasr City, Cairo 11371,
Egypt
Telephone: +202 670 25 35
Fax: +202 670 24 92 or 670 24 94
Email: postmaster@emro.who.int
Regional Director: Dr. Hussein Abdel-Razzak Al Gezairy

Regional Office for Southeast Asia
World Health House
Indraprastha Estate
Mahatma Gandhi Marg
New Delhi 110 002
India
Telephone: +91 11 2337 0804
Fax: +91 11 2337 9507
Email: pandeyh@whosea.org
Regional Director: Dr. Samlee Plianbangchang

Regional Office for the Americas
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Regional Director: Dr. Mirta Roses

Appendix 2: NATT FCTC Working Group

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Issah Ali, integratedaid@yahoo.co.uk

Consumer Information Network (Kenya)
Samuel Ochieng, cin@insightkenya.com and cin@swiftkenya.com

Consumers International Regional Office for Latin America and the Caribbean (CIROLAC, Chile)
Lezak Shallat, lshallat@consint.cl

ConsumerVOICE (India)
Bejon Misra, bejonm@hotmail.com; consumeralert@id.eth

Corporate Accountability International (US), NATT Secretariat
Megan Rising, mrising@stopcorporateabuse.org

Corporate Accountability International, Latin America Coordinator
Yul Francisco Dorado, yuldorado@stopcorporateabuse.org

Environmental Rights Action (Nigeria)
Akinbode Oluwafemi, bodufemi@hotmail.com

National Consumers and Environmental Alliance of Togo
Ebeh Kodjo, ebeh@cooperation.net

Zambia Consumers Association
Muyunda Ililonga, zaca@zamnet.zm

Appendix 3: FCTC and the United States

Decision to Sign
The Bush Administration's decision to sign the Framework Convention on Tobacco Control (FCTC) with great fanfare in May 2004 appears to have been one in a series of public relations maneuvers to gain positive recognition while working to undermine the world's first public health treaty. Throughout the FCTC negotiating process, the US government consistently took positions that would dilute the treaty at the expense of people's lives in the US and around the world. For example, the US opposed a comprehensive ban on tobacco advertising, promotion and sponsorship—even with exceptions based on constitutional constraints; fought to prioritize trade agreements over public health; and opposed excluding the tobacco industry from public health policymaking.

Obstructionist Tactics
At the Intergovernmental Working Group meetings in June 2004 and February 2005, the Bush Administration continued to engage in its obstructionist tactics, especially with regard to treaty funding. This Administration's past track record and current inaction on this lifesaving treaty call into question whether the US government is truly committed to the FCTC and accountable to the US public or more concerned with splashy PR.

Signatory Inaction
According to the Vienna Convention on the Law of Treaties, once a country signs a treaty it is bound to uphold the spirit and intent of the agreement. Signature provides a way to maintain momentum from the negotiations and gives countries the opportunity to demonstrate good faith in accepting treaty obligations. Unfortunately, the US has abused the process and not followed this practice with many humanitarian treaties it has signed. There is a clear pattern in recent history of the US negotiating down to the lowest common denominator, then failing to support environmental, human rights and other treaties. Since signing the FCTC, the Bush Administration has made no demonstrable progress—the treaty has not yet been introduced to the Senate Foreign Relations Committee for approval. Although the US is considered a leader in tobacco control, continued inaction on this life-saving agreement means it will not have a seat at the table as countries come together at the first Conference of the Parties.

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www.stopcorporateabuse.org ♦ mrising@stopcorporateabuse.org

The Framework Convention on Tobacco Control (FCTC): Breaking New Ground, Protecting Global Public Health

The adoption of the Framework Convention on Tobacco Control (FCTC) is a milestone in the history of corporate accountability and public health. This groundbreaking treaty will change the way tobacco giants like Philip Morris (now Altria), British American Tobacco (BAT), and Japan Tobacco International (JTI) operate globally. It also establishes important precedents for international regulation of other industries that profit at the expense of human health and the environment.

The story of the FCTC inspires hope. The developing world, led by a block of all 46 African nations and supported by dozens of non-governmental organizations (NGOs), united around protecting the health of their people from the deadly expansion of Big Tobacco. Throughout the process, the US practiced its now-predictable but increasingly unacceptable "cowboy diplomacy" approach to international treaties on the environment and human rights. Despite staunch US opposition and aggressive attempts by Philip Morris/Altria, BAT and JTI to derail the treaty, when implemented the FCTC will go a long way toward curbing the global spread of tobacco addiction.

History of the FCTC

The World Health Assembly (WHA) called for development of the world's first public health treaty to control the spread of tobacco addiction in 1996, and set the negotiating process in motion in 1999.[1] World Health Organization (WHO) Director-General Gro Harlem Brundtland put the FCTC on a "fast track," with the goal of adopting the treaty by May 2003. Member States have overcome opposition from the tobacco transnationals and their allies to successfully meet that challenge.

In October 1999 and March 2000, WHO and its Member States convened working groups to prepare the draft elements of the FCTC. In October 2000, an Intergovernmental Negotiating Body (INB) began formal talks on the FCTC. There have been a total of six formal negotiating sessions held between October 2000 and February 2003 involving 171 countries.[2]

A total of eight days of working groups and 49 days of formal negotiations were held between October 1999 and February 2003. An additional 39 Regional Intersessional Meetings were held between 2001 and 2003, beginning with the Johannesburg meeting of 21 African countries in March 2001.[3] Many of these intersessional meetings were attended by NGOs.

Well over 200 NGOs around the world have been active on the FCTC, including twenty-six public interest NGOs in official relations with WHO. The Network for Accountability of Tobacco Transnationals (NATT) was founded by Infact in the summer of 1999, and is comprised of 79 consumer, human rights, environmental, faith-based and corporate accountability organizations in 50 countries. The Framework Convention Alliance (FCA) was initiated in the fall of 1999, and has 187 members including major international tobacco control and public health organizations.

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www.infact.org/fctc.html

Throughout the FCTC process, NGOs have provided technical assistance to government delegates, monitored and exposed tobacco industry abuses such as interference in public health policy, generated direct pressure on tobacco transnationals through tactics like Infact's Boycott targeting Philip Morris/Altria's Kraft Foods, increased visibility of tobacco control issues in the media, and raised public awareness of the FCTC. NGOs will continue to play a vital role in the adoption and ratification of the treaty.

The INB reached agreement on the final text of the FCTC on 1 March 2003, and forwarded it to the World Health Assembly for adoption in May 2003.

Development of the FCTC Text

From the beginning of the FCTC process, developing countries have pushed for effective measures to reverse the global tobacco epidemic and hold tobacco transnationals accountable for their abuses. India, Iran, Jamaica, Palau, Senegal, South Africa and Thailand are a few countries that played key leadership roles during the FCTC negotiations. NATT and other NGOs backed these champions of public health with a global outcry for the FCTC to:

- Ban all tobacco advertising, promotion and sponsorship;
- Consistently establish the principle that public health takes precedence over trade in tobacco;
- Prohibit interference in public health policy by tobacco corporations, their subsidiaries, affiliates and agents;
- Ensure that tobacco corporations are held accountable for past, present and future harm caused by their products and practices;
- Establish strong mechanisms and institutions to fund and enforce treaty obligations.

However, the negotiating texts produced by the INB Chair with assistance from the WHO Secretariat repeatedly failed to reflect positions taken by the large majority of countries. At the final round of negotiations, the countries of Africa, Southeast Asia, the Eastern Mediterranean, Pacific and Caribbean Islands stood firm to protect their people from the tobacco giants' aggressive expansion. As a result the final text—while far from the FCTC these countries and NGOs dreamed of—is a major step forward for public health and corporate accountability.

	First Chair's Text of FCTC January 2001 [4]	Final FCTC Draft to WHA March 2003 [5]
Tobacco Advertising, Promotion and Sponsorship	— Prohibition of "direct and indirect advertising, promotion, sponsorship *targeted at* [emphasis added] persons under 18" would have forced parties to debate intent of tobacco corporations to appeal to youth. — Text failed to recognize effectiveness of comprehensive bans at reducing tobacco consumption.	+ *Article 13* requires parties to undertake a comprehensive ban on tobacco advertising, promotion and sponsorship within five years of FCTC's entry into force. — *Article 13.3* allows exceptions for constitutional reasons. + *Definitions* are broad enough to cover the range of tactics employed by the tobacco corporations to promote their products.

	First Chair's Text of FCTC January 2001 [4]	Final FCTC Draft to WHA March 2003 [5]
Priority of Public Health vs. Tobacco Trade	− As a *Guiding Principle*, "tobacco control measures should not constitute a means of arbitrary or unjustifiable discrimination in international trade."	+ First line of *Preamble*, establishing that parties to this convention are "determined to give priority to their right to protect public health," provides interpretive guidance if tobacco control measures based on the FCTC are attacked under trade and investment agreements. + *Guiding Principle* subordinating tobacco control to trade is removed.
Protection of Public Health Policy from Tobacco Industry Interference	+ *Surveillance, Research and Exchange of Information* required parties to promote and cooperate in exchange of information regarding practices of the tobacco industry. + *Education, Training and Public Awareness* called for parties to facilitate public access to information on the tobacco industry.	+ In *Preamble*, parties recognize "the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts. . ." + *Article 5.3* obligates parties to protect public health policies from commercial and other vested interests of the tobacco industry. + *Article 20.4(c)* calls for exchange of information on "the activities of the tobacco industry which have an impact on the Convention or national tobacco control activities." + *Article 12* excludes agencies and NGOs affiliated with the tobacco industry from participation in tobacco control programs and strategies.
Liability and Compensation for Harms Caused by Tobacco	+ As a *Guiding Principle*, "the tobacco industry should be held responsible for the harm its products cause to public health and the environment. . ." − No text developed on *Liability and Compensation.*	− *Article 4.5* no longer clearly states the tobacco industry's responsibility for harms caused by its products. + Inclusion of *Article 19* focusing on liability is a step toward holding tobacco transnationals accountable for their deadly practices.
Treaty Mechanisms and Institutions	− Established voluntary mechanism for provision of *Financial Resources.* + Recognized special responsibility of developed country parties that export manufactured tobacco products to provide technical support for tobacco control.	+ *Article 30* allows no reservations to this Convention, despite tremendous pressure from the US in this area. + *Articles 5.6 and 26* recognize the importance of dedicated funding for the FCTC.

"Aggressive promotional tactics like the Marlboro Man have driven the global profits of tobacco transnationals. When adopted and entered into force, this agreement will significantly reduce Philip Morris, BAT, and Japan Tobacco's ability to spread addiction, disease and death around the world. In the face of enormous pressure, developing countries have led the way toward meaningful, effective measures."
— Kathryn Mulvey, Executive Director of Infact (US), a founding member of NATT

"Quite simply, this is a matter of life and death. The final text is a good first step. It falls far short of what we dreamed, and while we are disappointed, we are also elated. This document confirms our feet are on the right path."
— Patricia Lambert, Chair of the South African Delegation, INB6 Closing Plenary

FCTC Negotiating Process, 1996-2003

May 1996
World Health Assembly (WHA) initiates development of FCTC

August 1997
10th World Conference on Tobacco or Health urges governments and WHO to formulate FCTC

Summer 1998
World Health Organization (WHO) establishes Tobacco Free Initiative, driving work on FCTC

May 1999
WHA sets in motion process to begin drafting FCTC

Summer 1999
Network for Accountability of Tobacco Transnationals (NATT) is formed

October 1999
1st Working Group

March 2000
2nd Working Group

May 2000
WHA calls for FCTC negotiations to begin[6]

August 2000
WHO Committee of Experts releases report condemning efforts by tobacco transnationals to derail public health initiatives[7]

October 2000
WHO Public Hearings on FCTC
1st session of Intergovernmental Negotiating Body (INB1): Ambassador Celso Amorim of Brazil elected Chair
NATT organizes 1st International Week of Resistance to Tobacco Transnationals (IWR2000), with events in 30 countries showcasing Infact's documentary film *Making a Killing: Philip Morris, Kraft and Global Tobacco Addiction*[8]

January 2001
1st Chair's text of FCTC released

March 2001
21 African countries participate in 1st intersessional meeting on FCTC in Johannesburg: strong regional position prioritizes public health over tobacco trade

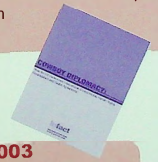
May 2001
INB2
IWR2001 includes events in 37 countries
WHA passes precedent-setting resolution to monitor the global impact of the tobacco industry's political activities[9]

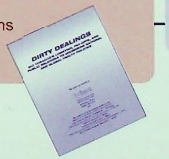
November 2001
INB3
NATT bestows inaugural Marlboro Man Awards, for taking positions that benefit the tobacco industry at the expense of public health, on US, Japan, Tunisia, Dominican Republic and Costa Rica[10]

March 2002
INB4: Ambassador Luiz Felipe de Seixas Corrêa takes over as Chair
IWR2002 highlights theme of public health over trade
NATT's Marlboro Man Awards go to US, Republic of Korea, Pakistan and Dominican Republic

July 2002
New Chair's Text condemned by leading governments and NGOs as too weak to reverse the global tobacco epidemic and hold tobacco transnationals accountable for their abuses

October 2002
INB5
NATT members and other NGOs release *Dirty Dealings: Big Tobacco's Lobbying, Pay-offs and Public Relations to Undermine National and Global Health Policies*
Africa, Southeast Asia, Eastern Mediterranean, Pacific and Caribbean Islands unite to champion key treaty provisions
NATT's Marlboro Man Awards go to US, China, Germany, BAT and Japan





January 2003
Revised Chair's Text fails to reflect strong positions taken by great majority of countries at INB5

February 2003
INB6
NATT's Marlboro Man Awards go to Chair—Ambassador Luiz Felipe de Seixas Corrêa, Japan, Cuba and twice to the US
Final text forwarded to WHA includes comprehensive ban on tobacco advertising, promotion and sponsorship; promotes public health as priority; obligates parties to protect public health policies from tobacco industry influence; fails to state tobacco industry's responsibility for harms caused by its products. No reservations allowed.

March 2003
Tobacco industry denounces FCTC
US threatens to reopen text

May 2003
WHA scheduled to adopt FCTC

June 2003
FCTC open for signature

Successful Treaty Ratification Examples

The FCTC will open for signature on 16 June 2003, and enter into force 90 days after the 40th country has ratified or accepted the treaty. Since the first FCTC Intergovernmental Negotiating Body meeting in October 1999, at least 13 million people have died from tobacco-related illnesses.[11] The sooner the treaty enters into force, the more lives will potentially be saved from this epidemic.

Some recent human rights and environmental treaties have entered into force rapidly, providing hopeful models for ratification of the FCTC. Fifty-seven countries from all the major regions ratified the Convention on the Rights of the Child within the first year. In addition, 43 countries ratified within two years. Fifty-seven countries ratified the Mine Ban Treaty within one year.[12] These treaties are considered to be the fastest humanitarian treaties to enter into force. The Framework Convention on Climate Change opened for signature in June 1992 and entered into force in March 1994, after the threshold of 50 ratifications was reached.[13]

Some countries that have played a leading role in the FCTC negotiations also have a good record of quickly ratifying human rights and environmental conventions—including island nations of the Pacific and Caribbean and several European and African countries. The Convention on the Rights of the Child, the Mine Ban Treaty, and the Framework Convention on Climate Change were all ratified within one year by Guinea, Mauritius, Mexico, Peru, St. Kitts and Nevis, Sweden and Zimbabwe. An additional 20 countries ratified at least two of these treaties within one year.

Although opposition to ratification of the FCTC is expected from the tobacco industry and its government allies, the FCTC should have the necessary momentum from governments, backed by broad-based NGO support, to enter into force within two years. The sooner governments take action, the more needless addictions and deaths will be prevented.

Who Stands to Gain from a Delay?

The tobacco transnationals—Philip Morris/Altria, JTI and BAT—and their investors in wealthy countries like the US, Japan and Germany have the most to gain in delaying the FCTC's entry into force.

Recently released Philip Morris/Altria internal documents indicate a key corporate strategy is to delay the FCTC, as recommended by the notorious Washington, DC-based firm Mongoven, Biscoe & Duchin (MBD). During Infact's campaign on the infant food industry in the late 1970s and early 1980s, Jack Mongoven of MBD advised Nestlé on how to fight the Nestlé Boycott and the WHO Code of Marketing of Breast-Milk Substitutes. With regard to the FCTC, MBD told Philip Morris that "the first alternative to an onerous convention is to delay its crafting and adoption . . . Any pressures to delay the finalisation of the convention would require the combined efforts of several individual or coalitions of countries and various NGOs." MBD suggested to Philip Morris/Altria that "key intervention points to delay or strongly influence movements in negotiations are the biennial meetings of the WHA." The firm also recommended focusing on the FCTC by regions, and having a "central corporate-wide" strategy.[14] The majority of governments have so far stood firm to keep the FCTC on schedule and to negotiate a strong text.

Governments must continue to be vigilant against industry tactics to delay the treaty's adoption and entry into force—including arguments in favor of reservations and against a ban on advertising, promotion and sponsorship. The time for negotiations is past, and governments have spoken overwhelmingly in support of the FCTC. Threats from the US or other powerful countries not to sign the treaty may in the long run have little impact on the treaty's effectiveness in reversing the global epidemic spread by tobacco transnationals.

A World With a Strong FCTC

Within five years of entry into force of the FCTC, the Marlboro Man and other ads for tobacco products will disappear from billboards, there will be no television or radio commercials promoting tobacco directly or indirectly, and merchandise with brand names like Marlboro Classics clothing will be a thing of the past. Sports and other events will no longer be associated with tobacco products, brands or corporations. Tobacco promotions by Philip Morris/Altria, JTI, BAT and other tobacco corporations will be far less visible in society and fewer children will become addicted to tobacco as a result. There has already been a dramatic drop in youth addiction in countries where most tobacco advertisements are prohibited as part of a comprehensive tobacco control program.

The FCTC will make it easier for governments to pass tobacco control legislation since the FCTC will make lobbying and other activities of the tobacco transnationals more transparent. Tobacco giants will be less able to hide and therefore not as able to undermine public policy. International cooperation in legal matters pertaining to tobacco will make it far more likely that the tobacco transnationals will begin to pay the true costs of their deadly business.

A shrinking rather than growing market of addicted consumers will result in fewer deaths and lower health care costs so governments have more resources to tackle other public health challenges. In impoverished areas, more money will be available for essentials like food rather than lining the pockets of giant tobacco corporations and wealthy shareholders.

> "This is indeed a milestone in the evolution of public health action and demonstrates the power of the collective will. But we must be reminded, while we applaud ourselves, that this is only the beginning. There are many more battles ahead."
>
> — Dr. Eva Lewis-Fuller, Chief Jamaican Delegate, INB6 Closing Plenary

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1 "WHA 49.17, International Framework Convention for Tobacco Control," http://tobacco.who.int/printer_content.cfm?tld=37, 25 May 1993.
2 "Intergovernmental Negotiating Body," www.who.int/gb/fctc/E/E_Frame.html.
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8 "Milestones of the FCTC Process," http:www.treatycheck.org/milestones%202000.htm.
9 "WHA 54.18, Transparency in Tobacco Control," http:tobacco.who.int/printer_content.cfm?tld=112, 22 May 2001.
10 "Report from International Negotiating Body Meetings," http:www.treatycheck.org/INB.htm.
11 Based on WHO estimates cited in "WHA 52.18, Towards a framework convention on tobacco control," http://tobacco.who.int/printer_content.cfm?tld=134, 24 May 1999.
12 "Status of Ratification of the Principle International and Human Rights Treaties," Office of the United Nations High Commission of Human Rights, as of 9 December 2002. "1997 Mine Ban Treaty Ratification Update," http://www.icbl.org/ratification, as of 1 April 2003.
13 "United Nations Framework Convention on Climate Change, Status of Signatories and Ratification of Convention" http://unfccc.int/resource/conv/kp.html.
14 Stacy M. Carter, "Mongoven, Biscoe & Duchin: Destroying Tobacco Control Activism from the Inside," *Tobacco Control* 2002, Vol. 11, Issue 2; Mongoven, Biscoe & Duchin, Inc., "An Analysis of the International Framework Convention Process: Executive Summary, The WHO Tobacco Control Convention," November 1997, Philip Morris document # 2074292078-2082.

Since 1977, **Infact** has been exposing life-threatening abuses by transnational corporations and organizing successful grassroots campaigns to hold corporations accountable to consumers and society at large. From the **Nestlé Boycott** of the 1970s and '80s over infant formula marketing, to the **GE Boycott** of the 1980s and '90s to curb nuclear weapons production and promotion, to today's **Boycott of Kraft Macaroni & Cheese**—a product of tobacco giant **Philip Morris/Altria**—Infact organizes to win! Infact is an NGO in official relations with the World Health Organization, and a founding member of the Network for Accountability of Tobacco Transnationals.

The Network for Accountability of Tobacco Transnationals (NATT) consists of more than 75 consumer, human rights, environmental, faith-based and corporate accountability NGOs in 50 countries. NATT was formed in the spring of 1999 to ensure a strong, unified voice for an effective Framework Convention on Tobacco Control that will:

- Institute effective controls over tobacco transnationals that are spreading tobacco addiction, disease and death; and
- Contribute to the establishment of broad global standards that hold corporations accountable for policies, practices and products that endanger human health and the environment.

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FCTC: Breaking New Ground, Protecting Global Public Health

World Health Organization
REGIONAL OFFICE FOR Europe

Regional Committee for Europe
Sixty-second session

Malta, 10–13 September 2012

Strategy and action plan for healthy ageing in Europe, 2012–2020

World Health Organization
REGIONAL OFFICE FOR Europe

Regional Committee for Europe
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Malta, 10–13 September 2012

Provisional agenda item 5(c)

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ORIGINAL: ENGLISH

Strategy and action plan for healthy ageing in Europe, 2012–2020

The WHO European Region has a rapidly ageing population. The median age is already the highest in the world, and the proportion of people aged 65 and above is forecast to almost double between 2010 and 2050. The average age of the population and the proportion of people above retirement age are also projected to increase fast, even in countries with life expectancies that are well below the European average.

Allowing more people to lead active and healthy lives in later age requires investing in a broad range of policies for healthy ageing, from prevention and control of noncommunicable diseases (NCDs) over the life-course to strengthening health systems, in order to increase older people's access to affordable, high-quality health and social services.

Investing in healthy ageing has become key for the sustainability of health and social policies in Europe. A closing window of opportunity of relative growth of the labour force along with unfavourable economic prospects in many countries in Europe have made the need to step up the implementation of policies for active ageing particularly urgent.

This document contains a draft strategy and action plan for healthy ageing in Europe. It focuses on priority action areas and interventions that correspond to the four priority areas of Health 2020, the new European policy framework for health and well-being. It is therefore in synergy with the core health policy developments being undertaken by the WHO Regional Office for Europe in the period 2011–2012, namely Health 2020, the European action plan for the prevention and control of noncommunicable diseases, and the European action plan for strengthening public health capacities and services.

This draft has been developed in consultation with Member States, guided by the Standing Committee of the WHO Regional Committee for Europe.

A draft resolution is attached, for consideration by the Regional Committee.

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Executive summary

This document contains the draft of a strategy and action plan for healthy ageing in Europe, 2012–2020. It proposes strategic action areas and a set of interventions that will be in synergy with Health 2020, the new European policy framework supporting action across government and society for health and well-being, to which its strategic areas correspond. It is the first European strategy to bring together, in a coherent manner, the ageing-related elements of the WHO Regional Office for Europe's work programme and to present them in the form of four strategic action areas and five priority interventions, together with three supporting interventions. The action plan is intended as a guide for Member States at different income levels or stages of ageing policy development or demographic transition.

At the core of this proposal is a list of priority interventions for which there is evidence to show that, if adequately implemented, they can provide "quick wins" (in the sense that they should be politically feasible), and for which progress is achievable and measurable even within a relatively short time span. Moreover, preference has been given to interventions with evidence to support their effectiveness and contribution to the sustainability of health and social policies.

The strategy and action plan is in four main sections. The first sets out the mandate, background and context. The second proposes four strategic priority areas for action that build on the Regional Office's existing tools, instruments and commitments, including tools that have been developed at the global level. These are (i) healthy ageing over the life-course; (ii) supportive environments; (iii) health and long-term care systems fit for ageing populations; and (iv) strengthening the evidence base and research. These priority areas comprise actions that help people to stay active as long as possible, including in the labour market, and actions to protect the health and well-being of people with (multiple) chronic conditions or at risk of frailty.

The third section suggests five priority interventions: (i) promoting physical activity, (ii) falls prevention; ; (iii) vaccination of older people and infectious disease prevention in health care settings; (iv) public support to informal care–giving, with a focus on home care; and (v) geriatric and gerontological capacity-building among the health and social care workforce. Three additional supporting interventions in the final section link healthy ageing to its wider social context: (i) prevention of social isolation and social exclusion; (ii) prevention of elder maltreatment; and (iii) quality of care strategies for older people including dementia care and palliative care for long-term care patients.

This strategy and action plan also outlines synergies and complementarities in cooperation with partners, in particular with European Commission initiatives. In implementing this strategy and action plan, the Regional Office will ensure that all countries in the WHO European Region are adequately covered, as population ageing is spreading fast in the Region, making the need to prepare health and social care systems for ageing populations particularly urgent.

Mandate, context and process

Mandate

1. At its sixty-first session in September 2011, the WHO Regional Committee for Europe (RC61) confirmed the Regional Office's mandate to develop a new European health policy, Health 2020, which would "focus in particular on policies and interventions that work and which make the greatest difference to the health and well-being of people in the Region" *(1)*.

2. Sound policies for healthy ageing are indispensable for reaching the goals of Health 2020 in response to fast demographic ageing in the WHO European Region, as well as to other major health and social challenges that have been identified in Health 2020, such as the increasing need for intersectoral action in order to reach public health goals and combat the noncommunicable disease (NCD) epidemic in the Region. Healthy ageing policies are key to preventing disease, disability and erosion of well-being, much of which is highly concentrated in older age groups. The actions under the four priority areas of this strategy and action plan all correspond to and support the four priority areas of Health 2020, as detailed below.

3. There is growing evidence that more can be done to create better people-centred health systems for older people and to improve coverage with and access to public health services for older age groups. Healthy ageing is indeed vitally important for making current levels of wealth and social protection sustainable in the future, including the contribution of families and voluntary action, and for responding to the specific needs of an ageing labour force in Europe.

4. In addition to proposing detailed actions for implementing the priority areas of Health 2020 through an "ageing lens", this draft strategy and action plan builds on a number of relevant resolutions and previous work at both global and European regional level. In 1999, the World Health Assembly, in its resolution WHA52.7 on active ageing, called upon Member States to ensure the highest attainable standard of health and well-being for their older citizens *(2)*, and more recently, in resolution WHA58.16 it focused on developing age-friendly primary health care *(3)*. In 2012, the World Health Assembly adopted resolution WHA65.3 on "Strengthening noncommunicable disease policies to promote active ageing" *(4)*. Links to the WHO reform are promoted at every stage.

5. Since the 1980s, Member States in the European Region have continuously requested that the Regional Office focus its work on healthy ageing *(5)*. For example, healthy ageing is one of the 21 targets of HEALTH21 – the "health for all in the 21st century" update of the European Health for All Strategy *(6)*.

6. In several resolutions (e.g. A/RES/58/134 and A/RES/59/150) the United Nations General Assembly has called on governments, United Nations organizations and others to incorporate the concerns of older people into their programmes of work. The Second World Assembly on Ageing that was held in Madrid, Spain in 2002 adopted the Madrid International Plan of Action on Ageing (MIPAA) *(7)*. As a contribution to this meeting, WHO developed a document entitled Active ageing: a policy framework *(8)*. In the same year, the United Nations Economic Commission for Europe (UNECE) Ministerial Conference on Ageing in Berlin adopted the Regional Implementation Strategy for MIPAA in Europe *(9)*.

Healthy ageing in Europe: challenges and opportunities

7. The population in the European Region has the highest median age in the world. People in many European countries enjoy some of the highest life expectancies in the world. As life expectancy increases, more people live past 65 years of age and into very old age, greatly

increasing the numbers of older people. By 2050, more than one quarter (27%) of the population is expected to be 65 years and older. However, trends in longevity gain are uneven, and gaps between and within countries of the European Region continue to grow *(10)*.

8. While many people are living longer and healthier lives, there are important uncertainties about future trends in the health and functional status of ageing populations. This calls for strong public health policies to allow more people to stay active and participate fully in society. Moreover, those with chronic conditions or at risk of frailty require access to adequate support and protection by health systems and public health actions.

9. In western European countries, the labour force is rapidly becoming older, a trend which is spreading eastward and which calls for particular attention to be paid to the health and well-being of persons aged 50 and above or in the last years of their working life. Moreover, in many countries old-age dependency ratios are projected to grow to unprecedented levels, and the concern this has caused about the financial sustainability of the current scope of publicly funded health and social protection has become even more acute in times of fiscal and economic crises *(11)*.

10. Demographic ageing is also high in eastern European countries and those in the Commonwealth of Independent States (CIS), where the median age is projected to increase by 10 years within less than two decades *(12)*. Differences between men and women are significant across the Region, not only in terms of life expectancy (women consistently make up the majority of the old, and particularly the oldest old) but also in relation to roles and experience of health and responses from the health system. There are currently 2.5 women for each man among those aged 85 years or over, and this imbalance is projected to increase by 2050 *(10)*.

11. In response to global trends in ageing, in the late 1990s WHO called for a paradigm shift towards a positive concept of ageing, defining healthy and active ageing as a process that "allows people to realize their potential for physical, social, and mental well-being throughout the life-course and to participate in society, while providing them with adequate protection, security and care when they require assistance" *(8)*.

12. Healthy ageing therefore has several dimensions.

- It responds to the growing needs and expectations of ageing populations for better health promotion and health and social services, including support for self-help.
- It recognizes everyone's fundamental right to the enjoyment of the highest attainable standard of physical and mental health, irrespective of age.
- It takes into account growing evidence about inefficiencies shortcomings in terms of quality and access to services, including prevention (at all levels – primary, secondary and tertiary).
- Besides maternal and child health, and the fight against the NCD epidemic, healthy ageing is a major contributor to closing the gap in health and well-being between countries in the Region, between socioeconomic groups and between men and women.
- Healthy ageing interacts with policies of social protection to prevent the risk of poverty among older people, a risk that is still widespread in Europe.
- Healthy ageing can contribute to the sustainability of health and welfare systems in Europe, in particular by allowing people in higher age groups to remain active, autonomous and fully integrated.

The need and opportunity to act now

13. The closing "window of opportunity", during which the share of the population of economically active age was growing, and the negative economic outlook in many countries have added to the urgent need to step up the implementation of policies for active ageing. Many countries have already launched healthy ageing initiatives at various levels of government, including national strategies. WHO is supporting this process with a number of tools that are relevant for healthy ageing, such as in the areas of NCD prevention and control, public health services, and health systems strengthening.

14. Postponing the implementation of healthy ageing policies in a period of economic austerity may prove more costly in the long term and can be counter-productive to the sustainability of welfare policies.

15. On a more positive note, there is a rapidly growing body of knowledge and evidence for action, as Europe is rich with innovative policy initiatives on population ageing. This strategy and action plan aims to offer a framework that leads to a better uptake of evidence in the field of ageing, including findings about interventions with known effectiveness that can contribute to the sustainability of health systems, such as targeted disease prevention strategies.

16. This strategy and action plan is being developed at a time when questions of healthy ageing are high on policy agendas in Europe and globally. The year 2012 sees the tenth anniversary of the United Nations Madrid International Plan of Action on Ageing and the thirtieth anniversary of the first International Plan of Action on Ageing *(13)*. The theme of World Health Day 2012 is "Ageing and health". At the level of the European Union, 2012 has been designated as the European Year for Active Ageing and Solidarity between Generations. This strategy and action plan will be at the core of the WHO Regional Office for Europe's response to the European Commission's call to all partners in the field of active and healthy ageing to join forces over the years ahead.

Guiding principles and scope

Guiding principles

17. In line with the principles at the core of Health 2020, this strategy and action plan is based on everyone's fundamental right to the enjoyment of the highest attainable standard of physical and mental health, irrespective of age, as articulated in the WHO Constitution and committed to by WHO's European Member States in various international treaties at both global and regional level *(14–17)*. Moreover, it incorporates the core values and principles set out in the global and European Regional documents listed above, with a particular emphasis on the United Nations Principles for Older Persons *(18)*.

18. Implementing policies for healthy ageing is essential to achieving the two linked strategic objectives of Health 2020, because many health challenges and inequalities are most pronounced in higher age groups. Policies on healthy ageing are a prime example of the need for cross-sectoral action at various levels of government, including:

- improving health for all and reducing health inequalities; and
- improving leadership and participatory governance for health.

19. Furthermore, the implementation of this strategy and action plan requires that a number of principles of the Health 2020 policy framework be applied.

- **Participatory approaches**: involving older persons in policy-making and evaluation has proven to be key for the design of successful initiatives and their implementation.
- **Empowerment at the personal and community levels**: involving people in community action, voluntary initiatives and informal care is at the core of successful healthy ageing strategies.
- **A focus on equity with attention to vulnerable or disadvantaged groups of older people**: inequalities accumulate over the life-course. Healthy ageing policies therefore can contribute to closing the gaps in health inequalities.
- **Gender perspective**: there are important differences between men and women in the roles and experiences during old age. Women are potentially more affected by living alone, and by poverty in old age, and they spend on average a larger part of their life with some form of functional limitations. At the same time, they constitute the vast majority of both formal and informal care-givers, as well as being clearly over-represented as care recipients, even when controlled for their higher average age. These and other aspects call for a gender perspective on healthy ageing policies throughout all strategic areas and priority interventions.
- **The need for intersectoral action**: "whole-of-society", "whole-of-government" and "health in all policies" approaches: not only the social determinants of healthy ageing but also the responsibility for care of older people and for strategy development and leadership on healthy ageing are usually joint responsibilities between health ministries and other government departments, and typically belong to different levels of government. Moreover, they involve other stakeholders, private sector, civil society and voluntary action at various levels.
- **Sustainability and value for money**: fiscal sustainability is a major concern in many countries that are in the process of reforming health systems and public health services for ageing populations. Improved quality of care and proven effectiveness of interventions are important concerns in this respect. This applies to countries at all income levels.

Scope

20. The scope of this strategy and action plan has two dimensions. The four suggested strategic action areas span the policy field of healthy ageing and link to corresponding priority areas of Health 2020. They follow earlier strategic approaches proposed by WHO, such as "Active ageing: a policy framework" *(8)*. The five priority interventions and three supporting interventions have been selected in an attempt to prioritize and select actions using a number of criteria.

- They build on existing WHO strategies, tools and expertise.
- Progress can be achieved in the WHO European Region within a limited timescale.
- They are relevant for countries at all income levels and stages of development of policies for healthy ageing.
- They have a high impact on health and well-being of older people, as identified by the available evidence base.
- They address the largest gaps and inequalities in access to good quality and effective interventions.
- They correspond to the major concerns that are regularly expressed by patient groups, families of people in need of care, and other stakeholder groups.
- There is evidence for their effectiveness and that they can contribute to making health and social systems more sustainable.

- The evidence exists to justify a concerted societal response to this burden, with tools that are effective and adaptable to countries at all levels of development.
- There is a mandate in global and regional strategies for the response by Member States.

Linkages

21. Healthy ageing is a cross-cutting concern, with linkages to a number of other strategic areas and existing action plans. The health and well-being of older people can be decisively improved, if the implementation of all actions takes the specific needs, concerns and barriers of access for older men and women into account. The main linkages are to the areas described below.

The new European policy framework for health and well-being, Health 2020

22. Responding to the challenges of ageing populations is one of the public health priorities in the European Region in the new European policy framework for health and well-being, Health 2020. This strategy and action plan is in line with the four priority areas of Health 2020, and thus provides an "ageing lens" through which to view activities undertaken in the context of Health 2020.

Noncommunicable diseases

23. There is a large overlap between the NCD agenda and strategies for healthy ageing over the life-course *(4)*. Shared topics (often found in national strategies) include prevention of malnutrition and obesity, physical activity and exercise, tobacco and alcohol. The first of the proposed strategic areas in this strategy and action plan focuses on addressing NCDs among older persons.

Mental disorders

24. Mental health is a vital, often neglected aspect of medical and social attention to older people, including preventive actions. The Regional Office's draft mental health action plan, which is currently being revised in consultation with Member States, already addresses these concerns *(19)*. In 2011, the High-level Meeting of the United Nations General Assembly on prevention and control of noncommunicable diseases adopted a political declaration which recognizes that "mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden" *(20)*. A report developed jointly by WHO and Alzheimer's Disease International calls for making dementia a public health priority *(21)*. The specific needs of older persons with dementia and the needs of their carers, are a cross-cutting concern that is supported by a range of actions and priority interventions in this strategy and action plan.

Violence and injury prevention

25. Injuries account for a large share of the burden of disease and disability of older people, in particular in the oldest age groups. Elder maltreatment has received more attention only over the last decade and has become an emerging field for international exchange of experience, in which WHO continues to play an important role.

Infectious diseases

26. There is growing recognition of the benefit for older people of proper vaccination strategies (such as against influenza), both for themselves and for health and social care staff

who are in contact with them. A corresponding priority intervention is proposed in this action plan.

Health systems strengthening

27. The complex care needs of chronic patients in ageing populations call for well-coordinated and high-quality services for older people. This includes better access to preventive services (at all levels – primary, secondary and tertiary) and to rehabilitation. It is a central concern of reform strategies to support self-management and delivery of care as close to home as is safe and cost-effective, by both increasing value for money and making the financing of health care systems sustainable, which are core goals of the Tallinn Charter "Health Systems for Health and Wealth" *(22)*.

Vision, overall goal and objectives

Vision

28. The vision of this strategy and action plan is of an age-friendly WHO European Region where population ageing is seen as an opportunity rather than a burden for society. It is the vision of a European Region where older people can maintain their health and functional capacity and enjoy well-being by living with dignity, without discrimination and with adequate financial means, in environments that support them in feeling secure, being active, empowered and socially engaged, and having access to appropriate high-quality health and social services and support. An age-friendly European Region helps people to reach older age in better health and to continue leading active lives in various roles including in employment and voluntary action.

Goals

29. The goals of this strategy and action plan are:

- to allow more people to live longer in good health, to remain active for longer, and to counteract growing inequalities in old age;
- to facilitate access to good quality health and social services for people in need of care and support, in order to make healthy life expectancy more equitable within and between Member States;
- to empower older women and men to remain fully integrated in society and to live in dignity, independent of their health or dependency status; and
- to raise awareness and contribute to overcoming age discrimination and ageing stereotypes of any form.

Objectives

30. The objectives of this strategy and action plan are:

- to foster enabling environments and to take health-promoting and disease prevention action on risk factors for older people in a life-course and gender perspective;
- to strengthen health systems for healthy ageing and better quality and more equitable health and social care for older people; and
- to strengthen the evidence base for health and social care policies for ageing populations in Europe.

International cooperation: working together

31. The implementation of the strategy and action plan calls for strengthening international cooperation and partnership between initiatives in Europe. There are also synergies and complementarities with initiatives from the European Commission, United Nations agencies and other international partner organizations, such as the UNECE, the Organisation for Economic Co-operation and Development (OECD) and the World Bank.

32. The implementation of the strategy and action plan has synergies with a number of the priorities and actions identified in the strategic implementation plan of the European Commission's Pilot European Innovation Partnership on Active and Healthy Ageing (EIP AHA) and shares its positive vision on ageing *(23)*. The strategic framework for action of the EIP AHA defines three pillars or "life stages" of older people in relation to care processes: (i) prevention, screening and early diagnosis; (ii) care and cure; and (iii) active ageing and independent living. The EIP AHA singles out, among others, falls prevention and the prevention of functional decline and frailty; training programmes for the health workforce; support for home care; and innovation for improving social inclusion.

33. The strategic framework for action of the EIP AHA complements this strategy and action plan by placing stronger emphasis on questions of research, innovation, and technology. Strong synergy between them is foreseen is under the horizontal topic of age-friendly environments of the EIP AHA, which also is a strategic priority area of the present strategy and action plan. The indicators on healthy ageing are another example of cooperation, complementing the interactive geographical information system of atlases on inequalities in health and their social determinants, which has been jointly developed with the European Commission's Directorate-General for Health and Consumers (DG SANCO). The development of other joint global indicators is under way with Eurostat and the OECD for gathering ageing-related data, such as for workforce planning.

34. Collaboration in this field has already started in the context of cooperation between the WHO Regional Office for Europe and the European Commission.

Strategic priority areas for action

35. The four strategic action areas described below complement each other and link to other WHO strategies and action plans that are mutually reinforcing *(24)*. The first three directly support, through a special "ageing lens", the four priority areas of Health 2020. Strengthening the evidence base and research is one of the cross-cutting priorities of Health 2020. Moreover, they reflect WHO's specific mandate for the European Region, where countries are at different stages of population ageing. Finally, they build on earlier WHO frameworks, such as "Healthy Ageing: A Framework for Action" *(8)*, and initiatives with a good track record of take-up in Member States. The Healthy Cities movement is a prime example *(25)*. These four strategic areas also bring together the elements that support the development and implementation of national healthy ageing policies that are referred to in resolutions WHA52.7 *(2)*, WHA58.16 *(3)* and WHA65.3 *(4)*.

Strategic area 1: Healthy ageing over the life-course

Background

36. Health and activity in older age are the result of the living circumstances and actions of an individual during his or her whole life span. The life-course approach to healthy ageing helps

people influence how they age by adopting healthier lifestyles earlier in life and by adapting to age-associated changes. This strategic area supports priority areas 1 and 2 of Health 2020, namely "Investing in health through a life-course approach and empowering people" and "Tackling Europe's major health challenges in communicable and noncommunicable diseases". The link between NCD prevention and healthy ageing over the life-course is also at the core of the resolution on "Strengthening noncommunicable disease policies to promote active ageing" endorsed by the Sixty-fifth World Health Assembly in May 2012 *(4)*.

37. In this strategy and action plan, one focus is on interventions targeted on "early old age", those aged 50 years or more, and on prevention, including secondary and tertiary prevention in older age groups. There is growing evidence about the underutilization of health promotion and disease prevention, including secondary and tertiary prevention that can be efficient and cost-effective for older age groups.

38. In national strategies and action frameworks, healthy ageing usually spans interventions on a broad range of NCDs and their most common risk factors and determinants, with a special focus on providing guidance that is targeted at older people: malnutrition, physical activity, a safe environment, smoking cessation, alcohol, obesity, hearing and eyesight, and mental health. All of these areas are covered in specific WHO strategies and action plans at regional or global level, and four main NCDs and their risk factors are covered in detail in the recent Action plan for the implementation of the European strategy for the prevention and control of noncommunicable diseases *(24)*.

39. This strategy and action plan focuses on a small set of priority interventions, and it consequently avoids repetitions of core components of existing strategies, such as the Framework Convention on Tobacco Control, on alcohol or mental health, while keeping in mind the importance of sufficiently including health aspects of older people in their implementation, which may not always be the case (examples are the widespread failure of proper screening, detection and subsequent treatment of tuberculosis, HIV/AIDS or depression among older persons). In this respect, primary care is important for providing for good quality general assessment of the health status of older persons, with the goal of early detection of physical and cognitive decline and for adequate preventive measures and timely treatment.

40. In the framework of the present strategy and action plan, this strategic area therefore has a clear focus on:

- mainstreaming of ageing into all relevant health promotion and disease prevention activities, and
- increasing coverage with and access to targeted priority interventions for older persons.

Objective

41. The objective in this strategic area is to deliver health promotion and disease prevention services for healthy ageing with a focus on adults aged 50 years and above.

Action by WHO

42. WHO will:

- prepare gender-responsive guidelines for evidence-based recommended "baskets" of health promotion and prevention services targeted at people aged 50 years and above that are based on good practice from Member States, with a focus on NCDs, vaccine-preventable diseases, injury and mental health;
- mainstream healthy ageing into existing regional actions for health promotion and disease prevention, including intersectoral policies, within the overall framework of Health 2020,

while ensuring that the special needs of older men and women are taken fully into account in the implementation of relevant regional action plans ;

- provide tools to monitor the gender aspects of implementation (for example, the balance between women's formal and informal work, their self-care and health protection) and the concentration of many risk factors affecting persons aged 50 years and above;
- assist Member States in developing instruments for evaluation and monitoring of the implementation of policies for healthy ageing by preventive actions and health promotion services, and foster cross-country learning and comparisons ;
- report on country progress with implementation of the specific measures covered under this action area in a regional report by 2016 and 2020; and
- develop tools to raise awareness among persons aged 50 years and above about the availability of disease prevention and health promotion (including services) and to foster their health literacy.

Action by Member States

43. Implications for Member States:

- paying particular attention to the needs and special risks of persons aged 50 years and above during the implementation of commitments under the strategic area "Promoting health and preventing disease" of the NCD action plan, ensuring that gender aspects are well addressed;
- extending the coverage of preventive action to people in older age groups and those in special settings, by ensuring that those living with functional limitations at home or in institutions, including those with dementia, are not excluded from or face high barriers of access to these services, including financial ones;
- supporting reporting systems and research in order to monitor the uptake, outcomes and social determinants of successful implementation of these actions.

Strategic area 2: Supportive environments

Background

44. A supportive environment at community level makes important contributions to the quality of life, associated with healthy ageing, better living and working conditions and healthier lifestyles for both urban and rural neighbourhoods. Alongside primary health care services, supportive environments are an important element of primary prevention. Creating healthy and supportive environments for health and well-being for all ages corresponds to priority area 4 of Health 2020 "Creating supportive environments and resilient communities". For older people, environmental factors of the built environment; transportation; support for social participation and social inclusion; security; education; and communication and information are the most relevant aspects of this priority area of Health 2020.

45. Important decisions influencing these wider determinants of health and well-being are often taken at local level. Within national policy frameworks, decisions that directly concern health and social services for older people are also often taken at local level. It is at community level that inequalities in healthy ageing can be effectively addressed.

46. In recent years, impressive "bottom-up" movements have been initiated by cities and rural communities that seek cooperation among themselves and with WHO on policies and tools for making their communities more age-friendly. Structured tools and processes of self-

evaluation and follow-up monitoring have been put in place, which ensure that older people and their representatives have a key role to play in their design and implementation. In the European Region, this support is organized via the WHO Healthy Cities subnetwork on healthy ageing. A global network of age-friendly cities has been established by WHO headquarters, and a process is under way for alignment and cooperation between both initiatives, in order to explore synergies and "bundle" the resources available at WHO.

Objective

47. The objective in this strategic area is to engage an increasing number of communities in the process of developing strategies for becoming more age-friendly, providing supportive environments for older persons to protect their health and well-being and to foster inclusion in their communities, and allowing them to play an active role in shaping their social environment and local policies for healthy ageing.

Action by WHO

48. WHO will:

- mobilize existing health-promoting networks, including the International Network of Health-Promoting Hospitals and Health Services, the Healthy Cities Network, and the Regions for Health Network, and extend further partnerships with appropriate international partners for implementing this strategy and action plan;
- contribute to the further development of evaluation tools and guidelines for supportive environments at the city/community level, building on existing WHO tools;
- review the use of "Healthy ageing profiles" for planning at community level, such as those based on the WHO/Europe guide and policy tool of "Healthy ageing profiles" *(26)*; based on this review, draft revised and amended guidelines for publication by 2013; and
- in cooperation with communities that are already part of the movement, strengthen the WHO governance for age-friendly communities in Europe, in cooperation with the global network of age-friendly cities.

Action by Member States

49. Implications for Member States:

- encouraging and advocating the uptake of age-friendly policy concepts and initiatives among the WHO European Region's Healthy Cities movement; and
- supporting unified approaches to local systems for evaluation and data collection on "healthy ageing profiles", in cooperation with WHO.

Strategic area 3: People centred health and long-term care systems fit for ageing populations

Background

50. Older people are far too often faced with barriers of access to good-quality health and long-term care, including lack of information and high private cost-sharing. In many cases, health systems continue to face challenges in overcoming age discrimination or age-rationing and putting adequate resources in place to respond to the growing needs of ageing populations, in terms of both human resources and public funding. A particular concern is to train sufficient numbers of health care staff with adequate knowledge of geriatrics and gerontology. Emphasis has been placed on the need to strengthen health systems in Europe: the Tallinn Charter calls for

strengthening of public health capacities and services *(22)*. Moreover, this strategic area brings together specific actions that contribute to priority area 3 of Health 2020 "strengthening people centred health systems, public health capacity and emergency preparedness", viewed through the lens of ageing.

51. Those with functional limitations and in need of long-term care are too often at risk of preventable further decline of their health status, in particular when faced with multiple morbidity and onset of frailty. Frail older people who live in institutions can be at heightened risks in this respect. But there are many ways of improving the quality of care and life in nursing homes, including by paying more attention to preventive actions, from malnutrition prevention to falls prevention or more effective use of medication and assistive devices matching the needs of older people.

52. There is growing evidence about effective ways of providing care for older people with multiple chronic conditions, including at the boundary between health and social care systems, where there is often scope for closer cooperation across sectors and levels of government, such as concerted action to allow older people to stay in their own homes for longer. This can be particularly relevant for care of people with dementia and the support needed for their families *(21)*.

53. Timely action on potential future shortages of human resources, more efficient health and social care for older people, including health promotion activities and better access to primary and secondary prevention, are all vital investments that can contribute to the sustainability of public funding for health systems in the future. This has become a major concern in times of economic uncertainty and fiscal constraints.

54. This strategic action area has important linkages and synergies with the strengthening of health systems for control of NCDs and chronic disease, and with mechanisms for the coordination of care, which all should be designed in ways that respect the special needs of older people, including those in older age groups and who are suffering from a decline in mental functioning.

Objectives

55. The objectives in this strategic area are to strengthen the capacity of health systems to respond to ageing populations and to improve the health and well-being of older people by facilitating appropriate use of high-quality services and mechanisms of financial and social protection, in order for older people to remain healthy and capable of living independently as long as possible, and to prevent health and functional impairment leading to social exclusion.

Action by WHO

56. WHO will:

- contribute to research, documentation and dissemination of good practice with regard to innovative models of coordinated service provision for older people, in particular at the boundary between health and social service systems, and related to fostering community-based partnerships for older people's health;
- contribute to the synthesis and dissemination of good practice with regard to initiatives to improve the quality of health and social care for older people, including those living in institutions;
- document and evaluate innovations in access to information and in service provision for older people, including eHealth to support the coordination of care, so that people with functional limitations can live in a community setting as long as possible;

- contribute to research, documentation and dissemination of recommended community preventive services for older persons, and good practice in enhancing the use of these services;
- disseminate good practice with regard to "horizontal governance" for healthy ageing, and particular in the design and implementation of national ageing strategies, with a special focus on gender aspects and the human rights of older people;
- ensure that human resource planning and monitoring take adequate account of the numbers and qualifications of staff needed for ageing populations; and
- exploit synergies with the strategic priority area of health systems strengthening under the NCD action plan, in particular on coordination of care for people with chronic conditions.

Action by Member States

57. Implications for Member States:

- within overall ageing strategies, ensuring coordinated responses to the health and social needs of people with chronic conditions and functional limitations, including dementia, as well as the quality of services, and availability of resources;
- improving surveys and reporting systems for ageing populations, and fostering the exchange of innovative modes of delivering care that are responsive to older peoples' needs;
- fostering health literacy and empowerment of older people, their relatives and voluntary support networks;
- putting in place a basic package of support for home care and informal caregivers, such as alternative modes of day care (see Priority intervention 4 below);
- ensuring that targeted disease management programmes adequately cover the oldest old and groups of vulnerable older persons;
- improving working conditions and staff retention for those providing services to older people;
- adopting staff training curricula that adequately cover geriatrics and gerontology and improve capacity planning for the future workforce;
- focussing community- and population-based public health services on the issues of older people;
- providing universal access to health and social care (financial protection), with cost-sharing regulations that protect low-income households, including older people; this includes coverage of affordable medicines and assistive devices; and
- strengthening cost-effective and evidence-based interventions in prevailing primary care settings to support healthy ageing, whereby a continuum of care is ensured within a balanced system of community care, disease prevention, primary care settings, outpatient care, and second- and third-level hospital care; providing mechanisms and policy coalitions across government departments and regional levels to ensure coordination of health and social care for older people with chronic conditions and long-term care needs.

Strategic area 4: Strengthening the evidence base and research

Background

58. Over the past ten years the WHO European Region has seen much progress in research and exchange of good practice in the area of health policy for ageing populations. But there

remain gaps in the evidence, and there is an urgent need to further promote the systematic review, synthesis and dissemination of information about effective interventions that can benefit health policy for various target audiences. One focus of attention has to be on spreading effective policies that contribute to closing the gap in the inequalities in health status and access to services between and within Member States in the Region.

59. There are also still important gaps in data systems and consequently in knowledge about health and social trends of ageing populations, such as basic trends in functional status and living conditions of older people. Data harmonization across the Region is at various stages, depending on the statistical domain in question.

60. There has been good progress in some data domains, such as longitudinal surveys (the Survey of Health, Ageing and Retirement in Europe – SHARE; the Study on Global Ageing and Adult Health – SAGE) on long-term care recipients, and on expenditure and workforce, in part of the Region, and this can serve as a model for a larger number of European countries. This progress has resulted in major new insights and evidence for policy, illustrating how important it is to have the relevant data systems in place and to harmonize them internationally.

Objective

61. The objective in this strategic area is to strengthen the technical capacity of Member States and of the Regional Office to monitor and evaluate the health and functional status of older people and their access to health and social services.

Action by WHO

62. The proposed action by WHO will fit within the overall vision of a joint European health information system and will support the WHO global health observatory and United Nations reporting systems, with shared data modules across agencies that are active in international data collection and cross-country comparisons (in particular the European Commission and OECD). WHO will:

- identify and subsequently advocate for closing the most important gaps in statistical evidence and for carrying out both the qualitative and the quantitative research that is needed to guide policy;
- advocate the use of WHO instruments and tools such as the International Classification of Functioning and SAGE, ensuring links to NCD surveillance (better disaggregation of data by age and sex in surveillance systems, including for older age groups) and monitor social determinants and health inequalities among older women and men, ensuring that a gender analysis of inequalities is done;
- cooperate with the European Advisory Committee on Health Research to identify gaps in evidence for policy and priority research for ageing and health;
- provide guidance on the production of health and ageing indicators for non-European Union countries by promoting existing tools and emerging statistical standards;
- intensify cooperation with and input to regional and global data initiatives such as those undertaken jointly by OECD and Eurostat, in cooperation with WHO headquarters;
- increase the number of WHO collaborating centres and intensify cooperation with national and international partners in this policy field;
- in cooperation with international partners such as UNECE, the European Commission and OECD, agree on definitions and indicators for healthy ageing.

Action by Member States

63. Implications for Member States:

- improving the capacity of surveys and reporting systems to monitor health and social care services, in particular preventive services, and their utilization and access by older persons, disaggregated by (five-year) age groups and sex, as well as evaluating the health of older people, in particular for monitoring functional status in the population;
- investing in longitudinal data surveys to monitor trends in the health and functional status of ageing populations;
- compiling national reports at regular intervals on the situation of older people and their health and well-being that are based on latest administrative data and research findings;
- establishing a centre of excellence for research into healthy ageing policies and strategies and their implementation, including for monitoring the demographic, social and health situation of older people, building on available expertise such as the network of nursing centres of excellence in Europe; and
- carrying out programmes for the prevention and management of chronic diseases that meet specific evidence-based requirements suited to the characteristics of older people.

Priority interventions

64. The proposed priority interventions have been selected keeping in mind the criteria described above in the introductory section under "scope" (see page 5). Each intervention is mapped to its corresponding priority area for action under Health 2020.

Priority intervention 1: Promoting physical activity

Goal

65. The goal of priority intervention 1 is to promote increased physical activity of older persons both through community environments and social activities.

Mapping to Health 2020

66. This intervention supports priority area 1 of Health 2020: Investing in healthy ageing over the life-course.

Rationale

67. The level of physical activity is one of the strongest predictors of healthy ageing, in particular for older age groups. Physical activity can improve respiratory and muscular fitness, and bone and functional health, and reduce the risk of NCD, depression and cognitive decline *(27)*. For older people, physical activity includes recreational or leisure-time physical activity, transportation (e.g. walking and cycling), occupational physical activity (if still engaged in work), household chores, play, games, sports or exercise planned in the context of daily, family, and community activities. The motivations and needs of men and women differ, and actions should therefore take gender norms, values and access to resources into consideration.

Actions

68. The following actions should be taken:

- foster cooperation and sharing of experience and good practice on effective measures to increase physical activity levels among older persons, in order to support their implementation and evaluation;
- develop and implement targeted community programmes for physical activity among older people, including a combination of individual and group-based behaviour change approaches with support and follow-up;
- provide advice about physical activity in all health and social care settings for older people, specifically targeting sedentary people, with a focus on promoting moderate-intensity physical activity (particularly walking) and providing ongoing support; and
- support local governments in creating motivating environments and infrastructure for physical activity (in particular active transport) for all ages.

Priority intervention 2: Falls prevention

Goal

69. The goal of priority intervention 2 is to reduce the burden of disease and disability from accidental falls among older persons.

Mapping to Health 2020

70. This intervention supports Priority area 1 of Health 2020: Investing in healthy ageing over the life-course.

Rationale

71. Falls among older people and the injuries to which they often lead are the underlying causes of a large share of the burden of disease and disability among older people in Europe and a major risk factor for developing frailty. The risk of falls increases steeply with age. Injuries from falls (such as femur fracture) usually require hospitalization and costly interventions, including rehabilitation. They are the underlying cause of many of the functional limitations that lead to the need for long-term care, including admission to a nursing home.

72. Environmental hazards account for between a quarter and a half of falls; other factors include muscle weakness, gait and balance disturbances, previous history of falls, and medication. Falls can happen in any setting: 30–40% of nursing home residents have been reported to fall each year. There is convincing evidence that most falls are preventable *(28)*. Some preventive measures have been shown to be cost-effective or even cost-saving, and there are examples of successful implementation of falls prevention strategies in different settings, when supported by public policies *(29)*.

Actions

73. The following actions should be taken:

- make the general population more aware of risk factors and effective falls prevention measures for older persons that can improve balance and prevent falls;

- in order to reduce falls and the proportion of falls that result in injuries, implement exercise programmes, physical therapy and balance retraining, and have home safety assessments and modification carried out by trained professionals;
- carry out multicomponent interventions incorporating gait and balance training, use of assistive devices, modification of environmental hazards and medication reviews (these have proven to be most effective in the community);
- improve training and access to relevant information for informal caregivers in the community;
- increase access to preventive measures for high-risk groups of older persons, such as wearing hip protectors; and
- include falls prevention measures in quality frameworks in all health and social care settings for older people.

Priority intervention 3: Vaccination of older people and infectious disease prevention in health care settings

Goal

74. The goal of priority intervention 3 is to reduce the health risks (morbidity and mortality) for older people that are due to gaps in vaccination against common infectious diseases.

Mapping to Health 2020

75. This intervention supports priority area 2 of Health 2020: Tackling major disease challenges (related to ageing).

Rationale

76. There is increasing evidence about the scope of vaccine-preventable disease that is due to inadequate immunization coverage of the population, including older people *(30)*. In many cases, low vaccine coverage rates are also seen among health (and social) care workers. This is in spite of the fact that there is convincing evidence about the difference that vaccination can make to morbidity and mortality of older persons in different settings, and not only for high-risk groups such as nursing home residents.

Actions

77. The following actions should be taken:

- implement national immunization schedules, including for higher age groups;
- continue to provide data on vaccine-preventable diseases and vaccination coverage among older people in order to obtain a better understanding of disease epidemiology; and
- ensure implementation of infectious disease control programmes in institutions, extending beyond hospitals to take in other facilities, including those for older people.

Priority intervention 4: Public support to informal caregiving with a focus on home care, including self-care

Goal

78. The goal of priority intervention 4 is to make informal care that is offered by family members and friends sustainable and to improve health and well-being of those in need of care, as well as of their caregivers, with special attention to the needs of the growing number of people with dementia.

Mapping to Health 2020

79. This intervention supports priority area 3 of Health 2020: Strengthening people centred health and long-term care systems (fit for ageing populations).

Rationale

80. In all European countries, the majority of care hours are informal care (mostly by women) even in countries with the largest publicly supported elderly care sectors. The growing prevalence of dementia will increase the need for support *(31)*. Public support to informal caregiving is therefore arguably the single most important public policy measure to contribute to the future sustainability of health and social care in ageing populations *(21,32)*. In contrast to their importance, statistical systems and cross-country comparative tools are frequently not up to the task of monitoring and analysing trends on informal care appropriately *(31)*.

Actions

81. The following actions should be taken:

- design strategies for training older adults in self-care and for training informal caregivers, and adapt self-care training programmes;
- disseminate good practice and foster international exchanges of information, including on gender-responsive practices that do not overburden women; and
- in cooperation with other international organizations, strengthen the evidence base and advocate for the improvement of international systems for reporting on the family situation and informal caregiving and carrying out evaluation and trend analysis.

Priority intervention 5: Geriatric and gerontological capacity-building among the health and social care workforce

Goal

82. The goal of this priority intervention is to ensure that training capacity in geriatrics and gerontology corresponds to the degree to which health and social care needs become increasingly concentrated in older people, many of whom suffer from dementia.

Mapping to Health 2020

83. This intervention supports priority area 3 of Health 2020: Strengthening people centred health and long-term care systems (fit for ageing populations).

Rationale

84. National and subnational capacity for training in geriatrics and gerontology is insufficient in many instances *(33)*. This concerns both gaps in the geriatric knowledge of general practitioners and other health care practitioners, as well as insufficient specialist training and specialists in geriatrics itself *(34)*. There is ample evidence of the problems with regard to access to training and shortcomings in the quality of care that are due to these shortages. Although these shortages have in many cases been identified for many years, insufficient progress has been made in many cases, increasing the urgency of action under this priority intervention. This intervention is therefore crucial for priority area 3 of Health 2020 "strengthening people centred health systems, public health capacity and emergency preparedness".

Actions

85. The following actions should be taken:

- draw up national guidelines on geriatric education and define standards for geriatric training;
- engage in geriatric and gerontological capacity planning as part of overall health and social workforce planning for ageing populations;
- contribute to closing the gap in capacity and training of health and social care staff between and within countries, and promote international networks in the Region; and
- foster international exchanges of information on good practice in the evaluation and promotion of continuous training in competencies for the health and social care of older people.

Supporting interventions

86. These supporting interventions underline the need for intersectoral action and linkages in three areas of national and community-level policies for healthy ageing. Two of the proposed supporting interventions aim at the broader social determinants of health and well-being of older men and women: the prevention of social isolation and social exclusion, and the prevention of elder maltreatment. The third supporting intervention addresses the need to step up national development, implementation and international exchange of strategies for ensuring the quality of care for older persons, in particular at the boundary of health and social services.

Supporting intervention 1: Prevention of social isolation and social exclusion

Goal

87. The goal of supporting intervention 1 is to reduce loneliness, social isolation and social exclusion, which are important risk factors affecting the health and well-being of older people.

Mapping to Health 2020

88. This intervention supports priority area 4 of Health 2020: Supportive environments and resilient communities.

Rationale

89. Loneliness, social isolation and social exclusion are important risk factors of ill health among older people, in particular in the absence of family networks or insufficient support for families. This affects all aspects of health and well-being, from mental health and dementia to the risk of emergency admissions to the hospital due to avoidable conditions such as severe dehydration or malnutrition *(8)*. Poverty among older people can greatly increase their risk of social exclusion. Innovative ways to combat social isolation are currently underused in many cases and deserve more international exchange and cooperation. Tackling this issue calls for strong intersectoral and gender approaches that tackle the impact of gender and other social determinants of health. For instance, in all countries older women are more at risk of social isolation than older men *(31)*. Most interventions combine public action with volunteering, activating the own potential of older people and their families or communities *(25)*. This takes into consideration important differences in Europe in the traditional family roles and in the number of older people who live with their extended family.

Actions

90. The following actions should be taken:

- promote the civil engagement of older people and strengthen the role of volunteering;
- foster intergenerational relations through positive media reporting and public image campaigns; and
- increase access to innovative models of support for older people to combat social isolation, including tele-links to social service providers and access to and training in the use of technology, to foster intergenerational exchange and bridge geographical distances within families.

Supporting intervention 2: Prevention of elder maltreatment

Goal

91. The goal of supporting intervention 2 is to prevent elder maltreatment.

Mapping to Health 2020

92. This intervention supports priority area 4 of Health 2020: Supportive environments and resilient communities.

Rationale

93. Elder maltreatment, which can take the form of physical, sexual, mental or financial abuse or neglect, is a significant cause of injuries, illness and despair. Older people may be maltreated in the home by family members and caregivers, or in institutions by professional staff or visitors. In the WHO European Region, at least 4 million elderly people were recently estimated to experience maltreatment in any one year. With the ageing population in the Region, the challenges are likely to increase *(35)*.

94. The violence or neglect involved are gross violations of human rights. It is only in the last two decades that the scope of the problem has been recognized, systematically studied and addressed in the various settings where older people live. Not only the scope of the problem but also the range of initiatives to address it that have emerged at all levels of government, among international organizations and other stakeholders call for improved international cooperation to provide guidance and facilitate exchanges of best practice. The gender dimension of elder

maltreatment needs further research. In addition pejorative attitudes towards old age and prejudices have to be taken into account. Among others, these factors cause disrespectful behaviour, humiliation and assaults.

Actions

95. The following actions should be taken:

- draw up national policies and plans for preventing elder maltreatment as part of intersectoral ageing strategies, building on the latest evidence from national good practice and regional and international guidance;
- improve the evidence base for elder maltreatment and strengthen capacity for research on effective interventions;
- build capacity and exchange good practices across sectors for protection and prevention;
- raise awareness and target investments on preventing elder maltreatment; and
- improve the quality of services in the community and in institutions, to adapt them better to the special needs of older people with functional limitations, and to ensure that quality guidelines are in place for preventing elder maltreatment.

Supporting intervention 3: Quality of care strategies for older people including dementia care and palliative care for long-term care patients

Goal

96. The goal of supporting intervention 3 is to improve the quality of care for older people, in particular for those with severe chronic disease and functional limitations, with a special focus on dementia care and palliative care for long-term care patients.

Mapping to Health 2020

97. This intervention supports priority area 3 of Health 2020: Strengthening people centred health and long-term care systems (fit for ageing populations).

Rationale

98. People of all ages who suffer from severe chronic conditions and functional limitations often need a complex package of care, including primary care, specialized care, access to affordable medication, assistive devices and social care *(33)*. There is growing evidence about shortcomings in the quality of care and lack of care coordination *(36)*. Moreover, for those living in institutions or needing long-term care at home, adequate nutrition, personal security and access to good-quality mainstream services can be an issue, in particular in resource-constrained situations *(32)*. Quality of care processes, guidelines and implementation in long-term care settings and chronic care are still only emerging in many countries; to remedy this calls for international exchanges of good practice and experience with quality improvement strategies. Persons with dementia deserve special attention in this respect *(37)*. More attention should be paid to the effective use of medicines as older persons with multiple chronic conditions may have a higher risk of either under-treatment or over-treatment.

Actions

99. The following actions should be taken:

- foster international cooperation on quality of care measurement and exchanges of best practices with implementing quality of care initiatives at various levels of governance; and
- provide training and transfer of knowledge and guidance for initiatives to improve the quality of care provided in resource-constrained settings and health care systems in transition.

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THE TRANSCENDENCE

आरोग्यम् सुखसम्पदा

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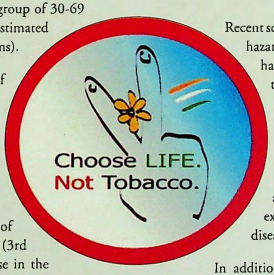
Use of Tobacco in India - *Challenges and Interventions*

Burden

Globally approximately 5.4 million people die each year as a result of diseases resulting from tobacco consumption. More than 80% of these deaths occur in the developing countries. Tobacco is a risk factor for 6 of the 8 leading causes of death and also is the most common preventable cause of death in the world.

More than 0.8 million people die due to tobacco consumption in India every year. Nearly 2200 Indians die each day due to tobacco related diseases. As per estimates, 10 million persons will die in India from smoking by 2010, and 70% of these will be in the age group of 30-69 years (This does not include the estimated deaths from consuming smokeless forms).

India is the second largest consumer of tobacco in the world. Tobacco is consumed in many forms, both smoking and smokeless, e.g. bidi, gutka, khaini, paan masala, hukka, cigarettes, cigars, chillum, chutta, gul, mawa, misri and others.



As per estimates from the latest round of National Family Health Survey (3rd Round), 2005-06, there is an increase in the prevalence of tobacco consumption in India, with 57% males and 10.8% females reportedly consuming tobacco in some form. The Global Youth Tobacco Survey (GYTS), 2006 for India also indicates that approximately 14.1% of children in the age group of 13-15 years are consuming tobacco in some form.

There are studies to indicate that approximately 40% of the disease burden in the country is related to diseases caused by tobacco. Approximately 50% of all cancer deaths in the country are due to tobacco consumption e.g. cancer of the oral cavity, lung, throat, esophagus, stomach and urinary bladder. India has the highest burden of oral cancer in the world and 90% of cases of oral cancer are tobacco related. As per recent evidence tobacco use is related to cancer of cervix in women, which is the most common cancer among Indian women and is a major killer.

The majority of the cardio-vascular diseases and lung disorders are directly attributable to tobacco consumption. Other diseases which are associated with tobacco consumption are stroke, cataract, peripheral vascular diseases and others. Moreover, studies have indicated that incidence of impotence is 85% higher among smokers. Tobacco use by pregnant women leads to low birth weight babies and birth defects.

Recent scientific evidence has proved the health hazards resulting from exposure to second hand smoke (SHS) or environmental tobacco smoke (ETS). SHS is known to contain more than 4000 chemicals, many of these are carcinogens. Inhalation of SHS results in cancer and heart diseases in adults, Sudden Infant Death Syndrome (SIDS), acute respiratory diseases, exacerbation of asthma and middle ear diseases in children.

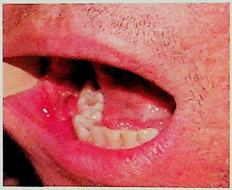
In addition to the disease and death burden resulting from tobacco use, tobacco has other implications also in the form of social, economic and ecological or environmental effects.

Approximately 0.27% of irrigated land is under tobacco crop. More than 10 million farmers, farm workers, tendu leaf pluckers, bidi rollers, middlemen, agents, retailers constitute tobacco workforce. (ILO 2002 estimates- 5.5 million bidi hand rollers, 85% of whom are women and children). Bidi rollers face exploitation in the form of low wages paid by the middlemen and are trapped in a vicious cycle of poverty.

Tobacco contributes to deforestation in three ways: forests cleared for cultivation of tobacco, fuel wood stripped from forests for curing of tobacco and forest resources used for packaging of tobacco, tobacco leaves, cigarettes, etc. Tobacco growing depletes soil nutrients at a much faster rate than many other crops, thus rapidly decreasing the fertility of the soil. Tobacco is a sensitive plant and therefore, requires huge chemical inputs and fertilizers. Such chemicals may run off into water bodies, contaminating local water supplies, causing excessive leeching and other problems. Frequent contact with and spraying of chemicals, and storage of tobacco in the residential premises of farmers have adverse health effects.

A Health Cost Study conducted in 1998-99 showed that cost of treatment of diseases caused by tobacco use far exceeded the revenue collected by taxing tobacco products. Total economic cost of the three major diseases due to tobacco use (cancer, cardiovascular diseases, lung diseases) in India was Rs. 30,833 crores (extrapolated to rates of 2002-03), while the revenue collected was approximately Rs. 27,000 crores for the same year.

Tobacco control initiatives



To control the menace of tobacco, Government of India enacted "Cigarette and other Tobacco Products Act in 2003 (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution). The specific provisions under the Act are as follows:

1. Ban on smoking in public places – To protect the people from harm effects of Second Hand Smoke (SHS), the smoking is banned in all public places, including auditoria, public conveyances, railway stations, railway waiting rooms, bus stops, airport lounges, libraries, all public and private offices, all work places, court buildings, hospital buildings, open auditoria, shopping malls, cinema theaters, amusement centres, hotels, restaurants including refreshment rooms, coffee houses/homes, canteens, banquet halls, discotheques, pubs, clubs, bars and many other places.
2. Ban on direct/indirect advertisement and sponsorship of tobacco products.
3. Ban on sale of tobacco products to minors (below 18 years of age) and ban on sale by minors.
4. Ban on sale of tobacco products within 100 yards of the educational institutions.
5. Specified health warnings on tobacco products.

India has also ratified the WHO-Framework Convention on Tobacco Control (FCTC) in 2005. This is the first global health treaty, ratified by more than 160 countries all over the world and provides a key set of recommendations to reduce the demand as well as to reduce the supply of tobacco products.

The Government of India launched pilot phase of National Tobacco Control Programme (NTCP) in 2007-08, in 9 States (18 districts) i.e. Assam, West Bengal, Madhya Pradesh, Tamil Nadu, Karnataka, Gujarat, Rajasthan, Delhi, and Uttar Pradesh to implement Anti Tobacco Laws and bring about greater awareness regarding harmful effects of tobacco and take 'Tobacco Control Initiatives' to the community level. The NTCP has now being expanded to 12 new states (24 districts). At present the programme is under implementation in 42 districts in the country.

The main components of the programme are:

1. Mass media awareness campaign.
2. Setting up of tobacco products testing labs.
3. Capacity building at the state/district level to create infrastructure under the overall umbrella of National Rural Health Mission for implementation of provisions under the law and undertake tobacco control initiatives e.g. school programmes, trainings, cessation facilities etc.
4. GATS – A Global Adult Tobacco Survey (GATS-India) is being undertaken in the country to build a statewise baseline database regarding prevalence of tobacco products use, related behaviour, practices and other issues. The same will serve as a useful tool for policy formulation and monitoring tobacco control initiatives.
5. Collaborate with concerned departments for projects on alternate crops and alternate livelihoods for tobacco farmers and bidi workers.

Other initiatives

1. To report the violations of prohibition of smoking in public places as defined under the law, a Toll Free National Helpline (24x7) (1800 - 110 - 456) has been established.
2. A series of advocacy workshops (at national, regional and state level) were carried out to generate awareness regarding harm effects of tobacco and set-up mechanism for effective implementation of tobacco control act.

Main challenges facing tobacco control:

1. Low level of awareness regarding harm effects of tobacco consumption, second hand smoke (SHS) and provisions under the law.
2. Availability of a large number of tobacco products in the country.
3. Low age of initiation into tobacco use.
4. Limited capacity of states to implement tobacco control initiatives and tobacco control law.
5. Limited availability of cessation facilities in the country.
6. Low priority to tobacco control in view of emphasis on maternal and child health problems and communicable diseases.
7. Providing alternate livelihoods to large workforce involved in tobacco farming and tobacco products manufacturing.
8. Lack of coordination among other stakeholder departments e.g. commerce, welfare, industry, HRD, environment, rural development and others.

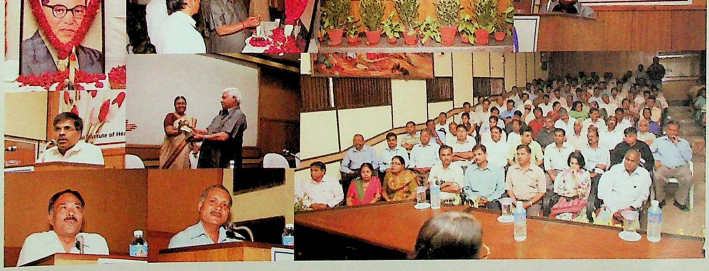
Suggested measures for effective implementation of NTCP and Tobacco Control Act

1. Integration of components of tobacco control in NRHM and on-going National Health Programmes e.g. National Cancer Control Programme, RNTCP, National Mental Health Programme, NCD Programme for School Health Programme.
2. Inclusion of tobacco control component in UG and PG medical/dental/nursing curriculum.
3. Starting new courses on tobacco control.
4. Smoke free environments – taking steps for smoke free institutions/hospitals/workplaces and "Tobacco Free Schools".
5. Expansion of cessation facilities to all medical/dental colleges and health care institutions. Setting up QUITLINES to increase accessibility to cessation help.
6. Development of training materials on tobacco control.
7. Building up of capacity of states for initiating tobacco control measures.

Dr. Jagdish Kaur, Chief Medical Officer, Directorate General of Health Services, Nirman Bhavan, New Delhi.

Celebration of Birth Anniversary of Bharat Ratna Dr. Bhimrao Ambedkar

The 118th Birth Anniversary of Bharat Ratna Dr. Bhimrao Ambedkar was celebrated on April 5, at the Institute. On this occasion Prof. Deoki Nandan, Director, NIHFW delivered an oration on the life and achievements of Dr. Ambedkar. In addition to the oration, some remarks about Dr. Amabedkar's life were made by Dr. V.K.Tiwari, Reader and Acting Deputy Director (Admn.), Mr. Salek Chand, Senior Documentation Officer and Mr. Jagmer Singh, Senior Technical Assistant at this event. A small metal statue of Dr. Ambedkar was presented to the Director for his oration by Prof. K.Kalaivani, Head, Department of RBM on behalf of the coordinating team of the event.



Research Brief - completed study of the quarter

Globalization as a Social Determinant of Health: Influences on Pattern of Food and Health Information among Young People (University Students)

Prof. A.M. Khan

General Objective

- To identify how the globalized and internationalized food and eating institution influence the young people's eating behaviour.

Major Findings

- Globalization has brought a lot of changes in the food habits of the children.
- Over concern of parents and an atmosphere for fast and junk food at home seems to be important forces in triggering habits of constant munching and bingeing in children.
- In trying to cajole and pacify the children and compensate the loss/grief, the parents shower a lot of affection in the form of eatables for the child; to the extent that the children develop a habit of munching snacks and a liking for fast food (noodles) and junk food like chips and soft drinks.
- Sufficient physical activity reduces the chances of fat getting assimilated in the body . But on shifting from school to the university, life becomes a lot more sedentary. This, associated with constant munching habits and drinking soft drinks, leads to weight gain.
- There seems to be a direct relation between increased availability and accessibility of the food, triggering the liking for the food. Fast food and junk food is available and accessible almost everywhere.
- There is a generalized opinion of growing craze of westernization among the youth, shaping their behaviour, emotions, lifestyle, and their outlook to culture, food and other practices. Today, the youth prefer fast food and junk food in lieu of traditional food and quench their thirst with soft drinks in lieu of water.
- Too much of pressure on the students in the university and the growing competitive atmosphere has brought in changes in the lifestyle, particularly affecting the bio-rhythmic changes, sleeping late, getting up late, skipping breakfast, preferring brunch over lunch, having a heavy dinner, leading a more sedentary lifestyle, working more on computers and many such practices. All these have effected the food behaviour, timing of food and the frequency of food intake.

- Taste of food is a compelling factor to decide the food behaviour of the people. Food institutions like Mc Donald, KFC and Pizza Hut have capitalized on this and have probably added some components which create an addiction to food on the basis of taste.
- Globalization becomes a catalyst by increasing the availability and affordability of commercial food as that it brings the friends together. Commercial food rich in the undesirable fats, preservatives, taste enhancers and varied chemicals, has kept the global food industry moving at a rapid and profitable speed. This is where globalization rears its ugly side and sabotages all honest attempts to combat obesity. The commercial glamour leads to increased intake of junk food and often proves too much to resist.
- Media has been grossly responsible for the growing publicity or promotional advertisements of fast/junk food. It has not shown any resolve in addressing the issue of hazards of fast/junk food to the health of the youth/children.
- The fast food and junk food is on fast track, has captured the nerves of the people at large and is fully assimilated by the people from all sections of the society.
- The food habit of the people is more geared to the taste than the nutritional value. The understanding of balanced diet is miserably poor.
- The educational institutions are unmindful to the implications of junk food and fast food and lack food policy.

Policy Implications

Worldwide scientific evidences have strongly proved the adverse effects of fast food and junk food, particularly the problem of obesity which is closely linked with it, which results in to series of chronic diseases. The study has revealed important information, which is vital for visualization of the health of the people. The country needs a widespread awareness programmes about the implications of fast food and junk food. Food industry and media promoting the culture of fast food and junk food need a national policy and regulations. Educational institutions need clear cut food policy to detract the growing culture of fast food. Country needs food industry which can promote traditional food with similar glamour as that of fast food.

Extra-mural Training Course

A Training Course for 'Senior and Middle Level Managers on Improving Quality of Care in Health Sector' was held from 22nd–26th June at Srinagar, Kashmir. The course was conducted in collaboration with the World Bank Institute and the GTZ. Forty two (42) Senior and Middle Level Managers from eight (8) different states (Chhattisgarh, Jammu and Kashmir, Rajasthan, Uttar Pradesh, Uttarakhand, West Bengal, Orissa and Delhi) participated in the course. The course was inaugurated by Dr. R.K. Srivastava, Director General Health Services, Government of India, New Delhi. Mr. R.K. Meena, Principal Secretary, Health and Family Welfare, Government of Rajasthan delivered the presidential address and Dr. Dinesh Baswal, Assistant Commissioner (Trg.), MOHFW gave special comments on the course. Dr. S.D. Gupta, Director, IIHMR, Jaipur and Chairperson of the 'Programme Advisory Committee' of the NIHFW put forth the special remarks about the course and Prof. Deoki Nandan, Director, National Institute of Health and Family Welfare introduced the course. The course included the senior level esteemed participants like Dr. S.K.Jain, Dr. B.S. Sharma, Dr. N.A. Oanoogo and Dr. R.K. Panth.

Lectures by Guest Speakers

Mr. Anil Chand Punetha, Commissioner Family Welfare, Government of Andhra Pradesh delivered a lecture on " Innovation in NRHM" on 6th April.

Mr. Samir Thapar, Avalon Health Group delivered a lecture on "Dev-Info" on 5th May.

Dr. Afaf Tawfik, Global Core Trainer delivered a lecture on "New Initiative of WHO Global Standard" on 16th June.

Meetings

- Meeting on "Standardization for Professional Development Course in Management, Public Health and Health Sector Reforms for District Medical Officers" was held at NIHFW on 15th and 16th May.

- Meeting of experts for "Making Undergraduates PSM Teaching Interesting and Interactive" was held from 13th-14th May at the Institute.
- A meeting was held with the World Bank Institute team on 29th and 30th June, comprising of Ms. Shiela Jagannathan and Ms. Sheeja Nair to initiate 'Post-graduate Certificate Course in Hospital Administration' through e-learning mode.

- An Expert Group Meeting for "Establishing Quality Monitoring Unit for Emergency Obstetric Care and Life Saving Anaesthetic Skill Training" was held on 1st May at the Institute.

- Three meetings on "Task force on Restructuring and Reform of National Institute of Health & Family Welfare" were held on 13th-14th April, 18th May and 13th June. The meetings were chaired by Prof. L.M. Nath, former Dean and Director, All India Institute of Medical Sciences, New Delhi.

Visitors to the Institute

- Dr. John O. Odondi, Ministry of Public Health, Kenya and Dr. Sanjiv Kumar, Chief Health Section, United Nations Children's Fund (UNICEF), Kenya, visited the Institute on 29th June.

A distinguished team of external resource persons including the learned international faculty from the GTZ and the World Bank Institute, namely Ms. Sylvia Jeanette Sax, International Public Health Consultant, Dr. Kai Stietenroth, Consultant, GTZ, Dr. Preeti Kudesia, Senior Public Health Specialist, Ms. Sheeja Nair, Research Analyst, World Bank, Mr. Bejon Kumar Misra, Consumer Expert and Mr. S. Malikarjuna, Consultant, EPOS. At the National Level, Resource Persons included

Mr. R.K. Meena, Principal Secretary, Health and Family Welfare, Rajasthan, Dr. S.D. Gupta, Director, IIHMR, Jaipur, Dr. M.L. Jain, Director Medical Health (RCH), Rajasthan, Dr. Sanjay Aggarwal, OSD (PPP), Department of Health and Family Welfare, Government of NCT, Delhi, Dr. B.S. Garg, Director, Professor & Head, Department of Community Medicine, MGIMS, Wardha, Maharashtra, Dr. Aniruddha Mukherjee, Technical Officer, SPSRC, West Bengal, Dr. Imtiyaz Ali, Dean, Sher-i-Kashmir Institute of Medical Sciences, Srinagar, Dr. Dinesh Baswal, Assistant Commissioner (Trg.), MOHFW, Dr. S.K. Sikdar, Assistant Commissioner (Family Planning), MOHFW, Prof. Deoki Nandan, Director, NIHFW, Dr. J.K. Das, Professor, NIHFW, Dr. Vivek Adhish, Reader, NIHFW and Dr. Neera Dhar, Reader, NIHFW.

The course was coordinated by Prof. J.K.Das and Dr. Neera Dhar under the able guidance of Prof. Deoki Nandan.

Training Courses/Workshops Conducted by the Institute: Intra-mural

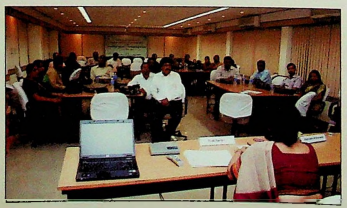
- **National Workshop for 'Training of Trainers of Medical Officer in Immunization' (Two Courses)**

Course Coordinator: Prof. M. Bhattacharya
Objective: To familiarize the trainers from the states with the contents and methods for immunization training of medical officers to enable them to effectively conduct divisional/district level trainings of medical officers.
Dates: (i) 20th-22nd April, (ii) 18th-20th May
No. Trained: Course I -Gujarat-11, Uttarakhand-10, Delhi-6, UNICEF-2 and WHO-NPSP-1
Course II: Jharkhand-8, Delhi-10, Haryana-3 and Chandigarh-3
Total: Course I: 30, Course II: 24

- **Refresher Training for 'Rapid Response Teams from Northern States in Avian Influenza and Pandemic Preparedness'**

General Objective : To enable the Rapid Response Team Members to manage the human cases of Avian Influenza.
Course Coordinators: Dr. S.V. Adhish and Dr. Gyan Singh
Dates: 22nd-25th April
No. Trained: U.P.(3), Haryana (3), Punjab(2), Delhi (3), Jammu (5), Uttarakhand (3), Himachal Pradesh (3), Chandigarh (3)
Total = 25

- **Training Course on 'Training Technology for Health Professionals'**



Course Coordinators: Dr. Poonam Khattar and Dr. Neera Dhar
Dates: 11th-15th May
Objective: To enhance the knowledge and skills of trainers in the area of training technology and management of training.
No. Trained: Assam 2, Haryana 4, Himachal Pradesh 1, Gujarat 3, Chhattisgarh 2, Punjab 2, West Bengal 1
Total: 15

- **Regional Workshop on 'Determinants of Under Nutrition in Children and Assessment of Management at Different Levels of Health Care'**

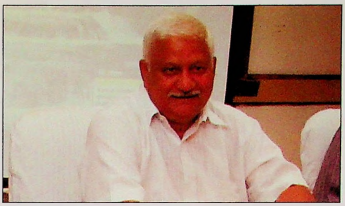
Workshop Coordinators: Mr. J.P. Shivdasani and Mrs. Vandana Bhattacharya
Dates: 10th-13th May

- **Capacity Building of Faculty of Medical Colleges in RCH-II/NRHM**

Coordinators: Dr. U. Datta and Dr. Poonam Khattar
Date: 18th June
Objective: To finalize the sessions and materials for the training programme for the faculty of medical colleges regarding NRHM/RCH-II.
No. Trained: Delhi 17, Maharashtra 1
Total: 18

Activities of the Director

- Attended the Core Group Meeting on 'Institutional Maternal Care' organized by the Ministry of Women and Child Development at MMPCCP on April 22.
- Attended the 'Executive Committee Meeting' of the Chhatrapati Shahuji Maharaj University, Lucknow on April 25.
- Attended the 'Executive Committee Meeting' of National Health Systems Resource Centre at MOHFW on May 1.
- Attended the 'Technical Advisory Panel Meeting' of PATH held in New Delhi on May 12.
- Delivered a lecture on 'Supportive Supervision' in the Training Course on Immunization held at NIHFW on May 19.
- Attended the 'Joint Review Mission Meeting' of National Rural Health Mission, in the MOHFW on May 20.
- Attended the Workshop on 'Maternal Death Review' at Post-graduate Institute of Medical Education and Research, Chandigarh on May 21 and May 22.
- Visited Muzaffarnagar and Lucknow during May 25-29, in connection with 'Joint Review Mission' (RCH).
- Attended 'National Core Trainers Training on Child Growth Assessment – WHO Child Growth Standards' organized by the Ministry of Women and Child Development with support from the NIHFW, NIPCCD, NIN and WHO/UNICEF at Hyderabad on June 8.
- Attended a meeting on 'Conditional Maternity Benefits Scheme at NIPCCD' organized by the Ministry of Women and Child Development on June 15.
- Attended a meeting on 'National Level Review of States under 6th Joint Review Mission' at MOHFW during June 15-18.
- Attended a workshop on 'National Consultation on Public Health Workforce in India' organized jointly by the MOHFW and WHO at New Delhi on June 24-25.
- Attended a meeting of the 'High Level Committee set-up by NCT of Delhi on Costing of Services in the Health Sector' at Delhi Institute of Pharmaceutical Sciences and Research on June 26.



Prof. Deoki Nandan delivering a lecture on Supportive Supervision in the Training Course on Immunization

Activities of the Faculty: Outside Institute and Country

Apart from their routine academic and administrative responsibilities, the faculty of the Institute participated in the activities quoted below:

INTERNATIONAL ACTIVITIES

Prof. (Mrs.) M. Bhattacharya

- Attended the Expert meeting on "HIV/AIDS Estimation and Projections" at Bangkok, Thailand on 27th & 29th April.
- Attended a workshop on "Crafting Effective Responses to the HIV Epidemics on Asia in the 40th Summer on Population" at the East West Centre in Honolulu, Hawaii from 2nd June to 2nd July.

Dr. S. V. Adhish and Dr. Geetanjali

- Attended a workshop on "National Training on Youth Friendly Health Services" at New Delhi from 18th to 30th May and at Malno, Sweden on 1st to 6th June.

Dr. Meerambika Mahapatra and Mrs. Vinod Joon

- Attended a four week "WHO Training Programme on Community Health Care and Research" organised by Department of Community Medicine, Khon Kaen University, Khon Kaen, Thailand from 3rd to 30th May.

CONSULTANCY OFFERED

Prof. T. Mathiyazhagan

- Served as an expert member in a meeting organized by NACO, New Delhi regarding 'Condom Promotion Impact Survey' on 18th May.

Dr. M.M. Misro

- Nominated as a member in the 'National Advisory Committee for the Symposium on Comparative Endocrinology and Reproductive Physiology: Current Advances'.

Acted as Guide

Dr. M.M. Misro

- Guided summer training students from Amity University, NOIDA during the quarter.

Dr. K.S. Nair

- Guided a summer trainee on "A Review of Performance of JSY in the EAG States" from 6th April – 5th June.

Dr. Rajesh Kumar

- Guided a dissertation on " A Study of Functioning of Delivery Huts Scheme of Haryana in Sample Block of District Rohtak" for the Post Graduate Diploma in Public Health Management.

Dr. Ankur Yadav

- Guided a dissertation on "An Overview of the Biological Control Measures against Malaria in CHC, Badkhalsa, Sonepat, Haryana" for the Post Graduate Diploma in Public Health Management.

GUEST LECTURES DELIVERED BY THE FACULTY

Prof. M. Bhattacharya

- Delivered a lecture on "Cold Chain and Logistics Management in Training of Trainers for Medical Officer in Immunization" from Gujarat, Delhi and Uttarakhand on 20th April at the NIHFW.

Prof. T. Mathiyazhagan

- Delivered a lecture on "Impact Evaluation of Radio Programme for Behavoiur Change" at the workshop held at NACO, New Delhi on 23rd April.

Prof. J.K. Das

- Delivered a lecture on "Disaster Management" at Haryana Institute of Public Administration, Gurgaon on 30th April.

Dr. Y.L. Tekhre

- Delivered a lecture on "Understanding more about HIV/AIDS in the Refresher Training for Community Leader on Reproductive Child Health and Life Skill Education Issues" at Swabhiman Smile Foundation, New Delhi.

Dr. Poonam Khattar

- Delivered a lecture on 'Enforcement of Section-5 in the National Workshop on Tobacco held at Nagaland on 27th June.
- Acted as a resource person in the workshop "Development of Teachers Guide in Health and Physical Education" from Class 1 to 10 at Laxmibai National Institute of Physical Education, Gwalior, organized by NCERT.

PAPERS REVIEWED/PUBLISHED

Prof. (Mrs.) M. Bhattacharya

- Reviewed a research paper on "Water handling and sanitation practices in rural community of Madhya Pradesh: A Knowledge, Attitude and Practice Study".
- Published a paper on "Making a difference - Better health care through GIS", Geospatial Today, May 2009, p. 44-46.

Dr. M.M. Misro

- As an Editorial Board Member "Reviewed two papers" for the International Journal - CWHR on 18th April, 2009.
- Reviewed the progress of the final report of the ad hoc ICMR project "Sperm DNA damage in male infertility and its influence on reproductive outcome".
- Three papers accepted for publication in International Journals on "Fertility and Sterility, Andrologia and Molecular Reproduction and Development".

Dr. T. G. Shrivastav

- Published a paper on "Development of ELISA for Measurement of Progesterone Employing 17 α-OHP-HRP as Enzyme Label". Sabana Khatoon, Shail K. Chaube, Kiran Rangari, Kiran P. Kariya, Tulsidas G. Shrivastav. Journal of Immunoassay and Immunochemistry, 2009, 30: 186-196.
- Reviewed the papers for the "International Journal of Microscopy and International Journal of Integrative Biology".

Dr. Utsuk Datta

- Published a paper on "Vitamin A First Dose Supplement Coverage Evaluation amongst Children Aged, 12-23 Months Residing in Slums of Delhi" in Indian Journal of Ophthalmology, 57(4):299-304.

Mrs. Manisha

- Published a paper on "Population Boom in India", in the monthly English journal, Kurukshetra, April 2009, p. 30-31.

ACTED AS EXAMINERS

Prof. (Mrs.) M. Bhattacharya

- Invited as an external examiner for "Practical Examination in MD Community Medicine" at M.L.N Medical College, Allahabad on 4th & 5th May.
- Invited as an external examiner at Chhatrapati Shahuji Maharaj Medical University, Lucknow, Uttar Pradesh for "Practical Examination of MD(SPM)" on 17th & 18th April.

Dr. T. G. Shrivastav

- Doctoral committee member for "Special centre for molecular medicine, Jawaharlal Nehru University", New Delhi for the research topics entitled "Modulation of intracellular dynamics and function of Pregnane and Xenobiotic Receptor (PXR) by endogenous and exogenous factors" and "Molecular characterization of Pregnane and Xenobiotic Receptor (PXR) and its potential isoforms in normal and pathological states".
- Adjudicated the Ph.D. thesis entitled "Morphological, biochemical and molecular (VDAC-2 in sperm ODFs) indicators in the semen of infertile/sub-fertile patients attending an infertility clinic" submitted to Bharathidashan University Tiruchirapalli, Tamil Nadu.

Mr. J.P. Shivdasani

- Attended the Selection Committee for Selection of Monitoring and Evaluation Officers at National AIDS Control Organization under NACP-III in New Delhi on 22.4.2009.

Mr. Salek Chand

- Acted as an examiner for "B. Lib. Science Paper II" from 27th to 29th April at Patna University, Patna.
- Acted as an examiner for "PGDLAN practical examination of IGNOU" in the course of MLIL-004, New Delhi on 19th June.

Special Activities

Rapid Appraisal of Health Interventions (RAHI-II)

Under the RAHI-II, twelve research studies were conducted with the financial assistance from UNFPA. The studies were undertaken by twelve medical colleges from six low performing States i.e. Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Jharkhand and Uttarakhand. Research papers based on these reports have been prepared and sent to Indian Journal of Public Health for publication in its forthcoming issue.

An Inclen-NIHFW Collaborative Study

Determinants of Under Nutrition in Children: An Assessment of Management at Different Levels of Health Care

Prof. Deoki Nandan, Director, NIHFW and Principal Investigator, Mr. J.P. Shivdasani, Senior Investigator and research team members, Dr. B.S. Dewan, Ex-MD Student; Mrs. Reeta Dhinga, Research Officer; Mrs. Vandana Bhattacharya, RO; Mr. Ramesh Gandotra, ARO and Mr. Ghanshyam Karol, ARO visited district Mathura for data collection during the quarter.

Annual Sentinel Surveillance Activities

Prof. M. Bhattacharya, Prof. J.K. Das, Dr. Utsuk Datta, Dr. Gyan Singh and Dr. Sanjay Gupta went for monitoring and supervision of High Risk Group (HRG) sites at Assam, West Bengal and Tamil Nadu during the quarter.

Joint Review Mission (JRM)

Prof. Deoki Nandan, Prof. J.K. Das, Dr. T. Bir and Dr. Sanjay Gupta visited Khagaria (Bihar), Lucknow, Muzaffarnagar and Lakhimpur Khiri (UP) under the Sixth Joint Review Mission during the month of June.

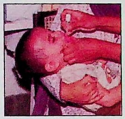
Mother NGO Evaluation Study

Dr. T. Bir along with his team completed external evaluation of "Mother Non-government Organizations (MNGOs) in four districts of Delhi state. For the external end-line evaluation of MNGO's scheme in the district of Pauri and Dehradun, Uttarakhand state, data collection has been completed.

Evaluation of Training in Routine Immunization

Dr. Utsuk Datta along with his team conducted an evaluation of "Health Workers' Training in Routine Immunization" (First Phase) for Uttar Pradesh, Bihar and Uttarakhand from 8th to 15th June.

Pulse Polio Immunization



The Pulse Polio Immunization rounds were conducted in the Institute on 5th April, 24th April and 28th June.

Trainers Course on Basic Newborn Care and Resuscitation

A trainers course on "Basic Newborn Care and Resuscitation" was conducted from 29th to 30th June by the Ministry of Health and Family Welfare, Government of India in collaboration with the NIHFW. The inaugural function was held at the NIHFW auditorium at 9:30 a.m. on 29th June. The function was attended by various distinguished delegates from national and international organizations, Ministry of Health and Family Welfare and the National Institute of Health and Family Welfare. At the outset a welcome address was given by Dr. B.Kishore, Assistant Commissioner Child Health-I, Ministry of Health and Family Welfare, Government of India. Shri Amarjeet Sinha, IAS, Joint Secretary (NRHM), Ministry of Health and Family Welfare, Government of India, Shri. Amit Mohan Prasad, IAS, Joint Secretary (RCH), Ministry of Health and Family Welfare, Government of India, and Professor Deoki Nandan, Director, NIHFW addressed the gathering. A vote of thanks was proposed by Dr. Sangeeta Saxena, Assisstant Commissioner, Child Health-II, Ministry of Health and Family Welfare, Government of India. The function was anchored by Dr. Neera Dhar, Reader, NIHFW.

Contact Programmes under Distance Learning Courses

Health and Family Welfare Management

Place	Date	NIHFW Coordinators	No. of Candidates Attended
Kolkata	20th -24th April, 2009	Prof. J.K. Das	18
Bangalore	18th -24th May, 2009	Prof. J.K.Das	18
Mumbai	4th -8th May, 2009	Dr. Vivek Adhish	11
Delhi	18th -22nd May, 2009	Dr. Poonam Khattar	63

Hospital Management

Place	Date	NIHFW Coordinators	No. of Candidates Attended
Lucknow	6th -10th April, 2009	Dr. Gyan Singh	17
Mumbai	13th -17th April, 2009	Dr. U.Datta	25
Kolkata	20th -24th April, 2009	Prof. J.K. Das	20
Hyderabad	4th -8th May, 2009	Prof. K. Kalaivani	11
Delhi	27th -1st May, 2009	Dr. Neera Dhar	225
Delhi (Additional)	8th -12 June, 2009	Dr. Neera Dhar	36

News from Administration

New Appointments

- ★ Sh. Vinay Kumar, Assistant on 1.5.2009 (Group B)
- ★ Sh. Dinesh Kumar, TA (Lab.) on 15.5.2009 (Group B)
- ★ Sh. Vikas Sharma, TA (Press) on 19.6.2009 (Group B)
- ★ Sh. Pawan Kumar Sharma, Projectionist on 9.6.2009 (Group C)

Fresh recruitments have been made under NRHM/RCH Project.

Promotions

- ★ Smt. Prem Lata, Assistant on 23.4.2009 (Group B)
- ★ Smt. Gurdeep Rawal, Steno. II on 23.4.2009 (Group B)
- ★ Smt. Paramjeet Arora, Steno. II on 23.4.2009 (Group B)
- ★ Smt. Savita Nandwani, Steno. II on 23.4.2009 (Group B)
- ★ Sh. Sherin Raj T.P., ARO (adhoc) on 24.6.2009 (Group B)
- ★ Sh. Prem Pal, U.D.C. on 23.4.2009 (Group C)
- ★ Smt. Shashi Bala Jain, U.D.C. on 24.4.2009 (Group C)

Renovations: Expanding and Modernizing Infrastructure

Other Highlights

Beauty is Truth, Truth is Beauty

Landscaping

Forthcoming Training Courses/Workshops

Sl. No.	Name of Course(s)	Dates
1.	Training Course on Hospital Management for Senior Hospital Administrators	July 6-24, 2009
2.	National Consultation on India Adaptation of Training Package on WHO Child Growth Standard (Integrating Mother Child Protection) in Collaboration with Ministry of Women and Child Development, NIPCCD, UNICEF, WHO and NIHFW	July 13-14, 2009
3.	Training Course for State and District Level Programme management unit of Jammu and Kashmir	July 13-17, 2009 – Course I August 3-7, 2009 - Course II Aug 31-Sept 4, 2009 - Course III September 14-18, 2009 - Course IV
4.	Professional Development Course in Management, Public Health and Health Sector Reforms for District Medical Officers	July 20- September, 26, 2009
5.	Training Course on Monitoring under NRHM	August 3-7, 2009
6.	Training Course on Logistic and Supply Management in Health and Family Welfare	August 24-28, 2009
7.	Training Course on Health and Human Rights	August 24-28, 2009
8.	Training Course on Increasing Human Capacity to Address Gender Equity in Health and Development	September 7-11, 2009
9.	Training Course on the Role of NGOs in NRHM in India	September 7-18, 2009
10.	Flagship Course on Health System Policy and Management (NIHFW-WBI Collaboration)	September 14-18, 2009
11.	Capacity Building for Health Officers in Communication Skills	September 14-19, 2009

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Corrigendum

Dr. Rajni Bagga delivered a lecture on "Motivation, Satisfaction and Job Preference in Nursing Leadership Course" at IIM, Ahmedabad on 8th January.

Announcement

Community Medicine Departments of Medical Colleges, State Institutes of Health and Family Welfare and Partner Institutions, Nursing Schools/Colleges, Mother NGOs are requested to become member of Public Health Education and Research Consortium: Network and Partnership.

Online Registration: www.nihfw.org

The Smoky Truth

"Along with the pleasures of cigarette smoking come real risks of serious diseases such as lung cancer, respiratory disease and heart disease. We also recognize that for many people, smoking is difficult to quit," confesses the Pakistan Tobacco Company in its Annual Report and Accounts for 1999.

Tobacco Free Initiative-Pakistan

Tobacco

The global killer

More than 70,000 scientific articles have established tobacco as the leading cause of premature death and disabling disease, yet tobacco products, especially cigarettes, remain the world's most accessible commodity. Available in posh malls of elite neighborhoods and ragged kiosks in the poorest of slums, cigarette consumption worldwide is rising sharply, increasing the incidence of preventable morbidity and mortality.

According to World Health Organization (WHO), the world's 1.15 billion smokers consume an average of 14 cigarettes every day. Of these smokers, 82% live in developing countries - a result of inadequate tobacco controls.

The latest global statistics on tobacco's toll on health are shocking. Worldwide 11,000 people die from tobacco-related diseases every day. Worldwide mortality from tobacco is likely to rise from about four million deaths a year in 1999 to about 10 million a year in 2030 - more than the combined deaths from malaria, maternal and major childhood conditions, tuberculosis and AIDS. And 7 million of these deaths will be in low-income and middle-income countries.

A lifelong smoker is as likely to die as a direct result of tobacco use than from all other potential causes of death combined. Half of all long-tern smokers will eventually be killed by tobacco, and of these, half will die during productive middle age, losing 20 to 25 years of life.

Scientific evidence establishes that in populations where smoking has been common for several decades, about 90% of lung cancer, 15-20% of other cancers, 75% of chronic bronchitis and emphysema and 25% of deaths from cardiovascular disease between 35 and 69 years of age are attributable to tobacco.

An economic drain

The economic costs of tobacco use are equally mind-boggling. The World Bank says the cost to the international community in terms of death and disability is much greater than the economic gain from the production and sale of tobacco products.

The Voluntary Health Association of India estimates that tobacco-related illness cost the country (population 1 billion) $11 billion a year in public health costs. In the small country of Costa Rica (population 3 million), smoking-related illness cost the social security system an estimated $534 million per year.

Besides being a drain on the cash-strapped economies of developing countries, tobacco use forms an avoidable burden on household budgets. Money saved could be spent on basic needs like shelter, food, clothing, education, etc. In Bangladesh an average laborer must toil approximately half a day to purchase a pack of 20 cigarettes. In 1990, the cost of 20 cigarettes in China was estimated as being 25% of the average daily income.

In Pakistan, where more than 48 million people live in absolute poverty, the cost of cigarettes is strikingly high compared with average incomes. A daily pack of 20 cigarettes bought at Rs 10 totals Rs 3,650 a year - nearly 16% of the per capita income. Low-income earning men in rural areas are more likely to smoke, found the National Health Survey 1990-94 conducted by the Pakistan Medical Research Council (PMRC).

Broad categories of smoking costs

1. **Health care**
   Medical services, Prescription drugs, Hospital and other institutional services
2. **Production losses resulting from:**
   Death, Sickness, Reduced productivity
3. **Welfare provision**
4. **Fires and accidents**
5. **Pollution, litter and environmental degradation**
6. **Research and education**

The government of Pakistan identified smoking as among country's leading causes of morbidity and mortality in its December 1997 health policy. This admission came against the backdrop of a rising incidence of tobacco-related diseases.

A recent World Bank report said cardiovascular diseases account for 10%, malignant neoplasm (cancers) 4.3%, and non-communicable respiratory diseases 3.2% of the total burden of disease in Pakistan. Another study profiling heart diseases in South Asia in 1983 found that up to 83% of heart disease patients in Pakistan are smokers.

The 1990-94 National Health Survey cites tobacco use as a major risk factor for heart trouble, chronic bronchitis and emphysema, cancers of lung, larynx, pharynx, oral cavity, esophagus, pancreas and bladder, and respiratory infections and stomach ulcers.

Smoking prevalence in Pakistan

Despite numerous health and economic costs, the consumption of cigarettes continues to rise in Pakistan, making it a high cigarette consumption country. According to the Pakistan Pediatric Association, 1,000 to 1,200 children between the ages of 6 and 16 years take up smoking every day. Twenty-nine percent of men and 3.4% of women smoke cigarettes regularly, concluded the National Health Survey, while the Pakistan Society for Cancer Prevention says 37% of men and 4% of women over 15 years of age are smokers.

1. Smoking is most common and most likely to be heavy (20 or more cigarettes per day) among men 25-44 years of age in Pakistan.
2. Approximately 90% of lung cancer cases in men and 79% in women are attributable to cigarette smoking.
3. Twenty-four percent of illiterate rural young men smoke as compared to 19% of illiterate urban young men.
4. Among rural smokers (15-64 years of age), 26% smoke heavily compared to 37% in urban areas.

Pakistan context

Who brought tobacco to Sub-Continent?

Tobacco was first grown by the original inhabitants of what is now North America. 'Tobacco' was their word for the Y-shaped tube they used to inhale smoke. The word 'nicotine', however, is of French origin, named after French Ambassador to Portugal Jean Nicot who was honored by the Queen of France when she was presented with a jeweled box containing snuff.

The Portuguese sailors brought this 'magic substance' to the Indian Sub-Continent in the early 17th century during Mughal King Akbar's reign. Although tobacco fascinated Akbar, he did not adopt it after a court debate between the physicians, clergy and nobles resulted in the rejection of tobacco use. His successor Jehangir also forbade tobacco use, as did his contemporary rulers in Persia.

The production of fine-cured Virginia tobacco was first initiated in lower Sindh in the 1950s and later extended northwards to the plains of Punjab. Subsequently, as its suitability for the higher altitude was established, it came to be grown exclusively in NWFP. Some accounts, however, say that Flue Cured Virginia tobacco was first grown on a limited scale in NWFP in 1948, a year after Partition.

Tobacco farming not that lucrative

It is popularly believed that tobacco is a lucrative crop, but that's not true. According to WHO, farmers do not benefit from tobacco cultivation as the lion's share of profits go to cigarette companies. In Malaysia, for example, the profit margin for farmers is only 2% as compared to 79% for the manufacturers.

Tobacco occupies 0.2 per cent of the total irrigated land in Pakistan and is grown in all four provinces. In 1995-96, tobacco was cultivated on an area of 46,100 hectares with the total production standing at 79,900 tonnes.

According to the Economics Wing of the Ministry of Food, Agriculture and Livestock, tobacco production from 1980-81 to 1995-96 has not been steady. During these years, the highest recorded yield was 101,600 tonnes in 1992-93 when the crop was grown on 582,000 hectares. The highest per hectare yield was 1,807 kilograms, in 1991-92.

The country registered an annual growth rate of 6% from 1981 to 1988. Moreover, Pakistan was ranked below only Japan and Korea in terms of per hectare yields.

As many as 80,000 people are engaged in tobacco production and marketing. The province-wise breakup of this figure is not available. However, NWFP has the highest number of people engaged in the tobacco production on a full-time basis.

The number of people turning to tobacco cultivation in NWFP is rising where the crop is considered economically beneficial and risk-free. Moreover, the government's drive to eradicate poppy cultivation and substitute it with tobacco is also luring people in various areas to replace one vice with the other.

"... the major beneficiaries are cigarette manufacturing companies who are looting all the labour, hard work and energy of the tobacco growers," said Ikramullah Khan, a prominent Pakistani tobacco grower, in a press statement published by The News on May 24, 2000.

Modes of tobacco intake

Tobacco use in Pakistan is not limited to cigarette smoking. Chilum, huqqah, chewing tobacco in pan, snuff and niswar are some other common ways of intake. Experts divide tobacco use into two broad categories - smoking and smokeless tobacco. Both uses of tobacco are very common in Pakistan as established by a survey conducted by the PMRC in 1994.

Smokeless tobacco includes primarily moist dry snuff and chewing tobacco. All forms of smokeless tobacco contain nicotine and their use can lead to nicotine dependence and cigarette use.

Smoking tobacco is used as cigarettes, huqqah and chilum, the latter two being the oldest means of tobacco intake in this region. Presently, cigarettes are most common, for they are ready to use and backed by aggressive promotion by manufacturers.

The tobacco industry in Pakistan

In Pakistan, two transnational companies British American Tobacco (BAT) and Philip Morris Industries (PMI) hold 78% of the cigarette market. BAT holds 67% shares in the Pakistan Tobacco Company (PTC), while PMI has a 30% share in Lakson Tobacco Company (LTC). PTC holds 38% of the market, while LTC has a market share of slightly over 40%. The rest of the market is held by local companies such as Sarhad Cigarette Industries, Khyber Tobacco Company, Souvenir Tobacco Company Limited and Saleem Cigarette Industries.

According to the Tobacco Statistical Bulletin 1994, there were 32 tobacco companies having 38 cigarette manufacturing factories with an installed capacity of over 87 billion sticks per annum.

However, unofficial reports put the number of factories much higher. According to one report, 75 unlicensed factories are in operation in the tobacco-rich Mardan Division and Lala Musa alone, which are manufacturing counterfeit major international brands and tax-evaded cigarettes.

The Frontier province has 25 factories with installed annual capacity of more than 35 billion sticks. The nine factories in Sindh and four in Punjab have annual capacities of nearly 22 billion sticks and nearly 30 billion sticks respectively.

Promotion or deception

The worst form of government patronage to the tobacco business is its reluctance to slap strict controls on the promotion and sale of cigarettes. The World Health Assembly in 1986 recommended the adoption of comprehensive tobacco control measures to eliminate the promotion of cigarettes in its member states. The Assembly reiterated its call in 1990 and urged member states to consider eliminating all direct and indirect tobacco advertising, promotion and sponsorship. These recommendations were aimed at protecting the young people from taking up smoking, assisting smokers to quit and challenging the social acceptability of smoking.

Ten years later the situation in Pakistan remains the same. Though the country is signatory to both resolutions, the tobacco companies continue to indulge in aggressive promotional activities.

Indeed, advertising is the industry's frontline in its ambitions to increase sales. Manipulative advertising and disinformation campaigns associate smoking with dreamlike promises of prestige, power, freedom and luxury. This promotes not only individual products but also tobacco use as a 'lifestyle'. Young people are especially susceptible to these messages and also more likely to develop nicotine addiction than people who take up the habit later in life.

Tobacco companies admit that advertisement campaigns result in increased sales. When PTC in March 2000 halved the price of its Gold Flake brand, in the words of the company, the campaign yielded positive results. "The response from the market was immediate, and demand for the brand escalated tremendously in some markets," read the February-March 2000 issue of PTC's in-house newsletter Pak Tobacco.

To advertise the Gold Flake price reduction, PTC ran an aggressive campaign on PTV during the Sharjah Cricket Cup and Triangular Series in the West Indies and bought three-day programming ownership on PTV World with Gold Flake Eid Hangama. A double-page advert also appeared in the Urdu-language newspaper Din.

Countrywide, 800,000 posters and buntings and 150,000 leaflets plastered market walls. Three thematic Gold Flake Floats operated in some cities for 10 days. They featured live music, male and female models and comedians and also sold the brand at the reduced price. The company sponsored a Gold Flake Canal Mela in Lahore featuring Gold Flake streamers on both sides of the busy Canal Road and 35 banners throughout the city. All this only to advertise a single price cut!

According to the prestigious Advertising Age magazine, LTC was the third largest advertiser in Pakistan in 1998, spending an astounding Rs 328 million (US $6.42 million). It was followed by BAT, which spent a staggering Rs 295 million (US $5.77 million) during the same year. The marketing expenses of the two companies neared Rs 1.5 billion in 1999, with LTC spending Rs 804.75 million and BAT Rs 680.643 - all in the name of hooking new users, the lifeline of the tobacco industry.

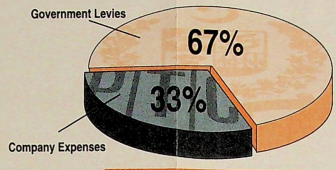
Who benefits from the tobacco business

Tobacco companies sell 50 billion sticks (out of their 87 billion stick installed capacity) every year in Pakistan. Around 10 billion smuggled, counterfeit or tax-evaded cigarettes are also consumed locally. The tobacco companies are continuously increasing their market size. The cigarette production rose from 29.9 billion sticks in 1990-91 to 48.21 billion sticks in 1997-98, an increase of more than 70% over seven years. Both companies rake in huge profits every year that run into millions of rupees.

But the beneficiaries in this deadly business are not the tobacco companies alone. As elsewhere in the world, the government of Pakistan patronizes the tobacco business - at the expense of public health. The reason for this patronage is simple: the tobacco business generates much-needed taxes for the cash-strapped government.

According to "Tobacco Control in the Third World: A Resource Atlas", the Pakistani government collected Rs 15.86 billion ($311 million) as tobacco tax in 1990, making up 10.5% of the total tax revenue. Tobacco taxes are continually rising since then. In 1999, only two companies, PTC and LTC, paid Rs 18.7 billion in government levies.

In fact, the revenues collected by the government from the tobacco industry each year exceed the profits posted by the companies. According to the Pakistan Tobacco Company's 1999 Annual Report and Accounts, the company paid Rs 10.03 billion in government levies, while it posted an after-tax-profit of only Rs 136 million. Similarly, Lakson Tobacco Company deposited Rs 8.66 billion in the government kitty during the fiscal year 1998-1999 and it recorded a net profit of 180.7 million. It is estimated that around 70% of revenues generated by the tobacco companies are paid as excise duties and other government levies.



Distribution of PTC Revenues During1999

How government patronizes tobacco industry

Addicted to tobacco revenues, the government patronizes the tobacco business in a number of ways:

1. The Pakistan Tobacco Board (PTB) was established in 1968 with headquarters in Peshawar after the government recognized 'tobacco potential'. Attached to the Ministry of Commerce, the Board is to promote tobacco cultivation on scientific lines for domestic use and export. It regulates, controls, grades and exports tobacco products; undertakes research and training for the tobacco industry; renders assistance for the development of existing and new growing areas and establishment of model farms.

2. The government ensures that the tobacco industry makes prompt payments to tobacco farmers, which is not the case for other crops like sugarcane, cotton and fruits. Under the Deferred Payment Leaf Voucher Scheme, introduced in 1975, the government constituted a consortium of nationalized commercial banks for providing additional loans to tobacco companies during the marketing season of tobacco. The scheme is aimed at ensuring that tobacco growers are promptly paid for purchases made by the industry. In 1994, Rs 434.14 million were handed out to tobacco companies under this scheme.

3. The Pakistan Sports Board and all sports associations under its aegis accept tobacco sponsorships. The monetary value of these sponsorships runs into millions of rupees.

4. The government gives tobacco companies a freehand to advertise their products on electronic and print media. While the total magnitude of tobacco advertisement in the print media is unknown, the state-owned Pakistan Television Corporation (PTV) earns almost 33% of its advertising income from the tobacco industry. According to press reports, PTV generated around Rs 280 million through tobacco advertisements during the Cricket World Cup 1999.

Gold Leaf, a brand marketed by the Pakistan Tobacco Company, is sold at a retail price of Rs 33 for a pack of 20. The government gets Rs 24.96 while the company keeps Rs 8.04 only.

A chronology of official anti-tobacco measures

1979: The government, through the Cigarettes (Printing of Warning) Ordinance, makes it mandatory for tobacco companies to print "Smoking is Injurious to Health" on all cigarettes packs.

Mid 1980s: The health ministry initiates its anti-tobacco campaign on electronic media through a meager allocation.

1988: State-owned Pakistan Television prohibits tobacco advertising before 10:00 p.m. and exaggeration of the pleasures of smoking. Ban is not enforced.

1992: State-owned Pakistan International Airlines declares all domestic flights 'smoke-free'.

1993: Government reduces import duty on cigarettes from 90% to 80% in an attempt to make smuggling less attractive and to recover evaded taxes and excise duties.

1994: Pakistan's lone private television station, Network Television Marketing (NTM), bans all forms of tobacco advertisements including program sponsorships by cigarette manufacturers.

1997: Government bans, through a notification, smoking in all government offices and public transport. Ban is not enforced.

The landmark case: an unfortunate decision

The Pakistan Chest Foundation and Pakistan Anti-Tuberculosis Association in 1996 moved the Lahore High Court against the aggressive tobacco promotion on PTV and radio. After an exhaustive hearing that spanned more than a year, the court on March 21, 1997 banned any cigarette commercials or programs on television and radio that might induce people to smoke. Exempt for three years were advertisements during the live telecast of tobacco-sponsored sports events, which were not to show anyone smoking and were to be followed by a warning against smoking. The court ordered that only a statement naming the sponsoring company could be relayed during radio sports commentaries.

PTC and LTC along with other manufacturers promptly challenged the ban, filing an appeal a few days after the ban, and were able to get a favorable verdict. On September 18 1997, the Lahore High Court's divisional bench set aside the ban on "technical grounds".

Islam and smoking

"Smoking, in whichever form and by whichever means, causes extensive health and financial damage to smokers. It is also the cause of a variety of diseases. Consequently, and on this evidence alone, smoking would be forbidden and should in no way be practised by Muslims," says Grand Imam of Al-Azhar, Cairo, Egypt, Sheikh Gadul Haq Ali Gadul Haq.

Chairman of the Permanent Committee of Academic Research and Fatwa, Saudi Arabia, Abdul-Aziz bin Baz, along with the Vice-President of the Committee, Abdul-Razzaq Afifi and members Abdullah bin Ghadian and Abdullah bn Qa'oud also adjudged smoking as 'haram' in Islam.

Global expansion of Big Tobacco

As high-income countries increasingly tighten the noose around cigarette companies and introduce measures to bring down the number of smokers, the multibillion transnational companies are now creating new markets in developing countries, where controls are non-existent and governments in dire need of revenues. While the consumption of cigarettes declines in the United States by 1.5% every year, it increases annually by 1.7% in developing countries as a result of the increasing presence of these companies.

The three big tobacco transnational companies - Philip Morris Industries (PMI), British American Tobacco (BAT) and RJ Reynolds (RJR) - bear substantial responsibility for rising smoking rates and projected increases.

The American PMI, which manufacturers Marlboro and holds 16% of the world tobacco market, has gained only a 4.7% increase in the US market since 1990, but its international sales during the same period have increased by 80%. In 1997 the company sold 235 billion cigarettes in the US, compared with 711 billion in international markets for a profit of Rs 239.7 billion (US $4.6 billion). Shockingly, PMI revenues in 1996 far exceeded the Gross Domestic Products of Malaysia, Kuwait, Guatemala, Pakistan and Croatia. The company generated 35% of its Rs 2805 billion (US $55 billion) revenues in the international market.

Similarly, BAT, which holds 15% of the global cigarette market and has subsidiaries in 65 countries, made a profit of Rs 102 billion (US $2 billion) on sales worth Rs 1209 billion (US $23.7) billion in the international market during 1997.

The American RJR, which controls around 4% of the international market, has seen a 75% rise in its international sales since 1990, reaching Rs 173.4 billion (US $3.4 billion) in 1997. International sales, particularly in Eastern Europe and Central Asian Republics, now account for almost 41% of the company's total tobacco sales.

While these transnational companies are having a field day in the markets of developing countries, it becomes all the more important for governments and people to put in place effective checks on tobacco consumption and to save future generations from falling prey to a deadly addiction. ◆

Success Stories

Several countries have effectively reduced the smoking rates through a mix of price and non-price measures.

A good example is **Thailand**, which has adopted a comprehensive control program. Smoking in cinemas and buses was banned in Bangkok in the 1970s. National advertising bans and other anti-smoking measures followed, and in 1993 the government raised the cigarette tax on health grounds. In 1997, Thailand became the second country (after Canada) to require tobacco companies to reveal the ingredients of their cigarettes. Overall smoking prevalence has dropped as a result.

The **United Kingdom** has reduced smoking substantially, through both price and non-price measures:

- From 1965 to 1995 annual UK cigarette sales fell from 150 billion to 80 billion.
- Annual UK tobacco deaths in the 35-69 year age group decreased from 80,000 to 40,000.
- In December 1998, the UK government announced a major campaign to help 1.5 million people stop smoking by the year 2010; it said taxes on tobacco products would continue to be increased. Its targets include reducing smoking among children from 13% to 9%, reducing adult smoking from 28% to 24% or less, and reducing the number of women who smoke during pregnancy from 23% to 15%.
- Tobacco taxes were increased to reduce cigarette consumption and increase the government's tobacco revenues.

France has had a comprehensive tobacco control law in force since 1993. The law bans tobacco advertising and requires strong health warnings on both the front and the back of packaging. It also controls smoking in transport, public places and workplaces by either banning it altogether or limiting it to smoking areas. Between 1991 (when the law was adopted) and 1995, tobacco consumption - measured in weight of tobacco products sold - had fallen by 7.3%.

Among Latin American countries, advertising controls apply in **Chile, Colombia, Costa Rica, Mexico** and **Panama**. Smoking is banned in domestic and international flights throughout the Americas. National tobacco control plans have been drafted in Brazil and Mexico.

WHO's Tobacco Free Initiative

The deadly impact of tobacco on health now and in the future is the primary reason for WHO's strong and explicit support to tobacco control on a worldwide basis. WHO established the Tobacco Free Initiative in July 1998 to coordinate an improved global strategic response.

The long-term mission of global tobacco control is to reduce smoking prevalence and tobacco consumption in all countries and among all groups, and thereby reduce the burden of disease caused by tobacco. In support of this mission, the goals of the Tobacco Free Initiative are to:

- Contribute in galvanizing national support for evidence-based tobacco control policies and actions;
- Build new partnerships for action at national and local levels and strengthen existing ones in the country;
- Heighten awareness of the need to address tobacco issues at all levels of society;
- Commission policy research to support rapid, sustained and innovative actions;
- Mobilize resources to support required actions at the national and local levels;
- To muster government support for the Framework Convention for Tobacco Control being finalized under the auspices of the WHO.

The Framework Convention on Tobacco Control (FCTC)

On 24 May 1999, the World Health Assembly (WHA), the WHO governing body paved the way for multilateral negotiations to begin on a set of rules and regulations that will govern the global rise and spread of tobacco and tobacco products in the next century. The 191-member WHA unanimously backed a resolution calling for work to begin on the Framework Convention on Tobacco Control (FCTC) - a new legal instrument that could address issues as diverse as tobacco advertising and promotion, agricultural diversification, smuggling, taxes and subsidies.

A record 50 nations took the floor to pledge financial and political support for the Convention. The list included the five permanent members of the United Nations Security Council, major tobacco growers and exporters as well as several countries in the developing and developed world which face the brunt of the tobacco industry's marketing and promotion pitch. The European Union and 5 NGOs also made statements in support of the Convention and the Director-General's leadership in global tobacco control.

The Tobacco Free Initiative-Pakistan

TheNetwork for Consumer Protection, which has been working to protect and promote consumer rights in the area of pharmaceutical products and baby milks and foods, has launched the Tobacco Free Initiative-Pakistan (TFI-Pak) with initial support from the WHO. The primary goal of TFI-Pakistan is to mount resistance to the onslaught by the tobacco industry, to educate the people about the hazards of tobacco use and to pressure the government to introduce adequate controls on tobacco sale and promotion.

TFI-Pak, in collaboration with WHO, the international anti-tobacco movement and domestic health groups, will mount a countrywide tobacco campaign to reduce smoking prevalence and tobacco consumption, thereby reducing the related burden of disease.

TFI-Pak's objectives include:

- Effective advocacy by mustering national support for evidence-based tobacco control measures e.g. ban on all kinds of tobacco promotion.
- Contribution towards development of comprehensive anti-tobacco legislation.
- Building a national awareness campaign about the hazards of tobacco through partnerships at all levels.
- Undertaking policy and operational research to fill knowledge gaps for effective anti-tobacco action.
- To lobby for and contribute towards the development of the Framework Convention for Tobacco Control at national and international levels.

TFI-Pak believes that the tobacco issue should be tackled in a holistic manner through a mix of price and non-price measures such as progressive taxation and bans on promotion. TFI-Pak considers a total ban on the direct and indirect promotion of tobacco products on print and electronic media the first and foremost step, but this ban should accompany pricing measures that have proved very effective in many countries.

According to the World Bank, evidence shows that price increases on cigarettes are highly effective in reducing demand. Higher taxes induce some smokers to quit and prevent other individuals from starting.

A recent World Bank report (Curbing the Epidemic) on the economics of tobacco control recommends a multipronged approach to curbing tobacco. Tailored to individual country needs, the strategy would include raising taxes to between 2/3 and 4/5 of the retail price of cigarettes, adopting comprehensive bans on advertising and promotion of tobacco, publishing and disseminating research results on the health effects of tobacco and increasing access to nicotine replacement and other cessation therapies.

Although Pakistan already has high tobacco taxes, customers have not felt the brunt of tobacco taxation as various brands of cigarettes remain within the financial accessibility of different income groups. In such a situation, the government could set a minimum price for the sale of tobacco to prevent the tobacco industry undercutting price controls introduced by higher taxation.

TFI-Pak's Anti-Tobacco Charter*

1. Promotion

a. Ban on direct and indirect promotion of tobacco products on electronic and print media.
b. Ban on tobacco sponsorship of sports, musical or cultural events.
c. Ban on product placement by tobacco companies in all types of media, movies, sports, musical or cultural events.
d. Ban on images of smokers on print media as well as on TV and movies.
e. Ban on tobacco-sponsored advertisements of other products and services.
f. Ban on use of tobacco brand names for promotion of other products and services

2. Restrictions to access

a. Ban on juvenile smoking envisaging punishment for sellers.
b. Restricted availability of tobacco products through licensed outlets.
c. Ban on sale of cigarettes by sticks.
d. Packing requirement of 25 sticks per pack should be made compulsory for all cigarettes brands.

3. Fiscal Measures

a. A progressive tax should be imposed on all tobacco products at the existing retail price. The proceeds thus collected should go to a National Health Fund.
b. A portion of excise duty collected from sale of tobacco should be spent on the strengthening of the public health delivery system.
c. Set a minimum price for the sale of tobacco to avoid the tobacco industry undercutting the price controls introduced by higher taxation.

4. Health warnings

a. Implement a public education program on the risks of tobacco use and second-hand smoke through money generated by tobacco taxes.
b. Industry should be bound to print clear and categorical health warnings mentioning instances of specific diseases. These messages should be highly visible on tobacco packs and use words and symbols that communicate effectively. These messages should also include specific health warnings for tobacco and its affects on children and in pregnant women. Hazards of passive smoking should be included in the purview of these messages.

5. Quit Smoking Programs

a. Medical students should be required to attain special courses on smoking cessation counseling.
b. Smoking cessation programs in all public and private hospitals should be established and the Health Fund could be used for the purpose.

6. Nicotine standards

a. Maximum nicotine and tar level per stick standards should be adopted and enforced.
b. The tobacco companies should be required to display the nicotine and tar content per stick on every pack.

7. Social acceptability

a. Establish smoke-free environment in all enclosed public places, particularly workplaces, health care facilities, schools, public transport, hotels and restaurants, etc.
b. Schools curriculum should include materials that could link tobacco with death and disease with a view to discouraging children from taking up smoking or any other tobacco use.

8. Phase out of tobacco crop

a. Funds should be made available into research for alternative crops that could be grown in tobacco growing areas.
b. Tobacco farmers should be encouraged through interest-free loans and subsidies to switch to other crops.

9. Elimination of government patronage

a. Immediate abolition of the Deferred Leaf Payment Voucher Scheme.
b. Abolition of all forms of subsidies to tobacco growers.
c. Role of the Pakistan Tobacco Board should gradually be minimized and eventually be abolished.

*The charter also provide elements for a comprehensive anti-tobacco legislation in Pakistan.

Let's join hands

TFI-Pakistan will strengthen with the support and cooperation of smokers and non-smokers, health workers, teachers and parents, politicians and opinion leaders, trade unions, commercial and industrial organizations, media, schools and other educational institutions, consumer groups, health services and medical associations, religious groups and researchers. Anybody and everybody can have a role to play in saving ourselves and future generations from death and disease. So, don't wait, join hands with TFI-Pakistan now!

For more information about TFI-Pakistan and other consumer protection work, please contact:

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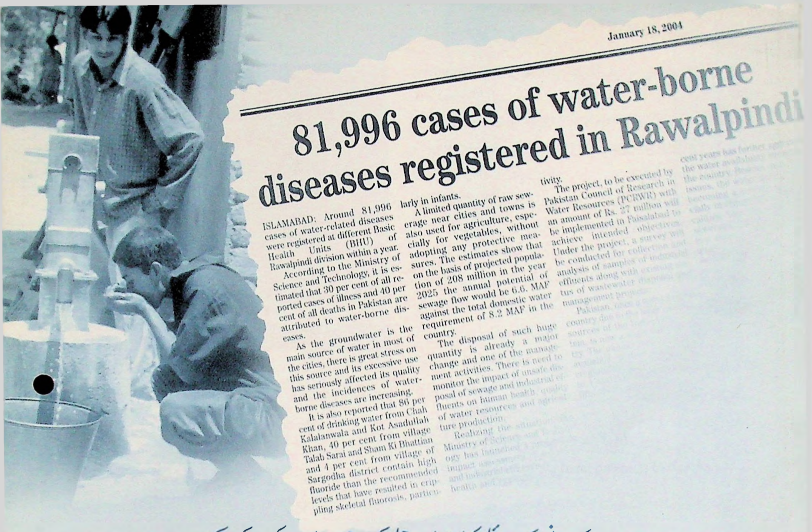

January 18, 2004

81,996 cases of water-borne diseases registered in Rawalpindi

ISLAMABAD: Around 81,996 cases of water-related diseases were registered at different Basic Health Units (BHU) of Rawalpindi division within a year.

According to the Ministry of Science and Technology, it is estimated that 30 per cent of all reported cases of illness and 40 per cent of all deaths in Pakistan are attributed to water-borne diseases.

As the groundwater is the main source of water in most of the cities, there is great stress on this source and its excessive use has seriously affected its quality and the incidences of water-borne diseases are increasing.

It is also reported that 86 per cent of drinking water from Chah Kalalanwala and Kot Asadullah Khan, 40 per cent from village Talab Sarai and Sham Ki Bhattian and 4 per cent from village of Sargodha district contain high fluoride than the recommended levels that have resulted in crippling skeletal fluorosis, particularly in infants.

A limited quantity of raw sewerage near cities and towns is also used for agriculture, especially for vegetables, without adopting any protective measures. The estimates show that on the basis of projected population of 208 million in the year 2025 the annual potential of sewage flow would be 6.6. MAF against the total domestic water requirement of 8.2 MAF in the country.

The disposal of such huge quantity is already a major change and one of the management activities. There is need to monitor the impact of unsafe disposal of sewage and industrial effluents on human health, quality of water resources and agricultural production.

Realizing the situation, the Ministry of Science and Technology has launched a ... impact assessment ... and industrial ... health and ...tivity.

The project, to be executed by Pakistan Council of Research in Water Resources (PCRWR) with an amount of Rs. 27 million will be implemented in Faisalabad to achieve intended objectives. Under the project, a survey will be conducted for collection and analysis of samples of industrial effluents along with existing status of wastewater disposal and management projects.

Pakistan, ... country due to ... sources of ...

... cent years has further ... the water availability ... the country. ... issues, the ... becoming ...

ہم پینے کے پانی کے مسائل کو بہتر طور پر حل کرنے میں آپ کی مدد کر سکتے ہیں۔

آیئے ہمارے ساتھ ملکر صارفین کی زور پکڑتی ہوئی تحریک کو مضبوط بنانے میں اپنا کردار ادا کیجئے۔

دی نیٹ ورک کی ممبر شپ حاصل کر کے مندرجہ ذیل سہولیات حاصل کیجئے:

- ہمارے باقاعدہ شائع ہونے والے چار رسائل میں سے ایک رسالہ مفت حاصل کریں
- صارفین شکایت مرکز سے اپنی شکایات کے ازالے کے لئے مفت معاونت حاصل کریں
- دی نیٹ ورک کے اہم کاموں سے باخبر رہنے کے لئے سہ ماہی نیوز لیٹر مفت حاصل کریں
- اپنے علاقے میں صارف گروپ بنانے کے لئے معاونت حاصل کریں۔ یہ گروپ اپنے علاقے میں پینے کے پانی کے حوالے سے کام کر سکیں گے اور دیگر صارف مسائل کی نشاندہی کر سکیں گے۔

ممبر شپ اور پینے کے پانی کے بارے میں مزید معلومات کے لیے ہم سے رابطہ کریں۔

دی نیٹ ورک
صارفین کے تحفظ کا ادارہ

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پینے کے پانی کی پالیسی کی ضرورت

موجودہ صورتحال میں قومی سطح پر پینے کے صاف پانی کی پالیسی کی ضرورت محسوس کی گئی ہے۔ دی نیٹ ورک نے قومی سطح پر اس پالیسی کو تشکیل دلوانے اور مستقل میں لاگو کرانے پر کام شروع کیا ہے۔ حکومتی اور غیر حکومتی اداروں اور متعلقہ افراد کی رائے سے پالیسی کا مسودہ تیار کیا جا رہا ہے۔ اس مسودے کی تیاری میں دوسرے ممالک کے تجربات، پہلے سے موجود قومی پالیسیوں اور قوانین کو مدنظر رکھا گیا ہے۔ اس سلسلے میں کنزیومر انفارمیشن کی مدد بھی کی جا رہی ہے۔ اس کے ساتھ ساتھ پینے کے پانی میں خواتین کا کردار، دیہی علاقوں میں پانی کی فراہمی اور ضلعی حکومتوں کے کردار کو بھی مدنظر رکھا جا رہا ہے۔

نیبل 1: مختلف شہروں میں پانی کا سروے

شہر کا نام	آلودگی کی اقسام	آلودہ نمونے (فیصد)
لاہور	جراثیمی آلودگی	13 فیصد
	سنکھیا (ARSENIC)	31 فیصد
	دھات، لوہا (IRON)	6 فیصد
راولپنڈی	جراثیمی آلودگی	87 فیصد
	ظاہری آلودگی بسبب مرکبات کی حل شدہ آلودگی	7 فیصد
اسلام آباد	جراثیمی آلودگی	74 فیصد
	پانی میں ظاہرہ آلودگی	37 فیصد

بحیثیت صارفین ہماری ذمہ داریاں

جیسا کہ نیٹ ورک اور حکومتی اداروں کی رپورٹوں سے ظاہر ہوتا ہے کہ پاکستان کی 94 فی صد آبادی پینے کے صاف پانی سے محروم ہے۔ عموماً ہمیں پینے کے پانی کے معیار (Quality) کے متعلق بھی مکمل معلومات نہیں ہوتیں۔ ہم مختلف طریقوں سے پانی کا ضیاع کرتے ہیں جن میں بہتی ہوئی نلکیاں (Leakage)، پانی کے ٹوٹے ہوئے پائپ، پانی کے ٹینکوں سے پانی کا ضیاع (Overflow)، نہانے میں پانی کا زائد استعمال، فرش دھونا، کاریں دھونا اور باغبانی کے لئے پانی کا اصراف وغیرہ شامل ہیں۔

پانی کے صارف کی حیثیت سے ہمیں پینے کے پانی کا معیار معلوم ہونا چاہئے، خواہ ہم پانی کا سرکاری کنکشن استعمال کر رہے ہوں یا اپنے طور پر حاصل کر رہے ہوں۔ اس کے لئے ہمیں اپنے پینے کے پانی کی آلودگی کا معائنہ کرانا چاہئے یا متعلقہ اداروں پر زور دینا چاہئے کہ وہ معائنہ کروائیں اور ہمیں معلومات پہنچائیں۔ گھریلو سطح پر پینے کا پانی صاف کرنے کے متعدد طریقے ہیں۔ نیٹ ورک اس سلسلے میں صارفین کے لئے ایک رہنما کتابچہ کے مسودے پر کام کر رہا ہے۔

پانی بچانا ہم سب کا اخلاقی و معاشرتی فرض ہے اور ہمیں پانی بچانے کے لیے مندرجہ ذیل طریقوں کا استعمال کرنا چاہیے:

پانی کی ٹونٹی کو کھلا نہ چھوڑنا

برتن دھونے کے لیے تھال کا استعمال کرنا

شاور سے نہانے کے وقت کو کم کرنا

باغبانی پر کم سے کم پانی کا استعمال کرنا

بارش کے پانی کو محفوظ کر کے قابل استعمال بنانا

شیو کرتے اور برتن دھوتے وقت پانی کی ٹونٹی کم سے کم کھلی چھوڑنا

ٹوٹے ہوئے پائپ اور بہتی ہوئی ٹونٹیوں (Leaking taps) کی بروقت مرمت کروانا وغیرہ

بوتل کا پانی یا منرل واٹر (Bottled water)

صاف پانی کی عدم دستیابی کو منرل واٹر بنانے والی کمپنیوں نے کاروباری مقاصد کے لئے استعمال کیا ہے۔ یہ عوام کے مسائل کا حل نہیں بلکہ انہیں مزید مشکلات میں ڈالنے کے مترادف ہے۔ پاکستان جیسے ملک میں جہاں ایک تہائی سے زیادہ آبادی انتہائی غربت میں زندگی بسر کر رہی ہے عام طور پر لوگ منرل واٹر یا بوتل کا پانی خریدنے کی سکت نہیں رکھتے۔ ایک مستند سروے کے مطابق 51 فیصد بوتلوں میں دستیاب پانی معیار کے مطابق نہیں اور مضر صحت ہے۔

نیبل 2: مختلف اقسام کی آلودگی کے مضر صحت اثرات اور مناسب حل (Solutions)

آلودگی کی اقسام	صحت پر اثرات	حل
جراثیمی آلودگی	اسہال، پیچش، ٹائیفائیڈ، ہیضہ، ہیپاٹائٹس، پیٹ اور آنتوں کی بیماریاں	زیر زمین پانی کی لائنوں کی مرمت، کلورینیشن (CHLORINATION) یا اوزونائزیشن (OZONIZATION)، پانی ابالنا، UV فلٹر
پانی میں ظاہرہ آلودگی	طبعی مکروہات، پانی میں نامیاتی مرکبات کے ہونے کا اندیشہ	پھٹکری (ALUM) برائے COAGULATION، فلاکیولیشن (FLOCULATION)، ریت سے پانی فلٹر کرنا (SLOW SAND FILTRATION)
حل شدہ مرکبات کی آلودگی	مرکبات پر منحصر صحت پر اثرات	پانی کے ذرائع (SOURCES) کو بدلنا، ANION EXCHANGE، REVERSE OSMOSIS
سنکھیا (ARSENIC)	دماغ پر اثرات، معدے پر اثرات، جلد کی بیماریاں، پٹھوں کی کمزوری، دل متاثر نہ	پانی کے ذرائع کی تبدیلی، سنکھیا ختم کرنے والے فلٹر، REVERSE OSMOSIS
لوہا (IRON)	خون کی بیماریاں	پانی کے ذرائع کی تبدیلی، فلٹریشن، OXIDATION، REVERSE OSMOSIS

پینے کا صاف پانی۔ایک بنیادی حق

پینے کا صاف پانی زندگی کی اہم ترین ضرورت اور ہر انسان کا بنیادی حق ہے۔ پینے کا صاف پانی بین الاقوامی طور پر ایک بنیادی حق تصور کیا جاتا ہے جو ہر سماجی پالیسی کا لازمی جزو ہے۔ حکومتیں اس بنیادی حق کی فراہمی کے لیے ذمہ دار ہوتی ہیں اور ترقی یافتہ ممالک کی حکومتیں اس ذمہ داری کو بڑی حد تک پورا کر رہی ہیں ۔ مگر ترقی پذیر ممالک میں حالات بالکل مختلف ہیں ۔ کنزیومرز انٹرنیشنل (Consumers International) کی ایک حالیہ رپورٹ کے مطابق دنیا کے ایک ارب سے زیادہ لوگ پینے کے صاف پانی سے محروم ہیں۔ اقوام متحدہ کے طے کردہ اہداف (Millenium Development Goals) کے مطابق 2015 تک یہ تعداد گھٹ کر آدھی رہ جانی چاہیے لیکن اس کے لئے ملکی طور پر سنجیدہ کوششیں لازم ہیں۔

15 مارچ۔صارفین کے حقوق کا عالمی دن

صارفین کا عالمی دن ایک سالانہ موقع ہے جس میں صارفین کے حقوق کے تحفظ اور بین الاقوامی صارف تحریک کے استحکام کی بات کی جاتی ہے۔ 2004 میں اس دن کا مرکزی خیال "پانی ایک بنیادی حق" ہے۔ کنزیومرز انٹرنیشنل جو 250 صارفین کے حقوق کے اداروں پر مشتمل ہے اور 115 ممالک کی نمائندگی کرتا ہے، اس بین الاقوامی ادارے نے اس سال دنیا کے 6 ارب صارفین کے لیے پینے کے صاف پانی تک رسائی کے لیے آواز بلند کی ہے۔

چونکا دینے والے حقائق

- دنیا میں ہر چھ (6) میں سے ایک فرد (1.1 ارب لوگ) صاف پانی کی دستیابی سے محروم ہے۔
- دنیا کے بہت سے ممالک میں پانی سپلائی کرنے والے ادارے اور ان کے بنیادی ڈھانچے ٹوٹ پھوٹ کا شکار ہیں اور مصرعت پانی مہیا کر رہے ہیں۔
- جن صارفین کو پانی کا کنکشن حاصل نہیں وہ پینے کا صاف پانی حاصل کرنے کے لیے 10 گنا زیادہ پیسے خرچ کرتے ہیں۔

پینے کے پانی کا معیار (Standard)

عالمی ادارہ صحت (WHO) نے پینے کے پانی کے معیار کے لئے رہنما اصول ترتیب دیئے ہیں، جن کو وقتاً فوقتاً بہتر بنایا جاتا ہے۔ یہ رہنما اصول ایسے قومی اور مقامی اداروں (ضلع وتحصیل کونسل) کے لئے ترتیب دیے جاتے ہیں جو پانی کا معیار مقرر کرتے ہیں اور پانی مہیا کرنے کے کام سے منسلک ہیں۔ پاکستان میں پانی کے معیار مقرر کرنے کا سلسلہ صرف دو سال قبل شروع ہوا ہے۔ پاکستان سینڈرز ڈ اینڈ کوالٹی کنٹرول اتھارٹی (PSQCA) نے پاکستان میں پینے کے پانی کے معیار کی ایک دستاویز (ICS No.13.060.20 - 2002 - 1932) بھی جاری کی ہے۔ یہ مقرر کردہ قومی معیار بوجل میں دستیاب پینے کے پانی پر قانوناً لاگو کردیے گئے ہیں، مگر پانی سپلائی کرنے والے اداروں کے لئے ان کی حیثیت رضا کارانہ طور پر اختیار کرنے کی ہے۔ نیٹ ورک کو یقین ہے کہ اگر پانی سپلائی کرنے والے تمام ادارے پانی سپلائی کرنے کے لئے مقرر کردہ قومی معیار اختیار کرلیں تو پینے کے پانی کی اوائی سے متعلق مسائل بہت حد تک حل ہوسکتے ہیں۔ اسی بات کو پیش نظر رکھتے ہوئے نیٹ ورک نے PSQCA کے تو سط سے پانی کے قومی معیار کا مسودہ ضلعی حکومتوں کو بھجوایا ہے جو کہ پانی سپلائی کرنے کے ذمہ دار ہیں تاکہ وہ پینے کا پانی ان معیارات کے مطابق سپلائی کرسکیں۔ نیٹ ورک نے یہ دستاویز تمام تحصیل ناظمین کو بھی اس استدعا کے ساتھ بھجوائی کہ وہ اپنے علاقے کے صارفین کو پینے کا پانی ان معیارات کے مطابق سپلائی کریں۔ اس کے ساتھ ساتھ نیٹ ورک پانی کے قومی معیار کو مقامی حکومتوں کے لئے لازم قرار دینے کی کوشش بھی کررہا ہے۔

پاکستان میں پینے کے پانی کی صورتحال:

پاکستان میں صرف 30 فی صد آبادی پائپ لائینوں کے ذریعے پانی حاصل کررہی ہے۔ اس میں مکمل طور پر صاف پانی کہیں بھی مہیا نہیں کیا جارہا۔ پانی کی کمی ایک اور بڑا مسئلہ ہے۔ اس کی وجوہات میں مطلوبہ شیریں کا نہ ہونا، خراب ہونا یا ساف کی مناسب تربیت نہ ہونا شامل ہیں۔ پانی کی کمی اور بری کوالٹی کی وجہ سے لوگ مجبور ہیں کہ وہ اپنے طور پر دوسرے ذرائع سے پانی حاصل کریں جن میں زیادہ تر گھریلو کنوئیں کا کھودنا اور ہینڈ پمپ یا موٹر کے ذریعے زمین سے پانی کھینچنا شامل ہیں۔ جس کی وجہ سے نہ صرف پانی میں مزید کمی واقع ہوجاتی ہے بلکہ ایسے نلکی اور ادارے بھی وجود میں آتے ہیں جو صارفین کو مہنگے داموں پانی فروخت کرنے کا کام کرتے ہیں۔

راولپنڈی، اسلام آباد میں نیٹ ورک کے زیر انتظام کئے گئے ایک سروے کے مطابق پانی کے 98 فی صد نمونے مضر صحت تھے۔ تقریباً اسی طرح کے نتائج کوہاٹ، کوئٹہ ستیاں (ضلع راولپنڈی) اور ایبٹ آباد میں پانی کی کوالٹی کے سروے کے دوران سامنے آئے۔ نیٹ ورک کی ان رپورٹوں کی تصدیق، سرکاری طور پر شائع ہونے والی پانی کی کوالٹی کے نتائج سے ہوتی ہے۔ ایسی ہی ایک رپورٹ حال ہی میں پاکستان کونسل برائے آبی وسائل (PCRWR) نے اپنی ویب سائٹ پر شائع کی ہے۔ جس میں پینے کے پانی کے حوالے سے خطرناک صورت حال سامنے آئی ہے۔ اس رپورٹ میں کونسل نے یہ کوشش بھی کی ہے کہ وہ کتنے پانی سے ہونے والے مضر اثرات کے بارے میں بھی بتائے۔ اس رپورٹ کے چند نتائج ٹیبل 1 اور ٹیبل 2 سے ظاہر ہیں۔

دی نیٹ ورک - پانی کا پراجیکٹ

دی نیٹ ورک فار کنزیومر پروٹیکشن ایک غیر منافع بخش ادارہ ہے جو کہ پاکستان میں صارفین کے تحفظ کے لیے کام کررہا ہے "پینے کا صاف پانی" نیٹ ورک کے کام میں کلیدی حیثیت رکھتا ہے۔

ادارے کا دائرہ پراجیکٹ پاکستان کے صارفین کے لیے حفوق سطح پر صاف پانی کی فراہمی کے لیے کام کررہا ہے، اور اس سلسلے میں صارفین کو ان کے اس بنیادی حق کا ادراک دلانے کا کام بھی کررہا ہے۔ ادارہ سمجھتا ہے کہ پینے کے پانی کی فراہمی سب کے لئے یکساں ہو اور اس میں کسی تم کی تفریق نہیں ہونی چاہیے۔

پینے کا صاف پانی۔ ایک بنیادی حق

TOBACCO IN SPORTS

KILLING THE SPIRIT

TFI-PAK

TOBACCO FREE INITIATIVE PAKISTAN

A PROJECT OF THENETWORK FOR CONSUMER PROTECTION IN PAKISTAN

TOBACCO IN SPORTS KILLING THE SPIRIT

To be a giant
This has forever been our passion
This desire to be a giant
Not to stand on one's shoulder or to have one for a friend
Though these may be fortunate things
But to be one
Giants step over barriers that seem never ending
They conquer mountains that appear insurmountable
Giants rise above fear
Triumph over pain
Push themselves and inspire others
To be a giant
To do giant things
To take giant steps
To move the world forward
Winter Olympics
Salt Lake City 2002

Introduction

Sport, a recreational and competitive activity, has been an aspect of all cultures since the dawn of time. Men and women have always run, jumped, climbed, lifted, thrown and wrestled but no one can say when sports actually began, as the transition of a physical activity into competitive contest involving intellect has led to the emergence of term 'sports' as we know it today.

Sport has come a long way from pre-historic times to the modern period in history and has been affected in more ways than one. Economic analysis demonstrates that the boom in sports participation and in sports spectatorship has been due to the realization of the sports as a marketable commodity. This transformation started from universities and schools where sports was recognized as a means of building a future through sponsorships for further studies and also as professional career. The people associated with business and industry also became involved. Modern football was invented in the elite boys' schools in Victorian England and is now the most widely watched sport in the world primarily due to the interest of the media which provided extensive coverage. The commercial motives have encouraged promoters to stage sports events like the 'World Cup Football' which are open to all age groups, and especially the youth. The sponsors' messages is not restricted to those who have the ability to pay for witnessing the event and are able to carry the it back home but are also available to those who see it in the comfort of their lounges and receive the sponsors' messages directly. Now that the world's sporting events are open to men and women who may earn millions of dollars by their athletic prowess, it is quite improbable that the promoters / sponsors of such sports persons would let this opportunity of promoting their product sneak away.

Along with bringing in the professionalism in sport and extending other benefits to the players and sports bodies, the sponsorship has also lured in industries with an inherent motive of exploiting the public. One such example is the tobacco industry, which has used sports to reach people with their messages and has linked a healthy activity to one that kills millions worldwide.

> According to an executive of the tobacco industry (RJ Reynolds), 'We're in the cigarette business. We use sports as an avenue for advertising our products….We can go into an area where we are marketing an event, measure sales during the event and measure sales after the event, and see an increase in sales."

In Pakistan sports are widely sponsored by the tobacco industry, which either directly links a particular sport with a cigarette brand like Red & White Snooker, Wills Cup Cricket, Royals Volley ball etc. or ensure their presence by buying televising rights of a 'tobacco free event' on the state run television. The absence of anti-tobacco legislation in Pakistan allows the tobacco industry to operate freely in all sporting events which ensures their presence in the field and the media while introducing their product to millions of people at home. Sponsorship of sports is the worst kind of promotional gimmick used by the tobacco industry to lure the young towards smoking. By presenting a 'socially acceptable face' the tobacco industry has always tried to divert the attention from the need to ban all kinds of tobacco promotion. Experiences from across the globe suggest that a complete ban on all kinds of direct and indirect promotion of tobacco products is one of the basic measures required to decrease the overall consumption of tobacco products and to save millions of lives from the disabling diseases and premature deaths caused by it.

Sports sponsorships in Pakistan

Currently there are 39 National Sports Federations in Pakistan operating independently, governed by their own constitutions and

supplemented by five provincial bodies and four provincial Olympic committees. With minimum of funds available from official quarters these federations depend upon sponsorship from the private sector.

The tobacco industry has used these sports structures in Pakistan for the promotion of their products. Notabie amongst these are cricket, golf, snooker, volleyball and baseball. The tobacco industry has approached these games differently. While the intention in cricket was to attach tobacco to an already established game in Pakistan, the other games were either introduced through the power of media and advertising for the increase in sales of their particular brand or were used to present a responsible face to the people who matter.

Cricket and Tobacco

Cricket in Pakistan is very popular sport and is now an established professional sport. Sponsorship in cricket has been lucrative with the tobacco industry pouring Rs. 145 lakh (14.5 million) every season in the domestic setup called, 'Wills cricket'. Malcom Bannister, Chairman Pakistan Tobacco Company Ltd termed Board of Cricket Control in Pakistan (BCCP) as 'friends of Wills' and indeed they are as the relationship was also highlighted by Mr. Justice Nasim Hassan Shah, the former president of BCCP, who wrote, 'Our deals with WILLS and Pepsi are illustrations of faith and commitment that allow both to achieve a better image …'

Pakistan's state owned television channel (PTV) has also been a

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recipient of the tobacco money. The sponsoring of cricket matches and airing of advertisements on match days to the extent of one after every over bowled meant that in a single day covering a one-day international match PTV received Rs. 36 lakh from tobacco industry alone. In a series of five matches this amount reached more than Rs. 1.8 crore (18 million).

Pakistan Cricket Board (PCB) and Pakistan television while allowing cricket to be used as a medium for the sponsorship of tobacco products has given the tobacco industry a chance to reach all age groups, especially the youth. These tactics are reflected in one of the projects of the tobacco industry called 'Project Virgo'. The project was launched by British American Tobacco (BAT) to develop an insight on the perceived benefits of smoking and to establish the situations in which a person is more likely to smoke. The sponsorship of sports can also be linked to these insights. The results of this project indicated that people smoke while relaxing and also as a reward after completion of a task. If the campaigns of tobacco industry are looked into carefully, these also reflect situations in which people are shown to smoke after doing something heroic along with friends and what better way to do it then at the time of watching your team win.

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PCB disassociated itself from 'WILLS' in the season of 1997 and 1998 under international pressure as other cricket playing nations had

moved away from tobacco sponsorships. The Pakistan Tobacco Company in its financial report of first half of 1999, just after removing itself from the cricketing scene registered a decrease in sales volume of over 7% over the same period the year before. By its own admission they saw a drop in sales of Wills, Gold Flake and Embassy brands. These brands were linked to cricket. The game of cricket survived in Pakistan and has flourished after disassociating itself from the tobacco industry. So it is not a matter of survival of the game but of the tobacco industry, which needs sports to survive.

Sportsmen who have won laurels for the country like Imran Khan captain of the successful 1992 Pakistan's world cup cricket squad, have felt the exploitation of sports by the tobacco industry. In the words of Imran Khan, 'Having played international cricket and having established the largest cancer hospital in Pakistan ..... I have witnessed the power and pervasiveness of tobacco promotion through sports and its disastrous health consequences in the form of cancer and death. I want to urge all the sport persons including sports organizers and their respective governments to make sport across the globe free from tobacco by not accepting sponsorships from the tobacco industry'.

The case of Snooker

Pakistan is traditionally not a snooker playing nation. Although our founder Quaid-e-Azam Mohammad Ali Jinnah enjoyed snooker and his image has been used by the tobacco industry to promote the game, it has however been restricted to the elite clubs of the country. Despite hosting the 2nd World Snooker Championship in 1966 the game had remained virtually unknown in Pakistan. The Pakistan Tobacco Industry (PTI) took up the sponsorship of the game in 1989 and attached its brand 'Red and White' with it. Simultaneously PTI also launched a promotional campaign using the popular image of 'James Bond' playing snooker. The campaign used all kinds of media including the state run Pakistan television. The effect of this could be seen on the ground as snooker clubs opened in all kinds of places including the rural areas. According to an official of Pakistan Billiard and Snooker Association (PBSA), the game had become synonymous with Red and White. These snooker clubs became a haven for children where they could smoke easily and freely.

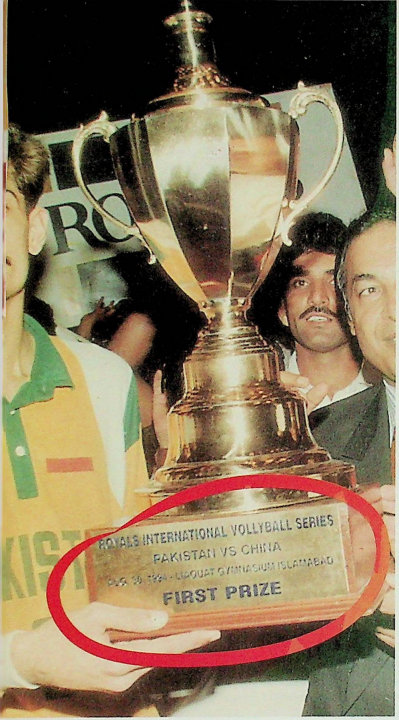
PTI paid Rs. 1.5 crore (15 million) to the PBSA for holding the 20th World Snooker Championship in 1993 while the Eighth Red & White Asian snooker championship received Rs. 20 Lakh (2 million). In the 1991 National snooker championship PTI spent Rs.40 lakh (4 million) on the event. The amount spent on a game which was not even recognized at that stage helped the Tobacco industry to further its intentions of recruiting young smokers as sales of RED & White went up during these years.

Ironically Latif Amir Bukhsh, the first National Snooker Champion and holder of record three consecutive national titles died at the age of 40 with cancer of the lungs and stomach. In his memory Latif memorial snooker is also held every year

Golf - Gaining official recognition.

To maneuver in the official quarters and to appear responsible the tobacco industry has used golf to reach people who matter. Golf in Pakistan remains a game of the elite class. Golf clubs have restricted memberships and usually have policy makers as their members. The tobacco industry's corporate and regulatory affairs body (CORA) organizes friendly golf tournaments in Pakistan regularly. In a similar one day tournament in November 1999, The Federal Minister of Finance, Mr. Shoukat Aziz, The Federal Minister for Petroleum Usman Aminuddin and the British High Commissioner were some of the players who played for a brand new Corolla car and other cash prizes. Spouses were also present at the tournament and at the dinner hosted at the end by the tobacco industry.

The participants and guests were given golf shirts, sun visors and golf balls and the spouses won prizes through a lucky draw thus ensuring that everyone went home with a present and a message from the tobacco industry.



Volleyball - a game for the masses.

Royal cigarettes, a brand popular with the low socio-economic strata has been involved in sponsoring volleyball at the local as well as national level. The contract between the tobacco industry and the controlling body for volleyball in Pakistan lasted for 5 years i.e from 1997 to 2001. The tobacco industry paid Rs. 4 lakh (0.4 million) for holding a tournament and had the rights for television and media coverage for that event. After 5 years of promotion of their product through the game the tobacco industry has not renewed its contract citing international pressures as one of the reasons for abstaining from further sponsorships. To many, and especially those associated with the game of volleyball, this is not a valid argument as the tobacco industry continues to sponsor other sporting events where it sees an opportunity to increase its sales. 'If the sales of Royals had improved the company would have stayed with us but as we did not get the coverage on media the company has parted ways as we were not serving their purposes' admitted one of the officials associated with volleyball on condition of anonymity.

Success stories
The First Tobacco Free World Cup Football

The Federation of International Football Associations (FIFA), the largest sports body in the world has not accepted any tobacco sponsorship for the last 16 years. According to FIFA spokesman Keith Cooper, 'Tobacco has no place in football or in any other sport, and any involvement of any tobacco company is entirely unwanted and actively rejected'

FIFA has signed an agreement with the World Health Organization for a smoke-free World Cup 2002 to end cigarette promotion and smoking at the games. To circumvent the situation the Korea Tobacco and Ginseng Corp. announced that it planned to begin marketing tobacco packaged to promote this summer's tournament, which South Koreans will cohost with Japan. These cigarette packs showed players in action. Reacting to this indirect use of sports FIFA commented, 'It is the latest example of how the tobacco industry sets out to mislead the public as it has been doing for so many years now. FIFA remains very conscious of the need to make the public--and especially young people--aware of the dangers of smoking and also wishes to ensure that the nonsmoking majority can enjoy the games without having to sit in somebody else's tobacco smoke'.

Football World cup is the most widely watched extravaganza in the history of sports and making it 'Smoke free' has helped in keeping the youngsters away from smoking.

South Asian Federation Games Pakistan March 2003.

The 9th South Asian Federation Games to be held in Islamabad in March 2003 were declared "tobacco-free" by the organizers of the game taking a lead from the initiatives of FIFA and World Health Organization and effective lobbying from the Tobacco Free Initiative-Pakistan and Pakistan Anti Tobacco Coalition.
SAF Games secretariat admitted that tobacco and sports do not go together as sports is a healthy activity which should not be linked with tobacco. No tobacco brand or product was included in the list of official sponsors where the audience of the games would include children and people under 18.

The Tobacco Industry managed to manipulate the situation and ensured its presence in the media by sponsoring the events related to SAF games. Though the tobacco industry is not an official sponsor, Pakistan Television allowed the tobacco industry to air its advertisements during programs related to SAF Games.

Participating in the 9th SAF Games are powerful contingents from India, Bangladesh, Sri Lanka, Nepal, Bhutan, Maldives and Pakistan. All these countries except hosts Pakistan have strict anti-tobacco laws which inhibit tobacco promotion in their countries.

TOBACCO IN SPORTS KILLING THE SPIRIT

What do sportsmen say?

Imran Khan

Former Captain - Pakistan Cricket Team

'Tobacco companies direct their advertisements and promotion towards young people. Internal tobacco industry documents disclosed in 1998 made clear that for decades the industry has systematically targeted children as an important market, carefully studying their smoking habits and developing products and marketing campaigns aimed at them. Sponsorships of popular sports like, motor racing, cricket and football are among the most common examples. By sponsoring individual sports persons, sporting events and teams the companies establish a link at subliminal between their products and health and athletic prowess'.

Abdur Razzak

All rounder Pakistan Cricket Team.

'The sportsmen have an internal energy on which they build their careers. Smoking drains this energy. If young people want to succeed as sportspersons they must choose between smoking and health. It is only physical fitness, hard work and dedication to the game which can make you an all rounder'

InzamamulHaq

Batsman, Pakistan Cricket Team

'There are lots of ways of relaxing and I do enjoy relaxing but what needs to be highlighted is that smoking cannot be included in that list. For a sportsperson fitness is very important and smoking can easily destroy your chances of reaching your maximum potential. We as sport persons should also recognize our responsibility as public figures and as idols of our fans who want to copy our every style and smoking should not be one of these'.

Muffy Davis

U. S. Disabled Ski Team and 1998 Paralympic Bronze Medallist 2000, Giant Slalom World Champion and 2001 World Cup Overall Champion

'Sports have kept me away from smoking and drugs. I grew up competing in sports and I knew I could never by my personal best if I was smoking or using drugs. After I broke my back and began competing in Disable Skiing, I was so thankful I never got into smoking because I now have diminished lung capacity due to my disability. Smoking affects the lungs and would have made it worse. I could never willingly mess up the limited lung capacity I have by smoking. I find it strange that so many kids start smoking because they think its cool. As an athlete, it's just the opposite, smoking is definitely not cool'.

What needs to be done?

The need to ban all kinds of direct and indirect promotion of tobacco products is highlighted by the tobacco industries ruthless approach to target young adults and its blatant refusal of the same. Tobacco industry has long exploited the official quarters hiding behind the garb of being a 'responsible company' and adopting 'voluntary codes of marketing of tobacco products' and using sports as a medium to enhance their sales. Anti-tobacco activists across the world have gathered enough evidence to firmly believe that 'voluntary codes' do not work and to decrease the consumption of tobacco across the world, a complete ban on all kinds of direct and indirect marketing of tobacco products is required. Only such a comprehensive ban can save the youth from premature deaths and disabling diseases caused by tobacco consumption especially in the developing countries like Pakistan.

TFI-Pakistan

Tobacco Free Initiative-Pakistan is a project of TheNetwork for Consumer Protection. TFI-Pak is an informed and organized response from civil society to promote and contribute towards effective tobacco control in the country. TFI-Pakistan approaches the tobacco issue in a holistic way and its strategies address problems on both the demand and supply sides.

In collaboration with the World Health Organization's Tobacco Free Initiative, Department for International Development United Kingdom, the international anti-tobacco movement and active national and local groups, TFI-Pakistan has launched a national anti-tobacco campaign.

The aim is to curb the tobacco epidemic in the country in order to minimize the related burden of disease by effective advocacy and by mustering national support for evidence-based tobacco control measures e.g. ban on all kinds of tobacco promotion. TFI-Pak coordinates all the activities of Pakistan Anti-Tobacco Coalition.

For more information about TFI-Pakistan and other consumer protection work, please contact: Coordinator, Tobacco Free Initiative-Pakistan

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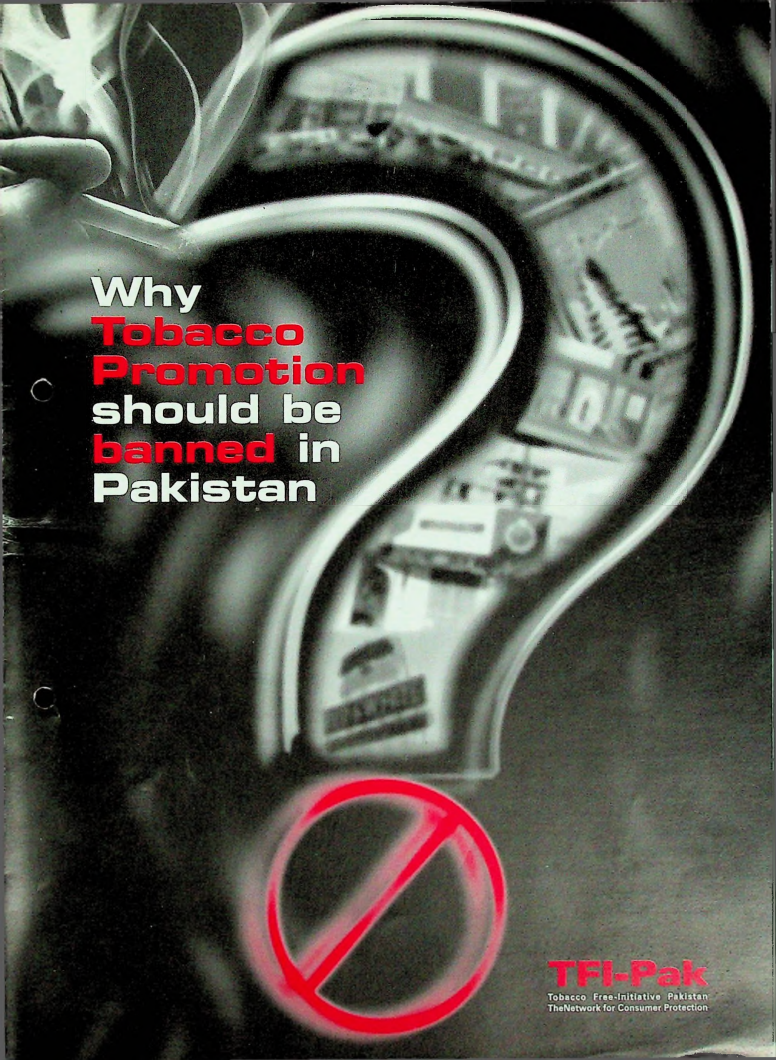

Why
Tobacco
Promotion
should be
banned in
Pakistan
TFI-Pak
Tobacco Free-Initiative Pakistan
TheNetwork for Consumer Protection

Why Tobacco Promotion Shou

An overwhelming majority of independent and peer reviewed studies have established tobacco promotion as a cause of increased tobacco consumption. Tobacco industry despite recognizing the same continues to indulge in its unethical marketing practices promoting its products to all sections of the society. The concept of civil society empowers individuals with a generalized responsibility to act with regard to the interests and collective life of the community. Tobacco promotion not only undermines these interests but also disrupts the collective life adding to the problem of increasing tobacco consumption.

Luring the young and innocent

Tobacco kills 1.1 million people worldwide, every year and about 500 million people alive today will eventually be killed by it. More than half of these are now children and teenagers. By 2030, tobacco is expected to be the single biggest cause of premature deaths, accounting for about 10 million deaths per year.

With trade barriers being curtailed to liberalize global trade, tobacco industry has found markets of developing countries an open haven primarily due to lack of relevant laws to monitor their activities. There is also an enhanced competition amongst the makers of tobacco products to capture these emerging markets, resulting in lower prices, greater advertising and promotion, and other similar activities that stimulate demand for their product.

The tobacco industry, like all other profit making industries, depends upon consumers for its growth, who it views as potential customers. Advertisements offer a means to create a positive image of tobacco products and link them to desirable personal traits. Their objective is to stimulate and increase demand for the product and broaden the base of people using it.

The tobacco industry pours billions of dollars into its media campaigns mainly those focusing on cigarettes, the world over.

Advertisements form a central part of these campaigns and are carefully designed and based on the habits, tastes and desires of targeted potential customers. These campaigns also take into consideration social and cultural aspects and include slogans that are specific and appealing to each society or intended age group.

Tobacco kills a smoker every 8 seconds and the tobacco industry needs to replace this smoker to maintain its market. The overwhelming growth of the tobacco industry in the past decade indicates that not only has it been able to replace its dying customer but has also been able to increase its customer base by the second. The media campaigns for tobacco products are focused mainly on young adults, categorized by the tobacco industry as a potential source of replacement smokers.

"They [young adults] represent tomorrow's cigarette business. As this 14 - 24 age group matures, they will account for a key share of the total cigarette volume for at least the next 25 years" writes one of the industries executives, J.W.Hind of R.J Reynolds Tobacco, now owned by the Japan Tobacco in an internal memorandum, dated 23rd January, 1975.

The tobacco industry in Pakistan indulges in aggressive promotional activities. Indeed, advertising is the industry's frontline in its ambition to increase consumption of tobacco products. If Pakistan is to achieve a reduction in tobacco products consumption, for the health of our people, a ban on all direct and indirect advertisements of tobacco products is imperative.

Countries like Australia, Finland, France, Italy, New Zealand, Portugal, Singapore, Thailand and Turkey recognized the increasing threat of tobacco consumption and imposed bans on all kinds of promotion of the tobacco products. The European Union aims to phase out all types of tobacco promotion by year 2006. But countries like Pakistan dependant on the perceived economic gains from tobacco industry, are still deliberating on how to tackle the issue focusing on the economic argument rather than its health impact.

Tobacco advertisements increase tobacco consumption

Researchers have concluded from evidence gathered around the world, including United States, New Zealand, United Kingdom, Australia and Germany, that there is a causal link between tobacco advertising and its subsequent consumption.

U.S. General's report of 1989 identifies four direct mechanisms by which tobacco advertising leads to an increase in tobacco consumption:

- Encouraging children or young adults to experiment with tobacco products and initiating regular use.
- Increased daily consumption.
- Reducing motivation to quit smoking.
- Encouraging former smokers to take up smoking again.

"Younger adult smokers have been the critical factor in the growth and decline of every major brand and the company in the last 50 years. ...Younger adult smokers are the only source of replacement smokers..... If younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle.

"Young adult smokers: strategies and Opportunities; Internal memorandum from R.J Reynolds, 29 February 1984

Bans on advertising lead to reduced consumption

Countries which have banned all kinds of promotion have witnessed a decrease in the overall drop in tobacco consumption.

According to a World Bank report entitled 'Curbing the epidemic'

"Bans on advertising and promotion prove effective, but only if they are comprehensive, covering all media and all uses of brand names and logos."

Addiction of government to easy revenues and sponsorships

d be banned in Pakistan

Country	Date of Ban	Percentage drop in consumption since year of ban on advertising
Norway	1 July 1975	-26%
Finland	1 March 1978	-37%
New Zealand	17 December 1990	-21%
France	1 January 1993	-14%

(Source: Luk Joossens, 'Questions and Answers: Why Ban Tobacco Advertising in the European Union,' International Union Against Cancer, February 1998. Quoted in "Tobacco Advertising & Promotion: The Need for a Coordinated Global Response, Ross Hammond.)

The Deceptive face of the Tobacco Industry

The truth behind voluntary marketing codes.

The tobacco industry in Pakistan has adopted a 'voluntary and self regulatory code for the marketing of cigarettes'. The Purpose of the code is to "establish a form of self -regulation, with uniform standards for the marketing of cigarettes, including advertising and promotion of cigarettes, [which] are directed solely at adults in the domestic market of Pakistan. This Code establishes uniform standards for the advertising and promotion of cigarette brands in Pakistan and provides a mechanism whereby compliance with this Code can be ascertained promptly, fairly and on a consistent basis".

The hidden agenda of the tobacco industry is illuminated by a Phillip Morris memo from Colin Goddard, "Pakistan - Meeting in London," 9 July 1994. (meeting between Philip Morris, BAT and Rothmans)

"Since the industry in Pakistan is facing unprecedented opposition, not only on the advertising front but on most other issues too, including ETS [Environmental Tobacco Smoke] the time had come for the companies to be considerably more proactive. This reflects the attitude that is currently prevailing in almost every country in the region to one degree or another...An industry code will be written ... so that it can be used as both a lobbying lever and an argument against not introducing formal legislation...it was proposed that we look at developing a minor's program that would show that industry to be willing to work cooperatively with the authorities in at least one area in which we have a mutual objective."

The tobacco industry's voluntary code adopted by it for marketing of tobacco products claims not to use models who appear to be under 25 years of age. They further claim that cigarette advertising shall not suggest that smoking is essential to social prominence, or sexual attraction, nor shall it picture a person inhaling or exhaling cigarette smoke and cigarette advertising should not suggest that as a result of smoking a person appears attractive or healthy.

An analysis of the tobacco advertisements undertaken by TFI-Pak indicated that models in all advertisements were portrayed as sophisticated, professionally successful, sexually attractive, athletic and brave, friends in need. In short, the characters portrayed in these ads are emblems of adulthood that are idolized by children trying to find a place in the adult world. Every brand carries a slogan around which the media campaign is built. These slogans are in local language and are developed after a meticulous research on the cultural and social aspects of the society. They are structured to appeal young adults psychologically as friendship, adventure and freedom are some of the traits one aspires to have at this age. Popular singers and their compositions are used to further enhance the appeal. These slogans are incorporated into media themes depicting the slogan and the activity of smoking as one.

Some of the slogans used by the industry are:

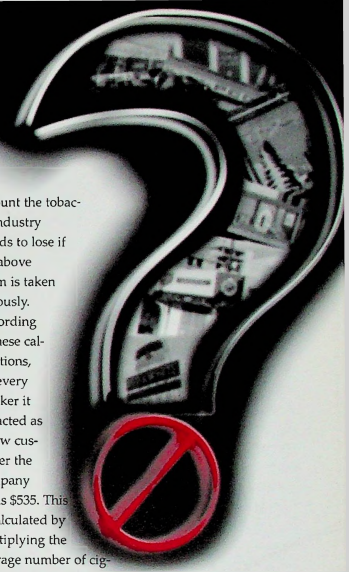
Brand name	Slogan
Benson and Hedges	Be gold (one & only)
Capstan	Men demand Capstan the world over
Diplomat	Enhances the taste*
Embassy	This is the friendship*
Gold Flake	Together in success*
Gold Leaf	For the taste alone, A taste apart
Gold Street	Share the golden moments
K-2	Always together*
Morven Gold	Share the taste of adventure
Red & White	Come for the style and stay for the taste
Wills Kings	The same great taste*

*. Translated from URDU

The Economics of Tobacco Advertising

One of the worlds largest multinational cigarette company, Philip Morris, (PM) with global sales of over $36 billion, spends $3.1 billion on its advertising campaigns, making it the world's ninth largest advertiser. British American Tobacco (BAT) with sales of over $26 billion spends almost $459 million on advertising on tobacco products. The tobacco industry has increased its expenditures on media campaigns by 2000% since 1965 with a significant rise in the early 90s. The tobacco industry still maintains that it focuses on brand loyalty or creating brand switches and does not aim to increase tobacco consumption.

Ross Hammond in his paper, "Tobacco Advertising and Promotion: The Need for a coordinated response" has calculated the amount the tobacco industry stands to lose if the above claim is taken seriously. According to these calculations, for every smoker it attracted as a new customer the company gains $535. This is calculated by multiplying the average number of cigarettes smoked per day by 365 days of the year and the average whole sale price of the company's brand. The companies spend almost $1180 per smoker who wants to change brands, again calculated by considering the amount spent on advertising campaigns and the percentage of people switching brands. Considering these figures, the companies stand to lose $644 for every smoker who switches to their brands. For each smoker who didn't change brands, the entire investment would be lost.



If the companies are true in their stance of promoting brand loyalty and brand switching, economic sense prevailing, they should stop promotion of tobacco products altogether.

Experiences with Health Programs

Many countries have undertaken health promotion and education programs to inform people of the hazards of tobacco. However, these efforts are continually undermined by the tobacco industry. Over 40 years of experience with health education and health promotion measures show that these measures alone are insufficient to combat the tobacco problem. If smoking is still perceived as socially acceptable, educational campaigns focused on the health hazards of tobacco use will have but modest results in getting large numbers of smokers to stop smoking or in preventing non-smokers especially teenagers from starting. The net effect will be a well-informed population of continuing smokers. For better results, education and health promotion must be accompanied by other actions, particularly legislation and tobacco tax measures that will reduce the social acceptability of tobacco use.

Tobacco advertising campaigns in Pakistan:

In Pakistan the tobacco companies pour millions of rupees into their advertising campaigns. According to, 'Advertising Age' a magazine which monitors the spending of different companies, Lakson Tobacco spent Rs. 328 million (32.8 crore) in 1998, making it the third largest advertiser in Pakistan. It was followed by British American Tobacco, which spent Rs.295 million (29.5 crore) on advertising.

Psychologists and researchers believe that the tobacco industry's media campaigns are carefully designed and aim to familiarize the younger generation with the act of smoking. The use of cultural events creates an aura which depicts smoking as an inherent part of society, thus creating an impression that the act of smoking is a part of the norm. The added attractions of prizes, lotteries, gift schemes and the use of celebrities is all a part of luring the younger generation towards smoking. The tobacco industry admits as much saying, "The adolescent seeks to display his new urge for independence with a symbol, and cigarettes are such a symbol since they are associated with adulthood and at the same time adults seek to deny them to the young" (Kwechansky Marketing Research Inc, Report for Imperial Tobacco Limited, Subject: "Project 16")

The tobacco industry's advertisements appearing in the local press, soon after their adoption of the 'self regulatory code' in early 2001 claiming that cigarettes are not sold to minors, generate the idea of making cigarettes an adult commodity, thus enticing the young to join the adult group and also portrays a hidden agenda of appearing responsible in the eyes of the public by promoting ineffective youth access measures. According to a Philip Morris executive, "If we don't do something fast to project the industry responsibility regarding the youth access issue, we are going to be looking at severe market restrictions in a very short time. Those restrictions will pave the way for equally severe legislation or regulation on where adults are allowed to smoke" (Philip Morris, Third draft of a speech, JJM to PM Invitational, Importance of youth issue. 10 Feb 1995, http://www.pmdocs.com)

Marketing death

Fritz Gahagan, once a marketing consultant for five tobacco companies offered insight into this business:
"The problem is how do you sell death? How do you sell a poison that kills 350,000 people per year, a 1,000 people a day? You do it with the great open spaces ... the mountains, the open places, the lakes coming up to the shore. They do it with healthy young people. They do it with athletes. How could a whiff of a cigarette be of any harm in a situation like that? It couldn't be - there's too much fresh air, too much health - too much absolute exuding of youth and vitality - that's the way they do it." (1988) Quoted in World in Action, Secrets of Safer Cigarettes, 1988

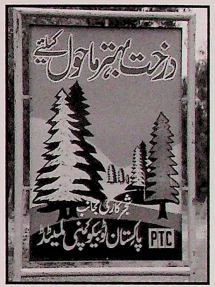
The view of the Council of Islamic Ideology, Pakistan

The Council of Islamic Ideology, Pakistan (CII) has recommended a ban on smoking and has described the Act as 'Makroh'. The members of the CII have also urged the Muslims not to indulge in this habit as it is a sheer waste of money that is strictly forbidden in Islam.

The CII also supports the call for a complete ban on advertisements of cigarettes on electronic media and has demanded the same from the government.

Some examples of advertising campaigns in Pakistan:

Gold Flake' a brand popular with the low income group, is manufactured by Pakistan Tobacco Company, (PTC). British American Tobacco holds 67% shares in PTC. In one of the media campaigns eight million posters and 350 banners advertised this product at a cultural event 'Canal Mela' in Lahore. Double page advertisements sponsoring the event were placed in the local newspapers and 1.5 million leaflets were also distributed. 'Eid Hungama' a celebrities stage show was also sponsored by the same brand.



Putting up a friendly face to reach children

PTC, manufacturers of 'Embassy' offered a 'Toyota Hilux' as a prize through a draw. Contestants entered by sending Embassy empty packs. The company received one million entries, which translates in to 20 million cigarettes sold.

Gold leaf's media campaign 'Voyage of Discovery' offered lucrative prizes including Rs. 150,000 in cash.

Capstan a local brand offered a free ride on an exclusive jet liner to any destination in the world in its "Jet Set Go campaign"

Who stands to lose if tobacco advertisements are banned?

The economic fears that have deterred policy makers from taking action are largely unfounded. Policies that reduce the demand for tobacco, such as bans on advertising, increase in tobacco taxes would not cause long term loses in the vast majority of countries. The effects, if any, would appear gradually and the growth in population in these countries would tend to compensate for these. The tobacco industry recognizes the need to advertise and according to a Philip Morris executive: "Advertising is critical to our ability to expand the geographical presence of our brands and sustain their premium image" (W.Webb, 1933 Board presentation Closing, 19 October 1992, www.pmdocs.com Bates No. 2500157095)

The tobacco pandemic is a communicated disease. It is spread through advertising, through the example of smokers and through the smoke to which non-smokers - especially children - are exposed. Our job is to immunize people against this pandemic.

Gro Harlem Brundtland, Director-General World Health Organization

TFI-Pakistan

Tobacco Free Initiative-Pakistan is a project of TheNetwork for Consumer Protection. TFI-Pak is an informed and organized response from civil society to promote and contribute towards effective tobacco control in the country. TFI-Pakistan approaches the tobacco issue in a holistic way and its strategies address problems on both the demand and supply sides.

In collaboration with the World Health Organization's Tobacco Free Initiative, Department for International Development United Kingdom, the international anti-tobacco movement and active national and local groups, TFI-Pakistan has launched a national anti-tobacco campaign. The aim is to curb the tobacco epidemic in the country in order to minimize the related burden of disease.

The need to work together

TFI-Pakistan will strengthen with the support and cooperation of smokers and non-smokers, health workers, teachers and parents, politicians and opinion leaders, trade unions, commercial and industrial organizations, media, schools and other educational institutions, consumer groups, health services and medical associations, religious groups and researchers

We need to present a collaborative front on the issue and protect our rights as consumers.

If we do not act now the future of our generations would be at the whims of the tobacco giants, whose sole interest is the 'profit'.

Objectives of the TFI-Pakistan

- Effective advocacy by mustering national support for evidence-based tobacco control measures e.g. ban on all kinds of tobacco promotion.
- Contribution towards development of comprehensive anti-tobacco legislation.
- Building a national awareness campaign about the hazards of tobacco through partnerships at all levels.
- Undertaking policy and operational research to fill knowledge gaps for effective anti-tobacco action.
- To lobby for and contribute towards the development of the Framework Convention for tobacco control at national and international levels.

What can you do to help?

- Do not allow the tobacco industry to put up promotional materials in your locality.
- Avoid buying goods from the stores that sell tobacco products.
- Ask people around you not to smoke. Do not feel shy, as this is your right.
- Ensure that you and your children are protected from tobacco by declaring your home a 'Tobacco Free Home'. (for further details on this campaign, please contact us)
- Try and make your working place tobacco free.
- Talk to your children's school administration and discuss it in Parent teacher meetings. Ask schools to take up this issue and declare schools tobacco free. It is important to provide information to children in a manner, which does not portray cigarettes as an adult commodity as most children view this habit to be a part of growing up.
- Write letters in newspapers and talk to your local people telling them about the hazards of tobacco use.
- Discourage people from advertising tobacco products in your area. Do not allow the tobacco industry to use the space of your residential area for posters and other exhibits.

For more information about TFI-Pakistan and other consumer protection work, please contact: **Coordinator, Tobacco Free Initiative-Pakistan**

TheNetwork
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U.S.A

Alcohol-related problems cost American society nearly $200 billion per year and cause as many as 100,000 deaths annually. The alcoholic-beverage industry's relentless marketing and powerful political influence, coupled with ineffective government alcohol policies, contribute to this ongoing public health and safety epidemic. In addressing alcohol problems, policy makers routinely have promoted a variety of education, law enforcement and rehabilitation programs that zero in on a few highly visible alcohol issues that concern individual drinking behavior. They have devoted little attention to public health policy measures that promise to help reduce alcohol problems across the board. These measures include implementing reforms of alcohol marketing and advertising to reduce the pressure on young people and heavy drinkers to drink, increasing excise taxes to reduce overall consumption – particularly among price-sensitive young consumers – and expanding requirements for the labeling of alcoholic beverages to provide consumers with a better balance of information about the drug they are consuming.

Alcohol Policies In USA

Taxation

Beer Taxes : This policy topic covers laws specifying the two major types of taxes levied on beer – "specific excise taxes" (taxes levied per gallon at the wholesale or

retail level) and "ad valorem excise taxes" (taxes levied as a percentage of the beverage's retail price).

General Information

This policy addresses beer taxes, one of three types of beverage taxes included in APIS (in addition to wine and distilled spirits taxes). Although some States have separate tax rates for other types of alcoholic beverages (e.g., sparkling wine), these beverages constitute a small segment of the market and their tax rates are not addressed by APIS.

State alcohol taxes fall into four main categories. The names applied to these categories may vary by jurisdiction, but the following terms are commonly used:

- ***Specific Excise (SE) Taxes*** – Taxes levied per gallon at the wholesale or retail level.

- ***Ad Valorem Excise (AVE) Taxes*** – Taxes levied as a percentage of the beverage's retail price (which may also be referred to as the percentage of gross receipts, gross proceeds, retail receipts or retail proceeds). Different ad valorem excise tax rates may apply to on- and off-premises sales.

- ***Sales Tax*** – A tax on goods in general rather than a tax that specifically applies to alcoholic beverages. APIS provides the sales tax rate only for those States in which: (1) a sales tax does not apply to an alcoholic beverage; and (2) an ad valorem excise tax does apply to that beverage.

- ***Sales Tax Adjusted Retail Ad Valorem Tax*** – In some States, AVE taxes are levied in lieu of sales tax. In these cases, an accurate index of the actual tax reflected in the retail price requires that the retail ad valorem excise tax be adjusted to reflect the fact that sales taxes are not levied.

Wine Taxes : This policy topic covers laws specifying the two major types of taxes levied on wine – "specific excise taxes" (taxes levied per gallon at the wholesale or retail level) and "ad valorem excise taxes" (taxes levied as a percentage of the beverage's retail price).

General Information

This policy addresses wine taxes, one of three types of beverage taxes included in APIS (in addition to beer and distilled spirits taxes). Although some States have separate tax rates for other types of alcoholic beverages (e.g., sparkling wine), these beverages constitute a small segment of the market and their tax rates are not addressed by APIS.

State alcohol taxes fall into four main categories. The names applied to these categories may vary by jurisdiction, but the following terms are commonly used:

- ***Specific Excise (SE) Taxes*** – Taxes levied per gallon at the wholesale or retail level.

- ***Ad Valorem Excise (AVE) Taxes*** – Taxes levied as a percentage of the beverage's retail price (which may also be referred to as the percentage of gross receipts, gross proceeds, retail receipts or retail proceeds). Different ad valorem excise tax rates may apply to on- and off-premises sales.

- ***Sales Tax*** – A tax on goods in general rather than a tax that specifically applies to alcoholic beverages. APIS provides the sales tax rate only for those States in which: (1) a sales tax does not apply to an alcoholic beverage; and (2) an ad valorem excise tax does apply to that beverage.

- ***Sales Tax Adjusted Retail Ad Valorem Tax*** – In some States, AVE taxes are levied in lieu of sales tax. In these cases, an accurate index of the actual tax reflected in the retail price requires that the retail ad valorem excise tax be adjusted to reflect the fact that sales taxes are not levied.

Underage Drinking

Possession/ Consumption/ Internal Posession : All States prohibit possession of alcoholic beverages (with certain exceptions) by those under age 21. In addition, most but not all States have statutes that specifically prohibit consumption of alcoholic beverages by those under the age of 21. Many States that prohibit

possession and/or consumption apply various statutory exceptions to these provisions (see below).

States that prohibit underage consumption may allow different exceptions for consumption than those that apply to underage possession.

In recent years, a number of States have passed laws prohibiting the "internal possession" of alcohol by persons under 21 years of age. These provisions typically require evidence of alcohol in the minor's body, but do not require any specific evidence of possession or consumption. Internal possession laws are especially useful to law enforcement in making arrests or issuing citations when breaking up underage drinking parties. Internal possession laws allow officers to bring charges against underage persons who are neither holding nor drinking alcoholic beverages in the presence of law enforcement officers. As with laws prohibiting underage possession and consumption, States that prohibit internal possession may apply various statutory exceptions to these provisions (see below).

APIS codes a State as having an internal possession law if its statutes or regulations prohibit a person under the age of 21 from having alcohol in her or his system as determined by a blood, breath or urine test. Laws that punish persons under the age of 21 for displaying "indicators of consumption," or for "exhibiting the effects" of having consumed alcohol, are not considered to be internal possession laws for the purpose of APIS coding.

Although all States prohibit possession of alcohol by minors, some States do not specifically prohibit underage alcohol consumption. In addition, States that prohibit underage possession and/or consumption may or may not address the issue of internal possession.

Exceptions

Some States allow an exception to possession, consumption, or internal possession prohibitions when a family member consents and/or is present. States vary widely in terms of which relatives may consent or must be present for this exception to apply and in what circumstances the exception applies. Sometimes a reference is made simply to "family" or "family member" without further elaboration.

APIS codes two types of family member exceptions. The first is an exception for either the consent or presence of a parent or guardian. The second is an exception for either the consent or presence of the spouse of a married minor.

When a statute or regulation is unclear as to which family members must be present and/or consent, APIS assumes that parents, guardians, and spouses are all included. Further detail and explanations for such statutes and regulations are provided in Row and/or Jurisdiction Notes in the comparison tables. Some jurisdictions limit family member exceptions to specific locations. For example, minors might be allowed to possess or consume alcohol with parental consent in their parents' residence, but not elsewhere.

Some States allow exceptions to possession, consumption, or internal possession prohibitions on private property. States vary in the extent of the private property exception, which may extend to all private locations, private residences only, or in the home of a parent or guardian only. In some jurisdictions, a location exception is conditional on the presence and/or consent of a parent, legal guardian, or spouse.

With respect specifically to consumption laws, some States prohibit underage consumption only on licensed premises. Because the number of underage persons who drink on licensed premises is small, APIS codes such States as having no law prohibiting consumption.

Purchase : This policy topic covers laws prohibiting minors from purchasing or attempting to purchase alcoholic beverages and laws allowing persons under age 21 to purchase alcoholic beverages for law enforcement purposes.

Most States, but not all, prohibit minors from purchasing or attempting to purchase alcoholic beverages. Note that a minor purchasing alcoholic beverages can be prosecuted for possession since, arguably, a sale cannot be completed until there is possession on the part of the purchaser. Purchase and possession are nevertheless separate offenses. A minor who purchases alcoholic beverages is potentially liable for two offenses in States that have both prohibitions.

In some States, a person under age 21 is allowed to purchase alcoholic beverages as part of a law enforcement action. These actions are checks on merchant compliance to identify merchants who illegally sell alcoholic beverages to minors. This allowance for purchase in the law enforcement context may exist even though a State does not have a law specifically prohibiting underage purchase.

Hosting Underage Drinking Parties : This policy topic covers laws that impose liability against individuals (social hosts) responsible for underage drinking events on property they own, lease, or otherwise control.

Prohibitions Against Hosting Underage Drinking Parties addresses laws that establish State-imposed liability against individuals (social hosts) responsible for underage drinking events on property they own, lease, or otherwise control. These laws often are closely linked to laws prohibiting furnishing alcohol to minors, although laws establishing State-imposed liability for hosting underage drinking parties may apply without regard to who furnishes the alcohol. Hosts who allow underage drinking on their property as well as supply the alcohol consumed or possessed by the minors may be in violation of two distinct laws: furnishing alcohol to a minor and allowing underage drinking to occur on property they control. APIS provides additional information on laws pertaining to furnishing alcohol to minors in the Furnishing Alcohol to Minors policy topic.

The primary purpose of laws that establish State-imposed liability for hosting underage drinking parties is to deter underage drinking parties. Although research on the topic is limited, what is available suggests that parties are high risk settings

for binge drinking and associated alcohol problems. Very young drinkers are often introduced to heavy drinking behaviors at these events (National Research Council Institute of Medicine, 2003). Law enforcement officials report that, in many cases, underage drinking parties occur on private property, but the adult responsible for the property is not present or cannot be shown to have furnished the alcohol. Statutes that establish State-imposed liability for social hosts address this issue by providing a legal basis for holding adults responsible for parties that occur on their property whether or not they provided the alcohol to minors.

Two general types of liability may apply to hosting underage drinking parties: State-imposed liability and private party civil liability. State-imposed liability involves a statutory prohibition that is enforced by the State, generally through criminal proceedings that can lead to sanctions such as fines or imprisonment. Private party civil liability involves an action by a private party seeking monetary damages for injuries that result from permitting underage drinking on the host's premises. Although related, these two forms of liability are quite distinct. For example, a social host may allow a minor to drink alcohol after which the minor causes a motor vehicle crash that injures an innocent third party. In this situation, the social host may be prosecuted by the State under a criminal statute and face a fine or imprisonment for the criminal violation. In a State that provides for private party civil liability, the injured third party could also sue the host for monetary damages associated with the motor vehicle crash. State-imposed liability is established by statute. Private party civil liability can be imposed either by statute or by a court using common law negligence principles. This policy topic addresses State-imposed liability for hosting underage drinking parties.

False Identification : This policy topic covers laws prohibiting the use of false identification by minors to obtain alcohol.

Retailers are responsible for insuring that sales of alcoholic beverages are made only to persons who are legally permitted to purchase alcohol. Inspecting government-issued identification (driver's license, non-driver identification card, passport, military identification) is one major mechanism for insuring that buyers meet minimum age requirements. In attempting to circumvent these safeguards,

minors may obtain and use apparently valid identification that falsely states their age as 21 or over. Age may be falsified by altering the birthdate on a valid identification, obtaining an invalid identification card that appears to be valid, or using someone else's identification.

Compliance check studies suggest that underage drinkers may have little need to use false identification because retailers often make sales without any inspection of identification [1]. However, concerns about false identification remain high among educators, law enforcement officials, retailers, and government officials. Current technology, including high quality color copiers and printers, has made false identification easier to fabricate, and the Internet provides ready access to a large number of false identification vendors.

All States prohibit use of false identification by minors to obtain alcohol. In addition to the basic prohibitions, States have adopted a variety of legal provisions pertaining to false identification for obtaining alcohol. These provisions can be divided into three basic categories:

Provisions that target minors who possess and use false identification to obtain alcohol

Provisions that target those who supply minors with false identification, either through lending of a valid ID or the production of invalid ("fake") IDs

Provisions that assist retailers in avoiding sales to potential buyers who present false identification

Government-issued IDs are used for a number of age-related purposes other than the purchase of alcohol: registering to vote, enlisting in the military, entering certain entertainment venues, etc. APIS confines its analysis to statutes and regulations relating to the use of false identification for the purpose of obtaining alcohol.

EUROPE

Every country in the European Union (EU) has a number of laws and other policies that set alcohol apart from other goods traded in its territory, often for reasons of public health. These policies take place in a specific cultural setting and are also adopted and enforced in the context of people's views on alcohol policy. These currently seem to be most in favour of controls on advertising and young people's drinking, although evidence is scarce in this area. Where a thorough European investigation has been done, most European drivers have been found to support a complete ban on alcohol use by new drivers, and many are in favour of a ban for all drivers.

Despite the ubiquity of alcohol policies, just under half the EU countries still do not have an action plan or coordinating body for alcohol. Even so, most countries have programmes for one aspect of alcohol policy, of which school-based education programmes are the most common throughout Europe. All countries also have some form of drink-driving restrictions, with everywhere except the UK, Ireland and Luxembourg having a maximum blood alcohol limit for drivers at the level recommended by the European Commission (0.5g/L). However, many European drivers believe that there is only a slim chance of being detected - a third overall believe they will never be breathalysed, although this is lower in countries with Random Breath Testing.

Sales of alcohol are generally subject to restrictions in most EU countries, in a few cases through retail monopolies but more often through licences, while the places that alcohol can be sold are frequently restricted. Over one-third of countries (and some regions) also limit the hours of sale, while restrictions on the days of sale or the density of off-premise retailers exist in a small number of countries. All countries prohibit the sale of alcohol to young people beneath a certain age in bars and pubs, although four countries have no policy on the sale of alcohol to children in shops. The cut-off point for allowing sales to young people also varies across Europe, tending to be 18 years in northern Europe and 16 years in southern Europe.

Alcohol marketing is controlled to different degrees depending on the type of marketing activity. Television beer adverts are subject to legal restrictions (beyond content restrictions) in over half of Europe, including complete bans in five countries; this rises to 14 countries for bans on spirits adverts. Billboards and print media are subject to less regulation though, with one in three countries having no controls. Sports sponsorship is subject to the weakest restrictions, with only seven countries having any legal restrictions at all.

The taxation of alcoholic beverages is another consistent feature of European

countries, although the rates themselves vary considerably between countries. This can be seen clearly for wine, where nearly half the countries have no tax at all, but one in five countries has a tax rate above €1,000, adjusted for purchasing power. In general, the average effective tax rate is highest in northern Europe, and weakest in southern and parts of central and eastern Europe. Four countries have also introduced a targeted tax on alcopops since 2004, which appears to have reduced alcopops consumption since.

When the different policy areas are combined into a single scale, the overall strictness of alcohol policy ranges from 5.5 (Greece) to 17.7 (Norway) out of a possible maximum of 20, with an average of 10.8. The least strict policies are in southern and parts of central and eastern Europe, and the highest in northern Europe – but the scores do not all decrease from north to south, as seen in the high score in France. Most countries with high policy scores also have high taxation levels, but there are some exceptions such as France (high policy score, low tax), Ireland, and the UK (both low policy score, high tax).

This picture of alcohol policy is very different from the one visible fifty years ago, with the overall levels of policy much closer together, partly due to a weakening of the availability restrictions in the northern European countries. However, the main factor in the policy harmonization is the increased level of policy in many countries, particularly in the area of drink-driving where all countries now have a legal limit. Marketing controls, minimum ages to buy alcohol, and public policy structures to deliver alcohol policy are also much more common in 2005 than in 1950. While European countries are, therefore, ahead of the world in print advertising restrictions and drink-driving limits, they are less likely to have high taxes or controls on availability such as limits on the days and hours of sales, or licences for the retail sale of alcohol.

Alcohol Policies In The Countries Of Europe

In a different way, the policies adopted by a country are also a barometer of the response to alcohol, and it is fortunate that much better data on this are available than for opinion polls. This enables a policy-by-policy comparison in a number of key areas, as well as several comparisons of the 'overall level' of alcohol policy in the countries and Europe as a whole.

The data for this come from the Global Status Report on Alcohol Policy (WHO 2004), updated by the Alcohol Policy Network which is co-financed by the European Commission. However, for some countries these policies are decided on a regional rather than country level, meaning that there is no single 'minimum age to buy alcohol in Spain', for example. In these countries (Austria, Spain and Switzerland in particular), the least strict of the regional policies is used to represent the national situation, as this was felt to reflect

better the country response than the most strict region.

Framework For The Policy

The starting point for dealing with alcohol on a country level is to decide what an alcoholic beverage is. Although there are internationally agreed definitions of alcohol for the purposes of classifying trade, most countries go further for the purposes of their own alcohol laws. In general, the countries of Europe fall into the World Health Organization's (WHO) 'low' definition band, which defines the maximum level of alcohol for a 'non- alcoholic' drink at 2% alcohol concentration or less. However, several countries (all in Northern Europe) have slightly higher definitions of 2-3%, while Romania and Slovakia do not define alcohol in this way at all. Clearly anomalous in this context is Hungary, whose definition of 5% alcohol concentration – above the level of most beers – is only significantly exceeded by two other countries in the world. In comparison, the EU's definition of alcohol for tax purposes is at least 0.5% (for beer) or 1.2% alcohol concentration (for all other drinks).

Framework for the policies

- Most countries define alcohol as less than 2% absolute volume
- Just under 1/2 of countries do not have an action plan or coordinating body
- Nearly all countries have 'moderately developed' school programmes

Risky environments

- Drink-driving: blood alcohol
- limits and enforcement
- Workplace restrictions
- Restrictions on drinking in parks and street

COMPARING ALCOHOL POLICIES

Global – How the EU compares to the rest of the world ***Policy score*** – How countries overall levels of alcohol policy compare, using the ECAS policy scale

Trends – Comparing the Europe of 1950 with the Europe of today

Market restrictions

- Monopolies and licences for production and retail
- Off-licence sales restrictions – days, hours, places, density

Tax and price

- Alcohol tax rates for beer, wine & spirits
- Taxes on alcopops
- Link of tax to the price of alcohol

Marketing controls

- Restrictions on TV, print or billboard adverts

Sports sponsorship restrictions

Young people

- Minimum legal age to buy alcohol in bars
- Minimum age in shops

The structure of alcohol policy further provides a useful background to the specific laws covered below. In just over half the EU countries this structure involves an action plan and/or a coordinating body, but this still leaves a number of other countries scattered across Europe who leave alcohol policy to the intersection of more general departments. The Global Status Report also

provides the country source's opinion of the status of alcohol awareness programmes in their country – this is a useful indication of how active the government has been, but is only a subjective measure. Bearing this in mind, it seems that EU15 states were more likely to have better developed workplace and drink-driving campaigns than EU10 states. On the other hand, only two countries – Greece and Portugal – do not have 'moderately developed' school-based alcohol programmes, suggesting that the EU10 has well-developed awareness campaigns in some areas despite lagging behind in others.

Risky environments: driving and working

One of the most common forms of alcohol policy is restricting drinking in inappropriate situations, often instigated by organisations with a remit that is broader than alcohol. The most common example of this is for drink-driving, where insurers and road safety organisations have seen alcohol as a major risk factor for driving- related damage and loss of life. Most of the EU countries have a maximum Blood Alcohol Concentration (BAC) of no more than 0.5g/L, although the UK, Ireland and Luxembourg continue to have a higher limit. Limits tend to be even lower, with three countries (Czech Republic, Hungary and Slovak Republic, as well as Romania) prohibiting any alcohol in drivers and three more having levels lower than the majority. Outside of the EU, the international community is more likely to have a limit of 0 – yet they are substantially more likely to have BACs above the EU Recommendation as well, with fewer countries lying between the two extremes. Some European countries also have different BACs for different groups, such as the 0.3g/L limit for novice and professional drivers in Spain.

An essential component of an effective drink-driving policy is enforcement, particularly using random breath testing. Data on the perceived chances of being breathalysed are available from the SARTRE project, which has been part-funded by the European Commission (Christ 1998; Sardi and Evers 2004). Across 21 EU countries (and Switzerland), nearly 30% of drivers believe they will never be breathalysed, with a further 45% believing they will only be breathalysed rarely. This correlates moderately strongly with drivers' own experiences of being breathalysed, with over 70% of drivers saying they have not been checked for alcohol in the last three years.

Although the perceived chances and experience of checks are lower in some countries than others, there appears to be no consistent geographical pattern to this – for example, drivers from Italy, Spain and Greece perceive low chances but so do those from the UK, Poland and Sweden, while those from France, Portugal and Slovenia see the chances as much higher. In contrast to the WHO's analysis of its country informant ratings, there is also no correlation in Europe

between the BAC and perceived levels of enforcement. However, a policy of Random Breath Testing made a significant difference to drivers' experiences and perceptions of alcohol checks. In the six SARTRE countries where RBT was not allowed (Germany, Ireland, Italy, Poland, the UK and Switzerland[5]), 86% of drivers had not been checked in the past three years compared to only 65% elsewhere. The effect was even stronger for drivers' perceptions – in the countries with RBT only 22% of drivers thought they would never be checked, compared to more than double this figure (46%) in the six countries without RBT.

Another frequently restricted environment is the workplace, probably due to both reduced productivity and a greater risk of workplace accidents with those who have drunk alcohol. In the certain EU countries these restrictions are nearly always in the form of a complete ban on alcohol use in the workplace, while the preference in some other countries is for voluntary or local action. Despite the absence of any controls in Greece (as well as Switzerland), the EU is much more likely to have at least a voluntary control on workplace drinking compared to the rest of the world, although as with drink-driving this is substantially less likely to be a complete ban. Similarly, bans on alcohol consumption in educational, healthcare and government establishments are often forbidden, and these follow a near-identical pattern in Europe.

A final area where drinking is often restricted is public spaces such as parks and streets. This tends to be less motivated by preventing harmful alcohol use and more focused on public disorder, nuisance, and anti-social behaviour. As such, it more often has a legal base in countries where there is strong public concern over anti- social behaviour, primarily in eastern and northern Europe (e.g. Belgium, Latvia). Elsewhere there is a roughly equal tendency to either have no restrictions, or to devolve these decisions onto a local level where they can be adapted to the particular situation in a locality. As for workplace restrictions, the EU overall is more likely than the rest of the world to have a policy but less likely to have a complete ban on public drinking (a policy pursued in Europe by Latvia alone).

Market restrictions

Retail monopolies are relatively uncommon within the EU, particularly given the EU- level cases over the past 15 years (Österberg and Karlsson 2002) – which has sometimes even induced countries to privatize in anticipation of EU membership talks, as in the case of Turkey in 2003. Only the four northern European countries maintain a retail monopoly adapted to the needs of EU/European Free Trade Association (EFTA) membership, with the majority of countries instead requiring special licences to sell alcohol. A minority of countries do not even require licences for any alcoholic drink, and these are

generally situated in a geographically continuous area of central and eastern Europe (Austria, Belgium, Czech Republic, Germany, Slovak Republic, Slovenia, Switzerland; and also Spain).

A similar pattern is visible for off-licence sales restrictions (unfortunately no comparable data are available for on-licences). The most common policy here is to restrict the places at which alcohol can be sold (for example, not within 500m of a school), which is practised in most countries. Eleven of the study countries restrict the hours of sale (for Latvia excluding beer), while six restrict the days of sale and five regulate the density of alcohol retailers (the EU figures are nine, three, and four countries respectively).

Again, a cluster of central and eastern European countries have none of these restrictions (Austria, the Czech Republic, Germany, Luxembourg and Slovakia) together with several southern European countries (Portugal, Italy and Greece; also Spain on a country basis). In contrast, Sweden, Finland and Norway have all types of restrictions (if not for all beverages). Nevertheless, this should not be understood as a simple cultural or geographical divide – for example, France has density and place restrictions that are absent in Denmark and Iceland, while some regions of Spain also strictly control off-licence sales.

Of the 14 countries with information on how these restrictions are enforced, only two (Hungary and Romania) describe rare or nonexistent enforcement. While these country-based opinions should be treated with some caution, they do suggest that enforcement is better in Europe than in the rest of the world with the exception of North America.

Controlling sales to young people

Besides the general restrictions on availability, all of the study countries have decided that only people above a certain age (16- 20) should be able to buy alcohol. This policy splits Europe cleanly into two – the Nordic countries, Denmark, UK, Ireland have a minimum age of 18 to purchase beer in a bar, while the rest opt for a lower age of 16 (the only partial exceptions are Malta (at 16), Greece (17), 3⁄4 of the Spanish regions (18) and Iceland (20)). The gap is even more striking for shop sales, with some southern/central countries sometimes not even having a minimum age, compared to the northern countries that put the limit at 18-20 years as before. This picture changes slightly when buying spirits rather than beer or wine (both on- and off-premise), as this is treated more severely by some of the central European countries leaving only those in the south of Europe with lower ages.

It is also evident that different countries view the different types and places of alcohol differently when it comes to young people. Strikingly, most countries

Table 9.1 The legal purchase age for alcohol in Europe.

B = Beer	**Min. Legal Age**					**Min. Legal Age**			
W = Wine	***On-premise***		***Off-premise***			***On-premise***		***Off-premise***	
S = Spirits	***B&W***	***S***	***B&W***	***S***		***B&W***	***S***	***B&W***	***S***
Austria	16	16-18	16	16-18	**Lithuania**	18	18	18	18
Belgium	16	18	None	18	**Luxembourg**	16	16	None	None
Bulgaria	18	18	18	18	**Malta**	16	16	None	None
Czech Rep.	18	18	18	18	**Netherlands**	16	18	16	18
Denmark	18	18	16	16	**Norway**	18	20	18	20
Estonia	18	18	18	18	**Poland**	18	18	18	18
Finland	18	18	18	20	**Portugal**	16	16	16	16
France	16	18	16	16	**Romania**	18	18	18	18
Germany	16	18	16	18	**Slovak Rep.**	18	18	18	18
Greece	17	17	None	None	**Slovenia**	18	18	18	18
Hungary	18	18	18	18	**Spain**	16-18*	16-18*	16-18*	16-18*
Iceland	20	20	20	20	**Sweden**	18	18	20	20
Ireland	18	18	18	18	**Switzerland**	16	18	16	18
Italy	16	16	16	16	**Turkey**	18	18	18	18
Latvia	18	18	18	18	**UK**	18	18	18	18

* Minimum legal age in Spain is 18 in all but 4 regions. Source: Global Status Report on Alcohol Policy (WHO 2004) and updates from the Alcohol Policy Network co-financed by the European Commission.

treat spirits more severely than beer or wine, with the exception of a few where the beverages are treated consistently. Equally, a number of countries have a more relaxed policy for off-premise sales than for on-premise, either by reducing the age to buy in shops (Denmark) or simply abandoning the age restriction altogether (Belgium, Greece, Luxembourg, Malta) – although in contrast the minimum age in Sweden is raised from 18 to 20 years for shop sales. Compared to the rest of the world (for beer only, both on- and off-premise), EU states are much more likely to have a minimum age to buy alcohol. However, countries that do have a policy choose an older age than the EU on average; in particular, a legal purchase age of 16 years is virtually unique to the EU.

While the legal purchase age has been shown to be an effective policy (see Chapter 7), levels of enforcement seem to be highly variable within Europe given the very weak relationship between perceived availability and the statutory minimum age.7 Beer is seen as the most available type of drink, and is seen as easily available by over 90% of students in central and eastern Europe (as well as Italy, Greece and Bulgaria) and over 80% of students elsewhere (except France and Turkey). Students feel spirits are much less available, yet over 80% of students still thought they were easy to get hold of in some countries (e.g. Italy, the Czech Republic) – only in the Nordic and Baltic countries (and Turkey) did the figures drop significantly.

Volume of alcohol marketing

Given the range of media containing alcohol marketing, it was decided to restrict the analysis to three of the more prominent types – national television, print media and billboards – as well as restrictions on sponsoring sports events. For each of these, country informants said whether there were:

- Voluntary agreements (also including delegated powers to regions)

- Partial legislation (by hours, type of programme/magazine, saturation limits, or place of advertisement, but not including content restrictions such as those in the EU-wide Television Without Frontiers Directive (TVWF); see Chapter 8).

- A complete ban on that form of alcohol advertising.

Given that the definition used for 'partial legislation' does not include content restrictions, and that all EU member states are legally obliged to have content restrictions in line with the TVWF Directive, it should be remembered that the discussion here concentrates on restrictions on the volume/placement of

marketing rather than its' content.

Controls on the volume of marketing

TV adverts are controlled by law in over ½ of Europe, including complete bans in five countries. One in three countries have no controls on print or billboard ads. Only seven countries have legal restrictions on sports sponsorship.

Television adverts for alcohol are subject to legal control in just over half of Europe,although this in the form of a complete ban in only five countries (of which only France and Sweden are in the EU).8 Voluntary agreements are relatively common, but these are not present where many countries have no controls at all. As with the legal purchase age, EU states – especially those in the domr countries control spirits advertising more tightly than wine or beer, to the extent that EU states are more likely to have complete bans on spirits than any of partial restrictions, voluntary agreements or no restrictions individually (although not combined). This change between drinks types is also much stronger than the rest of the world, meaning non-EU countries are more likely to have complete bans on beer TV advertising than EU states but less likely to have bans for spirits.

Controlling alcohol advertising in print or on billboards is noticeably less common than for television, with 1 in 3 European states not having any policy on them at all. Most of the uncontrolled advertising environments are found in eastern Europe (Bulgaria and Romania); as before, EU15 states often have voluntary agreements with only Greece, Luxembourg and Portugal lacking even these. Internationally the levels of voluntary agreements are only a third of the EU level, although both complete bans and complete deregulation are more frequently used. Raised restrictions for spirits are less common than for TV but are still used in five countries for print advertising and four for billboards – most strikingly, while only Norway has a complete ban on print adverts for alcohol, a further three countries have bans specific to spirits (Finland, Poland and Slovenia).

Sponsorship represents another way for alcohol producers and retailers to link brands to attractive lifestyles (see Chapter 7). However, sponsorship controls have tended to be slightly less widespread than those for television advertising, with only seven countries having any legal restrictions on sports sponsorship together with voluntary restrictions in a further five. Legal controls over youth event sponsorship are even less likely, being adopted only in six countries (Finland, France, Norway, Poland, Latvia, and Switzerland). In both cases, the EU is more likely to have some policy than the rest of the world but less likely to have legal restrictions, particularly complete bans.

TAX AND PRICE

Tax is a particularly hard policy to compare across countries due to the complexity in how it is calculated, as well as the difficulties in comparing monetary values across different contexts. To get around this, three methods have been used:

1. The rates in Euros (€) were calculated for a 'standard' strength of each drink type.9 The tax levels shown are for a given amount of alcohol rather than for the original beverage (i.e. for one hectolitre of pure alcohol – hlpa – rather than for a bottle of wine) – which enables the tax on alcohol itself to be compared.

2. These figures were converted to 'purchasing power parity (PPP)' to take into account the different costs in different countries, thereby giving a truer comparison of the impact of the tax on each country's citizens.

3. Finally, the WHO report asked country representatives around the world for the alcohol-specific tax expressed as a percentage of the shop retail price. These data are less reliable and only cover 14-19 EU countries (depending on the beverage), but allow an analysis of how the EU relates to the rest of the world.

CONCLUSION

Alcohol policy in Europe shows some striking similarities between countries – but also a number of continuing differences. For example, while all European countries have a set of policies relating to alcohol, sometimes these are uncoordinated and lacking an overarching strategy. Areas where the countries are relatively similar include blood alcohol limits for drivers, licences for alcohol sales, the existence of a minimum age at which alcohol can be purchased in bars, and some form of alcohol education in schools. In contrast, wide differences can be seen in the enforcement of drink-driving regulations (where large numbers in several countries believe they will never be breathalysed), the exact age at which young people can buy alcohol (particularly in shops), limits on availability, and advertising restrictions. Most of all, the tax rates in different European countries show an enormous variation, with the lowest rates found in southern and parts of central and eastern Europe. Despite this, it should be noted that there is not a simple north-south gradient in the strictness of alcohol policy, as seen by the high score in France and relatively low policy scores in Ireland and the UK. Controls on the availability of alcohol have declined over the second half of the 20th century, which some have argued

is associated with the growth of consumerism (Lund, Alavaikko, and Österberg)

Tax levels compared to alcohol prices are also lower in Europe than the rest of the world, a finding that must also be put in the context of the internal market policies. And while many effective policies to reduce harm are widespread in the EU today, there remain many situations where alcohol-related harm could be clearly reduced through the widespread implementation of policies that are adopted in the majority of the EU Member States.

However, it is equally important to highlight the positive trend of alcohol policy in Europe overall. Drink-driving controls in particular are now commonplace, in contrast to their relative rarity 50 years ago. To a lesser extent, a number of other policies have also diffused widely within Europe including marketing controls, minimum ages to buy alcohol, and public policy structures to deliver alcohol policy – all of which are possibly partially related to public attitudes to alcohol policy, although more research is needed in this area. And on a collective level, EU Member States are considerably closer in their alcohol policies than they were half a century ago, paralleling the harmonization in drinking levels discussed in Chapter 4. It is within this trend of improvement that the gaps should be seen, and worked upon in a positive light.

MH-2.C

STUDY ON :

ALCOHOL LAWS IN DIFFERENT COUNTRIES

-Satvika Krishnan

INDIA

Alcohol consumption has been steadily increasing in developing countries like India and decreasing in developed countries since the 1980s. The pattern of drinking to intoxication is more prevalent in developing countries indicating higher levels of risk due to drinking. 62.5 million alcohol users estimated in India

Per capita consumption of alcohol increased by 106.7% over the 15-year period from 1970 to 1996.Due to its large population, India has been identified as the potentially third largest market for alcoholic beverages in the world which has attracted the attention of multi national liquor companies.

Sale of alcohol has been growing steadily at 6% and is estimated to grow at the rate of 8% per year. About 80% of alcohol consumption is in the form of hard liquor or distilled spirits showing that the majority drink beverages with a high concentration of alcoholBranded liquor accounts for about 40% of alcohol consumption while the rest is in the form of country liquor.

People drink at an earlier age than previously . The mean age of initiation of alcohol use has decreased from 23.36 years in 1950 to 1960 to 19.45 years in 1980 to 1990.India has a large proportion of lifetime abstainers (89.6%). The female population is largely abstinent with 98.4% as lifetime abstainers. This makes India an attractive business proposition for the liquor industry.

Changing social norms, urbanization, increased availability, high intensity mass marketing and relaxation of overseas trade rules along with poor level of awareness related to alcohol has contributed to increased alcohol use.

Taxes generated from alcohol production and sale is the major source of revenue in most states (Rs.25,000 crores) and has been cited as a reason for permitting alcohol sale. Four states - Gujarat, Mizoram, Manipur and Nagaland - have enforced prohibition.Profile of clients in addiction treatment centers in 23 states (including states with prohibition) showed that alcohol was the first or second major drug of abuse in all except one state.

Revenue generated by alcohol

Large amount of revenue is generated from sale of alcohol. Yet, the hidden, cumulative costs of health care, absenteeism and reduced income levels related to heavy alcohol use are higher. These costs were estimated to be 60% more than the revenue generated in a study from Karnataka.

Work place:

· Twenty percent of absenteeism and 40% of accidents at work place are related to alcohol.

· Annual loss due to alcohol was estimated to be Rs.70 000 to 80 000 million .In a public enterprise, number of workplace accidents reduced to lesser then one fourth of the previous levels after alcoholism treatment.

Family:

· Eighty five percent of men who were violent towards their wives were frequent or daily users of alcohol. More than half of the abusive incidents were under the influence of alcohol. An assessment showed that domestic violence reduced to one tenth of previous levels after alcoholism treatment.

· 3 to 45 % of household expenditure is spent on alcohol. Use of alcohol increases indebtedness and reduces the ability to pay for food and education.

· Alcohol abuse leads to separations and divorces and causes emotional hardship to the family. The emotional trauma cannot be translated in terms of money but the impact it has on quality of lives is significant.

Alcohol Laws in India

The alcohol law in India is well –defined regarding sale and consumption of alcohol. It is believed that the laws vary from state to state and it is prohibited in states of Mizoram, Nagaland, Manipur and Gujarat, and also, in Union Territories of Lakshadweep.

Legal Drinking Age

The legal drinking ages in India vary between 18-25 years. In India, people are considered mature enough to drive and vote when they turn 18, but the legal drinking age largely varies from state to state. In western state of Maharashtra, a person is legally considered as eligible for having hard core drinks like vodka, rum, and whisky until he turns 25, whereas he can start with beer at 18. However, the minimum drinking age in Indian states of Haryana and Meghalaya are also the same. In West Bengal, Andhra Pradesh and Tamil Nadu, you can are eligible to buy a drink at the age of 21. In Goa, Kerala, Uttar Pradesh and Karnataka, you are eligible to buy a drink at 18 years. This diversity in alcohol laws are largely based on the cultural landscape of the land. Legal experts debate that the effects of age prohibitions are never judged in many of the Indian states, which has contributed to rise in young alcohol drinkers.

Drink Driving Law in India

The BAC limits are fixed at 0.03 %. Any person whose BAC values are detected more than this limit is booked under the first offense. A person may have to shell out about Rs. 2000, or he or she may have to spend at the most 6 months in jail. If a second offense is committed within 3 years of the first then a person may have to face a jail imprisonment of about 2 years or he or she may have to shell out three thousand rupees. Sometimes they have to face the both. Despite such stricter drink driving law, authorities acknowledge that many times they find it difficult to restrict and make the offenders to follow the law. The offenders tend to slip out by finding loop holes in the law.

Alcoholic Advertisements

The alcohol based advertisements are banned in India as per the Cable Television Network (Regulation) Amendment Bill, which was legalized on September 8, 2000. The government is very particular against broadcasting such advertisements in its channel Doordarshan, whereas some of the satellite channels still broadcast the alcohol advertisements.

Over the last few years Ministry of Social Justice and Empowerment have done their bit to counteract the alcohol consumption. The Ministry has combined with various other likeminded government and non-government organizations to spread awareness about dangers of alcohol amongst youngsters and other adults indulged in it.

Dry Days

Dry Days are specific days when the sale of alcohol is banned. Most of the Indian states observe dry days on major religious festivals/occasions depending on the popularity of the festival in that region. Dry days may also depend on the establishment selling alcohol. For example, generally 5-star hotels do not have to observe all the dry days that smaller bars may have to. Dry Days are fixed by the respective state government. These dry days are observed to maintain peace and order during the festival days. Dry days are also observed on and around voting days.

On dry days, sale and supply of liquor will be suspended meaning thereby all wholesalers will not make the supply of liquor and all the retail vendors will remain closed. However, service of liquor in licensed bars, hotels, clubs and restaurants is permissible even on dry days except on three national holidays. On the national holidays, even L-20 / L-49A licenses are not granted. These are special temporary licenses granted for service of liquor in parties/functions. These licenses may however, be granted on other dry days. Even on the three national holidays, liquor can be served by the hotels provided they have obtained L-3 license. L-3 licence allows hotels to serve liquor to the residents of their rooms.

There is no ban for service of liquor by anyone at his residence provided the liquor served is authorized and is within the permissible limits.

Conclusion

Drinking and driving is already a serious public health problem, which is likely to emerge as one of the most significant problems in the near future. Some database & research evidence in India is available already, which along with the international evidence be adequate for "preventive action", while the research & documentation is encouraged, specifically action research.

Strategies for prevention require to be inter-sectoral and multidisciplinary action plan-based. The various strategies for preventive action are seen as a "cascade of strategies", starting with implementation, through development of consensus, amendments to enactment of new laws.

Singapore

Alcohol law in Singapore is very strict and the country exercises stricter laws in terms of public conduct. According to recent statistics, Singapore tops the list of countries with low crime rates and it is partly due to strict alcohol and drug abuse law. Consumption or mere purchase of alcohol is not permitted to anyone below the age of 18. People who are found creating pandemonium in the public places under the influence of alcohol are subjected to heavy imprisonment of about three months and hefty fines are imposed too. Read through the blog to get familiar with the alcohol law in Singapore.

There are also strict laws regarding importing alcohol into the country. Only the alcohol which is meant for personal consumption is allowed to be imported into the country. A person has to pay hefty tax of $9.00 per liter of alcohol with 15% of alcohol.

Legalized Drinking Age and Related Problems

As indicated before, the legalized drinking age in Singapore is 18 years and anyone found violating the laws is punished severely. Despite all this the government is worried about the cases of drink abuses reported amongst the minors. According to some private blogs and articles every year hundreds of minors are admitted to hospital due to heavy drinking. Authorities believe that heavy restrictions related to drinking alcohol are driving the teenagers to go wayward. Experts believe that desensitizing alcohol will help to reduce underage drinking tendencies in teenagers. There are many organizations in Singapore like MADD, Mother Against Drink Driving, which forces the youngsters to seek parental permission before drinking. But instances have been reported when such youngsters who often seek parental permission show tendencies for heavy drinking.

Some reports suggest that binge drinking tendencies have increased among women. Frequent drinking incidents have been reported amongst women below the age of 18 and between the ages of 30-49. Also, reports suggest that due to stricter laws regarding alcohol consumption and due to various other reasons the tendencies for binge drinking has escalated amongst Singaporean population.

Also, the cases of unrecorded alcohol consumption in Singapore have been traced to 1 .0 liter pure alcohol for a population above the age of 15 years since 1995.

BAC Limits

In Singapore the BAC limits are 0.08%. The drunk driving is considered a non-compoundable offense in Singapore. Also, the law applies same for everyone, no matter who you are but punishment will be the same and harsher too. If you are caught driving under the influence of alcohol at the first instance then you may have to cough up $5000 or languish for 6 months in prison along with the humiliation of surrendering your license.

If you are a second time offender then you might be fined upto $10,000 with the imprisonment which lasts for a year and for the same time period your license will also be revoked. Subsequently the punishments will get harsher. If you are committing the offense for the third time then there are chances that you have to cough up $30,000 and 3 years of imprisonment. Also, the offenders involved in drunken driving accidents leading to death and serious accidents can be caned up to 6 strokes.

Hong Kong

Alcohol laws of Hong Kong are consistent with most common law jurisdictions, but sale of alcohol is more liberal than other countries like Canada. It is strict when compared to China (prior to 2006) and Macau where there is no legal drinking age.

Alcohol sales

Alcohol is available at licensed restaurants (any size), bars, clubs and many food retailers (mostly supermarkets). The Liquor Licensing Board of Hong Kong is responsible for licensing of alcohol serving establishments.

For consumption on-premises

The sale of liquor on a premises for consumption on that premises is not subject to any restriction on sale hours unless a special condition limiting hours is imposed by the Liquor Licensing Board on the liquor licence Cap 109 B laws of Hong Kong reg 17.

There are further restrictions if the premises are employing persons under the drinking age therein as to when they can work. —*There is no age restriction on drinking at at private residence or on drinking age at locations that are not the subject of liquor licenses. No licensee shall permit any person under the age of 18 years to drink any intoxicating liquor on any licensed premises - under Regulation 28.*

Drinking age

No licensee shall permit any person under the age of 18 years to drink any intoxicating liquor on any licensed premises. this is the primary legislation in Hong Kong under the DUTIABLE COMMODITIES (LIQUOR) REGULATIONS that speaks to the age at which a person may consume liquor in a premises that is the subject of a liquor licence: there are no other age restrictions on liquor consumption in Hong Kong however some retailers do limit sale of liquor at shops by age; others do not. There is no obligation on retailers to refuse to sell liquor to a person on the grounds of age.

Drunk driving

The law against what is known as *drink driving*, impaired driving in Hong Kong is strictly enforced. Hong Kong's maximum blood alcohol level (BAL) is 55 mg of

alcohol per 100 ml of blood, or 0.22 mg alcohol per litre breath alcohol content (BrAC)

With effect from 9 February 2009, police officers in uniform can require a person who is driving or attempting to drive a vehicle on a road to conduct a breath test without the need for reasonable suspicion. In the new random breath test operations, the Police will use pre-screening devices to conduct the test to reduce delay and inconvenience to drivers.

Fines for drivers found impaired:

- Maximum fine of HK$25,000 and imprisonment for 3 years
- Disqualification from driving for not less than 3 months on first conviction and not less than 2 years on second or subsequent conviction
- Mandated to attend a driving improvement course
- Incur 10 driving offence points

(The same penalty applies for failing to provide specimens for breath, blood or urine tests without reasonable excuse).