Tobacco and the developing world

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The opium wars of the 21st century: Tobacco and the developing world

The opium wars of the 21st centry: Tobacco and the developing worldSince the 1964 report of the Surgeon General's Advisory Committee on Smoking and Health 38 million adults in the United States have quit smoking (1) During the 1990's, the retreat of cigarette companies has become a near rout in some industrialized countries. The tobacco industry, quite to the contrary, is not on its knees nor about to surrender. Its long range global strategy is to maintain sales roughly constant in industrialized countries, while investing mammoth resources to increase market share in the Third World, in the former Soviet Union and in Eastern Europe. The struggle against tobacco is not being won, it is being relocated. In the past decade United States tobacco consumption dropped 17 percent while exports have skyrocketed 259 percent. At present, the two American giants, Philip Morris and R.J. Reynolds sell more than two thirds of their cigarettes overseas and half their profits come from foreign sales. (2)

The tobacco wars of the next century will increasingly be waged among vulnerable populations ill equipped to cope with the slick marketing techniques and the dirty tricks perfected by the tobacco industry. Most developing countries have no advertising controls, lack adequate health warning requirements, and have a dearth of pressure groups campaigning for stricter tobacco controls. They have set no age limits, nor imposed restrictions on smoking in public places. Their populations are poorly educated on the health hazards nor is information being provided to the burgeoning numbers of teen-agers who are most susceptible to advertising hype.

Tobacco already exacts an inordinate toll in the developing world. In Mexico, according to the Center for Disease Control (CDC), death rate for all smoking related disease has increased substantially, ranging in mortality increases of 60% for cerebrovascular disease to 220% for lung cancer. (3) In Brazil cigarette-related disease now leads infectious diseases as the principal cause of death.(4) In Bangladesh, as a result of increased smoking, cancer of the lung has become the third most common cancer among men and perinatal mortality is 270 per 1000 /children of smoking mothers-more than twice the rate for children of nonsmokers. (4) In India, a six-fold increase in mortality from bronchitis and emphysema has been noted, coincident with that country's skyrocketing cigarette consumption.(4,5) In developing countries, not only is the use of tobacco surging, but the cigarettes are more addictive and more lethal because of higher tar and nicotine content.

In Asia smoking is growing at the fastest rate in the world accounting for half of global cigarette use . The largest number of recruits are among the young and women. (6) The tobacco industry finds the Asian market particularly inviting because of its size and the love for smoking. In China 61 percent of men and 10% of women over 15 now smoke. These 320 million smokers consume 1.7 trillion cigarettes annually. While the Chinese account for a third of all smokers world wide, as yet this lucrative market has not reached its potential limit. The staggering health costs is a reckoning for the future. The Chinese Academy of Preventive Medicine forecasts 3.2 million deaths annually by the year 2030. (7, 8)

The United States has played a key role in promoting the global consumption of tobacco. More than a century ago the American tobacco magnate James B. Duke entered China. (9) Until his arrival very few Chinese smoked, mostly older men using a bitter native tobacco, usually in pipes. Duke hired "teachers", who traveled from village to village in Shantung province, marketing a milder North Carolina tobacco leaf and instructing curious onlookers how to light up and hold cigarettes. Duke installed the first mechanical cigarette-rolling machine in China and unleashed a panoply of promotional materials, including cigarette packs displaying nude American actresses. He set the precedent of having the United States government pressure the Chinese to permit the import of American cigarettes.

Pushing deadly merchandise abroad if anything it has intensified in recent years. In 1985 when US began its campaign to open Asian markets to tobacco exports, it shipped 18 billion cigarettes; by 1992 the figure had risen to 87 billion or nearly five-fold. The US government, while discouraging smoking at home, successfully pressured Japan, Taiwan, South Korea and Thailand into breaking their domestic tobacco monopolies to allow the sale of American cigarettes.(6) These national monopolies did not advertise and sold cigarettes largely to male adults. After US companies penetrated their markets smoking soared among young people. Two years after the entry of American cigarettes in Japan, their import increased by 75 percent with 10-fold increase in the number of television advertisements to encourage smoking. The US broke a healthy taboo against smoking by Japanese women. In but a few years the number of women smokers more than doubled. (6, 10)

In a single year after the ban against American tobacco was lifted, smoking among Korean teenagers rose from 18.4 to 29.8 percent and more than quintupled among female teens, from 1.6 to 8.7 per cent. (2) A poll among two thousand high school students in Taipei, Taiwan indicated that 26% boys and 1% of girls smoked a cigarette. After American tobacco companies entered their market in a survey of eleven hundred high school students, the figures shot up to 48 percent of boys and 20 percent of girls. (6) Words like Marlboro, Winston, Salem, and Kent have entered the vocabulary of every Asian nation.

The American government engaged in activities that would have provoked outrage if carried out in its own country. The US Trade representative refused the Taiwanese proposal not to allow advertisement in magazines read primarily by teen-agers. (6) The Taiwanese were not permitted to move the health warnings from the side to the front of the package nor increase the type size, nor were they allowed to prohibit wending machine sales. An unconscionable American trade imperialism fuels the rise in smoking. This prompted the former U.S. Surgeon General, Dr. C. Everett Koop to say about his country, "People will look back on this era of the health of the world, as imperialistic as anything since the British Empire-but worse." (10).

Even without the exercise of government muscle on their behalf, the tobacco titans present a formidable challenge to an unwary public. Tobacco promotion is pursued aggressively in less developed countries, with advertising budgets for many countries surpassing national funds appropriated for health research. The tobacco companies invest prodigious resources in targeting women and children. According to a recent editorial in the New York Times, "Hong Kong is one of the battlefronts of the modern-day Opium War. While Britain went to war last century to keep its Indian-grown opium streaming into Chinese ports, today American tobacco companies win profits and build addiction throughout Asia." (11)

In Hong Kong, where American tobacco blends make up 94 percent of the market, hip clothing stores pass out cigarettes free to their customers. Advertising is geared to the young in Asia by sponsoring sporting events and pop concerts with free disco passes given out in return for empty cigarette packs. The Marlboro bicycle tour is the biggest national summer sport in the Philippines. (5) Salem cigarettes sponsor a "virtual reality" dome, where teenagers attack each other with laser guns. (12) Empty packs of American cigarettes can be redeemed for tickets to movies, discos and concerts. In Kenya, cigarettes with brand names such as Life and Sportsman are promoted as the passport to success, health, and a Western lifestyle(13). In Taiwan, most smokers prefer Long Life, Prosperity Island, or New Paradise.(14)

The financial stakes are enormous. The international trade in tobacco is dominated by six multinational conglomerates, three of which are based in the United States (Philip Morris, RJ. Reynolds, and American Brands). Together, these six companies account for 40 percent of the world cigarette production and almost 85 percent of the tobacco leaf sold on the world market.(15) Since 1970, as American domestic smoking rates began to decline, intensive marketing campaigns supported by vast governmental resources tripled America's export of tobacco. Sales of Philip Morris in Africa is growing at 20% per year. It is projected that international sales of Philip Morris will jump 16% in 1997 to 764 billion cigarettes with a projection of 1 trillion by the year 2000. Foreign smoking is the major reason for the profitability of Philip Morris with earnings of $6.3 billions in 1996. This company now ranks third in profitability in the US behind Exxon and General Electric. By virtue of their great wealth the tobacco conglomerates are a world power having more political clout than a majority of developing nations.

From a public health perspective what is happening in the developing world is an unprecedented calamity. We know but little of the full impact of smoking on malnourished disease-ridden people. There is evidence that tobacco may interact synergistically with infectious diseases and with environmental hazards to cause increases in certain cancers. For example, tuberculosis which is widespread in developing countries, may enhance the risk of lung cancer and is further amplified by smoking. (16)) In Egypt, Schistosoma haematobium has been associated with an increased prevalence of bladder carcinoma among smokers (17) In less-developed countries, poorly controlled occupational hazards, such as organic dusts, uranium, or asbestos, may act as synergistic co-carcinogens in workers. (5) In addition, the health costs of fires resulting from cigarette smoking in countries where dwellings are often constructed of highly flammable materials is part of the tragic impact of tobacco.

The burden of disease due to tobacco is incalculable. Richard Peto and colleagues, (18) suggest that by the year 2025 mortality ascribable to global tobacco use will exceed 10 million annually and about 70% of the deaths will be in the developing countries. Such colossal mayhem is unprecedented in the annals of human barbarism. Cigarettes can not be permitted as a trade weapon that wastes the lives of unwitting victims to enrich the coffers of corporate America. The world has outlawed chemical weapons but tobacco is far more deadly. United States health professionals have an awesome moral burden to speak out and unrelentingly combat this global scourge. op

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Worldwide trends in tobacco consumption and mortality

World Health Organization

TOBACCO: THE TWENTIETH CENTURY'S EPIDEMIC

Every ten seconds, somewhere in the world, tobacco kills another victim. If current smoking trends continue, this toll will increase up to one tobacco-caused death every three seconds over the next thirty to forty years.

Recent data have confirmed that the risks of smoking are substantially higher than previously thought. With prolonged smoking, smokers have a death rate about three times higher than nonsmokers at all ages from young adulthood. Tobacco products are known or probable causes of over two dozen diseases or groups of diseases. If, as is likely, much of the excess mortality from these diseases is directly attributable to tobacco use, then this implies that the lifetime risk of a smoker being killed by the use of tobacco products is at least 50%. Therefore, a lifelong smoker is as likely to die as a direct result of tobacco use as from all other potential causes of death combined!

Other problems ensue because the negative health consequences of tobacco are not as immediate as with other hazardous substances. The health risks of tobacco are vastly underestimated by the public, and even by many of those who are responsible for protecting and promoting public health. Yet the risks of smoking are very high when compared to other risks faced in everyday life (See Table 1). Widespread underestimation of risks associated with tobacco use, is a major reason why tobacco products are still widely available, and why lenient tobacco policies have been allowed to occur. But nothing can alter the fact that tobacco use is one of the major public health challenges facing the world as it enters the twenty-first century.

TOBACCO USE IS A KNOWN OR PROBABLE CAUSE OF DEATH FROM:

Cancers of the:

- Lip, oral cavity and pharynx
- Oesophagus
- Pancreas
- Larynx
- Lung, trachea and bronchus
- Urinary bladder
- Kidney and other urinary organs

Cardiovascular diseases:

- Rheumatic heart disease
- Hypertension
- Ischaemic heart disease
- Pulmonary heart disease

- Other heart diseases
- Cerebrovascular diseases
- Atherosclerosis
- Aortic aneurysm
- Other arterial diseases

Respiratory diseases:

- Tuberculosis
- Pneumonia and influenza
- Bronchitis and emphysema
- Asthma
- Chronic airway obstruction

Paediatric diseases:

- Low birth weight
- Respiratory distress syndrome
- Newborn respiratory conditions
- Sudden infant death syndrome

Tobacco products have no safe level of consumption, and are the only legal consumer products that kill when used exactly as the manufacturer intends. Researchers have rated nicotine as even more addictive than heroin, cocaine, marijuana or alcohol. The Tenth Revision of the International Classification of Diseases reserves classification F17.2 for "tobacco dependence syndrome". Yet tobacco products continue to be aggressively marketed by tobacco companies. The result is that global tobacco consumption has doubled since medical science conclusively proved, 30 years ago, that these products were unrivalled killers. And consumption is still increasing in many areas of the world.

An analysis of trends in cigarette consumption for WHO regions indicates that the two regions with the highest average per capita (adult) consumption in 1990-1992 were Europe (2290 cigarettes per adult per year) and the Western Pacific (2000). The lowest consumption was observed in the African Region (540). For the developed countries as a whole, per capita adult consumption is currently about 2400 cigarettes, which is still significantly greater than the average consumption in the developing world (1370 cigarettes).

The gap is rapidly narrowing, however. In 1970-1972, consumption per adult in the developed countries was 3.25 times higher than in the developing world (see Figure 1). By 1980-1982, this ratio had narrowed to 2.38, and by 1990-1992, to 1.75. During the last decade, per capita consumption has declined by an average of 1.4% per year in developed countries, but has risen by 1.7% annually in developing countries. If these trends were to continue, consumption of cigarettes per adult in the developing world will exceed levels in the developed world some time between the years 2005 and 2010, i.e., within two decades.

There have been very noticeable differences in trends among WHO regions. Over the last decade, the fastest decline in per capita consumption occurred in the Americas. Nor was this entirely due to declines in consumption in Canada and the United States of America; excluding those two countries, per capita consumption in the Region still declined by an annual average of 1.7%. On the other hand, the increasing consumption in the Western

Pacific (2.2%) and South-East Asia (1.8%) is primarily due to the trends in China and India respectively. From 1983, per capita (adult) consumption in China rose by 3.9% per year to reach 1990 cigarettes in 1990-1992. In India, where about 90% of cigarettes are consumed in the form of bidis (traditional hand-rolled cigarettes), adult consumption has risen by about 2% per year over the last decade and now exceeds 1200 cigarettes (including bidis).

WHO estimates that there are about 1100 million regular smokers in the world today. About 300 million (200 million males and 100 million females) are in the developed countries, and nearly three times as many (800 million: 700 million males and 100 million females), in developing countries. In developed countries, 41% of men are regular smokers, as are 21% of women (see Figure 2). Half the men living in developing countries are smokers, compared with about 8% of women.

The health consequences of the smoking epidemic in developed countries have been quantified by WHO, in close collaboration with the Imperial Cancer Research Fund's Cancer Studies Unit at the University of Oxford, UK. A major report giving detailed estimates of the numbers and rates of smoking-attributed deaths for over 50 countries or groups of countries, has been published. Between 1950 and 2000, it is estimated that smoking will have caused about 62 million deaths in the developed countries (12.5 % of all deaths: 20% of male deaths and 4% of female deaths). More than half of these deaths (38 million) will have occurred at ages 35-69 years. Currently, smoking is the cause of more than one in three (36%) male deaths in middle age, and about one in eight (13%) of female deaths. Each smoker who dies in this age-group loses, on average, 22 years of life compared with average life expectancy. During the 1990s, the report estimates that almost 2 million people a year will die from smoking in developed countries (1.44 million men and 0.48 million women).

As regards cigarettes the health consequences of tobacco use are much more difficult to estimate in developing countries owing to lack of data. Currently, it is estimated that tobacco causes about 1 million deaths a year in developing countries, but there is substantial uncertainty about this figure. If current trends continue, and if the risks of death from tobacco use are similar in developing countries to those that have been observed in the industrialized world, then the annual toll of mortality from tobacco will rise dramatically to around 7 million deaths per year in the 2020s or early 2030s (see Table 2). The chief uncertainty is not whether, but rather when, these deaths will occur if current trends in tobacco use persist.

Table 2. Estimated number of Deaths caused every year by Tobacco

	Decade 1990s	Decades 2020s/early 2030s
Developed countries	2 million	3 million
Developing countries	1 million	7 million
Total	3 million	10 million

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UICC *GLOBALink*

The International Tobacco-Control Network Selected documents: The Death Toll form Tobacco - A Crime Against Humanity

September 1998

Deaths caused by smoking

There are between 1.1 -1.4 billion smokers in the world out of a total population of around 5.8 billion. It has been estimated that 50% of smokers will die prematurely from tobacco related illness, half in middle age (defined as 35 - 69 years of age) with an average loss of life expectancy of 20 - 25 years (8 years over all ages).

This means that over half a billion people (in excess of 500 million) or about 10% of the existing population will die from smoking. Of these, 27% will die from lung cancer, 24% will die from heart disease, 23% will die from chronic obstructive lung disease, emphysema or bronchitis and the remaining 26% will die from other diseases including other circulatory disease (18%) and other cancers (8%).

Currently, 3 million people worldwide die every year from smoking related disease. This represents about 1 person every ten seconds. One third of all people aged fifteen years and over smoke and this proportion is increasing in Asia, Eastern Europe and the former Soviet States. Consumption trends indicate that smoking prevalence is reducing in developed countries (DCs) (down 1.5% per annum in the United States) whilst increasing in lesser-developed countries (LDCs)(up 1.7% per annum on average).

The World Health Organisation (WHO) has estimated that, based on current trends, the death toll from smoking will rise to 10 million people per year by the year 2025. Currently two million deaths occur each year in developed countries and 1 million deaths occur each year in lesser-developed countries. By 2025 this proportion will alter to 3 million deaths per year in developed countries and 7 million deaths per year in lesser-developed countries. No other consumer product in the history of the world had come even close to inflicting this degree of harm on the world community. If anything else posed a threat to life of this magnitude whether human induced or naturally occurring - be it world war, genocide, ethnic cleansing, natural disaster or disease - it would demand immediate international action. The response to HIV, the prosecution of war crimes (both current and dating back to World War II), germ warfare, nuclear weapons or even climate change are but a few examples.

The history of the smoking pandemic of the 20th century can be traced back to the invention of the mechanical cigarette machine in the late 1800's. Until that time cigarettes were rolled by hand, production was low and smoking was not overly prevalent. The cigarette machine meant that millions of cigarettes could be produced each day at a lower cost and distributed more widely. The result was that cigarette smoking increased such that by the late 1940's smoking rates in developing countries were up to 70% in adult males and up to 25% in adult females. Smoking rates in LDCs were significantly less.

From the discovery of the link between increased smoking and disease in the early 1950's, and major reports publicising the need for public health action, smoking rates among adult males in developed countries has declined although prevalence in adult females increased to some degree

but now the levels are roughly equal at about 25% in many developed countries. Meanwhile, smoking rates in lesser-developed countries has increased in both the adult male and adult female population.

Due to the latency in the development of disease from smoking, the effects were first detected among adult males in developed countries. The effect of increased smoking among adult females is now being reflected in disease rates with similar observations in lesser-developed countries. Hence the WHO estimates by the year 2025.

Transnational tobacco companies

Tobacco consumed by the world's 1.1 - 1.4 billion smokers is produced by a handful of transnational tobacco companies and a number of state owned manufacturers. China's state owned production accounts for 31% of all tobacco sales with Italy, Russia, Japan, Taiwan, Indonesia and Thailand, amongst other countries, having substantial government owned factories as well.

However, transnational tobacco companies account for 40% of the global market and control 70% of world production, and this is increasing. In many cases, the state owned producer was a state monopoly but, increasingly, this has been broken down through free trade agreements to a point where transnational tobacco companies are not only marketing in countries previously the subject of a state monopoly but there are reports of expressions of interest by transnational tobacco companies in obtaining an interest in formerly state owned monopolies now being privatised.

Whilst all tobacco consumption contributes to the overall death toll, state owned production is arguably an internal matter to the nation - state in question. The activities of privately owned, transnational tobacco companies is a matter on international concern. The major transnational tobacco companies, in order of sales, are: US based Philip Morris Inc., followed by British based BAT Industries p.l.c., United States based RJR Nabisco and Rothmans. Under agreements apparently reached among these transnational tobacco companies, Rothmans does not market in the United States and BAT does not market in Britain. There are reports that Philip Morris and BAT have entered into collusive agreements that fix cigarette prices and divide markets in South America (apparently such anti competitive arrangements are not illegal in those countries). It is a mark of the power of the major transnational tobacco companies that they can reach such agreements dividing up markets in sovereign nations consequently inflicting the harm identified above. In 1996, Philip Morris had annual revenues of $55 billion, just over half from tobacco with the rest coming from domestic and international food and alcohol sales. Only 18% was from domestic tobacco sales (20% in 1992) compared with 35% from international sales (21% in 1992). Total tobacco sales comprised 53% in 1996 (41% in 1992) or about 23 billion. BAT revenue in 1996 was $23 billion. RJR Nabisco had total revenues of $17 billion in 1996 of which 48% or about 8 billion was from tobacco sales. These massive levels of turnover and the economic, political and social influence of the transnational tobacco companies has led to the industry being described collectively as "Big Tobacco". A comparison is made that these revenues exceed the gross domestic product of many countries. For example, Philip Morris has a turnover larger than the GDP of Ecuador, Guatemala, Kenya, Kuwait, Malaysia and Peru. It is roughly the equivent of Ireland, Singapore or Hungary. RJR Nabisco's turnover is roughly the equivalent of the GDP of Costa Rica, Croatia, Cuba, El Salvador, Lebanon or Jamaica. Whilst these companies undoubtedly have significant economic, political and social influence, the fact remains (with all due respect to the countries with which comparison is made), these transnational tobacco companies, either individually or collectively, are not an overwhelmingly dominant force on a world scale.

Deceit and duplicity of the tobacco industry

The current status of the tobacco industry is anomalous insofar as cigarette consumption clearly inflicts a degree of mortality totally at odds with fundamental human rights and human values. At the same time the tobacco industry defends itself on the basis that tobacco is a "legal product". This occurred because the tobacco industry had already acquired a substantial degree of economic, political and social influence by the time the link between smoking and disease was established. Since that time the tobacco industry worldwide has engaged in a deliberate campaign of deceit and duplicity to protect and even expand its influence through a process of denial and disputation of the now proven link between smoking and disease, the addictive properties of nicotine and their marketing strategies directed at youth.

This deceit and duplicity is currently being exposed by litigation in the United States which is spreading worldwide. The position has now been reached where continued disputation and distortion is untenable, particularly in the face of the projected increase in tobacco deaths by the year 2025 if current trends are continued. This is all the more so given the disparity in the projected increase between developed and less developed countries, reflecting an exploitation of lesser developed countries which will only increase to offset liabilities the tobacco industry is incurring in the United States. This is a circumstance calling for international action. It must not be allowed to happen. Were it to occur it would be, without doubt, a crime against humanity.

Crimes against humanity in the International Criminal Court

On 17 July 1998 the United Nations Rome Statute of The International Criminal Court established a permanent Court having power to exercise jurisdiction over persons for the most serious crimes of international concern. Article 5 confers jurisdiction on the International Criminal Court with respect to the following crimes:

1. The crime of genocide;
2. Crimes against humanity;
3. War crimes;
4. The crime of aggression.
5.

For the purposes of the Statute, Article 7 defines a "crime against humanity" to mean any of the following acts when committed as part of a widespread or systematic attack directly against any civilian population, with knowledge of the attack;

1. Murder;
2. Extermination;
3. Enslavement;
4. Deportation or forcible transfer of population;
5. Imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law;
6. Torture;
7. Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation, or any other form of sexual violence of comparable gravity;
8. Persecution against any identifiable group or collectively on political, racial, national ethnic, cultural, religious, gender as defined in paragraph 3, or other grounds that are universally recognized as impermissible under international law, in connection with any act referred to in this paragraph or any crime within the jurisdiction of the Court;

9. Enforced disappearance of persons;
10. The crime of apartheid;
11. Other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

Given what is known about smoking and disease and the deceit and duplicity of the tobacco industry, were the death toll from tobacco to increase from 3 million a year to 10 million a year by the year 2025, especially with the dramatic increase in lesser developed countries from 1 million a year to 7 million a year, it is impossible to describe that consequence as anything other than the result of an inhumane act of a character similar to murder, causing great suffering, or serious injury to body or to mental or physical health committed as part of a widespread or systematic attack directed against the civilian population of the world.

Given that the directors and executives of the major transnational tobacco companies must now have knowledge of the consequences of their activities, if those activities continue then each and every one of them must face the prospect of being charged with committing a crime against humanity in the International Criminal Court. Article 11 of the Statute provides that the Court has jurisdiction only with respect to crimes committed after the entry and the force of the Statute. This means that the opportunity exists for these directors and executives to escape liability under the provisions of the Statute providing there is no increase in mortality from tobacco use. Arguably they should be responsible for a reduction. Given the likely increase in mortality from past smoking, because of the latency of tobacco related disease, every effort would need to be made to reduce consumption in order to avoid a significant increase in the current death toll. Certainly expansion in lesser-developed countries should not occur. As a means of securing this outcome, each of the major transnational tobacco companies, and each of their directors and executives, should formally be put on notice of the consequences of their activities such that charges of a crime against humanity can be laid and successfully prosecuted if radical action is not taken to reverse current trends.

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Globalization and Increasing Trend of Alcoholism *

1. Introduction

Although alcohol consumption has existed in India for many centuries, the quantity patterns of use, and resultant problems have undergone substantial changes over the past two decades. Alcohol consumption produces individual health and social problems. The global burden of disease from alcohol exceeds that of tobacco and is on a par with the burden attributable to unsafe sex world wide (Global Status Report on alcohol, WHO, 1999). Although recorded alcohol consumption per capita has fallen since 1980 in most developed countries, it has risen steadily in developing countries and alarmingly so in India. The per capita consumption of alcohol by adults of 15 years and above in India increased by 106.67 percent between 1970-72 and 1994-96!

2. Alcohol industry

Based on beverage type the Indian alcohol industry has three prominent sectors: The IMFL (Indian Made Foreign Liquor) and beer sector, the country liquor sector, and the illicit liquor sector. The IMFL and beer sector is the most visible part of the alcohol Industry, with a few large companies with multiple production units and nation wide marketing networks. These companies control much of the market. They have been present in India for several decades and have established several brand names regionally or nationally. These companies aggressively advertise and promote their brands and their corporate identities, and constantly monitor and protect their products and market shares. They are also cash rich, since profit margins are high in this industry.

Beginning in 1992 under liberalized industrial laws, some Indian alcohol companies developed collaborative ties with international corporations. Joint ventures have been established to use local production capacity to manufacture international brands under a technology transfer and licensing system. These joint ventures have served a dual purpose: they have brought international alcohol brands to India, and they have utilized the existing production and marketing strengths of Indian Industry. Hence they have been mutually supportive. Nearly all of the major transnational alcohol companies now have a presence in India and many internationally popular brands of whisky and beer have become available. The upper middle and higher socioeconomic classes now purchase these 'famous' brands locally rather than having to carry these back from trips to other countries or to buy them from illegal importers. The price of these products remains high, but since they carry high social prestige value, there is good demand in this premium range.

With liberalization and globalization, foreign liquor has become freely available. The IMFL and beer industry spends much effort and money to promote and advertise their brands. Since direct advertisement of liquor was not permitted in the print and electronic media, the industry has found methods to advertise indirectly (Saxena, 1994). Alcohol brands are advertised in the form of same or similarly named other products (e.g. mineral water, soda, and playing cards) made by the same company. The advertisements

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**Compiled by Mr. S D Rajendran, Community Health Cell for the Asia Social Forum, 2nd – 7th January 2003, Hyderabad. India.*

display the alcohol product prominently. In addition, beverage ads have become common on satellite cable television beamed to India from neighboring countries. IMFL and beer producers also financially sponsor major sporting events that attract sustained media attention, including live television coverage of the event. With its new international linkages, the Indian alcohol industry has also got into the entertainment and fashion world. It is now common for a liquor company to sponsor a fashion show or musical event. Hence the Indian IMFL and beer industry has initiated a high level of sustained marketing and promotional activities and these have become especially aggressive in the 1990s.

The Indian alcohol industry produces a large amount of revenue for the government. It has been estimated that direct collections of excise and sales tax are approximately US$ 5 billion per year for the country as a whole. In Karnataka, it is approximately Rs. 2400.00 crores per year. States derive as much as 25% of money from alcohol sales for their annual budget. Besides the generation of legal revenues for the government, the alcohol industry is thought to create an approximately equal sum in "black money" that takes the form of bribes, protection payments and profits from illicit alcohol. This gives the alcohol industry enormous political power and clout, which may be used to help influence and maintain government policies 'beneficial' to the industry but harmful to the people. Studies indicate that the losses borne by household, states and the nation out weigh financial gains.

Table 1: Annual Distilled Spirits Production in India, by Year (April to March)

Year	AMOUNT OF ABSOLUTE ALCOHOL PRODUCED (IN THOUSANDS HECTOLIRES)
1982 – 83	2862.55
1983-84	3104.75
1984—85	3310.64
1985-86	3407.49
1986-87	3204.80
1987-88	3432.48
1988-89	4190.45
1989-90	No data available
1990-91	No data available
1991-92	4895.00
1992-93	3467.00
1993-94	3626.00
1994-95	6056.00
1995-96	7888.04

Source: Alcohol and Public Health in 8 developing countries, WHO, Geneva, 1999.

3. Alcohol – Related Problems

It is probable, given equal amounts of drinking, that developing countries like India experience more problems than developed countries (Saxena, 1997). Among the reasons for this may be such things as a highly skewed distribution of drinkers in the society, the prevalence of nutritional and infectious diseases, economic deprivation, more hazardous and accident-prone physical environments, and lack of any organised support system. Although conclusive scientific evidence for alcohol related health and social problems is lacking for India, there are enough

indications in the available literature to infer that these are substantial. Women's sanghas participating in a women health empowerment training in several districts in Karnataka have consistently said that the biggest problem they face relate to alcohol abuse. Community health groups in different parts of the country also recognize the importance of the problem. The rapid rise in alcohol consumption in recent years has increased the likelihood of further growth of the following health problems in the years to come.

3.1 Health problems include

- Cirrhosis of the liver and premature death
- Cardiomyopathy
- Cancer of the upper gastrointestinal tract
- Pancreatitis
- Cognitive impairment or neuropsychiatric disorders
- Road traffic accidents and injuries
- Nutritional deficiencies and infections
- HIV infections and STD
- Hypertension

3.2 SOCIAL PROBLEMS

Excessive drinking produces a variety of closely inter related social problems in India. For ease of description these have been divided into the following broad categories.

3.2.1 *Violence and Crime*

Violence within and outside the home is frequent in India and a substantial proportion of it is alcohol – related. Wife beating and child abuse under the influence of alcohol are common, and street brawls and group violence happen often after drinking

3.2.2 *Workplace effects*

Heavy drinking affects work performance in a number of negative ways. When compared to their sober counterparts, drinkers are more frequently absent, are less efficient, have more accidents at work, and also show maladjustment with other workers which leads to over all decreased performance.

3.2.3 *Economic Effects*

While alcoholic beverages are less expensive in India, their purchase may still require a substantial portion of a poor persons meager income. With one in three people in India falling below the poverty line, the economic consequences of expenditures on alcohol attain special significance. Besides money spent on alcohol, a heavy drinker also suffers other adverse economic effects. These include reduced wages (because of missed work and lowered efficiency on the job), increased medical expanses for illness and accidents, legal cost of drink-related offences, and decreased eligibility of loans. Most individuals with severe alcohol dependence find it difficult to reduce their expenditure on drink, and hence their families often must do without essential necessities. Although the overall economic

effect of alcohol use at the national level has not been estimated, it is likely that it represents a substantial proportion of India's national income.

3.2.4 *Family Effects*

Excessive drinking by one or more family member results in several negative consequences for others in the family, especially for the wife and children of a male drinker. These effects are particularly serious for poor families. As has been mentioned above, much of the family income may be used to buy alcohol, wages may decline, and the drinker may eventually lose his job. In such situation the wife and children are forced into work, often in low paid, hazardous jobs. Children may be unable to continue their schooling and may also suffer from nutritional deficiencies because there is not enough to eat at home. Wife and child battering are common, which lead to physical and mental trauma. Failure of the man to use contraceptive methods often leads to unwanted pregnancies, further increasing family size. These factors contribute towards greater poverty, often to the point of destitution.

Strong family ties and social disapproval of divorce save many of these families from a formal breakdown, but the prevalence of intermittent or prolonged marital separation, as well as suicide, in heavy drinking families is high. Problems faced by wives of alcoholic men have been studied scientifically by Gambat et al. (1983), but the many descriptive accounts by the lay press offer more vocal testimony of these phenomena. Wives of alcoholic men show a high degree of depression (Devar et al., 1983) and of suicide (Ponnudurai & Jayakar, 1980)

4. Govt. of India Response

Govt. of India should seriously think about the alarmingly increasing alcohol related problems and work towards developing a clear-cut and comprehensive Alcohol Policy.

The Indian Charter on Alcohol should be adopted with the following principles, which would be agreed upon by all the health ministries of the States:

1. **All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.**

2. **All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.**

3. **All the children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.**

4. **All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.**

5. **All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non – drinking behavior.**

5. National Master Plan

The government of India formed an expert committee in 1986 to develop a comprehensive strategy for reduction of both supply and demand of all substances of abuse, including alcohol. The details of the master plan and its position on alcohol – related issues are not yet available. Again Govt. of India should review the National Master Plan and revise it for up to date condition. This plan should be implemented through Primary Health Centres and through health workers. It should contain the following broad areas:

1. Training to PHC doctors and Health Workers
2. Raise awareness of the effects of alcohol in rural areas
3. Arrange community based de-addiction treatment involving family members and the community
4. Proper after care should be provided with the family and community support
5. Introduce Life Skills programme in high schools to increase the ability of young people to meet the needs and challenges of every day life and avoid high risk behaviors
6. Provide and / or expand meaningful alternatives to alcohol and drug use and increase education, training and networking among community development workers ad organisations.

In monitoring and implementing the above plan, the local NGOs and community action groups should be encouraged to participate fully.

6. Conclusion

Globalisation is based on commercial interests, which want to increase the consumption of alcohol. They promote the expansion of drinking into new social context and situations. Their central perspective is that of the market, seeing developing countries as 'emerging markets'. Drinking is shown as a symbol of 'cosmopolitan outlook'. European and North American life styles are presented glamorously and attractively. We have to counter them. Globalisation has brought in global methods of manufacture, distribution, advertisements and promotion of alcohol consumption. We have to adopt or adopt global strategies to reduce alcohol consumption and its ill effects on the health and social life of our people. While interventions for primary prevention and community health based approaches are required along side medical deaddiction approaches, it is imperative that social movements also address the broader policy aspects and economic underpinnings of the problem.

PH-12

Towards Tobacco Control in a Globalised Economy

The 21st century witnessed the world markets being thrown open to free trade rules, raising alarming consequences especially to the developing world. Nevertheless, it worked to the benefit of certain interest groups in the market, one of the prominent among them being the tobacco industry.

The form, nature and the magnitude of the tobacco industry varies from country to country. But globalisation, has primarily given them all access to the global market, thereby expanding their business territories and areas of operation.

The Multinational Tobacco Industry

Tobacco industry today spans across seas, with companies like Philip Morris (PM), British American Tobacco (BAT) and Japan Tobacco expanding its horizons way beyond their countries of origin. These cigarette majors have managed to take their brands to remote corners of the world either through large buyouts of domestic tobacco companies or by opening up subsidiaries and branches. For example, in India, Philip Morris holds 41% shares in Godfrey Philips (popular for their Four Square brand) and BAT holds 31.4% shares in Indian Tobacco Company (ITC). Thailand stands out for its resistance in 1995 to the US Trade Representative trying to force open its market to the US tobacco companies.

The political links of tobacco companies are no secret. Philip Morris has been the largest contributor of unregulated political donations in the last two federal elections in the US[1]. Considering the leading role-played by the US in the global economy, it is but strategic for tobacco corporations to maintain political influence in the US. In 1995, the company capitalising its close association with high political offices drafted a law on growing, manufacturing and advertising of tobacco which was later approved by the Lithuanian government [2]. Thus, tobacco trade has moved on from being a token of goodwill between kings to that which dictates the world order. What is wrong about building a billion-dollar business that boosts the world economy?

The true color of the industry

a) Tobacco is the only consumer product, which if consumed as per the manufacturer's instructions kills half of its life-long users;
b) Tobacco industry has known about the harmful effects of tobacco for more than 30 years but intentionally opted to keep its consumers in the dark about it
c) Besides inflicting 44-odd illnesses in human beings, tobacco poses serious threat to the environment;
d) Tobacco depletes national reserves by way of high medical costs for treating tobacco-related diseases
e) Tobacco is more addictive than cocaine or marijuana thereby robbing its user of the freedom to decide to continue or discontinue its use.

Magnitude of the Tobacco Menace

According to World Health Organisation (WHO), 4 million people die globally from tobacco-related illnesses every year. This is more than the combined global death toll from HIV, Tuberculosis, maternal mortality, homicide, alcohol, suicide and automobile accidents put together [3]. WHO projects that by 2030, the global tobacco death toll would rise to 10 million and 70 % of these deaths would occur in poor developing countries. In India, tobacco kills more than 8 lakh persons every year. If current trends continue, 250 million children alive today will be killed by tobacco [4].

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[1] From research conducted by the Center for Responsive Politics, Washington, D.C. www.opensecrets.org
[2] INFACT survey by Tomas Stanikas, Kaunas Medical Academy, Lithuania, presented at the 10th World Conference on Tobacco or Health, Beijing, August 1997.
[3] Hoard, Barnum. "*The Economic Burden of the Global Trade in Tobacco*," Paper presented at the 9th World Conference on Tobacco or Health, October 1994.
[4] C.J. Murray and A.D. Lopez, Eds. The Global Burden of Disease: *A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020* (Cambridge MA: Harvard School of Public Health, 1996).

Youth are favorite target of the tobacco industry. Tobacco companies use aggressive advertising geared towards getting the children addicted at an early age so that they remain tobacco users for a lifetime. This is in clear violation of the commitments the countries from the region have made under the UN Convention on the Rights of the Child, which guarantees right to life, survival and development of a child.

Scientific studies have shown that Tobacco has been proven to cause cancer of the lungs, mouth and throat, breast, urinary bladder and cervix. Smoking is a leading cause for Peripheral Vascular Disease, which could eventually lead to amputation of limbs and even early death. A cigarette smoker has two to three times the risk of having a heart attack or a stroke compared to a non-smoker. Smokeless tobacco users are more likely to develop cancers of the lip, tongue, and floor of the mouth, cheek and gum than non-users.

Non-smokers who are exposed to tobacco smoke at home, have a 25 per cent increased risk of heart diseases and lung cancer. WHO estimates that 700 million, or almost half of the world's children, breath air polluted by tobacco smoke, particularly at home. Children of smoking parents are more prone to respiratory tract infections such as bronchitis, pneumonia, cot death, middle ear diseases and asthma attacks[5].

Tobacco production costs the environment dearly. In 66 tobacco-growing countries of the world, 4.6% of national deforestation is due to cutting of trees for curing tobacco and for building curing barns. Around 6-8 kilograms of wood are required to cure 1 kilogram of tobacco. Trees are also cut to produce paper for wrapping cigarettes and for packaging of tobacco products. In Thane district in Maharashtra (India), vast acres of forest land is cleared to procure "katha", an ingredient of the indigenous tobacco products Gutkha and pan masala from the bark of Khaire trees[6]. Smoking causes an estimated 10 % of the global deaths from fire. Disposal of the butts, packs, and cartons of tobacco products produces much trash that workers in the US complain that sweeping up cigarette butts causes them hours of extra work each month [7].

Challenges Posed by Tobacco

Factors Influencing Demand For Tobacco And Feasible Solutions

Entrapping Advertising: Tobacco industry is the largest advertiser in the world. Obviously, they have to try hard to sell their product against all its proven dangers to public health. In 1996, Philip Morris the world's largest multinational cigarette company spent $3.1 billon advertising its tobacco and food products [8]. In India, approximately Rupees 400 crore is spent on tobacco ads every year. In Bangladesh, British American Tobacco which owns controlling share of Bangladesh's former tobacco monopoly, spent $ 3.4 million on brand promotions and development in 1998.

With the growing restrictions on direct advertising of tobacco products world wide, the industry is evolving dubious and unscrupulous marketing strategies to circumvent law. A quick look at these promos exposes their tactic to hook young and fresh consumers to their products through indirect means like brand stretching and sponsoring youth programmes such as sports and cultural meets. The industry has always opposed ad bans and ingeniously suggests voluntary restrictions, which have proven to be ineffective in other countries. In a recent study involving 22 high-income countries it was revealed that where most comprehensive advertising restrictions were in place, tobacco consumption had fallen by 6 %[9].

Package Advertising: Tobacco companies for decades have been effectively using the tobacco package space as an excellent advertising media. Countries like Canada, Brazil and European Union have realised the power of package advertising and have made it mandatory to display pictorial health messages on tobacco packs. The

[5] Report of the Scientific Committee on Tobacco and Health. Department of Health, UK, 1998.
[6] "*Dawood is diversifying into Gutkha*", Bombay Times, 04/12/2000.
[7] Novotny & Zhao 1999.
[8] R. Hammond. *Tobacco Advertising and Promotion: The Need for a Co-ordinated Global Response*. Geneva: World Health Organisation. 2000
[9] P. Jha & F.J. Chaloupka. Curbing the Epidemic,Governments and the Economics of Tobacco Control. Washington. 1999.

Canadian experience as revealed in a recent survey has been that 44 % of smokers said that the new warning increased their motivation to quit and among those attempted to quit in 2001, 38% cited the warnings as a motivating factor. 35 percent of smokers and 34 percent of nonsmokers said they know more about the health effects of smoking than they did before the new warnings [10].

Tobacco & Poverty: Researchers from Bangladesh and India report that tobacco use further impoverishes poor-income households. In a recent survey conducted among 400 pavement dwelling families in Mumbai, India, the poor spend more on purchasing tobacco than on nutritious food like meat, milk, fruits or egg[11]. Similarly, among the poor income households in Bangladesh a typical male smoker spends 5 times as much on cigarettes as the per capita expenditure on housing, 18 times as much as for health and 20 times as much as for education[12]. Obviously, tobacco reduces the purchasing capacity of the poor to procure basic life needs.

Affordability : Increasing tax is a feasible strategy to reduce accessibility and affordability especially among income-sensitive groups. This should be a popular strategy among the Governments as it brings additional revenue to the Government exchequer..

Increasing taxes, increases smuggling" is the typical industry line of argument. However, it has been found that increase in contraband and smuggling arises out of poor low enforcement and customs regulations rather than from tax increases.

Sale of loose tobacco products also accentuates the tobacco consumption especially among the price-sensitive groups.

Rights and Awareness: Addictive as tobacco is, it robs its user of the power to choose to continue or discontinue its use. In doing so, it deprives the consumer of the basic right to choose. Tobacco companies hide information about the harmful effects of their products thereby denying the consumers the right to information based on which they could otherwise make an "informed choice". Children's rights to life, survival and development are jeopardized in terms of reduced access to health and education from increasing tobacco expenses incurred by adults in the family. They are choked from passive smoking, which the adults in their environment are unmindful of.

Issues related to the Supply of Tobacco

The tobacco industry perpetually whips up farmers' associations and unions creating fear that tobacco control would lead to massive unemployment in the tobacco production sectors. However, economists Jha & Chaloupka (1999) who have done extensive macro analysis of tobacco producing economies allay these fears[13].

They opine that the negative effects of tobacco control on employments have been grossly overstated. While there would be no net loss of jobs, there might even be job gains if global tobacco consumption fell. This is because money spent on tobacco would be spend on other goods and services thereby generating more jobs. Even in economies heavily dependent on tobacco, aid adjustment, crop diversification, rural training and other safety net systems would take care of the problem.

Even in countries with comprehensive tobacco control policies, tobacco consumption reduces at best by 1 %. With increasing population in most of the developing countries it would be a while before there would be any considerable impact on tobacco production, giving farmers sufficient time to diversify into alternate avenues.

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[10] Research by Canadian Cancer Society on the Effectiveness of Pictorial Health Warnings. 2001.

[11] S. John, S. Vaite & D. Efroymson. *Tobacco and Poverty: Observations from India and Bangladesh.* PATH Canada. October 2002.

[12] D. Eforymson & S. Ahmed. *Hungry for Tobacco.* Work for a Better Bangladesh. 2001.

[13] P. Jha & F.J. Chaloupka. Curbing the Epidemic, Governments and the Economics of Tobacco Control. Washington. 1999.

A recent study conducted among tobacco farmers in Karnataka, one of the leading tobacco producing States in India, reveals that diversification to alternate livelihood is a feasible option for those engaged in various tobacco production avenues. Tobacco farmers have been found to suffer from several occupational health hazards and complain of perpetual state of poverty and debts[14].

Envisaging future decline in bidi smoking, Kerala Dinesh Bidi, the largest co-operative society in Asia launched its diversification efforts into food processing and other consumer products. In the first three years of diversification, 15 out of the 30 products have been reported to be breaking even[15].

Another major argument leveled against diversification is that with these efforts countries would cease to receive the tax they are currently getting from tobacco taxes. This is a fallacy. In India, for instance, the Government revenue from tobacco is way below what it spends on treating tobacco-related illnesses.

Also, with tobacco users reducing its consumption in response to tobacco control measures, it is likely that they would invest in other consumer products. This would lead to development of other sectors of the economy and thus contribute to overall national growth.

Framework Convention on Tobacco Control (FCTC)

In 1998, the World Health Organisation invoked its prerogative to propose an international tobacco control treaty named Framework Convention on Tobacco Control to contain the global tobacco epidemic. This first global public health treaty addresses transnational issues pertaining to tobacco advertising, smuggling, packaging, testing and reporting of toxic constituents, environmental tobacco smoke and resource sharing.

The treaty is currently moving towards the final stages of its negotiation by 190 odd Member Nations of WHO in the last and sixth round of negotiation scheduled for Mid February 2003. It is slated to be adopted by World Health Assembly in May 2003.

The treaty is significant for the Asian countries, primarily in resisting the tobacco industry which considers us the prime target in this decade. It serves as a booster to build national tobacco control policies and programmes. The negotiations for the first time in the history of tobacco control movement, has brought together people, Governments, NGOs, energy and resources from all over the world to address the tobacco pandemic.

Tobacco Control in Asia

In the last decade, several organisations in the region have initiated awareness programmes among children, youth, women and workers as a prevention strategy. Some of them advocate strong tobacco control policies home and abroad. In India, research and surveillance have been carried out on different population groups on their tobacco control patterns.

Thailand has advanced tobacco control programmes and policies. India has of late proposed the Tobacco Products Bill, banning tobacco advertising, promotions and smoking in public places among others. Bangladesh and Nepal are also drafting national policies to contain the tobacco epidemic.

In the recent years, tobacco control activists have realised the power of collective strength and have formed networks and coalitions at local and national levels. The Consortium for Tobacco Free Karnataka, Indian Coalition for Tobacco Control, Bangladesh Anti Tobacco Alliance, South Asia Tobacco Control Forum and South East Asia Tobacco Control Alliance, Framework Convention Alliance are a few of the active alliances in the region.

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[14] S. John, S. Vaite & D. Efroymson. *Tobacco and Poverty: Observations from India and Bangladesh.* PATH Canada. October 2002.

[15] *Ibid.* Interview with Kerala Dinesh Bidi Office Bearers.

In 1998, World Health Assembly launched the drafting of an international treaty to address trans-national tobacco control issues. The treaty, Framework Convention on Tobacco Control is currently is in the last stages of its development, with over 150 world countries concluding its negotiations soon in Geneva. Countries and organisations from the region play a vital role in demanding stringent tobacco control measures in this treaty.

Emerging Needs of Tobacco Control in Asia

Industry documents and operations reveal that they are now training their guns on Asia and Africa. Lack of adequate tobacco control policies and failure in implementing the existing policies make all of us more vulnerable to the attacks of these companies as also to tobacco epidemic. Illiterate masses and cultural practices also seem to be hurdles in tobacco control in Asia. The emerging needs therefore for the region are:

a) Building awareness among the Asian people about the health and socio-economic consequences of tobacco use and trade
b) Exposing myths and cultural practices that promotes the habit
c) Training development workers and organization on tobacco control issues
d) Building networks and coalitions that would serve as pressure groups in policy advocacy
e) Engaging in active advocacy for tobacco control policies at national and regional level
f) Advocacy for effective implementation of FCTC commitments in the region

Possibilities for Collaboration

The issues involved in tobacco control demands a matching o-ordinated response from different sectors of the civil society. World Health Organisation responded to this global epidemic by setting up the Tobacco Free Initiative in 1998, which in turn supports various global campaigns and programmes in tobacco control. It calls upon the civil society each year to observe 31st of May as the World No Tobacco Day.

Besides, there are various networks, coalitions and organizations already engaged in active tobacco control. If you are further interested in learning or engaging in tobacco control issues, feel free to contact any of the organisors of the event listed below:

Thelma Narayan, Community Health Cell
Consortium for Tobacco Free Karnataka
International Secretariat
People's Health Assembly
Email: sochara@vsnl.com.

Shoba John, PATH Canada
South East Asia Focal Point,
Framework Convention on Tobacco Control.
Member, Indian Coalition for Tobacco Control
Email: sjohn_pathcan@vsnl.net

Dr. Srinath Reddy
Professor of Cardiology, AIIMS.
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Naveen Thomas
Fellow, Oxfam India Trust
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Paper prepared by:

Shoba John
PATH Canada, India.

January 2003

for **Asia Social Forum**
Workshop on "Working Towards Tobacco Control"

PH-12.

ACTION TOWARDS A TOBACCO FREE WORLD

A Workshop on Tobacco Control, Asia Social Forum, Hyderabad

Date: 3rd January, 2003
Time: 2:15 to 6:30 P.M.

Venue: Taj Mahal Hotel,
Abids Road,
Hyderabad - 01
Ph: 24758221

Facilitated by:

Community Health Cell, Bangalore on behalf of Jan Swasthya Abhiyan / People's Health Movement

Partner Organizations

Consortium For Tobacco Free Karnataka
PATH-Canada

Indian Coalition for Tobacco Control
LIFE HRG

Introduction

This workshop will present a canvas of the entire range of activities and effects related to tobacco production, supply, distribution, consumption, health, socio-economic spheres and the environment. It would also include an overview of the tobacco control initiatives at the local, Asian and global levels. Discussion will be held on working together and evolving strategies at various levels for tobacco control.

Proposed Format of Workshop

2:15 to 2: 30 p.m.: Street Play on the Tobacco industry and its effects

Duration of the workshop: 4 hours

Sl. No.	EVENT	DURATION
1.	**Presentation on the following issues:** An Introductory Overview **Chairperson: Dr. Ramesh Bilimaga**	1 hr 10 mins (2.30 – 3.40pm)
	Welcome Note: Profile of Tobacco related issues in Asia/ India – Dr.Thelma Narayan, CHC – An introduction to the Workshop. **Objective:** To highlight the various aspects of the problem and to update participants on the current situation	10 mins
	Magic show & Talking Doll Show on the ill effects of tobacco	
	• Tobacco control initiatives at various levels – Global, National : - Mr. Sonam, Ministry of Health & Education, Bhutan - Mr. Ratan Deb, BATA, Bangladesh, - Dr. Prakash C Gupta, India) State [IMA, Karnataka Task Force, CFTFK – Mr Chander (CHC)] **Objective:** To inform participants about the ongoing initiatives in tobacco control and to record our recognition of important innovative initiatives	45 mins

	• **Clarifications / responses**	15 mins
2.	**People's Health Celebration** **Chairperson: Ms. Devaki Jain**	**25 mins** (3.40 – 4.05pm)
	• Felicitation of people/ groups who have made efforts for tobacco control in the Asian region • Cultural event (Song, Testimonies- Mr.Jaggaiah(Patient), Ms. Lalithamma (Ex Tobacco Cultivator and Patient) **Objective:** To honour people who have made concerted efforts in tobacco control in their local areas and to celebrate the spirit of working together.	
	TEA BREAK / EXHIBITION OF POSTERS	**15 mins** (4.05 – 4.20pm)
3.	**Panel Discussion** **Chairperson : Ms. Devaki Jain**	**1 hr 10 mins** (4.20 – 5.30pm)
	• **Panel Discussion** 1. Epidemiological / Public Health Issues posed by Tobacco – Dr. Prakash C Gupte 2. FCTC* Update- Dr. Srinath Reddy 3. Socio-Economic Concerns Tobacco Raises and Exposing the Tobacco Industry– Ms. Shoba John, PATH, Canada (India). 4. The Environment, Gender and Child Rights Issues around Tobacco Production – Ms. Suvarna, Shimoga, Karnataka **Objective:** Analysis of the Social, Economic, Environmental & Health effects of tobacco; Introduction to * Framework Convention for Tobacco Control (FCTC) and to introduce the Challenges and Initiatives for action towards a tobacco control in Asia.	50 mins
	• **Open House** **Objective:** To provide an opportunity for the participants to seek clarifications and participate in the discussion.	20 mins
4.	**Group Work** **Chairperson: Dr. Srinath Reddy**	**30 mins** (5.30 – 6.00pm)
	• Presentation of tentative 'Workshop Statement'. • Group discussion tentatively on: a) What strategies to be adopted to work with Government and civil society at local, national and international levels to advance tobacco control policy efforts? b) How do we work with the media and various pressure groups (including international groups) to advance tobacco control? c) How do we mobilise community support towards advocating for policy changes as well as to initiate and implement tobacco control programmes. d) Discussion on the 'Statement' and possible modifications **Objective:** To identify issues, evolve strategies and devise mechanisms for working together in the future.	30 mins

5.	**Concluding Session** **Chairperson: Dr. Thelma Narayan**	**30 mins** (6.00 – 6.30pm)
	• Presentations by the group , declaration of 'Workshop Statement' and vote of thanks. **Objective:** To share the discussions of the group and discuss concrete follow-up plans.	30 mins

Rapporteurs:
Dr. Prakash Vinjamuri, LIFE HRG
Mr. Naveen Thomas, Fellow, Oxfam GB
Dr.Anant Bhan, Fellow, CHC

There will be a poster exhibition; background papers, books and pamphlets from various regions in Asia will be available at the venue. Nine banana carts from LIFE, a Hyderabad organisation involved in Health and Nutrition Education will carry posters, flags and handbills celebrating tobacco control in different parts of Hyderabad city, at the ASF and Youth Forum venue.

PH-12

UICC *GLOBALink*

The International Tobacco-Control Network Selected documents: The Death Toll form Tobacco - A Crime Against Humanity

September 1998

Deaths caused by smoking

There are between 1.1 -1.4 billion smokers in the world out of a total population of around 5.8 billion. It has been estimated that 50% of smokers will die prematurely from tobacco related illness, half in middle age (defined as 35 - 69 years of age) with an average loss of life expectancy of 20 - 25 years (8 years over all ages).

This means that over half a billion people (in excess of 500 million) or about 10% of the existing population will die from smoking. Of these, 27% will die from lung cancer, 24% will die from heart disease, 23% will die from chronic obstructive lung disease, emphysema or bronchitis and the remaining 26% will die from other diseases including other circulatory disease (18%) and other cancers (8%).

Currently, 3 million people worldwide die every year from smoking related disease. This represents about 1 person every ten seconds. One third of all people aged fifteen years and over smoke and this proportion is increasing in Asia, Eastern Europe and the former Soviet States. Consumption trends indicate that smoking prevalence is reducing in developed countries (DCs) (down 1.5% per annum in the United States) whilst increasing in lesser-developed countries (LDCs)(up 1.7% per annum on average).

The World Health Organisation (WHO) has estimated that, based on current trends, the death toll from smoking will rise to 10 million people per year by the year 2025. Currently two million deaths occur each year in developed countries and 1 million deaths occur each year in lesser-developed countries. By 2025 this proportion will alter to 3 million deaths per year in developed countries and 7 million deaths per year in lesser-developed countries. No other consumer product in the history of the world had come even close to inflicting this degree of harm on the world community. If anything else posed a threat to life of this magnitude whether human induced or naturally occurring - be it world war, genocide, ethnic cleansing, natural disaster or disease - it would demand immediate international action. The response to HIV, the prosecution of war crimes (both current and dating back to World War II), germ warfare, nuclear weapons or even climate change are but a few examples.

The history of the smoking pandemic of the 20th century can be traced back to the invention of the mechanical cigarette machine in the late 1800's. Until that time cigarettes were rolled by hand, production was low and smoking was not overly prevalent. The cigarette machine meant that millions of cigarettes could be produced each day at a lower cost and distributed more widely. The result was that cigarette smoking increased such that by the late 1940's smoking rates in developing countries were up to 70% in adult males and up to 25% in adult females. Smoking rates in LDCs were significantly less.

From the discovery of the link between increased smoking and disease in the early 1950's, and major reports publicising the need for public health action, smoking rates among adult males in developed countries has declined although prevalence in adult females increased to some degree

but now the levels are roughly equal at about 25% in many developed countries. Meanwhile, smoking rates in lesser-developed countries has increased in both the adult male and adult female population.

Due to the latency in the development of disease from smoking, the effects were first detected among adult males in developed countries. The effect of increased smoking among adult females is now being reflected in disease rates with similar observations in lesser-developed countries. Hence the WHO estimates by the year 2025.

Transnational tobacco companies

Tobacco consumed by the world's 1.1 - 1.4 billion smokers is produced by a handful of transnational tobacco companies and a number of state owned manufacturers. China's state owned production accounts for 31% of all tobacco sales with Italy, Russia, Japan, Taiwan, Indonesia and Thailand, amongst other countries, having substantial government owned factories as well.

However, transnational tobacco companies account for 40% of the global market and control 70% of world production, and this is increasing. In many cases, the state owned producer was a state monopoly but, increasingly, this has been broken down through free trade agreements to a point where transnational tobacco companies are not only marketing in countries previously the subject of a state monopoly but there are reports of expressions of interest by transnational tobacco companies in obtaining an interest in formerly state owned monopolies now being privatised.

Whilst all tobacco consumption contributes to the overall death toll, state owned production is arguably an internal matter to the nation - state in question. The activities of privately owned, transnational tobacco companies is a matter on international concern. The major transnational tobacco companies, in order of sales, are: US based Philip Morris Inc., followed by British based BAT Industries p.l.c., United States based RJR Nabisco and Rothmans. Under agreements apparently reached among these transnational tobacco companies, Rothmans does not market in the United States and BAT does not market in Britain. There are reports that Philip Morris and BAT have entered into collusive agreements that fix cigarette prices and divide markets in South America (apparently such anti competitive arrangements are not illegal in those countries). It is a mark of the power of the major transnational tobacco companies that they can reach such agreements dividing up markets in sovereign nations consequently inflicting the harm identified above. In 1996, Philip Morris had annual revenues of $55 billion, just over half from tobacco with the rest coming from domestic and international food and alcohol sales. Only 18% was from domestic tobacco sales (20% in 1992) compared with 35% from international sales (21% in 1992). Total tobacco sales comprised 53% in 1996 (41% in 1992) or about 23 billion. BAT revenue in 1996 was $23 billion. RJR Nabisco had total revenues of $17 billion in 1996 of which 48% or about $ billion was from tobacco sales. These massive levels of turnover and the economic, political and social influence of the transnational tobacco companies has led to the industry being described collectively as "Big Tobacco". A comparison is made that these revenues exceed the gross domestic product of many countries. For example, Philip Morris has a turnover larger than the GDP of Ecuador, Guatemala, Kenya, Kuwait, Malaysia and Peru. It is roughly the equivent of Ireland, Singapore or Hungary. RJR Nabisco's turnover is roughly the equivalent of the GDP of Costa Rica, Croatia, Cuba, El Salvador, Lebanon or Jamaica. Whilst these companies undoubtedly have significant economic, political and social influence, the fact remains (with all due respect to the countries with which comparison is made), these transnational tobacco companies, either individually or collectively, are not an overwhelmingly dominant force on a world scale.

Deceit and duplicity of the tobacco industry

The current status of the tobacco industry is anomalous insofar as cigarette consumption clearly inflicts a degree of mortality totally at odds with fundamental human rights and human values. At the same time the tobacco industry defends itself on the basis that tobacco is a "legal product". This occurred because the tobacco industry had already acquired a substantial degree of economic, political and social influence by the time the link between smoking and disease was established. Since that time the tobacco industry worldwide has engaged in a deliberate campaign of deceit and duplicity to protect and even expand its influence through a process of denial and disputation of the now proven link between smoking and disease, the addictive properties of nicotine and their marketing strategies directed at youth.

This deceit and duplicity is currently being exposed by litigation in the United States which is spreading worldwide. The position has now been reached where continued disputation and distortion is untenable, particularly in the face of the projected increase in tobacco deaths by the year 2025 if current trends are continued. This is all the more so given the disparity in the projected increase between developed and less developed countries, reflecting an exploitation of lesser developed countries which will only increase to offset liabilities the tobacco industry is incurring in the United States. This is a circumstance calling for international action. It must not be allowed to happen. Were it to occur it would be, without doubt, a crime against humanity.

Crimes against humanity in the International Criminal Court

On 17 July 1998 the United Nations Rome Statute of The International Criminal Court established a permanent Court having power to exercise jurisdiction over persons for the most serious crimes of international concern. Article 5 confers jurisdiction on the International Criminal Court with respect to the following crimes:

1. The crime of genocide;
2. Crimes against humanity;
3. War crimes;
4. The crime of aggression.
5.

For the purposes of the Statute, Article 7 defines a "crime against humanity" to mean any of the following acts when committed as part of a widespread or systematic attack directly against any civilian population, with knowledge of the attack;

1. Murder;
2. Extermination;
3. Enslavement;
4. Deportation or forcible transfer of population;
5. Imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law;
6. Torture;
7. Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation, or any other form of sexual violence of comparable gravity;
8. Persecution against any identifiable group or collectively on political, racial, national ethnic, cultural, religious, gender as defined in paragraph 3, or other grounds that are universally recognized as impermissible under international law, in connection with any act referred to in this paragraph or any crime within the jurisdiction of the Court;

9. Enforced disappearance of persons;
10. The crime of apartheid;
11. Other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

Given what is known about smoking and disease and the deceit and duplicity of the tobacco industry, were the death toll from tobacco to increase from 3 million a year to 10 million a year by the year 2025, especially with the dramatic increase in lesser developed countries from 1 million a year to 7 million a year, it is impossible to describe that consequence as anything other than the result of an inhumane act of a character similar to murder, causing great suffering, or serious injury to body or to mental or physical health committed as part of a widespread or systematic attack directed against the civilian population of the world.

Given that the directors and executives of the major transnational tobacco companies must now have knowledge of the consequences of their activities, if those activities continue then each and every one of them must face the prospect of being charged with committing a crime against humanity in the International Criminal Court. Article 11 of the Statute provides that the Court has jurisdiction only with respect to crimes committed after the entry and the force of the Statute. This means that the opportunity exists for these directors and executives to escape liability under the provisions of the Statute providing there is no increase in mortality from tobacco use. Arguably they should be responsible for a reduction. Given the likely increase in mortality from past smoking, because of the latency of tobacco related disease, every effort would need to be made to reduce consumption in order to avoid a significant increase in the current death toll. Certainly expansion in lesser-developed countries should not occur. As a means of securing this outcome, each of the major transnational tobacco companies, and each of their directors and executives, should formally be put on notice of the consequences of their activities such that charges of a crime against humanity can be laid and successfully prosecuted if radical action is not taken to reverse current trends.

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Worldwide trends in tobacco consumption and mortality

World Health Organization

TOBACCO: THE TWENTIETH CENTURY'S EPIDEMIC

Every ten seconds, somewhere in the world, tobacco kills another victim. If current smoking trends continue, this toll will increase up to one tobacco-caused death every three seconds over the next thirty to forty years.

Recent data have confirmed that the risks of smoking are substantially higher than previously thought. With prolonged smoking, smokers have a death rate about three times higher than nonsmokers at all ages from young adulthood. Tobacco products are known or probable causes of over two dozen diseases or groups of diseases. If, as is likely, much of the excess mortality from these diseases is directly attributable to tobacco use, then this implies that the lifetime risk of a smoker being killed by the use of tobacco products is at least 50%. Therefore, a lifelong smoker is as likely to die as a direct result of tobacco use as from all other potential causes of death combined[1].

Other problems ensue because the negative health consequences of tobacco are not as immediate as with other hazardous substances. The health risks of tobacco are vastly underestimated by the public, and even by many of those who are responsible for protecting and promoting public health. Yet the risks of smoking are very high when compared to other risks faced in everyday life (See Table 1). Widespread underestimation of risks associated with tobacco use, is a major reason why tobacco products are still widely available, and why lenient tobacco policies have been allowed to occur. But nothing can alter the fact that tobacco use is one of the major public health challenges facing the world as it enters the twenty-first century.

TOBACCO USE IS A KNOWN OR PROBABLE CAUSE OF DEATH FROM:

Cancers of the:

- Lip, oral cavity and pharynx
- Oesophagus
- Pancreas
- Larynx
- Lung, trachea and bronchus
- Urinary bladder
- Kidney and other urinary organs

Cardiovascular diseases:

- Rheumatic heart disease
- Hypertension
- Ischaemic heart disease
- Pulmonary heart disease

- Other heart diseases
- Cerebrovascular diseases
- Atherosclerosis
- Aortic aneurysm
- Other arterial diseases

Respiratory diseases:

- Tuberculosis
- Pneumonia and influenza
- Bronchitis and emphysema
- Asthma
- Chronic airway obstruction

Paediatric diseases:

- Low birth weight
- Respiratory distress syndrome
- Newborn respiratory conditions
- Sudden infant death syndrome

Tobacco products have no safe level of consumption, and are the only legal consumer products that kill when used exactly as the manufacturer intends. Researchers have rated nicotine as even more addictive than heroin, cocaine, marijuana or alcohol. The Tenth Revision of the International Classification of Diseases reserves classification F17.2 for "tobacco dependence syndrome". Yet tobacco products continue to be aggressively marketed by tobacco companies. The result is that global tobacco consumption has doubled since medical science conclusively proved, 30 years ago, that these products were unrivalled killers. And consumption is still increasing in many areas of the world.

An analysis of trends in cigarette consumption for WHO regions indicates that the two regions with the highest average per capita (adult) consumption in 1990-1992 were Europe (2290 cigarettes per adult per year) and the Western Pacific (2000). The lowest consumption was observed in the African Region (540). For the developed countries as a whole, per capita adult consumption is currently about 2400 cigarettes, which is still significantly greater than the average consumption in the developing world (1370 cigarettes).

The gap is rapidly narrowing, however. In 1970-1972, consumption per adult in the developed countries was 3.25 times higher than in the developing world (see Figure 1). By 1980-1982, this ratio had narrowed to 2.38, and by 1990-1992, to 1.75. During the last decade, per capita consumption has declined by an average of 1.4% per year in developed countries, but has risen by 1.7% annually in developing countries. If these trends were to continue, consumption of cigarettes per adult in the developing world will exceed levels in the developed world some time between the years 2005 and 2010, i.e., within two decades.

There have been very noticeable differences in trends among WHO regions. Over the last decade, the fastest decline in per capita consumption occurred in the Americas. Nor was this entirely due to declines in consumption in Canada and the United States of America; excluding those two countries, per capita consumption in the Region still declined by an annual average of 1.7%. On the other hand, the increasing consumption in the Western

Pacific (2.2%) and South-East Asia (1.8%) is primarily due to the trends in China and India respectively. From 1983, per capita (adult) consumption in China rose by 3.9% per year to reach 1990 cigarettes in 1990-1992. In India, where about 90% of cigarettes are consumed in the form of bidis (traditional hand-rolled cigarettes), adult consumption has risen by about 2% per year over the last decade and now exceeds 1200 cigarettes (including bidis).

WHO estimates that there are about 1100 million regular smokers in the world today. About 300 million (200 million males and 100 million females) are in the developed countries, and nearly three times as many (800 million: 700 million males and 100 million females), in developing countries. In developed countries, 41% of men are regular smokers, as are 21% of women (see Figure 2). Half the men living in developing countries are smokers, compared with about 8% of women.

The health consequences of the smoking epidemic in developed countries have been quantified by WHO, in close collaboration with the Imperial Cancer Research Fund's Cancer Studies Unit at the University of Oxford, UK. A major report giving detailed estimates of the numbers and rates of smoking-attributed deaths for over 50 countries or groups of countries, has been published. Between 1950 and 2000, it is estimated that smoking will have caused about 62 million deaths in the developed countries (12.5 % of all deaths: 20% of male deaths and 4% of female deaths). More than half of these deaths (38 million) will have occurred at ages 35-69 years. Currently, smoking is the cause of more than one in three (36%) male deaths in middle age, and about one in eight (13%) of female deaths. Each smoker who dies in this age-group loses, on average, 22 years of life compared with average life expectancy. During the 1990s, the report estimates that almost 2 million people a year will die from smoking in developed countries (1.44 million men and 0.48 million women).

As regards cigarettes the health consequences of tobacco use are much more difficult to estimate in developing countries owing to lack of data. Currently, it is estimated that tobacco causes about 1 million deaths a year in developing countries, but there is substantial uncertainty about this figure. If current trends continue, and if the risks of death from tobacco use are similar in developing countries to those that have been observed in the industrialized world, then the annual toll of mortality from tobacco will rise dramatically to around 7 million deaths per year in the 2020s or early 2030s (see Table 2). The chief uncertainty is not whether, but rather when, these deaths will occur if current trends in tobacco use persist.

Table 2. Estimated number of Deaths caused every year by Tobacco

	Decade 1990s	Decades 2020s/early 2030s
Developed countries	2 million	3 million
Developing countries	1 million	7 million
Total	3 million	10 million

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Tobacco and the developing world

Published In Prof. Off.

Bernard Lown, MD

The opium wars of the 21st century: Tobacco and the developing world

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The tobacco wars of the next century will increasingly be waged among vulnerable populations ill equipped to cope with the slick marketing techniques and the dirty tricks perfected by the tobacco industry. Most developing countries have no advertising controls, lack adequate health warning requirements, and have a dearth of pressure groups campaigning for stricter tobacco controls. They have set no age limits, nor imposed restrictions on smoking in public places. Their populations are poorly educated on the health hazards nor is information being provided to the burgeoning numbers of teen-agers who are most susceptible to advertising hype.

Tobacco already exacts an inordinate toll in the developing world. In Mexico, according to the Center for Disease Control (CDC), death rate for all smoking related disease has increased substantially, ranging in mortality increases of 60% for cerebrovascular disease to 220% for lung cancer. (3) In Brazil cigarette-related disease now leads infectious diseases as the principal cause of death.(4) In Bangladesh, as a result of increased smoking, cancer of the lung has become the third most common cancer among men and perinatal mortality is 270 per 1000 /children of smoking mothers-more than twice the rate for children of nonsmokers. (4) In India, a six-fold increase in mortality from bronchitis and emphysema has been noted, coincident with that country's skyrocketing cigarette consumption.(4,5) In developing countries, not only is the use of tobacco surging, but the cigarettes are more addictive and more lethal because of higher tar and nicotine content.

In Asia smoking is growing at the fastest rate in the world accounting for half of global cigarette use . The largest number of recruits are among the young and women. (6) The tobacco industry finds the Asian market particularly inviting because of its size and the love for smoking. In China 61 percent of men and 10% of women over 15 now smoke. These 320 million smokers consume 1.7 trillion cigarettes annually. While the Chinese account for a third of all smokers world wide, as yet this lucrative market has not reached its potential limit. The staggering health costs is a reckoning for the future. The Chinese Academy of Preventive Medicine forecasts 3.2 million deaths annually by the year 2030. (7, 8)

The United States has played a key role in promoting the global consumption of tobacco. More than a century ago the American tobacco magnate James B. Duke entered China. (9) Until his arrival very few Chinese smoked, mostly older men using a bitter native tobacco, usually in pipes. Duke hired "teachers", who traveled from village to village in Shantung province, marketing a milder North Carolina tobacco leaf and instructing curious onlookers how to light up and hold cigarettes. Duke installed the first mechanical cigarette-rolling machine in China and unleashed a panoply of promotional materials, including cigarette packs displaying nude American actresses. He set the precedent of having the United States government pressure the Chinese to permit the import of American cigarettes.

Pushing deadly merchandise abroad if anything it has intensified in recent years. In 1985 when US began its campaign to open Asian markets to tobacco exports, it shipped 18 billion cigarettes; by 1992 the figure had risen to 87 billion or nearly five-fold. The US government, while discouraging smoking at home, successfully pressured Japan, Taiwan, South Korea and Thailand into breaking their domestic tobacco monopolies to allow the sale of American cigarettes.(6) These national monopolies did not advertise and sold cigarettes largely to male adults. After US companies penetrated their markets smoking soared among young people. Two years after the entry of American cigarettes in Japan, their import increased by 75 percent with 10-fold increase in the number of television advertisements to encourage smoking. The US broke a healthy taboo against smoking by Japanese women. In but a few years the number of women smokers more than doubled. (6, 10)

In a single year after the ban against American tobacco was lifted, smoking among Korean teenagers rose from 18.4 to 29.8 percent and more than quintupled among female teens, from 1.6 to 8.7 per cent. (2) A poll among two thousand high school students in Taipei, Taiwan indicated that 26% boys and 1% of girls smoked a cigarette. After American tobacco companies entered their market in a survey of eleven hundred high school students, the figures shot up to 48 percent of boys and 20 percent of girls (6) Words like Marlboro, Winston, Salem, and Kent have entered the vocabulary of every Asian nation.

The American government engaged in activities that would have provoked outrage if carried out in its own country. The US Trade representative refused the Taiwanese proposal not to allow advertisement in magazines read primarily by teen-agers. (6) The Taiwanese were not permitted to move the health warnings from the side to the front of the package nor increase the type size, nor were they allowed to prohibit wending machine sales. An unconscionable American trade imperialism fuels the rise in smoking. This prompted the former U.S. Surgeon General, Dr. C. Everett Koop to say about his country, "People will look back on this era of the health of the world, as imperialistic as anything since the British Empire-but worse." (10).

Even without the exercise of government muscle on their behalf, the tobacco titans present a formidable challenge to an unwary public. Tobacco promotion is pursued aggressively in less developed countries, with advertising budgets for many countries surpassing national funds appropriated for health research. The tobacco companies invest prodigious resources in targeting women and children. According to a recent editorial in the New York Times, "Hong Kong is one of the battlefronts of the modern-day Opium War. While Britain went to war last century to keep its Indian-grown opium streaming into Chinese ports, today American tobacco companies win profits and build addiction throughout Asia." (11)

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The financial stakes are enormous. The international trade in tobacco is dominated by six multinational conglomerates, three of which are based in the United States (Philip Morris, RJ. Reynolds, and American Brands). Together, these six companies account for 40 percent of the world cigarette production and almost 85 percent of the tobacco leaf sold on the world market.(15) Since 1970, as American domestic smoking rates began to decline, intensive marketing campaigns supported by vast governmental resources tripled America's export of tobacco. Sales of Philip Morris in Africa is growing at 20% per year. It is projected that international sales of Philip Morris will jump 16% in 1997 to 764 billion cigarettes with a projection of 1 trillion by the year 2000. Foreign smoking is the major reason for the profitability of Philip Morris with earnings of $6.3 billions in 1996. This company now ranks third in profitability in the US behind Exxon and General Electric. By virtue of their great wealth the tobacco conglomerates are a world power having more political clout than a majority of developing nations.

From a public health perspective what is happening in the developing world is an unprecedented calamity. We know but little of the full impact of smoking on malnourished disease-ridden people. There is evidence that tobacco may interact synergistically with infectious diseases and with environmental hazards to cause increases in certain cancers. For example, tuberculosis which is widespread in developing countries, may enhance the risk of lung cancer and is further amplified by smoking. (16)) In Egypt, Schistosoma haematobium has been associated with an increased prevalence of bladder carcinoma among smokers (17) In less-developed countries, poorly controlled occupational hazards, such as organic dusts, uranium, or asbestos, may act as synergistic co-carcinogens in workers. (5) In addition, the health costs of fires resulting from cigarette smoking in countries where dwellings are often constructed of highly flammable materials is part of the tragic impact of tobacco.

The burden of disease due to tobacco is incalculable. Richard Peto and colleagues, (18) suggest that by the year 2025 mortality ascribable to global tobacco use will exceed 10 million annually and about 70% of the deaths will be in the developing countries. Such colossal mayhem is unprecedented in the annals of human barbarism. Cigarettes can not be permitted as a trade weapon that wastes the lives of unwitting victims to enrich the coffers of corporate America. The world has outlawed chemical weapons but tobacco is far more deadly. United States health professionals have an awesome moral burden to speak out and unrelentingly combat this global scourge. op

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In Hong Kong, where American tobacco blends make up 94 percent of the market, hip clothing stores pass out cigarettes free to their customers. Advertising is geared to the young in Asia by sponsoring sporting events and pop concerts with free disco passes given out in return for empty cigarette packs. The Marlboro bicycle tour is the biggest national summer sport in the Philippines. (5) Salem cigarettes sponsor a "virtual reality" dome, where teenagers attack each other with laser guns. (12) Empty packs of American cigarettes can be redeemed for tickets to movies, discos and concerts. In Kenya, cigarettes with brand names such as Life and Sportsman are promoted as the passport to success, health, and a Western lifestyle(13). In Taiwan, most smokers prefer Long Life, Prosperity Island, or New Paradise.(14)

The financial stakes are enormous. The international trade in tobacco is dominated by six multinational conglomerates, three of which are based in the United States (Philip Morris, RJ. Reynolds, and American Brands). Together, these six companies account for 40 percent of the world cigarette production and almost 85 percent of the tobacco leaf sold on the world market.(15) Since 1970, as American domestic smoking rates began to decline, intensive marketing campaigns supported by vast governmental resources tripled America's export of tobacco. Sales of Philip Morris in Africa is growing at 20% per year. It is projected that international sales of Philip Morris will jump 16% in 1997 to 764 billion cigarettes with a projection of 1 trillion by the year 2000. Foreign smoking is the major reason for the profitability of Philip Morris with earnings of $6.3 billions in 1996. This company now ranks third in profitability in the US behind Exxon and General Electric. By virtue of their great wealth the tobacco conglomerates are a world power having more political clout than a majority of developing nations.

From a public health perspective what is happening in the developing world is an unprecedented calamity. We know but little of the full impact of smoking on malnourished disease-ridden people. There is evidence that tobacco may interact synergistically with infectious diseases and with environmental hazards to cause increases in certain cancers. For example, tuberculosis which is widespread in developing countries, may enhance the risk of lung cancer and is further amplified by smoking. (16)) In Egypt, Schistosoma haematobium has been associated with an increased prevalence of bladder carcinoma among smokers (17) In less-developed countries, poorly controlled occupational hazards, such as organic dusts, uranium, or asbestos, may act as synergistic co-carcinogens in workers. (5) In addition, the health costs of fires resulting from cigarette smoking in countries where dwellings are often constructed of highly flammable materials is part of the tragic impact of tobacco.

The burden of disease due to tobacco is incalculable. Richard Peto and colleagues, (18) suggest that by the year 2025 mortality ascribable to global tobacco use will exceed 10 million annually and about 70% of the deaths will be in the developing countries. Such colossal mayhem is unprecedented in the annals of human barbarism. Cigarettes can not be permitted as a trade weapon that wastes the lives of unwitting victims to enrich the coffers of corporate America. The world has outlawed chemical weapons but tobacco is far more deadly. United States health professionals have an awesome moral burden to speak out and unrelentingly combat this global scourge. op

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PH-12

Worldwide trends in tobacco consumption and mortality

World Health Organization

TOBACCO: THE TWENTIETH CENTURY'S EPIDEMIC

Every ten seconds, somewhere in the world, tobacco kills another victim. If current smoking trends continue, this toll will increase up to one tobacco-caused death every three seconds over the next thirty to forty years.

Recent data have confirmed that the risks of smoking are substantially higher than previously thought. With prolonged smoking, smokers have a death rate about three times higher than nonsmokers at all ages from young adulthood. Tobacco products are known or probable causes of over two dozen diseases or groups of diseases. If, as is likely, much of the excess mortality from these diseases is directly attributable to tobacco use, then this implies that the lifetime risk of a smoker being killed by the use of tobacco products is at least 50%. Therefore, a lifelong smoker is as likely to die as a direct result of tobacco use as from all other potential causes of death combined!

Other problems ensue because the negative health consequences of tobacco are not as immediate as with other hazardous substances. The health risks of tobacco are vastly underestimated by the public, and even by many of those who are responsible for protecting and promoting public health. Yet the risks of smoking are very high when compared to other risks faced in everyday life (See Table 1). Widespread underestimation of risks associated with tobacco use, is a major reason why tobacco products are still widely available, and why lenient tobacco policies have been allowed to occur. But nothing can alter the fact that tobacco use is one of the major public health challenges facing the world as it enters the twenty-first century.

TOBACCO USE IS A KNOWN OR PROBABLE CAUSE OF DEATH FROM:

Cancers of the:

- Lip, oral cavity and pharynx
- Oesophagus
- Pancreas
- Larynx
- Lung, trachea and bronchus
- Urinary bladder
- Kidney and other urinary organs

Cardiovascular diseases:

- Rheumatic heart disease
- Hypertension
- Ischaemic heart disease
- Pulmonary heart disease

- Other heart diseases
- Cerebrovascular diseases
- Atherosclerosis
- Aortic aneurysm
- Other arterial diseases

Respiratory diseases:

- Tuberculosis
- Pneumonia and influenza
- Bronchitis and emphysema
- Asthma
- Chronic airway obstruction

Paediatric diseases:

- Low birth weight
- Respiratory distress syndrome
- Newborn respiratory conditions
- Sudden infant death syndrome

Tobacco products have no safe level of consumption, and are the only legal consumer products that kill when used exactly as the manufacturer intends. Researchers have rated nicotine as even more addictive than heroin, cocaine, marijuana or alcohol. The Tenth Revision of the International Classification of Diseases reserves classification F17.2 for "tobacco dependence syndrome". Yet tobacco products continue to be aggressively marketed by tobacco companies. The result is that global tobacco consumption has doubled since medical science conclusively proved, 30 years ago, that these products were unrivalled killers. And consumption is still increasing in many areas of the world.

An analysis of trends in cigarette consumption for WHO regions indicates that the two regions with the highest average per capita (adult) consumption in 1990-1992 were Europe (2290 cigarettes per adult per year) and the Western Pacific (2000). The lowest consumption was observed in the African Region (540). For the developed countries as a whole, per capita adult consumption is currently about 2400 cigarettes, which is still significantly greater than the average consumption in the developing world (1370 cigarettes).

The gap is rapidly narrowing, however. In 1970-1972, consumption per adult in the developed countries was 3.25 times higher than in the developing world (see Figure 1). By 1980-1982, this ratio had narrowed to 2.38, and by 1990-1992, to 1.75. During the last decade, per capita consumption has declined by an average of 1.4% per year in developed countries, but has risen by 1.7% annually in developing countries. If these trends were to continue, consumption of cigarettes per adult in the developing world will exceed levels in the developed world some time between the years 2005 and 2010, i.e., within two decades.

There have been very noticeable differences in trends among WHO regions. Over the last decade, the fastest decline in per capita consumption occurred in the Americas. Nor was this entirely due to declines in consumption in Canada and the United States of America; excluding those two countries, per capita consumption in the Region still declined by an annual average of 1.7%. On the other hand, the increasing consumption in the Western

Pacific (2.2%) and South-East Asia (1.8%) is primarily due to the trends in China and India respectively. From 1983, per capita (adult) consumption in China rose by 3.9% per year to reach 1990 cigarettes in 1990-1992. In India, where about 90% of cigarettes are consumed in the form of bidis (traditional hand-rolled cigarettes), adult consumption has risen by about 2% per year over the last decade and now exceeds 1200 cigarettes (including bidis).

WHO estimates that there are about 1100 million regular smokers in the world today. About 300 million (200 million males and 100 million females) are in the developed countries, and nearly three times as many (800 million: 700 million males and 100 million females), in developing countries. In developed countries, 41% of men are regular smokers, as are 21% of women (see Figure 2). Half the men living in developing countries are smokers, compared with about 8% of women.

The health consequences of the smoking epidemic in developed countries have been quantified by WHO, in close collaboration with the Imperial Cancer Research Fund's Cancer Studies Unit at the University of Oxford, UK. A major report giving detailed estimates of the numbers and rates of smoking-attributed deaths for over 50 countries or groups of countries, has been published. Between 1950 and 2000, it is estimated that smoking will have caused about 62 million deaths in the developed countries (12.5 % of all deaths: 20% of male deaths and 4% of female deaths). More than half of these deaths (38 million) will have occurred at ages 35-69 years. Currently, smoking is the cause of more than one in three (36%) male deaths in middle age, and about one in eight (13%) of female deaths. Each smoker who dies in this age-group loses, on average, 22 years of life compared with average life expectancy. During the 1990s, the report estimates that almost 2 million people a year will die from smoking in developed countries (1.44 million men and 0.48 million women).

As regards cigarettes the health consequences of tobacco use are much more difficult to estimate in developing countries owing to lack of data. Currently, it is estimated that tobacco causes about 1 million deaths a year in developing countries, but there is substantial uncertainty about this figure. If current trends continue, and if the risks of death from tobacco use are similar in developing countries to those that have been observed in the industrialized world, then the annual toll of mortality from tobacco will rise dramatically to around 7 million deaths per year in the 2020s or early 2030s (see Table 2). The chief uncertainty is not whether, but rather when, these deaths will occur if current trends in tobacco use persist.

Table 2. Estimated number of Deaths caused every year by Tobacco

	Decade 1990s	Decades 2020s/early 2030s
Developed countries	2 million	3 million
Developing countries	1 million	7 million
Total	3 million	10 million

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Towards Tobacco Control in a Globalised Economy

The 21st century witnessed the world markets being thrown open to free trade rules, raising alarming consequences especially to the developing world. Nevertheless, it worked to the benefit of certain interest groups in the market, one of the prominent among them being the tobacco industry.

The form, nature and the magnitude of the tobacco industry varies from country to country. But globalisation, has primarily given them all access to the global market, thereby expanding their business territories and areas of operation.

The Multinational Tobacco Industry

Tobacco industry today spans across seas, with companies like Philip Morris (PM), British American Tobacco (BAT) and Japan Tobacco expanding its horizons way beyond their countries of origin. These cigarette majors have managed to take their brands to remote corners of the world either through large buyouts of domestic tobacco companies or by opening up subsidiaries and branches. For example, in India, Philip Morris holds 41% shares in Godfrey Philips (popular for their Four Square brand) and BAT holds 31.4% shares in Indian Tobacco Company (ITC). Thailand stands out for its resistance in 1995 to the US Trade Representative trying to force open its market to the US tobacco companies.

The political links of tobacco companies are no secret. Philip Morris has been the largest contributor of unregulated political donations in the last two federal elections in the US[1]. Considering the leading role-played by the US in the global economy, it is but strategic for tobacco corporations to maintain political influence in the US. In 1995, the company capitalising its close association with high political offices drafted a law on growing, manufacturing and advertising of tobacco which was later approved by the Lithuanian government [2]. Thus, tobacco trade has moved on from being a token of goodwill between kings to that which dictates the world order. What is wrong about building a billion-dollar business that boosts the world economy?

The true color of the industry

a) Tobacco is the only consumer product, which if consumed as per the manufacturer's instructions kills half of its life-long users;
b) Tobacco industry has known about the harmful effects of tobacco for more than 30 years but intentionally opted to keep its consumers in the dark about it
c) Besides inflicting 44-odd illnesses in human beings, tobacco poses serious threat to the environment;
d) Tobacco depletes national reserves by way of high medical costs for treating tobacco-related diseases
e) Tobacco is more addictive than cocaine or marijuana thereby robbing its user of the freedom to decide to continue or discontinue its use.

Magnitude of the Tobacco Menace

According to World Health Organisation (WHO), 4 million people die globally from tobacco-related illnesses every year. This is more than the combined global death toll from HIV, Tuberculosis, maternal mortality, homicide, alcohol, suicide and automobile accidents put together [3]. WHO projects that by 2030, the global tobacco death toll would rise to 10 million and 70 % of these deaths would occur in poor developing countries. In India, tobacco kills more than 8 lakh persons every year. If current trends continue, 250 million children alive today will be killed by tobacco [4].

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[1] From research conducted by the Center for Responsive Politics, Washington, D.C. www.opensecrets.org
[2] INFACT survey by Tomas Stanikas, Kaunas Medical Academy, Lithuania, presented at the 10th World Conference on Tobacco or Health, Beijing, August 1997.
[3] Hoard, Barnum. "*The Economic Burden of the Global Trade in Tobacco*," Paper presented at the 9th World Conference on Tobacco or Health, October 1994.
[4] C.J. Murray and A.D. Lopez, Eds. The Global Burden of Disease: *A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020* (Cambridge MA: Harvard School of Public Health, 1996).

Youth are favorite target of the tobacco industry. Tobacco companies use aggressive advertising geared towards getting the children addicted at an early age so that they remain tobacco users for a lifetime. This is in clear violation of the commitments the countries from the region have made under the UN Convention on the Rights of the Child, which guarantees right to life, survival and development of a child.

Scientific studies have shown that Tobacco has been proven to cause cancer of the lungs, mouth and throat, breast, urinary bladder and cervix. Smoking is a leading cause for Peripheral Vascular Disease, which could eventually lead to amputation of limbs and even early death. A cigarette smoker has two to three times the risk of having a heart attack or a stroke compared to a non-smoker. Smokeless tobacco users are more likely to develop cancers of the lip, tongue, and floor of the mouth, cheek and gum than non-users.

Non-smokers who are exposed to tobacco smoke at home, have a 25 per cent increased risk of heart diseases and lung cancer. WHO estimates that 700 million, or almost half of the world's children, breath air polluted by tobacco smoke, particularly at home. Children of smoking parents are more prone to respiratory tract infections such as bronchitis, pneumonia, cot death, middle ear diseases and asthma attacks[5].

Tobacco production costs the environment dearly. In 66 tobacco-growing countries of the world, 4.6% of national deforestation is due to cutting of trees for curing tobacco and for building curing barns. Around 6-8 kilograms of wood are required to cure 1 kilogram of tobacco. Trees are also cut to produce paper for wrapping cigarettes and for packaging of tobacco products. In Thane district in Maharashtra (India), vast acres of forest land is cleared to procure "katha", an ingredient of the indigenous tobacco products Gutkha and pan masala from the bark of Khaire trees[6]. Smoking causes an estimated 10 % of the global deaths from fire. Disposal of the butts, packs, and cartons of tobacco products produces much trash that workers in the US complain that sweeping up cigarette butts causes them hours of extra work each month [7].

Challenges Posed by Tobacco

Factors Influencing Demand For Tobacco And Feasible Solutions

Entrapping Advertising: Tobacco industry is the largest advertiser in the world. Obviously, they have to try hard to sell their product against all its proven dangers to public health. In 1996, Philip Morris the world's largest multinational cigarette company spent $3.1 billon advertising its tobacco and food products [8]. In India, approximately Rupees 400 crore is spent on tobacco ads every year. In Bangladesh, British American Tobacco which owns controlling share of Bangladesh's former tobacco monopoly, spent $ 3.4 million on brand promotions and development in 1998.

With the growing restrictions on direct advertising of tobacco products world wide, the industry is evolving dubious and unscrupulous marketing strategies to circumvent law. A quick look at these promos exposes their tactic to hook young and fresh consumers to their products through indirect means like brand stretching and sponsoring youth programmes such as sports and cultural meets. The industry has always opposed ad bans and ingeniously suggests voluntary restrictions, which have proven to be ineffective in other countries. In a recent study involving 22 high-income countries it was revealed that where most comprehensive advertising restrictions were in place, tobacco consumption had fallen by 6 %[9].

Package Advertising: Tobacco companies for decades have been effectively using the tobacco package space as an excellent advertising media. Countries like Canada, Brazil and European Union have realised the power of package advertising and have made it mandatory to display pictorial health messages on tobacco packs. The

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[5] Report of the Scientific Committee on Tobacco and Health. Department of Health, UK, 1998.

[6] "*Dawood is diversifying into Gutkha*", Bombay Times, 04/12/2000.

[7] Novotny & Zhao 1999.

[8] R. Hammond. *Tobacco Advertising and Promotion: The Need for a Co-ordinated Global Response*. Geneva: World Health Organisation. 2000

[9] P. Jha & F.J. Chaloupka. Curbing the Epidemic,Governments and the Economics of Tobacco Control. Washington. 1999.

Canadian experience as revealed in a recent survey has been that 44 % of smokers said that the new warning increased their motivation to quit and among those attempted to quit in 2001, 38% cited the warnings as a motivating factor. 35 percent of smokers and 34 percent of nonsmokers said they know more about the health effects of smoking than they did before the new warnings [10].

Tobacco & Poverty: Researchers from Bangladesh and India report that tobacco use further impoverishes poor-income households. In a recent survey conducted among 400 pavement dwelling families in Mumbai, India, the poor spend more on purchasing tobacco than on nutritious food like meat, milk, fruits or egg[11]. Similarly, among the poor income households in Bangladesh a typical male smoker spends 5 times as much on cigarettes as the per capita expenditure on housing, 18 times as much as for health and 20 times as much as for education[12]. Obviously, tobacco reduces the purchasing capacity of the poor to procure basic life needs.

Affordability : Increasing tax is a feasible strategy to reduce accessibility and affordability especially among income-sensitive groups. This should be a popular strategy among the Governments as it brings additional revenue to the Government exchequer..

Increasing taxes, increases smuggling" is the typical industry line of argument. However, it has been found that increase in contraband and smuggling arises out of poor low enforcement and customs regulations rather than from tax increases.

Sale of loose tobacco products also accentuates the tobacco consumption especially among the price-sensitive groups.

Rights and Awareness: Addictive as tobacco is, it robs its user of the power to choose to continue or discontinue its use. In doing so, it deprives the consumer of the basic right to choose. Tobacco companies hide information about the harmful effects of their products thereby denying the consumers the right to information based on which they could otherwise make an "informed choice". Children's rights to life, survival and development are jeopardized in terms of reduced access to health and education from increasing tobacco expenses incurred by adults in the family. They are choked from passive smoking, which the adults in their environment are unmindful of.

Issues related to the Supply of Tobacco

The tobacco industry perpetually whips up farmers' associations and unions creating fear that tobacco control would lead to massive unemployment in the tobacco production sectors. However, economists Jha & Chaloupka (1999) who have done extensive macro analysis of tobacco producing economies allay these fears[13].

They opine that the negative effects of tobacco control on employments have been grossly overstated. While there would be no net loss of jobs, there might even be job gains if global tobacco consumption fell. This is because money spent on tobacco would be spend on other goods and services thereby generating more jobs. Even in economies heavily dependent on tobacco, aid adjustment, crop diversification, rural training and other safety net systems would take care of the problem.

Even in countries with comprehensive tobacco control policies, tobacco consumption reduces at best by 1 %. With increasing population in most of the developing countries it would be a while before there would be any considerable impact on tobacco production, giving farmers sufficient time to diversify into alternate avenues.

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[10] Research by Canadian Cancer Society on the Effectiveness of Pictorial Health Warnings. 2001.

[11] S. John, S. Vaite & D. Efroymson. *Tobacco and Poverty: Observations from India and Bangladesh.* PATH Canada. October 2002.

[12] D. Eforymson & S. Ahmed. *Hungry for Tobacco.* Work for a Better Bangladesh. 2001.

[13] P. Jha & F.J. Chaloupka. Curbing the Epidemic, Governments and the Economics of Tobacco Control. Washington. 1999.

A recent study conducted among tobacco farmers in Karnataka, one of the leading tobacco producing States in India, reveals that diversification to alternate livelihood is a feasible option for those engaged in various tobacco production avenues. Tobacco farmers have been found to suffer from several occupational health hazards and complain of perpetual state of poverty and debts[14].

Envisaging future decline in bidi smoking, Kerala Dinesh Bidi, the largest co-operative society in Asia launched its diversification efforts into food processing and other consumer products. In the first three years of diversification, 15 out of the 30 products have been reported to be breaking even[15].

Another major argument leveled against diversification is that with these efforts countries would cease to receive the tax they are currently getting from tobacco taxes. This is a fallacy. In India, for instance, the Government revenue from tobacco is way below what it spends on treating tobacco-related illnesses.

Also, with tobacco users reducing its consumption in response to tobacco control measures, it is likely that they would invest in other consumer products. This would lead to development of other sectors of the economy and thus contribute to overall national growth.

Framework Convention on Tobacco Control (FCTC)

In 1998, the World Health Organisation invoked its prerogative to propose an international tobacco control treaty named Framework Convention on Tobacco Control to contain the global tobacco epidemic. This first global public health treaty addresses transnational issues pertaining to tobacco advertising, smuggling, packaging, testing and reporting of toxic constituents, environmental tobacco smoke and resource sharing.

The treaty is currently moving towards the final stages of its negotiation by 190 odd Member Nations of WHO in the last and sixth round of negotiation scheduled for Mid February 2003. It is slated to be adopted by World Health Assembly in May 2003.

The treaty is significant for the Asian countries, primarily in resisting the tobacco industry which considers us the prime target in this decade. It serves as a booster to build national tobacco control policies and programmes. The negotiations for the first time in the history of tobacco control movement, has brought together people, Governments, NGOs, energy and resources from all over the world to address the tobacco pandemic.

Tobacco Control in Asia

In the last decade, several organisations in the region have initiated awareness programmes among children, youth, women and workers as a prevention strategy. Some of them advocate strong tobacco control policies home and abroad. In India, research and surveillance have been carried out on different population groups on their tobacco control patterns.

Thailand has advanced tobacco control programmes and policies. India has of late proposed the Tobacco Products Bill, banning tobacco advertising, promotions and smoking in public places among others. Bangladesh and Nepal are also drafting national policies to contain the tobacco epidemic.

In the recent years, tobacco control activists have realised the power of collective strength and have formed networks and coalitions at local and national levels. The Consortium for Tobacco Free Karnataka, Indian Coalition for Tobacco Control, Bangladesh Anti Tobacco Alliance, South Asia Tobacco Control Forum and South East Asia Tobacco Control Alliance, Framework Convention Alliance are a few of the active alliances in the region.

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[14] S. John, S. Vaite & D. Efroymson. *Tobacco and Poverty: Observations from India and Bangladesh.* PATH Canada. October 2002.

[15] *Ibid.* Interview with Kerala Dinesh Bidi Office Bearers.

In 1998, World Health Assembly launched the drafting of an international treaty to address trans-national tobacco control issues. The treaty, Framework Convention on Tobacco Control is currently is in the last stages of its development, with over 150 world countries concluding its negotiations soon in Geneva. Countries and organisations from the region play a vital role in demanding stringent tobacco control measures in this treaty.

Emerging Needs of Tobacco Control in Asia

Industry documents and operations reveal that they are now training their guns on Asia and Africa. Lack of adequate tobacco control policies and failure in implementing the existing policies make all of us more vulnerable to the attacks of these companies as also to tobacco epidemic. Illiterate masses and cultural practices also seem to be hurdles in tobacco control in Asia. The emerging needs therefore for the region are:

a) Building awareness among the Asian people about the health and socio-economic consequences of tobacco use and trade
b) Exposing myths and cultural practices that promotes the habit
c) Training development workers and organization on tobacco control issues
d) Building networks and coalitions that would serve as pressure groups in policy advocacy
e) Engaging in active advocacy for tobacco control policies at national and regional level
f) Advocacy for effective implementation of FCTC commitments in the region

Possibilities for Collaboration

The issues involved in tobacco control demands a matching o-ordinated response from different sectors of the civil society. World Health Organisation responded to this global epidemic by setting up the Tobacco Free Initiative in 1998, which in turn supports various global campaigns and programmes in tobacco control. It calls upon the civil society each year to observe 31st of May as the World No Tobacco Day.

Besides, there are various networks, coalitions and organizations already engaged in active tobacco control. If you are further interested in learning or engaging in tobacco control issues, feel free to contact any of the organisors of the event listed below:

Thelma Narayan, Community Health Cell
Consortium for Tobacco Free Karnataka
International Secretariat
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UICC *GLOBALink*

The International Tobacco-Control Network Selected documents: The Death Toll form Tobacco - A Crime Against Humanity

September 1998

Deaths caused by smoking

There are between 1.1 -1.4 billion smokers in the world out of a total population of around 5.8 billion. It has been estimated that 50% of smokers will die prematurely from tobacco related illness, half in middle age (defined as 35 - 69 years of age) with an average loss of life expectancy of 20 - 25 years (8 years over all ages).

This means that over half a billion people (in excess of 500 million) or about 10% of the existing population will die from smoking. Of these, 27% will die from lung cancer, 24% will die from heart disease, 23% will die from chronic obstructive lung disease, emphysema or bronchitis and the remaining 26% will die from other diseases including other circulatory disease (18%) and other cancers (8%).

Currently, 3 million people worldwide die every year from smoking related disease. This represents about 1 person every ten seconds. One third of all people aged fifteen years and over smoke and this proportion is increasing in Asia, Eastern Europe and the former Soviet States. Consumption trends indicate that smoking prevalence is reducing in developed countries (DCs) (down 1.5% per annum in the United States) whilst increasing in lesser-developed countries (LDCs)(up 1.7% per annum on average).

The World Health Organisation (WHO) has estimated that, based on current trends, the death toll from smoking will rise to 10 million people per year by the year 2025. Currently two million deaths occur each year in developed countries and 1 million deaths occur each year in lesser-developed countries. By 2025 this proportion will alter to 3 million deaths per year in developed countries and 7 million deaths per year in lesser-developed countries. No other consumer product in the history of the world had come even close to inflicting this degree of harm on the world community. If anything else posed a threat to life of this magnitude whether human induced or naturally occurring - be it world war, genocide, ethnic cleansing, natural disaster or disease - it would demand immediate international action. The response to HIV, the prosecution of war crimes (both current and dating back to World War II), germ warfare, nuclear weapons or even climate change are but a few examples.

The history of the smoking pandemic of the 20th century can be traced back to the invention of the mechanical cigarette machine in the late 1800's. Until that time cigarettes were rolled by hand, production was low and smoking was not overly prevalent. The cigarette machine meant that millions of cigarettes could be produced each day at a lower cost and distributed more widely. The result was that cigarette smoking increased such that by the late 1940's smoking rates in developing countries were up to 70% in adult males and up to 25% in adult females. Smoking rates in LDCs were significantly less.

From the discovery of the link between increased smoking and disease in the early 1950's, and major reports publicising the need for public health action, smoking rates among adult males in developed countries has declined although prevalence in adult females increased to some degree

but now the levels are roughly equal at about 25% in many developed countries. Meanwhile, smoking rates in lesser-developed countries has increased in both the adult male and adult female population.

Due to the latency in the development of disease from smoking, the effects were first detected among adult males in developed countries. The effect of increased smoking among adult females is now being reflected in disease rates with similar observations in lesser-developed countries. Hence the WHO estimates by the year 2025.

Transnational tobacco companies

Tobacco consumed by the world's 1.1 - 1.4 billion smokers is produced by a handful of transnational tobacco companies and a number of state owned manufacturers. China's state owned production accounts for 31% of all tobacco sales with Italy, Russia, Japan, Taiwan, Indonesia and Thailand, amongst other countries, having substantial government owned factories as well.

However, transnational tobacco companies account for 40% of the global market and control 70% of world production, and this is increasing. In many cases, the state owned producer was a state monopoly but, increasingly, this has been broken down through free trade agreements to a point where transnational tobacco companies are not only marketing in countries previously the subject of a state monopoly but there are reports of expressions of interest by transnational tobacco companies in obtaining an interest in formerly state owned monopolies now being privatised.

Whilst all tobacco consumption contributes to the overall death toll, state owned production is arguably an internal matter to the nation - state in question. The activities of privately owned, transnational tobacco companies is a matter on international concern. The major transnational tobacco companies, in order of sales, are: US based Philip Morris Inc., followed by British based BAT Industries p.l.c., United States based RJR Nabisco and Rothmans. Under agreements apparently reached among these transnational tobacco companies, Rothmans does not market in the United States and BAT does not market in Britain. There are reports that Philip Morris and BAT have entered into collusive agreements that fix cigarette prices and divide markets in South America (apparently such anti competitive arrangements are not illegal in those countries). It is a mark of the power of the major transnational tobacco companies that they can reach such agreements dividing up markets in sovereign nations consequently inflicting the harm identified above. In 1996, Philip Morris had annual revenues of $55 billion, just over half from tobacco with the rest coming from domestic and international food and alcohol sales. Only 18% was from domestic tobacco sales (20% in 1992) compared with 35% from international sales (21% in 1992). Total tobacco sales comprised 53% in 1996 (41% in 1992) or about 23 billion. BAT revenue in 1996 was $23 billion. RJR Nabisco had total revenues of $17 billion in 1996 of which 48% or about 8 billion was from tobacco sales. These massive levels of turnover and the economic, political and social influence of the transnational tobacco companies has led to the industry being described collectively as "Big Tobacco". A comparison is made that these revenues exceed the gross domestic product of many countries. For example, Philip Morris has a turnover larger than the GDP of Ecuador, Guatemala, Kenya, Kuwait, Malaysia and Peru. It is roughly the equivent of Ireland, Singapore or Hungary. RJR Nabisco's turnover is roughly the equivalent of the GDP of Costa Rica, Croatia, Cuba, El Salvador, Lebanon or Jamaica. Whilst these companies undoubtedly have significant economic, political and social influence, the fact remains (with all due respect to the countries with which comparison is made), these transnational tobacco companies, either individually or collectively, are not an overwhelmingly dominant force on a world scale.

Deceit and duplicity of the tobacco industry

The current status of the tobacco industry is anomalous insofar as cigarette consumption clearly inflicts a degree of mortality totally at odds with fundamental human rights and human values. At the same time the tobacco industry defends itself on the basis that tobacco is a "legal product". This occurred because the tobacco industry had already acquired a substantial degree of economic, political and social influence by the time the link between smoking and disease was established. Since that time the tobacco industry worldwide has engaged in a deliberate campaign of deceit and duplicity to protect and even expand its influence through a process of denial and disputation of the now proven link between smoking and disease, the addictive properties of nicotine and their marketing strategies directed at youth.

This deceit and duplicity is currently being exposed by litigation in the United States which is spreading worldwide. The position has now been reached where continued disputation and distortion is untenable, particularly in the face of the projected increase in tobacco deaths by the year 2025 if current trends are continued. This is all the more so given the disparity in the projected increase between developed and less developed countries, reflecting an exploitation of lesser developed countries which will only increase to offset liabilities the tobacco industry is incurring in the United States. This is a circumstance calling for international action. It must not be allowed to happen. Were it to occur it would be, without doubt, a crime against humanity.

Crimes against humanity in the International Criminal Court

On 17 July 1998 the United Nations Rome Statute of The International Criminal Court established a permanent Court having power to exercise jurisdiction over persons for the most serious crimes of international concern. Article 5 confers jurisdiction on the International Criminal Court with respect to the following crimes:

1. The crime of genocide;
2. Crimes against humanity;
3. War crimes;
4. The crime of aggression.
5.

For the purposes of the Statute, Article 7 defines a "crime against humanity" to mean any of the following acts when committed as part of a widespread or systematic attack directly against any civilian population, with knowledge of the attack;

1. Murder;
2. Extermination;
3. Enslavement;
4. Deportation or forcible transfer of population;
5. Imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law;
6. Torture;
7. Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation, or any other form of sexual violence of comparable gravity;
8. Persecution against any identifiable group or collectively on political, racial, national ethnic, cultural, religious, gender as defined in paragraph 3, or other grounds that are universally recognized as impermissible under international law, in connection with any act referred to in this paragraph or any crime within the jurisdiction of the Court;

9. Enforced disappearance of persons;
10. The crime of apartheid;
11. Other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

Given what is known about smoking and disease and the deceit and duplicity of the tobacco industry, were the death toll from tobacco to increase from 3 million a year to 10 million a year by the year 2025, especially with the dramatic increase in lesser developed countries from 1 million a year to 7 million a year, it is impossible to describe that consequence as anything other than the result of an inhumane act of a character similar to murder, causing great suffering, or serious injury to body or to mental or physical health committed as part of a widespread or systematic attack directed against the civilian population of the world.

Given that the directors and executives of the major transnational tobacco companies must now have knowledge of the consequences of their activities, if those activities continue then each and every one of them must face the prospect of being charged with committing a crime against humanity in the International Criminal Court. Article 11 of the Statute provides that the Court has jurisdiction only with respect to crimes committed after the entry and the force of the Statute. This means that the opportunity exists for these directors and executives to escape liability under the provisions of the Statute providing there is no increase in mortality from tobacco use. Arguably they should be responsible for a reduction. Given the likely increase in mortality from past smoking, because of the latency of tobacco related disease, every effort would need to be made to reduce consumption in order to avoid a significant increase in the current death toll. Certainly expansion in lesser-developed countries should not occur. As a means of securing this outcome, each of the major transnational tobacco companies, and each of their directors and executives, should formally be put on notice of the consequences of their activities such that charges of a crime against humanity can be laid and successfully prosecuted if radical action is not taken to reverse current trends.

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WHY DO YOUNG PEOPLE SMOKE?

There are a number of complex and inter-relating factors that predispose young people to smoke, and these vary among individuals and among populations. However, years of research have identified certain factors that commonly play a role in smoking initiation. These include high levels of social acceptability for tobacco products, exposure and vulnerability to tobacco marketing efforts, availability and ease of access, role modelling by parents and other adults, and peer group use.

Minimizing of risk

Adolescents frequently experiment with new behaviours, but don't often take into serious consideration the long-term consequences. Some youths who are exposed to tobacco messages from an early age come to accept the notion that tobacco provides certain psychological benefits which will help them through adolescence. For them, the risks of tobacco use, which are perceived to be remote, are outweighed by the immediate psychological benefits. Young people tend to underestimate the addictiveness of nicotine and the difficulties associated with quitting, tending to believe that it is easier for young people to quit than adults. However, they soon find that the addiction to nicotine remains long after any psychological benefits are gone. Studies in some countries show that four-fifths of everyone who has smoked as many as 100 cigarettes will be smoking two years later, and half will still be smoking in 20 years. This means that, at least in the countries studied and possibly elsewhere, about half of those who became addicted as adolescents will still be smoking at age 35.

Exposure to tobacco advertising and promotion

The role of advertising is critical to the adolescent's conditioning process. In advertisements, tobacco users are portrayed as glamourous, popular, independent, adventurous, and macho. By selecting brands that present these images, young people may feel that they are internalizing these characteristics. A study in the United States found that among teens who smoke, 85% chose the three most heavily advertised brands of cigarettes, compared to only 35% of adults. Data suggest that children are more responsive than adults to the messages and images contained in tobacco advertisements. And young people who are more aware of tobacco promotions are more susceptible to become users of tobacco products.

Children's attitudes and behaviour regarding tobacco are influenced by advertising. Thus, tobacco advertising subverts the understanding and ability of young people to make a free, informed choice whether or not to smoke. Advertising also leads teens to believe that smoking is more common than may actually be the case, particularly among their peers. (See *In search of new customers: Advertising plays an important role.*)

Modelling of adults

"The (tobacco) industry knew that as long as young adults....provided role models for children, it didn't matter how much you tried to educate children not to smoke, they would not take any notice." Sir Richard Doll, 1991

Children perceive smoking to be an adult behaviour, and children may often appear more grown-up. Studies show that young children are influenced by parents who smoke, forming more positive attitudes towards smoking than those living with non-smoking parents. This association was found in children as young as three years old. In one study, twice as many children of smokers say that they want to smoke compared to children of non-smokers. Adolescent children of parents who successfully quit smoking are also much less likely to smoke compared to those of parents who do smoke.

Adults should be made aware of the impact of their own smoking behaviour on the future smoking behaviour of children. It is essential for adult smoking to be reduced and marginalized as part of a comprehensive strategy to decrease smoking among young people.

Candy or chocolate cigarettes may be one of the first experiences a child has of imitating adult smoking behaviour, and these kinds of cigarettes deliver a very inappropriate message. The encouragement to imitate smoking as a desirable adult behaviour through the use of these confectionary products aimed specifically at children should be discouraged. Some countries already have a ban on such products.

Susceptibility to starting to smoke

There are many environmental influences that help determine the likelihood that an adolescent will become susceptible and experiment with cigarettes. An adolescent is labelled as cognitively susceptible to smoke if she or he is not absolutely sure that she or he will not smoke a cigarette in a given situation. Those who develop a cognitive susceptibility are twice as likely to experiment with smoking than other adolescents. In the USA, susceptibility to start smoking starts around age 10 years and peaks by age 14 years in close to 60% of the population. Once adolescents have experimented, approximately half continue to smoke and become addicted. An adolescent who thinks that the health problems of smoking can be alleviated, provided that you stop smoking before the age of 35, appears to be at much greater risk of experimentation.

Peer pressure

Exposure to peers who smoke increases the risk of adolescents starting to smoke. However, it appears that this influence is particularly important after the adolescent has already become susceptible to smoking. Indeed, the effect of peers is most noticeable in the transition from experimental smoking to addiction.

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CHANGING THE ENVIRONMENT TO HELP KIDS GROW UP TOBACCO-FREE

COMPREHENSIVE POLICIES AND PROGRAMMES ARE NECESSARY

Children do not simply "choose" to smoke. They are greatly influenced by their environment, which is greatly influenced by public policies. Children are much more likely to smoke if they are surrounded by attractive tobacco advertising and promotion: if their favourite sport is sponsored by a tobacco company; if their film idols smoke in the movies; if they see people smoking all around them; and if tobacco products are cheap and readily available to them.

Educational programmes serve a purpose, particularly in countries where the harms of tobacco use are not widely known. However, without sound public policies, the billions of dollars tobacco companies spend promoting their products and creating a "pro-tobacco" environment for children can overwhelm the healthy messages children receive from parents and in the schools. Strong public policies help level the playing field and give children a real chance to grow up tobacco-free.

Which Youth-Oriented Policies Work?

Policy experts agree that a combination of the policies described below should significantly reduce tobacco use by youth, provided they are **sustained over time**, and **strictly enforced**, and **adequately funded**. For real progress to be made, it is also important that all of the recommended policies be implemented. Although benefits will be realized through the implementation of even one of these policies, a comprehensive approach works best. Tobacco companies denied one approach to marketing or selling tobacco products to children will redouble efforts using any other methods that are not prohibited.

All of these policies are included within *WHO's Ten-Point Programme for Successful Tobacco Control*. The following points, derived from World Health Assembly resolutions, along with recommendations from other international and intergovernmental bodies lists some key elements that should be included in comprehensive national tobacco control programmes.

A TEN-POINT PROGRAMME FOR SUCCESSFUL TOBACCO CONTROL

1. Protection for children from becoming addicted to tobacco.
2. Use of fiscal policies to discourage the use of tobacco, such as tobacco taxes that increase faster than the growth in prices and income.
3. Use of a portion of the money raised from tobacco taxes to finance other tobacco control and health promotion measures.
4. Health promotion, health education and smoking cessation programmes. Health workers and institutions set an example by being smoke-free.
5. Protection from involuntary exposure to environmental tobacco smoke (ETS).
6. Elimination of socio-economic, behavioural and other incentives which maintain and promote use of tobacco.
7. Elimination of direct and indirect tobacco advertising, promotion and sponsorship.
8. Controls on tobacco products, including prominent health warnings on tobacco products and any remaining advertisements; limits on and mandatory reporting of toxic constituents in tobacco products and tobacco smoke.
9. Promotion of economic alternatives to tobacco growing and manufacturing.
10. Effective management, monitoring and evaluation of tobacco issues.

Higher tobacco taxation

Studies consistently show that children are more sensitive to price increases than adults In the United States, for example, youth are about three times more likely than adults to quit smoking, or not to start smoking, in response to a tobacco price increase. Increasing the price puts a higher barrier between youths and easy access. Thus, tobacco tax increases are good health policy and good fiscal policy. Cheap cigarettes are not a social benefit, because they encourage more smoking, causing higher health care costs and more death and disease. One other way to make cheap cigarettes less accessible to young people would be to legislate against single sales of cigarettes as well as half-size cigarette packages, known in some countries as "kiddie packs".

In many countries, governments earn substantial tax revenue from illegal sales of tobacco products to minors, but often are putting only a small percentage of it back into prevention programmes for young people. It is uniquely appropriate that a portion of funds raised by tobacco taxes be used to fund programs to protect children and reduce tobacco use. This funding approach has been used in Australia, the United States. Canada and other countries, and has proven to be effective and politically popular.

Multisectoral collaboration

The Jakarta Declaration On Leading Promotion into the 21st Century (Jakarta, July 1997) identifies international trade in tobacco as having a major negative impact on public health, and consequently the health of children. It calls for the creation of new partnerships for health, between governmental and nongovernmental organizations, between public and private sectors at all levels of governance in society and for the formation of a global health promotion alliance. Such concerted intersectoral and transnational efforts are urgently required to counteract the efforts of the multinational tobacco companies.

Marketing restrictions

Advertising affects young people's perceptions of the pervasiveness, image, and functions of smoking. Studies have shown that in some countries, tobacco advertising is twice as influential as peer pressure in encouraging children to smoke. Children are often more likely to buy the most heavily advertised brands of cigarettes. Because tobacco advertising is inherently misleading, public policies should prohibit all tobacco advertising and promotions, including free samples and other giveaways, sale of non-tobacco products that carry a tobacco brand name, point of sale advertising and tobacco company sponsorship of sporting and cultural events. Those countries which have adopted bans on tobacco advertising as part of a comprehensive tobacco control programme have seen significant declines in tobacco consumption.

Prohibition of sales to minors

In many countries, tobacco products are routinely sold to children, while selling other addictive, lethal drugs to children is not tolerated. A minimum age of 18 or older should be established for tobacco sales. All tobacco retailers should be licensed and their license should be contingent on obeying the law. A graduated schedule of civil penalties ranging from a warning to license revocation should be established. Enforcement is critically important! If these laws are not enforced, they will not be obeyed. Enforcement funds may be raised from licensing fees and penalties, so these measures can be self-supporting. To eliminate possibilities of unsupervised sales of tobacco products, vending machine sales should be prohibited.

In recent years, tobacco control programmes in a number of countries have attempted to limit the possibility that cigarettes will be sold to minors. However, even where these programmes are effective in limiting actual sales, the majority of young people still think that obtaining cigarettes is easy. Studies found that many regular adolescent smokers do not buy their own cigarettes. Older siblings and acquaintances are clearly prepared to purchase for underage minors. Therefore, while strategies to reduce the availability of tobacco products to young people are important, they will be of only limited value unless accompanied by comprehensive tobacco control programmes.

Countermarketing and education programmes

Many governments have established successful programmes using the mass media to provide strong messages designed to counter the image promoted by cigarette companies of tobacco use as sexy, glamorous and normal. Equally important are school-based and community-based programmes to teach children about the dangers of tobacco use and to teach them the skills they need to resist tobacco marketing efforts and peer pressure. Research shows that coordinated mass media programmes and education programmes produce much better results than either approach by itself.

Protection from environmental tobacco smoke

It is important that smoking be legally prohibited in public places, especially where children may be present. First, environmental tobacco smoke has been established beyond question to be harmful to all people, and especially to children. Second, if public places become smoke-free, then young people will have far fewer places to light up, and this could go a long way in reducing smoking. Finally, children who grow up seeing smoking permitted all around them will wrongly conclude that smoking must not be very harmful, and that it is socially acceptable to smoke. Incidently, tobacco companies work very hard to make smoking appear socially acceptable. The 1988 mission statement of one tobacco company in Canada included the following intention: "support to continued social acceptability of smoking through industry and/or corporate actions."

HOW TO PROMOTE TOBACCO CONTROL POLICIES

Although tobacco is much more than a youth issue, emphasising the harms to young people may be useful in generating support for tobacco control among politicians and the general public. Even smokers are more likely to support tobacco control legislation if they believe it will help prevent children from starting to smoke. The rationale that children may not be in a position to make informed and rational decisions about whether or not to become tobacco users can also help further policies which will help protect children from the pressures to use tobacco.

Policies to protect children from tobacco can be passed in many forms and at many different levels of government (e.g., local, provincial, national and international). Policies may be passed most easily as regulations in some places and as legislation in others. In most countries, however, nongovernmental organizations (NGOs) play a critical role in promoting passage of tobacco prevention laws.

Successful campaigns generally follow three stages:
Advance research and planning

It is important to gather as much information as possible at the outset about the issue, define feasible objectives and strategies, and determine who are likely allies and opponents, what the public thinks, whether a strong coalition can be formed, and how a campaign can be funded. Research and planning will be necessary throughout, but it is never more important than at the beginning.

Launching the campaign

If the advance research and planning suggests that a full-scale campaign is warranted, the next step is to bring the issue into focus for the media and politicians and get it onto the public agenda. Events such as release of a study supporting new policies, a press conference, introduction of legislation, expressions of support by leading politicians, etc., can be planned to keep public attention on the issue. Positive media exposure is often the key to success.

Lobbying for passage

If the proposal is a good one, opposition from the tobacco industry will be fierce and the campaign will be hard-fought. There will be many challenges; clever tactics by the opposition will have to be anticipated and defeated. A successful campaign must be tireless, strategic and aggressive. Help from experienced lobbyists who know the politicians involved can be extremely helpful. International support for the measures can also prove very useful.

It will be important to broaden the base of support for the proposal at every stage, and to maintain a positive, reasonable approach. Politicians and the media alike will shun organizations and individuals they believe are too extreme.

Of course, many campaigns do not succeed at first, and so the issue must be fought again and again until a proposal passes. Even after the proposal becomes law, the job is not done. The gain must be protected from future attacks. For example, will the law be strictly enforced? Is adequate funding appropriated? After every victory or defeat, it is important to thank allies, learn from successes and failures, and regroup for the next campaign.

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THE TOBACCO EPIDEMIC: A CRISIS OF STARTLING DIMENSIONS

Tobacco kills nearly 10,000 people every day

The facts speak for themselves. Tobacco use worldwide has reached the proportion of a global epidemic with little sign of abatement. Each year, tobacco causes about three and a half million deaths throughout the world. This translates to nearly ten thousand deaths per day. Based on current trends, this will increase to ten million annual deaths during the 2020s or 2030s, with seven million of these deaths occurring in developing countries. Based on current patterns of consumption, it is predicted that over 500 million people currently alive will be killed by tobacco.

In developed countries, where smoking became widespread during the 1940s and 1950s, the catastrophic effect of past smoking trends can now be seen. About 20% of all deaths occurring at present in developed countries are due to tobacco. By 2020, it is predicted that tobacco use will cause over 12% of all deaths globally. By 2020, it is predicted that tobacco will cause more deaths worldwide than HIV, tuberculosis, maternal mortality, motor vehicle accidents, suicide and homicide combined.

HOW TOBACCO AFFECTS YOUNG PEOPLE

Tobacco affects young people in an extraordinary number of ways. Due to environmental tobacco smoke (ETS) and maternal smoking, children's health may even be compromised from before the time they are born. In many countries, children may grow up in a haze of tobacco smoke, wreaking further havoc with their health. Household money that is spent on tobacco reduces the amount available for food, education and medical care. Children may also suffer the emotional pain and financial insecurity that comes from the loss of a parent or caretaker who dies an untimely death due to tobacco.

On another level are the pervasive pressures for young people to use tobacco. People everywhere seem to be smoking. Attractive advertisements and exciting tobacco promotions are difficult to resist. Especially when the price is affordable, and it's no problem for minors to buy tobacco.

Even if the health risks are understood, the message that tobacco kills is not very relevant to young smokers, who believe themselves to be immortal. By the time they are ready to quit smoking, addiction has taken hold. These factors all contribute to the grim statistics. Based on current trends, about 250 million children alive in the world today will eventually be killed by tobacco.

WHO believes that every child has the right to grow up without tobacco. This means without the rampant pressures to use tobacco, which in many countries emanates from all corners. There is a need to change the environment to one where non-smoking is considered normal social behviour and where the choice not to smoke is the easier choice.

Tobacco is fast becoming a greater cause of death and disability than any single disease

REF:

Research shows that the risks from smoking are substantially higher than previously thought. With prolonged smoking, smokers have a death rate about three times higher than non-smokers at all ages starting from young adulthood. On average, smokers who begin smoking in adolescence and continue to smoke regularly have a 50% chance of dying from tobacco. And half of these will die in middle age, before age seventy, losing around 22 years of normal life expectancy. Therefore, a lifelong smoker is as likely to die as a direct result of tobacco use as from all other potential causes of death combined. Tobacco is a known or probable cause of about 25 diseases, and the sheer scale of its impact on global disease burden is still not fully appreciated. For example, it is well know that tobacco is the most important cause of lung cancer. Less known is the fact that tobacco kills more people through many other diseases, including cancers in other parts of the body, heart disease, stroke, emphysema and other chronic diseases. Studies in the United Kingdom have shown that smokers in their 30s and 40s are five times more likely to have a heart attack than non-smokers.

TOBACCO USE IS A KNOWN OR PROBABLE CAUSE OF DEATH FROM:

Cancers of the:

- Lip, oral cavity and pharynx
- Oesophagus
- Pancreas
- Larynx
- Lung, trachea and bronchus
- Urinary bladder
- Kidney and other urinary organs

Cardiovascular diseases:

- Rheumatic heart disease
- Hypertension
- Ischaemic heart disease
- Pulmonary heart disease
- Other heart diseases
- Cerebrovascular diseases
- Atherosclerosis
- Aortic aneurysm
- Other arterial diseases

Respiratory diseases:

- Tuberculosis
- Pneumonia and influenza
- Bronchitis and emphysema
- Asthma
- Chronic airway obstruction

Paediatric diseases:

- Low birth weight
- Respiratory distress syndrome
- Newborn respiratory conditions
- Sudden infant death syndrome

Lung cancer and other diseases caused by passive smoking

According to WHO estimates, there are around 1.1 billion smokers in the world--about one-third of the global population aged 15 years and over. Of these, 800 million are in developing countries. Data suggest that, globally, approximately 47% of men and 12% of women smoke. In developing countries, 48% of men and 7% of women smoke, while in developed countries, 42% of men smoke as do 24% of women. By the mid 2020s, the transfer of the tobacco epidemic from rich to poor countries will be well advanced, with only about 15% of the world's smokers living in rich countries. Health care facilities in poorer countries will be hopelessly inadequate to cope with this epidemic.
In certain regions, the health consequences of tobacco use are particularly devastating. In the Former Socialist Economies, around 17% of all deaths in 1995 were due to tobacco use. This figure is expected to increase so that in 2020, more than 22% of all deaths in this region will be due to tobacco. In 1995, it was estimated that 41% of all deaths among men aged 35-69 years in this region were caused by tobacco.
There has occured a shifting of the tobacco epidemic. The apparent success in tobacco control in some countries has been negated by growth in tobacco use in less developed countries. So, globally there has been no net progress in reducing tobacco consumption.
In absolute figures, the biggest and sharpest increases in disease burden are expected in India and China, where the use of tobacco has grown most steeply. In China alone, where there are about 300 million smokers, new data show there are already about three-quarters of a million deaths a year caused by tobacco. Based on current trends, of all the children and young people under the age of 20 years alive today in China, at least 50 million of these will eventually die prematurely because of tobacco use.
Although life expectancy for both sexes is predicted to rise, in many countries, the gap between them is growing significantly due to the large number of men who smoke and die of tobacco-related diseases. However, the number of women and girls who smoke is also rising, and so too will the number of tobacco-related deaths among women.

HEALTH BENEFITS OF QUITTING SMOKING

- One year after quitting, the risk of coronary heart disease (CHD) decreases by 50%, and within 15 years, the relative risk of dying from CHD for an ex-smoker approaches that of a long-time non-smoker.
- The relative risk of developing lung cancer, chronic obstructive lung diseases, and stroke also decreases, but more slowly.
- Ten to fourteen years after smoking cessation, the risk of mortality from cancer decreases to nearly that of those who have never smoked.
- Quitting smoking benefits health, no matter at what age one quits.

ENVIRONMENTAL TOBACCO SMOKE SERIOUSLY DAMAGES HEALTH OF NON-SMOKERS

Environmental tobacco smoke (ETS) contains basically all of the same carcinogens and toxic agents that are inhaled directly by smokers. Evidence is quickly mounting as to the serious health consequences of ETS, both for adults and for children. These findings make a strong case for swift and tough policies to limit smoking in public places.

Exposure to ETS is a cause of disease, including lung cancer and possibly coronary heart disease in healthy non-smokers. Prolonged exposure to environmental tobacco smoke increases the risks of lung cancer and heart disease in healthy adults, possibly by as much as 20-30%.

ETS can also result in aggravated asthmatic conditions, impaired blood circulation, bronchitis and pneumonia. It also is a frequent cause of eye and nasal irritation.

Health consequences of ETS particular to young people:

Children exposed to ETS

- get more coughs and colds and are more likely to suffer acute upper and lower respiratory tract infections. One study showed that children exposed to ETS during the first 18 months of life have a 60% increase in the risk of developing lower respiratory illnesses such as croup, bronchitis, bronchiolitis and pneumonia.
- have an increased chance of developing asthma. If they already have asthma, second-hand smoke can bring on asthma attacks and make them worse.
- are at risk of impaired lung function, and may have breathing problems in the future.
- have an increased frequency of middle-ear infections, which can lead to reduced hearing.
- Babies born to women who smoke during pregnancy, as well as those infants exposed to ETS have a significantly greater risk of dying of sudden infant death syndrome (SIDS).

Smokeless tobacco use - A growing addiction

Smokeless tobacco is used in many forms around the world. In the United States and parts of Europe, it is marketed as chewing tobacco and as oral snuff . In south and south east Asia, it is most commonly consumed in a 'betel quid' or 'pan' consisting of tobacco flakes, mixed with powdered or chopped areca nut, slaked lime and catechu, wrapped in a betel leaf. This practice is a part of culture and tradition. Smokeless tobacco use has also been reported in parts of Africa and the former Soviet Union. In India, the more recent trend of chewing prepacked powdered areca nut with tobacco, lime and catechu (termed 'pan masala') has started to replace the habit of betel quid chewing. In Sudan, "toombak" is used orally, while "nass" is widely used in Central Asian republics.

Although the term "smokeless tobacco" is commonly used for tobacco products used orally, this is a term promoted by the tobacco industry that suggests that the product is harmless. To avoid that innocuous connotation, the term "spit tobacco" is increasingly used in countries such as the United States.

In the United States, recent surveys have shown alarming increases in use of spit tobacco among children and younger adults . This increase is primarily due to the growing

popularity of oral snuff use among teenage and young adolescent males. It is estimated that in one million adolescent boys in the USA use spit tobacco. Spit tobacco is also used by many athletes, particularly baseball players, who are often role models for these boys. Other populations with notable patterns of spit tobacco consumption are south and southeast Asian immigrant communities in the United States and the United Kingdom. These groups continue to use spit tobacco products manufactured and imported from the Indian subcontinent.

Use of smokeless tobacco, including snuff and chewing tobacco varieties, has been established to cause oral cancer (one of the ten leading cancers worldwide), irreversible gingival recession, other oral pathologies, nicotine addiction and cardiovascular diseases. Smokeless tobacco and betel quid chewing, particularly with tobacco, is the most common cause of oral cancer in high incidence regions, and ranks globally as the greatest single risk factor for oral cancer. There have been cases of six year old children in India with submucous fibrosis, a precancerous condition . In south and southeast Asia, more than 100,000 new cases of oral cancer are diagnosed annually. Some 1,700 and 30,000 cases of oral cancer are diagnosed in the UK and the USA respectively, each year. It is believed that as many as 75% of oral cancers diagnosed in the United States are attributed to regular use of smokeless tobacco products and alcohol combined.

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Beyond prevention helping teens quit smoking

There is often a lack of smoking cessation resources designed for young people

As countries strive towards tobacco-free societies, prevention of smoking among youth is of key importance. However, around the world, high rates of smoking among teens provides a strong argument for effective youth-oriented smoking cessation programmes. Available information suggests that physical and psychological dependence on smoking can develop quickly in young people. By the time teens have been smoking on a daily basis for a number of years, the smoking habit and addiction levels may well have become entrenched, and they are faced with the same difficulties in quitting as adult smokers. Although intentions to quit and quit attempts are common among teenagers, only small numbers of teenagers actually quit. One of the problems may well be the lack of smoking cessation resources tailored to young people.

Recent studies have found that students would welcome smoking cessation assistance if provided in acceptable ways. It appears that some groups of students prefer more independent quitting strategies, such as self-help programmes or "quit and win" style incentives. However, this will vary among populations, and will need to be determined before interventions are planned.

Tobacco addiction and kids

The younger people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine.

Tobacco products contain substantial amounts of nicotine, which is absorbed easily from tobacco smoke in the lungs and from smokeless tobacco in the mouth or nose. Nicotine has been clearly recognized as a drug of addiction, and tobacco dependence has been classified as a mental and behavioural disorder according to the WHO International Classification of Diseases, ICD-10 (Classification F17.2). Experts in the field of substance abuse consider tobacco dependency to be as strong or stronger than dependence on such substances as heroin or cocaine. Moreover, because the typical tobacco user receives daily and repeated doses of nicotine, addiction is more common among all tobacco users than among other drug users. In many countries, about 90% of smokers smoke every day, and approximately that proportion or perhaps even more are dependent on tobacco. Among addictive behaviours, cigarette smoking is the one most likely to take hold during adolescence. A study found that 42% of young people who smoke as few as three cigarettes go on to become regular smokers. What often starts out as an act of independence may rapidly become an addictive dependence on tobacco. Studies by health scientists in the United States have found that about three-fourths of under-age smokers consider themselves addicted, while a majority of adolescent smokers in Australia had tried to quit and found it very difficult. About two-thirds of adolescent smokers in another USA study indicated that they wanted to quit smoking, and 70% said that they would not have started if they could choose again. These responses are remarkably similar to the conclusions of studies conducted years earlier for a Canadian tobacco company:

"However intriguing smoking was at 11, 12 or 13, by the age of 16 or 17 many regretted their use of cigarettes for health reasons, and because they feel unable to stop smoking when they want to."

Danger!

PR in the playground

Tobacco industry initiatives on Youth smoking

"We believe in our right to provide adult smokers with brand choice and information, alongside our responsibility to ensure that our marketing does not undermine efforts to prevent children from smoking. [Martin Broughton, Chairman of BAT, 2000][1]

"In all my years at Philip Morris, I've never heard anyone talk about marketing to youth." [Geoffrey Bible, CEO of Philip Morris, 1998][2]

"If younger adults turn away from smoking, the industry will decline, just as a population which does not give birth will eventually dwindle."
[Diane Burrows, RJ Reynolds, 1984][3]

"... We refined the objective of a juvenile initiative program as follows: "Maintain and proactively protect our ability to advertise, promote and market our products via a juvenile initiative*".
* Juvenile Initiative = a series of programs and events to discourage juvenile smoking because smoking is an adult decision."
[Cathy Leiber, Philip Morris International, 1995][4]

"As we discussed, the ultimate means for determining the success of this program will be: 1) A reduction in legislation introduced and passed restricting or banning our sales and marketing activities; 2) Passage of legislation favorable to the industry; 3) greater support from business, parent, and teacher groups."
[Joshua Slavitt, Philip Morris, "Tobacco Industry Youth Initiative," 1991] [5]

"A cigarette for the beginner is a symbolic act. I am no longer my mother's child. I'm tough. I am an adventurer. I'm not square ... As the force from the psychological symbolism subsides, the pharmacological effect takes over to sustain the habit."
[Philip Morris, 1969][6]

addressed three seminars.

TOBACCO CULTIVATION RUINS HEALTH OF WORKERS

That moving out from tobacco cultivation is a feasible alternative is the message that has emanated from the workshop on "Action Towards a Tobacco-Free World" at the Asian Social Forum. The workshop brought together development workers, researchers, medical and economic experts besides the labourers who were previously engaged in tobacco related work.

Latha, a labourer from Shimoga, Karnataka, narrated her experiences. " We used to get a paltry wage of Rs.30/- a day for 20 hours of back breaking work in the tobacco farms. Tobacco dust infected several parts inside by body and I spent more than Rs.30,000/- for treatment". She has since become a crusader persuading her co-workers to give up toiling on tobacco farms at the cost of their health. "I will never go back to those fields, even if they offer me one hundred rupees a day", reaffirms a decided Latha.

Tobacco Board officials from the region admit that 80% of the forest in some of these villages has been depleted due to massive felling of trees to cure tobacco. Their records confirm that many tobacco farmers are leaving tobacco cultivation. Some of these farmers have found safer havens in growing maize and groundnut and tobacco labourers in Shimoga and other parts of Karnataka have shifted to income-generating activities like rearing cattle.

Suvarna, a development worker, who works with women in tobacco farming, says, "Tobacco work drains them of their energy and health and often strains family relationships to the point of breaking them due to the long hours of work during the farming season. It leaves them no time to attend to household chores and children". Many of these children eventually drop out of school and are taken to work on tobacco farms.

Several of the workers at the workshop who despise working on tobacco farms pointed out that government policies in this regard are anti-poor. Government promotes tobacco farming, research and marketing through support institutions and these essentially benefit the rich farmers who own land and resources. They opine that unless these are reversed and alternatives explored and developed, this exploitative industry would continue to thrive undeterred at the cost of the health of the workers and smokers.

TODAY AT ASF ... PEOPLE'S VOICES

Prajashakti - daily newspaper brought out at ASF

ASF Sidelights

The venue of Asia Social Forum, Nizam College grounds, thundered with the resounding rythms of dappu(drums).

Marxist intellectuals to Gandhians were seated on the dias.

From revolutionary groups to anti tobacco groups participated in the programme.

Nora Cartinos an octagenarian from Argentina seized the attention with her active approach and inspirative speech.

Budhist monks from Sri Lanka not withstanding the scorching sun sheltered under unmbrellas.

Medha Patkar and the leaders of the Left parties squatted in the masses before the Plenary.

Worldwide trends in tobacco consumption and mortality

World Health Organization

TOBACCO: THE TWENTIETH CENTURY'S EPIDEMIC

Every ten seconds, somewhere in the world, tobacco kills another victim. If current smoking trends continue, this toll will increase up to one tobacco-caused death every three seconds over the next thirty to forty years.

Recent data have confirmed that the risks of smoking are substantially higher than previously thought. With prolonged smoking, smokers have a death rate about three times higher than nonsmokers at all ages from young adulthood. Tobacco products are known or probable causes of over two dozen diseases or groups of diseases. If, as is likely, much of the excess mortality from these diseases is directly attributable to tobacco use, then this implies that the lifetime risk of a smoker being killed by the use of tobacco products is at least 50%. Therefore, a lifelong smoker is as likely to die as a direct result of tobacco use as from all other potential causes of death combined!

Other problems ensue because the negative health consequences of tobacco are not as immediate as with other hazardous substances. The health risks of tobacco are vastly underestimated by the public, and even by many of those who are responsible for protecting and promoting public health. Yet the risks of smoking are very high when compared to other risks faced in everyday life (See Table 1). Widespread underestimation of risks associated with tobacco use, is a major reason why tobacco products are still widely available, and why lenient tobacco policies have been allowed to occur. But nothing can alter the fact that tobacco use is one of the major public health challenges facing the world as it enters the twenty-first century.

TOBACCO USE IS A KNOWN OR PROBABLE CAUSE OF DEATH FROM:

Cancers of the:

- Lip, oral cavity and pharynx
- Oesophagus
- Pancreas
- Larynx
- Lung, trachea and bronchus
- Urinary bladder
- Kidney and other urinary organs

Cardiovascular diseases:

- Rheumatic heart disease
- Hypertension
- Ischaemic heart disease
- Pulmonary heart disease

- Other heart diseases
- Cerebrovascular diseases
- Atherosclerosis
- Aortic aneurysm
- Other arterial diseases

Respiratory diseases:

- Tuberculosis
- Pneumonia and influenza
- Bronchitis and emphysema
- Asthma
- Chronic airway obstruction

Paediatric diseases:

- Low birth weight
- Respiratory distress syndrome
- Newborn respiratory conditions
- Sudden infant death syndrome

Tobacco products have no safe level of consumption, and are the only legal consumer products that kill when used exactly as the manufacturer intends. Researchers have rated nicotine as even more addictive than heroin, cocaine, marijuana or alcohol. The Tenth Revision of the International Classification of Diseases reserves classification F17.2 for "tobacco dependence syndrome". Yet tobacco products continue to be aggressively marketed by tobacco companies. The result is that global tobacco consumption has doubled since medical science conclusively proved, 30 years ago, that these products were unrivalled killers. And consumption is still increasing in many areas of the world.

An analysis of trends in cigarette consumption for WHO regions indicates that the two regions with the highest average per capita (adult) consumption in 1990-1992 were Europe (2290 cigarettes per adult per year) and the Western Pacific (2000). The lowest consumption was observed in the African Region (540). For the developed countries as a whole, per capita adult consumption is currently about 2400 cigarettes, which is still significantly greater than the average consumption in the developing world (1370 cigarettes).

The gap is rapidly narrowing, however. In 1970-1972, consumption per adult in the developed countries was 3.25 times higher than in the developing world (see Figure 1). By 1980-1982, this ratio had narrowed to 2.38, and by 1990-1992, to 1.75. During the last decade, per capita consumption has declined by an average of 1.4% per year in developed countries, but has risen by 1.7% annually in developing countries. If these trends were to continue, consumption of cigarettes per adult in the developing world will exceed levels in the developed world some time between the years 2005 and 2010, i.e., within two decades.

There have been very noticeable differences in trends among WHO regions. Over the last decade, the fastest decline in per capita consumption occurred in the Americas. Nor was this entirely due to declines in consumption in Canada and the United States of America; excluding those two countries, per capita consumption in the Region still declined by an annual average of 1.7%. On the other hand, the increasing consumption in the Western

Pacific (2.2%) and South-East Asia (1.8%) is primarily due to the trends in China and India respectively. From 1983, per capita (adult) consumption in China rose by 3.9% per year to reach 1990 cigarettes in 1990-1992. In India, where about 90% of cigarettes are consumed in the form of bidis (traditional hand-rolled cigarettes), adult consumption has risen by about 2% per year over the last decade and now exceeds 1200 cigarettes (including bidis).

WHO estimates that there are about 1100 million regular smokers in the world today. About 300 million (200 million males and 100 million females) are in the developed countries, and nearly three times as many (800 million: 700 million males and 100 million females), in developing countries. In developed countries, 41% of men are regular smokers, as are 21% of women (see Figure 2). Half the men living in developing countries are smokers, compared with about 8% of women.

The health consequences of the smoking epidemic in developed countries have been quantified by WHO, in close collaboration with the Imperial Cancer Research Fund's Cancer Studies Unit at the University of Oxford, UK. A major report giving detailed estimates of the numbers and rates of smoking-attributed deaths for over 50 countries or groups of countries, has been published. Between 1950 and 2000, it is estimated that smoking will have caused about 62 million deaths in the developed countries (12.5 % of all deaths: 20% of male deaths and 4% of female deaths). More than half of these deaths (38 million) will have occurred at ages 35-69 years. Currently, smoking is the cause of more than one in three (36%) male deaths in middle age, and about one in eight (13%) of female deaths. Each smoker who dies in this age-group loses, on average, 22 years of life compared with average life expectancy. During the 1990s, the report estimates that almost 2 million people a year will die from smoking in developed countries (1.44 million men and 0.48 million women).

As regards cigarettes the health consequences of tobacco use are much more difficult to estimate in developing countries owing to lack of data. Currently, it is estimated that tobacco causes about 1 million deaths a year in developing countries, but there is substantial uncertainty about this figure. If current trends continue, and if the risks of death from tobacco use are similar in developing countries to those that have been observed in the industrialized world, then the annual toll of mortality from tobacco will rise dramatically to around 7 million deaths per year in the 2020s or early 2030s (see Table 2). The chief uncertainty is not whether, but rather when, these deaths will occur if current trends in tobacco use persist.

Table 2. Estimated number of Deaths caused every year by Tobacco

	Decade 1990s	Decades 2020s/early 2030s
Developed countries	2 million	3 million
Developing countries	1 million	7 million
Total	3 million	10 million

UICC *GLOBALink*

The International Tobacco-Control Network Selected documents: The Death Toll form Tobacco - A Crime Against Humanity

September 1998

Deaths caused by smoking

There are between 1.1 -1.4 billion smokers in the world out of a total population of around 5.8 billion. It has been estimated that 50% of smokers will die prematurely from tobacco related illness, half in middle age (defined as 35 - 69 years of age) with an average loss of life expectancy of 20 - 25 years (8 years over all ages).

This means that over half a billion people (in excess of 500 million) or about 10% of the existing population will die from smoking. Of these, 27% will die from lung cancer, 24% will die from heart disease, 23% will die from chronic obstructive lung disease, emphysema or bronchitis and the remaining 26% will die from other diseases including other circulatory disease (18%) and other cancers (8%).

Currently, 3 million people worldwide die every year from smoking related disease. This represents about 1 person every ten seconds. One third of all people aged fifteen years and over smoke and this proportion is increasing in Asia, Eastern Europe and the former Soviet States. Consumption trends indicate that smoking prevalence is reducing in developed countries (DCs) (down 1.5% per annum in the United States) whilst increasing in lesser-developed countries (LDCs)(up 1.7% per annum on average).

The World Health Organisation (WHO) has estimated that, based on current trends, the death toll from smoking will rise to 10 million people per year by the year 2025. Currently two million deaths occur each year in developed countries and 1 million deaths occur each year in lesser-developed countries. By 2025 this proportion will alter to 3 million deaths per year in developed countries and 7 million deaths per year in lesser-developed countries. No other consumer product in the history of the world had come even close to inflicting this degree of harm on the world community. If anything else posed a threat to life of this magnitude whether human induced or naturally occurring - be it world war, genocide, ethnic cleansing, natural disaster or disease - it would demand immediate international action. The response to HIV, the prosecution of war crimes (both current and dating back to World War II), germ warfare, nuclear weapons or even climate change are but a few examples.

The history of the smoking pandemic of the 20th century can be traced back to the invention of the mechanical cigarette machine in the late 1800's. Until that time cigarettes were rolled by hand, production was low and smoking was not overly prevalent. The cigarette machine meant that millions of cigarettes could be produced each day at a lower cost and distributed more widely. The result was that cigarette smoking increased such that by the late 1940's smoking rates in developing countries were up to 70% in adult males and up to 25% in adult females. Smoking rates in LDCs were significantly less.

From the discovery of the link between increased smoking and disease in the early 1950's, and major reports publicising the need for public health action, smoking rates among adult males in developed countries has declined although prevalence in adult females increased to some degree

but now the levels are roughly equal at about 25% in many developed countries. Meanwhile, smoking rates in lesser-developed countries has increased in both the adult male and adult female population.

Due to the latency in the development of disease from smoking, the effects were first detected among adult males in developed countries. The effect of increased smoking among adult females is now being reflected in disease rates with similar observations in lesser-developed countries. Hence the WHO estimates by the year 2025.

Transnational tobacco companies

Tobacco consumed by the world's 1.1 - 1.4 billion smokers is produced by a handful of transnational tobacco companies and a number of state owned manufacturers. China's state owned production accounts for 31% of all tobacco sales with Italy, Russia, Japan, Taiwan, Indonesia and Thailand, amongst other countries, having substantial government owned factories as well.

However, transnational tobacco companies account for 40% of the global market and control 70% of world production, and this is increasing. In many cases, the state owned producer was a state monopoly but, increasingly, this has been broken down through free trade agreements to a point where transnational tobacco companies are not only marketing in countries previously the subject of a state monopoly but there are reports of expressions of interest by transnational tobacco companies in obtaining an interest in formerly state owned monopolies now being privatised.

Whilst all tobacco consumption contributes to the overall death toll, state owned production is arguably an internal matter to the nation - state in question. The activities of privately owned, transnational tobacco companies is a matter on international concern. The major transnational tobacco companies, in order of sales, are: US based Philip Morris Inc., followed by British based BAT Industries p.l.c., United States based RJR Nabisco and Rothmans. Under agreements apparently reached among these transnational tobacco companies, Rothmans does not market in the United States and BAT does not market in Britain. There are reports that Philip Morris and BAT have entered into collusive agreements that fix cigarette prices and divide markets in South America (apparently such anti competitive arrangements are not illegal in those countries). It is a mark of the power of the major transnational tobacco companies that they can reach such agreements dividing up markets in sovereign nations consequently inflicting the harm identified above. In 1996, Philip Morris had annual revenues of $55 billion, just over half from tobacco with the rest coming from domestic and international food and alcohol sales. Only 18% was from domestic tobacco sales (20% in 1992) compared with 35% from international sales (21% in 1992). Total tobacco sales comprised 53% in 1996 (41% in 1992) or about 23 billion. BAT revenue in 1996 was $23 billion. RJR Nabisco had total revenues of $17 billion in 1996 of which 48% or about 8 billion was from tobacco sales. These massive levels of turnover and the economic, political and social influence of the transnational tobacco companies has led to the industry being described collectively as "Big Tobacco". A comparison is made that these revenues exceed the gross domestic product of many countries. For example, Philip Morris has a turnover larger than the GDP of Ecuador, Guatemala, Kenya, Kuwait, Malaysia and Peru. It is roughly the equivent of Ireland, Singapore or Hungary. RJR Nabisco's turnover is roughly the equivalent of the GDP of Costa Rica, Croatia, Cuba, El Salvador, Lebanon or Jamaica. Whilst these companies undoubtedly have significant economic, political and social influence, the fact remains (with all due respect to the countries with which comparison is made), these transnational tobacco companies, either individually or collectively, are not an overwhelmingly dominant force on a world scale.

Deceit and duplicity of the tobacco industry

The current status of the tobacco industry is anomalous insofar as cigarette consumption clearly inflicts a degree of mortality totally at odds with fundamental human rights and human values. At the same time the tobacco industry defends itself on the basis that tobacco is a "legal product". This occurred because the tobacco industry had already acquired a substantial degree of economic, political and social influence by the time the link between smoking and disease was established. Since that time the tobacco industry worldwide has engaged in a deliberate campaign of deceit and duplicity to protect and even expand its influence through a process of denial and disputation of the now proven link between smoking and disease, the addictive properties of nicotine and their marketing strategies directed at youth.

This deceit and duplicity is currently being exposed by litigation in the United States which is spreading worldwide. The position has now been reached where continued disputation and distortion is untenable, particularly in the face of the projected increase in tobacco deaths by the year 2025 if current trends are continued. This is all the more so given the disparity in the projected increase between developed and less developed countries, reflecting an exploitation of lesser developed countries which will only increase to offset liabilities the tobacco industry is incurring in the United States. This is a circumstance calling for international action. It must not be allowed to happen. Were it to occur it would be, without doubt, a crime against humanity.

Crimes against humanity in the International Criminal Court

On 17 July 1998 the United Nations Rome Statute of The International Criminal Court established a permanent Court having power to exercise jurisdiction over persons for the most serious crimes of international concern. Article 5 confers jurisdiction on the International Criminal Court with respect to the following crimes:

1. The crime of genocide;
2. Crimes against humanity;
3. War crimes;
4. The crime of aggression.
5.

For the purposes of the Statute, Article 7 defines a "crime against humanity" to mean any of the following acts when committed as part of a widespread or systematic attack directly against any civilian population, with knowledge of the attack;

1. Murder;
2. Extermination;
3. Enslavement;
4. Deportation or forcible transfer of population;
5. Imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law;
6. Torture;
7. Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation, or any other form of sexual violence of comparable gravity;
8. Persecution against any identifiable group or collectively on political, racial, national ethnic, cultural, religious, gender as defined in paragraph 3, or other grounds that are universally recognized as impermissible under international law, in connection with any act referred to in this paragraph or any crime within the jurisdiction of the Court;

9. Enforced disappearance of persons;
10. The crime of apartheid;
11. Other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

Given what is known about smoking and disease and the deceit and duplicity of the tobacco industry, were the death toll from tobacco to increase from 3 million a year to 10 million a year by the year 2025, especially with the dramatic increase in lesser developed countries from 1 million a year to 7 million a year, it is impossible to describe that consequence as anything other than the result of an inhumane act of a character similar to murder, causing great suffering, or serious injury to body or to mental or physical health committed as part of a widespread or systematic attack directed against the civilian population of the world.

Given that the directors and executives of the major transnational tobacco companies must now have knowledge of the consequences of their activities, if those activities continue then each and every one of them must face the prospect of being charged with committing a crime against humanity in the International Criminal Court. Article 11 of the Statute provides that the Court has jurisdiction only with respect to crimes committed after the entry and the force of the Statute. This means that the opportunity exists for these directors and executives to escape liability under the provisions of the Statute providing there is no increase in mortality from tobacco use. Arguably they should be responsible for a reduction. Given the likely increase in mortality from past smoking, because of the latency of tobacco related disease, every effort would need to be made to reduce consumption in order to avoid a significant increase in the current death toll. Certainly expansion in lesser-developed countries should not occur. As a means of securing this outcome, each of the major transnational tobacco companies, and each of their directors and executives, should formally be put on notice of the consequences of their activities such that charges of a crime against humanity can be laid and successfully prosecuted if radical action is not taken to reverse current trends.

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4th January 2003

For Immediate Release

Asian Tobacco Control Activists Suggest Alternatives to Tobacco-Related Work

Hyderabad: Moving out from tobacco cultivation is a feasible alternative, was the message that emanated from the workshop on "Action Towards a Tobacco Free World" at the Asia Social Forum in the citadel of tobacco farming. The workshop held yesterday brought together development workers, researchers, medical and economic experts besides the labourers who were previously engaged in tobacco related work.

Latha, a labourer from Shimoga, Karnataka narrated her experiences working in the tobacco fields, " We used to get a paltry wage of Rs. 30/-a day for 20 hours of back-breaking work in the tobacco farms. Tobacco dust infested my insides and I spent more than Rs. 30,000/- in treatment". She has since become a crusader persuading her co-workers to give up toiling on tobacco farms at the cost of their health. " I will never go back to those fields, even if they offer me Hundred rupees a day", reaffirms a decided Latha.

Tobacco Board officials from the region admit that 80 % of the forest in some of these villages have been depleted due to massive felling of trees to cure tobacco. Their records confirm that many tobacco farmers are therefore leaving tobacco cultivation. Some of these farmers have found safer havens in growing maize and groundnut and tobacco laborers in Shimoga and other parts of Karnataka have shifted to income generation activities like rearing cattle.

Suvarna, a development worker who works with women in tobacco farming relates, " Tobacco work drains them of their energy and health and often strains family relationships to the point of breaking them due to the long hours of work during the farming season. It leaves them with hardly any time to attend to household chores and children". Many of these children eventually drop out of school and are taken to work on tobacco farms.

Several of the workers at the workshop who despise working on tobacco farms pointed out that Government policies in this regard are anti-poor. Government promotes tobacco farming, research and marketing through support institutions and these essentially benefit the rich farmers who own land and resources. They opine that unless these are reversed and alternatives are explored and developed, this exploitative industry would continue to thrive undeterred.

For Further details, contact:
Thelma Narayan, Co-ordinator, Community Health Cell, Bangalore.
Email: sochara@vsnl.net

Statement issued by the participants of the

"WORKSHOP ON ACTION TOWARDS A TOBACCO FREE WORLD"

On 3rd January 2003

ASIAN SOCIAL FORUM, HYDERABAD, INDIA

FIGHT TOBACCO THE KILLER !!!

Realizing that tobacco and its products including cigarettes, bidis, guthka, and chewed tobacco...

- Is one of the biggest killers worldwide and particularly among the poor killing 4.9 million people every year and reducing life by 15-20 years. Tobacco causes cancer of the various organs, diseases of heart, blood vessels, lungs and other organs leading to suffering disability and death.
- Is highly addictive with nicotine being more addictive than cocaine or heroin.
- Is the only freely available consumer product that kills.
- Has an adverse environmental impact, using of millions of tonnes of wood for curing tobacco, excessive use of pesticides and chemicals, depleting soil fertility.
- The tobacco industry results in an overall fiscal loss, with loss of productivity and cost of treating tobacco related illnesses being more than the revenue gainded.
- The tobacco industry indulges in misinformation through aggressive advertisement and sponsorship targeting children, youth and women.
- Affects millions of non-smokers and particularly pregnant women, retarding the growth of the unborn children and causing abortion through passive smoking.
- Tobacco use perpetuates poverty at household and larger levels.

We the participants of the workshop on Action Towards a Tobacco Free World in the Asia Social Forum issues this statement and call upon Government, civil society, media and the people to take up urgent action .....

- On public policies In the context of right to food, right to health and right to work and poverty reduction.
- Work through local government and local bodies, focussing on women and dalits.
- Hold the tobacco companies responsible for the losses incurred and the adverse consequences on individuals and families of tobacco use.
- Ban all direct and indirect advertisement of tobacco and its products including sponsorship of sports and cultural event by the tobacco companies and affiliated bodies.
- Ban the manufacture and sale of chewed tobacco in any form, since minors are especially vulnerable.
- Progressively reduce the area of cultivation of tobacco utilizing the area thus freed for other beneficial crops.
- Prevent the cutting down of trees and denudation of forests for curing and packaging tobacco.
- Increase progressively the tax on tobacco and its products and utilize the revenue thus received for health promotion.
- Introduce legislation and effectively implement laws for prohibition of smoking in public places.
- Use all means to increase public awareness
- Reduce glamorization of tobacco products through films and media.

"WORKING TOGETHER FOR TOABCCO CONTROL""" TOGETHER WE CAN DO IT!

Action Towards a Tobacco Free World

A workshop at Asia Social Forum, Hyderabad

Date: 3rd January 2003

Time: 2:15 to 6:30 P.M.

Venue: Taj Mahal Hotel, Abids Road, Hyderabad

Facilitated by:

Community Health Cell, Bangalore on behalf of Jan Swasthya Abhiyan / People's Health Movement)

Partner Organizations

Consortium For Tobacco Free Karnataka
PATH-Canada, LIFE

A Report by Dr. Anant Bhan, Community Health Cell

The workshop began with registration of all participants. They were given files with background material about the purpose of the workshop. Around 40 people participated in the workshop.

The workshop began with an introduction to the purpose of conducting the workshop by Mr. S.J. Chander from the Community Health Cell who spoke about the global problem that Tobacco had become and the targeting of Asia and developing countries by Tobacco MNC's and hence the importance of a concerted effort to network for freedom from tobacco.

Dr. Ramesh S. Bilimagga, Radiation Oncologist and member, CFTFK (Consortium For Tobacco Free Karnataka, Bangalore, chaired the first session. He welcomed all the participants to the workshop and reiterated that tobacco was a major problem not just in India but also across the world. He stressed that a small step by everybody in the direction of a tobacco free world would make a big difference. He then invited Dr. Thelma Narayan from CHC to give an overview of the problem.

Dr. Thelma explained that the workshop was being held under the platform of Jan Swasthya Abhiyan (PHM) which was active in more than 92 countries ands was working towards making the govts. and WHO and international bodies accountable to their commitment for Health For All. She stressed that many coordinating and facilitating agencies had helped in organizing the workshop and also enumerated the other events at ASF being facilitated by CHC/JSA/PHM. She said that the workshop would help us understand the tobacco issue especially in regards to dealing with the tobacco industry. It was needed to share our solidarity in the ASF platform and to strategize and reflect. The effect of globalization on public health needed to be studied in depth. Opium had been used in the past by Britain to subjugate China and now the western powers through the tobacco MNCs were using tobacco to subjugate the Asian countries. The US was promoting the global consumption of tobacco and there had been a sharp increase in tobacco usage in many areas; the issue of tobacco advertising was also an important issue. While tobacco use was reducing in the North America and Western Europe, the tobacco market was being relocated with increasing use in Asia and developing countries. Data from different Asian Countries was presented. The

dynamics and intricacies influencing the negotiations of the Frame Work Convention For Tobacco Control (FCTC) led by the WHO (World Health Organization) needs to be more transparent in order to evolve a useful instrument.

A Magic Show and a talking doll show followed this. The magician stressed on the ill effects of tobacco and requested people to not let their lives go up in smoke and to avoid the bad habits. It was well appreciated by the audience. He also wished everybody present a very happy and tobacco free New Year.

Dr.Ramesh then invited Dr. Prakash C. Gupta, an epidemiologist and a public health consultant from Mumbai having 36 years of research experience in the field of tobacco. Dr.Prakash began by saying that tobacco is a public health problem even at the grassroots level. Understanding the problem was not enough and something needed to be done about the problem. There were various organizations working in the field of tobacco control in India-a loose coalition of which was the ICTC (the Indian Coalition for Tobacco Control). Each of the organizations was free to pursue their own agenda but it was an interactive forum for all participating organizations to pool their resources. He expressed hope that more organizations would join the fold. He also mentioned that a death clock had been installed in Delhi that would register the deaths being caused by tobacco usage in India.

After thanking Dr. Prakash, Dr. Ramesh introduced Mr. Sonam, a bureaucrat form the Ministry of Health and Education in Bhutan. Mr. Sonam said that Bhutan had initiated tobacco control regulations as early as 1729; the state religion (Buddhism) did not permit the usage of tobacco. He cautioned that in their experience regulation alone was not enough and there was he need to take undertake aggressive information dissemination and work for anti-tobacco legislation. The Hon'ble Minister of Health had ensured that the sale and consumption of tobacco had been banned in public places. The effort had come through a decentralized approach wherein 18 out of the 20 districts in the country had themselves taken up the initiative to work for local tobacco control. He said that a dilemma that faced the govt. was the continuing sale of tobacco in the duty free shops in the capital city, which could not be stopped because of diplomatic problems- he invited suggestions from the participants on how to deal with the problem. He said that one of the queens in Bhutan was committed to the cause of tobacco control and had been appointed as a goodwill ambassador by the UNFPA and she advocated the tobacco and health issues in various districts that she regularly visited. Appreciating the people of Bhutan, Dr. Ramesh said that it was important to remember that perseverance was the key.

Dr. Ramesh then called upon two members of the Bangladesh Anti Tobacco Alliance to speak about efforts at tobacco control in their country. One of them Mr. Ratan Deb said that sometime ago though there were many groups working in the field not many were working together ;only school level programs were being organized to raise awareness about the harmful effects of tobacco and these also not very effective as they were leading to rebellion in many cases. He felt that what would work is strict enforcement, high taxes, controlling of advertising, more elaborate warning in the packs. He said that BATA has little resources compared to other groups and tobacco companies. BATA had filed a case in the Bangladeshi courts and had managed to achieve a significant legal victory which led to decrease in the rampant advertisement of tobacco companies and had also proved that British American Tobacco Company's antismoking campaign was a sham. BATA has been closely working with the Bangladeshi govt. and have been attempting to spread the message of harmful effects of tobacco even in the regional languages. A law for stricter tobacco control is now pending in the parliament. A second writ petition is now pending in the courts under the Right to Life campaign against the Imperial Tobacco company; the court has given a stay order on all relevant advertisements for two months. Many organizations and facilities in Bangladesh are now tobacco free due to the efforts of BATA. He ended stressing that

working together was very important for tobacco control. Mr. Naveen Thomas expressed the view here that one major factor for the success of the campaign in Bhutan was the fact that the political, religious and local leadership had come together to fight the problem and were very much involved.

Dr. Ramesh appreciated the efforts of BATA and raised the fact that the various govts. had a dichotomous attitude towards tobacco wherein e.g. the Karnataka govt. had an anti tobacco cell in the Kidwai Memorial Institute of Oncology, it also had a research wing in the Tobacco Board to try to improve productivity and quality of tobacco crops. He said that in K'taka

- There were 8 million tobacco addicts.
- 6000 children under the age of 15 yrs of age and as many between the ages of 15-24 enter the pool of tobacco users.

There was a need to publicize the tobacco issue among the lay public as they had the right to information.

Mr. Jaggaiah, a security guard from Hyderabad who used to smoke around 48-50 beedis a day for over 40 years presented his medical problems directly related to his tobacco addiction. He used to get cough, dyspnoea and chest pain; he had to undergo surgery (pneumonectomy) for pathology arising from his tobacco usage; he said that he had now stopped smoking and was proud to be free from tobacco.

Ms. Lalitamma from Karnataka, an ex-cultivator then shared her experience .She said that she had been working in the tobacco fields for over 15 years; most of the workers used to be employed as daily wage workers by the rich cultivators and had work for only 3-4 months/yr. The workers had very hectic work in the fields everyday and at the end of each day they were so tired that they could not adopt any hygienic methods before consuming food or have a bath before sleeping. They also used to use a lot of pesticides in the tobacco nurseries in their homes and because of all this problems she felt that they used to inadvertently consume a lot of pesticides. During the course of her work, she developed health problems and approached a medical practitioner who advised admission – her treatment bills were in the range of about Rs 30,000. She said that she had resolved to never do that kind of work again and was hoping that other people also left that hazardous work.

Dr. Ramesh thanked all the speakers for giving an insight into the various issues related to tobacco that were affecting their lives and work. He then thanked the organizers for having given him the opportunity to chair the session and handed over the stage to the next chairperson, Ms. Devaki Jain.

Ms. Devaki then chaired the next session, which was distribution of certificates and mementoes of appreciation to

- The people of Bhutan for having shown great collective resolve for the fight against tobacco. This was received by Mr.Sonam Thunsho, secretary, government of Bhutan in charge of health education.
- The members of BATA for their work for tobacco control in their country and for dragging the guilty tobacco companies to court and make them accountable for their unlawful practices. This was received by Mr.Ratan and Mr. Biplob
- Dr. Prakash C. Gupta for his extensive work in research in the field of tobacco.

A short tea break was then announced which gave the opportunity for the audience to interact with the speakers and also for them to view the exhibition of anti tobacco posters that had been put up by Community Health Cell in the hall.

The tea break was followed by a panel discussion on various facets of the tobacco issue. The discussion was chaired by Ms. Devaki Jain. She said that the amount of money the govt. spent on treating diseases arising from the usage of tobacco was more than the money it received through excise. Tobacco related deaths were more than the number of deaths caused due to HIV, Malaria, and T.B. combined. There was a need for campaign mode activists, as knowledge about the ill effects of tobacco did not deter people from harmful habits. Death was a close phenomenon in India especially among the poor and hence morbidity and mortality due to tobacco could not be used as an effective deterrent in that sector. There was a need to work to change attitudes; also important was to fight the tobacco industry, which was targeting the young by using unfair advertising means. There was a need to talk about it in the background of globalization and macro-economic program. The relation between poverty in India and the addiction to tobacco, alcohol and the susceptibility to HIV in poor communities was well known and proven in studies such as one done by NIMHANS. Also, interestingly, the govt. had included Tobacco in the Foods and Beverages list.
Dr. Devaki then invited Dr. Prakash Gupta to give his presentation. Dr. Prakash's presentation had the following salient points:-

1. There were only two causes of death that were increasing worldwide- HIV and Tobacco.

2. Death was an objectively measured event; Tobacco usage was the single most preventable cause of death in the world.

3. Current WHO estimates of tobacco attributable premature deaths are in the range of4.9 million/yr. This is expected to rise to 10 million / yr by the year 2030; already in the 20th century approx. 100 million people had died due to health problems related to tobacco usage.

4. India was the second largest producer and consumer of tobacco in the world; ICMR estimate for the annual attributable mortality from tobacco was 8,00,000.

5. Tobacco causes a lot of medical problems and addiction is a key issue because of the nicotine content

6. Children are the mot severely affected and unfortunately they are powerless to fight against this evil.

7. There were many misconceptions related to tobacco e.g. that it was not a high-risk product and that tobacco users do not have any choice, once addicted.

8. The truth was that more than half of chronic tobacco users would die of health problems arising from that habit.

9. Tobacco smoke had a lot of toxic chemicals and carcinogens and had an effect even on passive smokers; hence there was a need for concerned people to fight for their right for clean air.

10. Tobacco and social justice was also an important issue- as its usage was more among the lower SE strata and the relative risks were also higher in this group; beedis, commonly used by this group were more harmful than cigarettes; also unfortunately, most of the interventions were aimed at the higher SE strata.

11. The rising usage of tobacco among the women was alarming- one study had shown that as many as 10% of college going women in Mumbai were using tobacco.

Dr. Devaki then invited Dr. Srinath Reddy to present his views and experience as the Indian govt. nominee and as a NGO health activist at the FCTC deliberations. FCTC was an attempt by WHO to exercise its treaty making power for tobacco control. The critical issues included stronger action required on the demand and supply sides. There were the issues of trade and public health involved; most country representatives participating in the deliberations were advocating a total ban on all forms of advtg.- direct and indirect. But there had been pressures from some quarters and in the ongoing round the talk was around restriction of advtg; unfortunately the issue of surrogate advtg had not been addressed. The WB and developed countries were of the view that there was a continued increasing demand for tobacco irrespective of control measures (more in the developing countries and lesser in the developed ones). Global resources were lacking for implementation unless a global fund was set up. Also, cross border advertising continued to be an issue and trade v/s public health was a battle that was still being fought out in the FCTC. The recent draft of the FCTC was disappointing. It has been prepared for the next round of negotiation in February 2003.

Ms. Devaki thanked Dr. Reddy and mentioned that the UN precincts and most eateries in the developed countries are smoke free. She then invited Ms. Shobha John of PATH Canada (Programme For Appropriate Technology for Health) based at Mumbai to make a presentation. Shobha spoke about the poor being affected the most by tobacco usage and she presented some data from her PATH studies which showed that the tobacco consumption among the pavement dwellers was 82% and among the street children was 76% - these people were spending less amount of money on food than tobacco. She also raised the issue of misplaced targeting by activists who were not addressing the tobacco problem that was afflicting the poor SE strata and the need to reach out to that group. In Bangladesh, a study had proven that many households were spending 18 times more on tobacco than health. The tobacco issue was causing a loss to the country as the estimated health costs were in the range of Rs 6.5 billion while the excise returns were only Rs.4.5 billion; hence the economic loss to the nation was immense. Also the tobacco industries were themselves promoting smuggling of their products and were using a lot of front groups for surrogate advertisements. The industry's argument that a lot of workers would lose their job had to be viewed with scepticism because the companies as they were getting mechanized were laying off a lot of workers; also experience had shown that the industry was actually quite exploitative; Ms. Devaki mentioned that some traders in B'lore had been subletting the space outside their shops which was actually govt. property to vendors; she then invited Ms. Suvarna to share the findings of her study in Shimoga in Karnataka.

Suvarna mentioned that she had been working in the area for the last 12 yeras and she had noticed that tobacco cultivation had decreased by more than 50% - this had sparked an interest to initiate the study. They had discovered that the cultivators were actually the large farmers as the govt. Tobacco board regulations were that all tobacco cultivators should a possess a minimum of at least 3-4 acres of land .Tobacco cultivation was labour intensive. It also required a lot of wood for curing which had led the farmers to steal wood from the forests. Almost 80% of the forests had been depleted and now the local populace had sometimes to walk a distance of 10 kms to collect firewood. Good quality wood was required for curing wherein temperatures were maintained at 90-120 degrees Fahrenheit for 4 days. The alternative crops that some families had shifted to in the state were maize etc.; they had noticed that the land became more fertile if tobacco cultivation was decreased. As tobacco was a very labour intensive work, the people used to be busy from morning to evening in their work, which had affected families, as there was nobody to look after children and the elderly. This has been shown in falling attendance in school for the children of cultivators and agricultural laborers. The Sanghas and self-help groups discussed this and decided to utilize the govt. programs. Supporting each other, they

cultivation, women were the most affected – they had occupational problems, were made to work hard and do menial jobs; there was gender insensitivity and the women were made to do the most difficult and strenuous work. This had affected the lives of many women and children adversely. Ms. Devaki appreciated the presentation and mentioned the need for linked narratives to help with advocacy issues.

This was followed by a group discussion involving all participants that was chaired by Dr. Srinath Reddy. The main points that were highlighted in the discussion by various participants were: -

- Coronary Artery Disease (CAD) caused by tobacco usage needs to be studied and publicized.
- FCTC needs to advocate strong regulations- local and national.
- Need to sensitize the politicians about the issue.
- Need for effective political lobbying and policy level interventions.
- Need to safeguard the interests of the involved people and to try to bring the larger forces to come together.
- Lesser emphasis to be laid on health and more on the fiscal and the environmental aspects.
- To try to attempt a linkage with the right to food campaign and the environmental issues.
- Promote the usage of the 73rd and the 74th amendments that promote local governance.
- Need for economists to study the long term effects of tobacco usage.
- Promote the ban of tobacco consumption in public places as it gives the right to people to protest tobacco usage.
- Alternate employment strategies to be promoted.
- Need to understand that there was no direct subsidy by the Govt. of India to the tobacco industry but indirect subsidy.
- Legislation against tobacco would be ineffective if people were not informed and convinced about the reasons for legislation.
- Need to approach and convince even the local and vernacular media to cover tobacco related issues.
- Need to convince the film producers and artists to not promote the usage of tobacco in the movies/serials; this was especially relevant as the theme of the World No Tobacco Day this year was '*Free Films from the influence of Tobacco*'.
- The information about tobacco to be integrated into existing health programs and through the educational system in school and colleges.

Mr. Niranjan from the People's Health Movement in Sri Lanka shared that the cost of one cigarette in Sri Lanka was 7-8 rupees and that was an effective deterrent also; it was discussed that Prof. Panchamukhi's study on Karnataka had proven that tobacco farmers were ready to diversify into vegetable cultivation but the market support was not in place. Whereas the tobacco industry was picking up its produce and taking it to the market, this support was not available for the farmers involved in vegetable farming to transport their produce to the distant markets.

The group then discussed the statement to be issued by the workshop participants- certain changes were suggested for incorporation in the statement before finalization and distribution to the ASF organizers and the media. The modified statement and the press release are attached.

Dr. Srinath thanked the participants for their active participation in the group discussion.

A formal vote of thanks was proposed and the workshop ended.

ACTION TOWARDS A TOBACCO FREE WORLD

A Workshop on Tobacco Control, Asia Social Forum, Hyderabad

Date: 3rd January, 2003
Time: 2:15 to 6:30 P.M.

Venue: Taj Mahal Hotel,
Abids Road,
Hyderabad – 01
Ph: 24758221

Facilitated by:

Community Health Cell, Bangalore on behalf of Jan Swasthya Abhiyan / People's Health Movement

Partner Organizations

Consortium For Tobacco Free Karnataka
PATH-Canada

Indian Coalition for Tobacco Control
LIFE HRG

Introduction

This workshop will present a canvas of the entire range of activities and effects related to tobacco production, supply, distribution, consumption, health, socio-economic spheres and the environment. It would also include an overview of the tobacco control initiatives at the local, Asian and global levels. Discussion will be held on working together and evolving strategies at various levels for tobacco control.

Proposed Format of Workshop

2:15 to 2: 30 p.m.: Street Play on the Tobacco industry and its effects

Duration of the workshop: 4 hours

Sl. No.	EVENT	DURATION
1.	**Presentation on the following issues:** An Introductory Overview **Chairperson: Dr. Ramesh Bilimaga**	**1 hr 10 mins** (2.30 – 3.40pm)
	Welcome Note: Profile of Tobacco related issues in Asia/ India Dr.Thelma Narayan, CHC – An introduction to the Workshop. **Objective:** To highlight the various aspects of the problem and to update participants on the current situation	10 mins
	Magic show & Talking Doll Show on the ill effects of tobacco	
	• Tobacco control initiatives at various levels – Global, National : - Mr. Sonam, Ministry of Health & Education, Bhutan - Mr. Ratan Deb, BATA, Bangladesh, - Dr. Prakash C Gupta, India) State [IMA, Karnataka Task Force, CFTFK – Mr Chander (CHC)] **Objective:** To inform participants about the ongoing initiatives in tobacco control and to record our recognition of important innovative initiatives	45 mins

	• **Clarifications / responses**	15 mins
2.	**People's Health Celebration** **Chairperson: Ms. Devaki Jain**	**25 mins** (3.40 – 4.05pm)
	• Felicitation of people/ groups who have made efforts for tobacco control in the Asian region • Cultural event (Song, Testimonies- Mr.Jaggaiah(Patient), Ms. Lalithamma (Ex Tobacco Cultivator and Patient) **Objective:** To honour people who have made concerted efforts in tobacco control in their local areas and to celebrate the spirit of working together.	
	TEA BREAK / EXHIBITION OF POSTERS	**15 mins** (4.05 – 4.20pm)
3.	**Panel Discussion** **Chairperson : Ms. Devaki Jain**	**1 hr 10 mins** (4.20 – 5.30pm)
	• **Panel Discussion** 1. Epidemiological / Public Health Issues posed by Tobacco – Dr. Prakash C Gupte 2. FCTC* Update- Dr. Srinath Reddy 3. Socio-Economic Concerns Tobacco Raises and Exposing the Tobacco Industry– Ms. Shoba John, PATH, Canada (India). 4 The Environment, Gender and Child Rights Issues around Tobacco Production – Ms. Suvarna, Shimoga, Karnataka **Objective:** Analysis of the Social, Economic, Environmental & Health effects of tobacco; Introduction to * Framework Convention for Tobacco Control (FCTC) and to introduce the Challenges and Initiatives for action towards a tobacco control in Asia.	50 mins
	• **Open House** **Objective:** To provide an opportunity for the participants to seek clarifications and participate in the discussion.	20 mins
4.	**Group Work** **Chairperson: Dr. Srinath Reddy**	**30 mins** (5.30 – 6.00pm)
	• Presentation of tentative 'Workshop Statement'. • Group discussion tentatively on: a) What strategies to be adopted to work with Government and civil society at local, national and international levels to advance tobacco control policy efforts? b) How do we work with the media and various pressure groups (including international groups) to advance tobacco control? c) How do we mobilise community support towards advocating for policy changes as well as to initiate and implement tobacco control programmes. d) Discussion on the 'Statement' and possible modifications **Objective:** To identify issues, evolve strategies and devise mechanisms for working together in the future.	30 mins

5.	**Concluding Session** **Chairperson: Dr. Thelma Narayan**	**30 mins** (6.00 6.30pm)
	• Presentations by the group . declaration of 'Workshop Statement' and vote of thanks. **Objective:** To share the discussions of the group and discuss concrete follow-up plans.	30 mins

Rapporteurs:
Dr. Prakash Vinjamuri, LIFE HRG
Mr. Naveen Thomas, Fellow, Oxfam GB
Dr.Anant Bhan, Fellow, CHC

There will be a poster exhibition; background papers, books and pamphlets from various regions in Asia will be available at the venue. Nine banana carts from LIFE, a Hyderabad organisation involved in Health and Nutrition Education will carry posters, flags and handbills celebrating tobacco control in different parts of Hyderabad city, at the ASF and Youth Forum venue.

WHO/NMH/TFI/02.03

World No Tobacco Day activities are coordinated every year by the Tobacco Free Initiative of the World Health Organization.

World No Tobacco Day


tobacco free sports
play it clean
World No Tobacco Day
31 May
TOBACCO FREE
SPORTS
31 May
tobacco free sports tobacco free sports tobacco free sports

Enter The Stadium – Tobacco Free Sports

Sports and tobacco do not mix... FIFA's decision to back our public health cause is a significant step towards achieving this goal. The world's biggest sporting event is now tobacco free.

Dr Gro Harlem Brundtland, Director-General, World Health Organization commending FIFA for declaring the 2002 World Cup Tobacco Free

If our sport could once be used to promote tobacco when we did not know better, we have an obligation to use it to discourage tobacco now that we do. This is an obligation towards all those who, in the past, have suffered as a consequence of having been duped into thinking tobacco and football have something in common...That's why FIFA has been very ready to work with the World Health Organization and the US Centers for Disease Control to see how we can use the World Cup... to reflect modern knowledge and modern awareness of the dangers of tobacco use.

Keith Cooper, Director of Communications Fédération Internationale de Football Association (FIFA) November 2000

May 31, 2002.
World's largest sporting event, the FIFA 2002 World Cup games, to begin in Seoul, Republic of Korea.

May 31, 2002.
The World Health Organization's 191 Member States celebrate World No Tobacco Day (WNTD).

Two mandates. Two dreams. A shared vision and a global event. The world of health and the world of sport came together on May 31, 2002 to write a piece of public health history. The World Cup games were declared tobacco free for the first time ever. Billions of viewers watched the kick-off game beginning with tobacco free messages flashing around the world as well as in the stadium.

The journey to rid sports of the influence of tobacco, however, began much earlier and it was routed through knowledge, outrage, decision, and action on the one hand and science, policy, and implementation on the other. In his remarks quoted above, the former FIFA official says it all.

Knowledge, provoking a new understanding of an issue. Knowledge, setting people free. Knowledge, spurring some to act, others to legislate, and yet others to agitate.

In the beginning, people did not know that tobacco was a killer. Most people still do not know that a cigarette is a highly engineered product designed to bring on early addiction and sure death in one in two of its regular users. Most people do not know that tobacco companies use sports, from playgrounds to national and international stadia as well as sports goods, as marketing and recruitment settings to attract new and younger victims while keeping the old ones addicted. When the World Health Organization (WHO) decided in 1998 to begin work on a set of global rules to curb the marketing and promotion of tobacco and its products, its focus turned to the sports arena. The reasons were obvious. Tobacco companies pump hundreds of millions of dollars every year into sponsoring sports events worldwide.

Until recently, they were everywhere. From your humble sports field around the corner to the grand stadia of the world, not to mention clothing and equipment used by athletes and fans, tobacco beckoned from every corner.

The glare of boisterous publicity around tobacco products was deliberately designed to keep the gore of deaths caused by them away from the public eye. The deception was for the public. The profits were for the companies and the death and disease burden were for countries to cope with.

Sports is a celebration of life. It inspires healthy living, fair competition and above all, fun and camaraderie. Associating tobacco with sports helped hide the grim truth about the death-causing ingredients these products contain. All this was done in the name of freedom. All this was done in the name of choice. It took half a century of knowledge generation, outrage and court action to expose the inherent deceit behind the way tobacco companies designed, manufactured, sold, promoted and protected their products.

Something started to change in 1998 when 191 countries set about working on the proposed Framework Convention on Tobacco Control (FCTC). As WHO readied the ground for a tobacco treaty, first about tobacco related diseases, and later about the product that was allowed to cause 4.2 million deaths annually now and an estimated 10.4 million deaths in 2025. The first barrage of questions led to more questions until suddenly the floodgates were opened for truth to pour out. The story was ugly. It was a tale of deception and deceit with tobacco industry's own documents showing that they were enticing children as young as nine to smoke or chew tobacco. Sports stadia where unsuspecting children and youth go to kick a ball or ride a bicycle were prime settings for tobacco promotion. WHO focused on the eye of the needle when it told the world that tobacco was a communicated disease, communicated through advertising, marketing and promotion.

WHO's call for rules around tobacco has met with success in many areas. Some countries have seized their courts for redress, others have worked through their parliaments to strengthen existing rules or write in new ones. One area where the call has been strong and unanimous has been sports. Country after country has called for abolishing any links between tobacco and sports. The WHO launched its own Tobacco Free Sports in 1999 joining forces with the US Centers for Disease Control (CDC). From sports clubs, to stadia around the world, from sports goods manufacturers to sports television broadcasters to governments negotiating the FCTC, the verdict was unequivocal and unrelenting: tobacco and sport do not mix.

Declaring sport an important link in the communication of tobacco-related diseases, WHO has called for global bans on tobacco marketing, advertising and sponsorship of sport. It has called for an end to pernicious association between the life-affirming activity that is sports and a life-taking product. This movement into centre court has become a metaphor for the FCTC, whose principal aim is to reclaim ground, including policy ground, from vested interests.

Athletes, sports organizations, national and local sports authorities, schools and university teams, sports media and everyone interested in physical activity are invited to join this campaign for Tobacco Free Sports. WHO urges people everywhere to take back their right to health and healthy living and to protect future generations from the preventable death and disease caused by tobacco.

Dr Gro Harlem Brundtland, Director-General, World Health Organization
November 2001

In relation to the theme Tobacco Free Sports for World No Tobacco Day, 2002, I want to urge all the sportspersons including sports organizers and their respective governments to make sports across the globe free from tobacco by not accepting sponsorships from the tobacco companies.

Having played international cricket for twenty-one years and having established the largest cancer hospital in Pakistan, Shoukat Khanum Memorial Hospital, which is providing free medical services to the poor suffering from cancers, I have witnessed from close the power and pervasiveness of tobacco promotion through sports and its disastrous health consequences in the form of cancers and deaths. Approximately 90% of the lung cancer in Pakistan is attributable to cigarette smoking. The fact that sports people are used as promoters of this killer and that disease and death caused by smoking is absolutely avoidable saddens me.

Wherever and whatever you are playing, as sportsman or woman, let's make a personal resolution on this World No Tobacco Day that we will not accept any tobacco sponsorships either personally or as teams. We will not play in any such events, which directly or indirectly promote tobacco – the killer, and hence we will not contribute to millions of avoidable deaths every year in the world due to tobacco.

Imran Khan
Former Captain of Pakistan Cricket Team

guatemala guinea guinea-bissau guyana haiti honduras hungary iceland india indonesia ir
slamic republic and israel italy jamaica japan jordan kazakhstan kenya kiriba
kuwait kyrgyzst public latvia lebanon lesotho liber
luxembourg madagascar malawi malaysia maldives mali malta marsha

sport is about p

Tobacco Free Sports, launched as part of the global advocacy project "Tobacco Kills – Don't be Duped", was designed to capture and channel the outrage over tobacco-related deaths into the policy domain. The ploughing of the policy arena with science and economics sought to reframe tobacco deaths and bring to it new understanding. From that of a nasty individual dependence, tobacco is now seen as a public health disaster, exacerbated by the rapacious marketing of tobacco companies to an unsuspecting public. The Tobacco Free Sports campaign's contribution to this global debate has been significant.

In 1998, the IOC and WHO, in cooperation with the Organizing Committee of the Games, prohibited smoking in all Olympic sports venues. In 1999, the concept of a global Tobacco Free Sports initiative was included as a part of the Tobacco Kills, Don't be Duped media advocacy initiative. An early partner was the CDC.

Building on the momentum created by tobacco free Olympics, the idea was carried to other sports. With the US Women's Soccer team in 2000 and the South African Football Federation in 2001 going tobacco free, the stage was set for the initiative moving ahead in leaps and bounds. In November 2001, WHO, CDC, IOC and FIFA, joined by international athletes, officially launched the Tobacco Free Sports initiative and ushered in the topic as the official theme for the 2002 World No Tobacco Day celebrations.

In 2002, Tobacco Free Sports came of age and started reclaiming ground in ways unprecedented in WHO's history. The 2002 Salt Lake City Winter Olympics and the 2002 Paralympic Winter Games kicked off the year's tobacco free sports activities, followed by numerous national and international events. Working jointly with FIFA, the WHO was able to ensure that the 2002 FIFA World Cup soccer games were tobacco free.

fairness

Good athletes do not smoke because they know sport and physical activity are deeply incompatible with tobacco use. We will continue to support the campaign for tobacco control and healthy lifestyles in the future.

Dr Jacques Rogge,
President, International Olympic Committee

Sports is about health. We firmly believe that the Olympics should not be associated with unhealthy behaviours, that's why we work so hard to promote policies such as the tobacco-free Olympics. We can promote many such healthy lifestyles and are actively working with WHO in drafting similar policies.

Juan Antonio Samaranch
Former president, International Olympic Committee

I am looking forward to being able to live and compete in fresh air during the 2002 Games. Tobacco use and sports just don't mix. Its not just smoking that can harm you, but breathing in other people's smoke can also hurt an athlete's performance.

Jean Racine
US women's bobsled team

federation rwanda saint kitts and nevis saint lucia saint vincent and the r
marino sao tome and s o senegal seychelles sierra leone singapore slovak
slovenia solomon i sri lanka somalia sudan surinam
sweden switzerland syrian arab republic tajikistan thailand the former yugoslav

sport is about

The 2002 FIFA World Cup

May 2002 was a time for reckoning. In addition to the games themselves being tobacco free, WHO achieved a major breakthrough with the development of a Memorandum of Cooperation with FIFA for the World Cup in Korea and Japan in 2002. It contained very specific measures that would be taken to protect the players, spectators, staff, volunteers, media as well as television viewers from the harmful effects of tobacco exposure, consumption, advertising, marketing and promotion during the World Cup and future FIFA events. This policy and its development will have long term impact in ensuring smoke-free stadiums in the seated areas for future events as well, and was achieved through the collaboration with the WHO Western Pacific Regional Office and WHO Country Office in Korea.

Tobacco use, in any form, was restricted to specifically designated areas, clearly indicated and well apart from the main seating areas of the venues. No tobacco products were sold or distributed freely at the games; vending machines were disactivated or removed. Signs and audio messages in many languages notified the public of the tobacco-free policy. These policies applied to players' and coaches' zones, and areas for media and VIPs as well. There was no tobacco advertising or promotion material at the venues. In addition, health information on the dangers of tobacco use, the false premises of the association of tobacco and sports in advertising and promotion, and FIFA's decision to go tobacco free, was distributed at the stadium.

There was more. Before the start of the games and during the interval, a Public Service Announcement (PSA) on Tobacco Free Sports ran on the stadium's screens and around the world on television. The Tobacco Free Sports logo appeared around the side by side with the corporate sponsors of the games. The logo appeared during the entire opening match, watched by millions of television viewers around the world and continues to appear in the countless photos that were taken during the match. The PSA was also beamed to national broadcasters in over 80 countries for broadcast in association with the games as part of FIFA's basic feed. The official site of the World Cup, www.fifaworldcup.com, hosted by Yahoo!, broke all records, as the most frequently visited site in World Cup and indeed international sport history. The Tobacco Free Sports logo, poster and links to more information about the tobacco epidemic and the work of WHO figured prominently on the site and were viewed by billions of people.

Together, FIFA and WHO wrote a piece of public health history.

Talking about tobacco-free sports is the first step toward generating broad public support to reclaim sports for health. By talking about tobacco-free sports we pave the way for a complete ban on advertising of tobacco products consistent with the draft international Framework Convention on Tobacco Control, the first international public health treaty that seeks to regulate tobacco.
Let us talk about tobacco-free sports.

Dr Shigeru Omi, Director
Regional Office for the Western Pacific
World Health Organization

Tobacco and sport simply do not mix. Sport supports health and well-being. Tobacco takes health away.

Dr Marc Danzon, Director
Regional Office for Europe
World Health Organization

Thanks to the unstinting effort of WHO and its partners the rate of sponsorship by the tobacco industry in the world is declining, but in this, the Eastern Mediterranean Region, it is on the rise. People think that tobacco money is essential for certain sports events to survive. This is untrue. The real truth is that tobacco products needed sports to survive not the opposite. In the countries of this Region, the tobacco industry sponsors many sports events, such as car rallies and football matches. I hope that decision-makers in the Region will address this challenge so that we may see our sports totally free of tobacco.

We have a commitment and obligation to ourselves and to our children to help them achieve the best possible life in terms of health and opportunities and also to support them in choosing a healthy lifestyle, as well as healthy habits based on solid scientific information. Let us all work to make our favourite sports tobacco-free and help in creating a tobacco-free generation.

Dr Hussein A. Gezairy, Director
Regional Office for the Eastern Mediterranean
World Health Organization

Africa has one of the fastest growing prevalence rates of tobacco use among young people. The tobacco epidemic is spread through tobacco advertising, sports sponsorship, marketing and promotion. This is a reality in every country of our Region. All countries should prohibit tobacco marketing, promotion and advertising as well as the distribution of free samples of tobacco products...I call on all heads of government , sports directors, teams and organizers, the community, political leaders and young people to create and maintain Tobacco Free Sports environments in our communities, towns, cities, and nations.

Dr E. M. Samba, Director
Regional Office for Africa
World Health Organization

"There are many difficult choices that public health has to make. This choice is not a difficult one: we can sell cigarettes, or we can protect our children. The cost of the first is unacceptably high, while the while the benefit of the second has no price. PAHO urges sports events to refuse tobacco sponsorship and to make their venues smoke-free. We also urge governments to prohibit the use of sports – or any other event sponsorship – to promote tobacco products. There has never been a better opportunity than now."

Dr George A.O. Alleyne, Director,
Regional Office for the Americas
World Health Organization

Joining WHO in this campaign of "tobacco-free sports" are some of the best sportspersons from the Region, including cricketing legend Roshan Mahanama from Sri Lanka, cricketer Mohammed Akram Khan and ace swimmer Mohammed Mosharraf Hossain Khan from Bangladesh; shooter Jaspal Rana and cricketer Virender Sehwag from India; Karma Lam Dorji basketball coach from Bhutan; tennis champion Angelique Widjaya and body builder Ade Rai from Indonesia; athlete Baikuntha Manandhar and taekwando trainer Sabita Rajbhandari from Nepal; football player Mohamed Kaleem from Maldives, Wushu player Khine Khine Maw, football player Hein Zeyar Kyaw and weightlifter Swe Swe Win from Myanmar; boxer Wincharn Polrit, tennis player Tammarine Tanasukarn and football player Theerathep Winothai (Leesaw) from Thailand. These "tobacco-free champions" will collaborate with national health authorities in efforts to free sports from the vicious grip of tobacco. Sportspersons, with their strong influence over the young, can be useful ambassadors in promoting healthy lifestyles and tobacco -free life. Sportspersons should also be aware that smoking and other forms of tobacco consumption can affect their own performance.

Dr Uton Muchtar Rafei, Director
Regional Office for South East Asia
World Health Organization

afghanistan albania algeria andorra angola antigua and barbuda argentina armenia australia
austria azerbaijan bahamas bahrain **achievement** belgium belize
bhutan bolivia bosnia and herzegovina
burkina faso burundi cameroon cambodia canada cape verde central african republic chad

WHO Director-General's World No Tobacco Day 2002 Award

The Director General's World No Tobacco Day award is given to people and organizations who have shown exceptional courage and vision in tobacco control. In 2002, it seemed only fit to grant this honour to an organization which, in addition to representing the sport of all sports, football, had shown exemplary leadership in the field of tobacco control. "Sports and tobacco do not mix. We have a common goal - that all sports are free from tobacco. FIFA's decision to back our public health cause is a significant step towards this goal. The world's biggest sporting event is now tobacco free," she added when the award was announced. FIFA received the award at the opening congress of the games in a glittering event where WHO was the only non-sporting organisation to be represented.

s sport is about p t

Media coverage

International media interest in this initiative was very lively and sustained, peaking in particular during high profile events such as the November 2001 official launch, the Salt Lake City Olympics in February 2002, the FIFA World Cup kick-off in May 2002 and the World No Tobacco Day celebrations on May 31, 2002. Individual events in countries received wide local and regional coverage, peaking around the activities connected to World No Tobacco Day celebrations but also around announcements by local sport federations or athletes pledging to go tobacco free. In Egypt, former Egyptian footballer Mahmoud El-Khatib joined the campaign, and Public Service Announcements featuring the athlete was aired repeatedly on both national and satellite channels. Imran Khan, former Pakistani cricketer, generated both public and media interest with Tobacco Free Sports messages aired on Pakistan TV and radio.

Global media coverage of the WHO-FIFA initiative as well as Tobacco Free Sports set a new threshold exploding around the world in languages and mediums. In addition to reporting on the event, they served as watchdogs worldwide, reporting on violations of the agreement with sports organizations or the use of deceptive advertising methods adopted by tobacco companies in the run-up to the games.

The Tobacco Free Sports initiative expanded WHO's coverage beyond its regular constituency of health reporters and enabled public health to be reflected in entirely new areas such as the sport pages, business and financial pages, society pages and even by leading advertising industry information services such as Advertising Age and Brand Republic. The pick-up of what is essentially a public health story by such a wide array of media points to the popularity and appeal of this initiative among all sections of the public.

The tone and content of the coverage was very positive. Every print article included either one or more of the main messages that the initiative aimed to convey:

- Tobacco kills.
- Tobacco companies promote, encourage and initiate the use of tobacco by associating it with the positive imagery of sports. This makes tobacco appear more glamorous, appealing, fun and even healthy.
- The young are a particular target of this kind of marketing, and are particularly susceptible.
- WHO is calling for global bans on advertising, marketing and sponsorship of sports by tobacco companies.

WHO is calling for global bans on smoking in public areas such as stadiums and play-areas to protect people from second-hand smoke.

The call for global bans received by far the most media attention as every story covered this particular angle. As bans were the core policy issue involved in the campaign, the media communication goal of this initiative was fully realised.

Clearing the haze: why we must make the national games in Hyderabad smoke free
The Indian Express

UN Health agency awards anti tobacco prize to FIFA for smoke free
Associated Press Worldstream

WHO calls for tougher tobacco control laws in Asia
Deutsche Presse- Agentur

Selling of cigarette to be banned in World Cup stadiums in Japan
Xinhua News Agency

World No Tobacco Day to be observed by road race
Africa News

World Cup football to be tobacco free
The Press Trust of India

UEFA, EU to launch anti tobacco campaign in Europe when the World Cup starts.
Associated Press Worldstream

Tobacco targets children
Jakarta Post

Tobacco free Sports drive launched by WHO, DoH
Manila Bulletin

FIFA gets no tobacco award for Korea and Japan World Cup
Agence France Presse

No Smoke
Financial Times

Advertising an addiction to Asia's youth
The Korea Herald

WHO presents highest tobacco control award to FIFA
Xinhua News Agency

Athletes urged to butt out
Canada Newswire

World Health Organisation launches regional campaign in India to get sports to kick its tobacco habit
Associated Press Worldstream

mauritania geneva mauritius mexico micronesia federated states of monaco
morocco mozambique myanmar netherlands new zealand nicaragua
niger nigeria niue norway oman pakistan panama papua new guinea paraguay peru
philippines poland portugal qatar republic of korea republic of moldova romania russia

tobacco kills

World No Tobacco Day coincides with the World Cup kick off
Agence France Presse

Volleyball joins Tobacco Free Sports Initiative
Xinhua News Agency

Two chinese sports figures win WHO Health award
Xinhua News Agency

Smoking urges to butt out of sports
China Daily

FIFA must strictly enforce no tobacco rule
Thai Health Institute
Agence France Presse

Poland marks World no Tobacco Day
PAP news wire

A smoke free vision: The next step is for government to ban smoking in public places
The Guardian

World Cup fever sparks public bans in smoking on No Tobacco Day
Agence France Presse

Celebrate a smoke free World Cup
New Straits Times (Malaysia)

Health and Sports officials join in World fight against smoking
The New York Times

BAT angers footballers over image rights
sportbusiness.com

Tobacco giant sidesteps ban on World Cup ads
The Guardian

Anti Tobacco Campaign to target 2002 sports events
PR week

Call for tobacco free sport
Financial Times

federation rwanda saint lucia saint kitts and nevis saint vincent and the grenadines samoa san marino sao tome and principe saudi arabia senegal serbia and montenegro seychelles singapore slovakia slovenia solomon islands somalia south africa sri lanka sudan suriname swaziland sweden switzerland syrian arab republic tajikistan bahamas thailand togo tonga trinidad and tobago

don't be duped

Policy Implications and Challenges

The core goals of Tobacco Free Sports have caught the imagination of the public at large in ways that have surpassed all expectations. These include calls

- To deglamourise tobacco use among the public and particularly young people.

- To expose the truth about the tobacco industry's decades-long cynical manipulation of sport for profit.

- To build support among the public and governments for public bans on smoking within sport settings to protect people from second-hand smoke; and a ban on advertising, marketing and promotion of sport by tobacco companies.

The rush for Tobacco Free Sports posters, brochures, pins, stickers and advocacy material has equalled interest in WHO's landmark "Bob, I've got Cancer" campaign that depicts two cowboys riding horses talking about cancer.

Global agencies such as the International Volleyball Federation (FIVB) have gone tobacco free and regional sport events such as the XXI Central American and Caribbean Games for November 2002 and the 14th Asian Games in Busan, Korea, have pledged to go tobacco free. Nationally, announcements to go tobacco free by 33 sport federations in El Salvador and over 17 national sport organizations in Switzerland are being joined by their counterparts all over the world on a monthly basis. The Tobacco Free Sports initiative has truly become a movement that spans across global, regional and national interests.

The actual implementation of the tobacco free policy in stadiums and during games has shown that people really appreciate watching their games without having to cope with smoke in their eyes. Sports organizations and settings are now under scrutiny from a public whose knowledge about tobacco the issue grows along with the raging global debate on it. Tobacco companies are on notice and their attempts to link to sports is no longer an unquestioned right. That is already a significant step forward, made possible at least in part by the Tobacco Free Sports initiative.

Non-governmental organizations (NGOs) have played a key role in the FCTC process and sustained the debate with information and challenges. For Tobacco Free Sports, they made common cause with the media an exposed how tobacco companies continued to thwart public opinion and violate public health measures by associating their products with the popularity of the World Cup. Violations were reported in Korea, Malaysia, Pakistan, and Niger.

Welcome to the World's largest sporting event

Public response to these violations was very encouraging and several NGOs petitioned their local broadcasters and other sports organizations to be alert to these moves. Focus on these violations served to highlight the simple fact that the tobacco industry never gives up and will circumvent any rule that comes in the way of its marketing and sales pitch. Hemmed in on one side, tobacco companies are now parading their new "social responsibility" mantra informing governments that they do not market to youth and are responsible enough to regulate themselves accordingly.

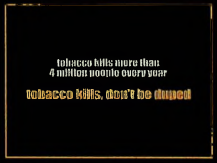
The jury on self regulation has been out for a while as it has been on restrictions on marketing to only young people. The verdict is that both do not work. When you market a product as an "adult choice," the young are doubly enticed. Working on developing a treaty governments are in the throes of legalese calling for regulation of the tobacco industry and a phase out of tobacco advertising beginning with sports stadiums. At the same time, an high profile event like the tobacco-free world cup has shown them the real benefits of the work, giving their legal work a real-life dimension. For government, it's no longer reading and analysing some documents at the negotiations in Geneva, it also means taking a position, it also means relating to a tangible global event like the World Cup. This synergy has worked to the benefit of public health and while they wait for the FCTC to be adopted, governments around the world are looking at litigation and legislation as a viable tool with which to sever all links between tobacco and sports.

At the FCTC negotiations governments that fall on both sides of the global ban on advertising bans have expressed interest in banning the association of tobacco with sport. The FCTC is being negotiated by 191 Member States of WHO, and represents the first time WHO's treaty-making clause has been invoked to address a public health issue. The latest text being negotiated by governments, called the New Chair's text on the FCTC, contains language that requires the phasing out of tobacco sponsorship of sporting and cultural events. Once negotiated and signed, the FCTC will be the world's first legally enforceable international treaty on tobacco control. It is expected to be ready by 2003 and address issues such as tobacco advertising and marketing, cessation, taxation, smuggling, education and other tobacco control measures.

Policy change often begins before it is recognized as such. WHO's gambit with Tobacco Free Sports when the organization entered the stadium, is beginning to pay off.

t a b **which is also tobacco free** belgium belize

Storyboard from the FIFA-WHO public service announcement



film promo

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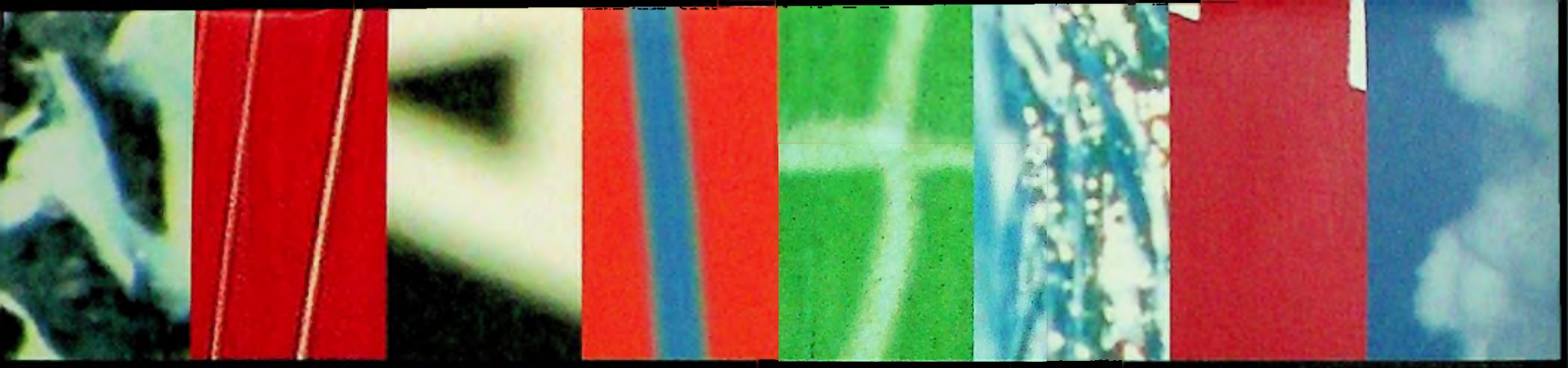
tel: 41 22 791 2126
fax: 41 22 791 4832

tfi@who.int
www.who.int/tobacco

for more **information**



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World Health Organization

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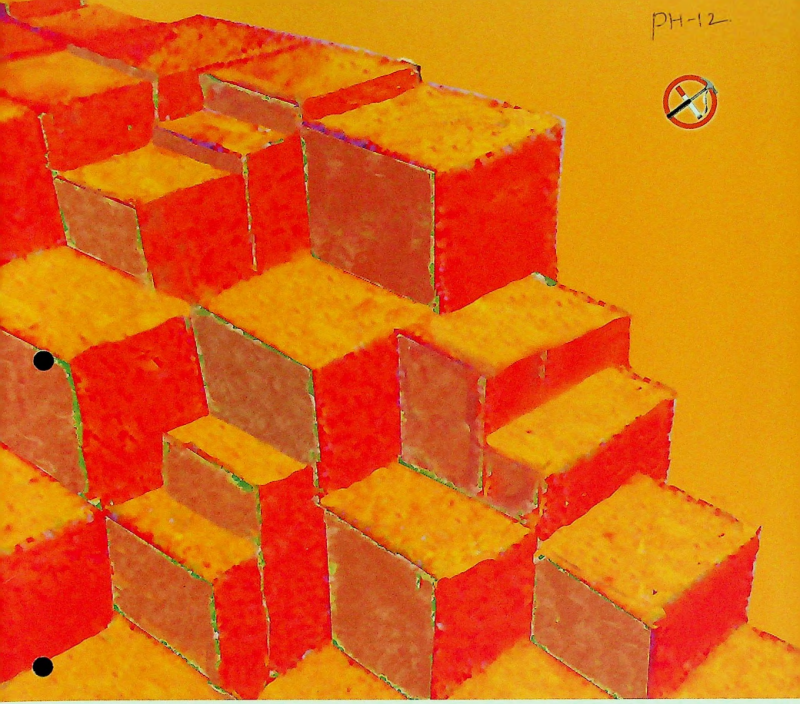

World Health Organization

Building Blocks for

TOBACCO CONTROL

A Handbook

Available Autumn 2004

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THE TOBACCO EPIDEMIC IS A GLOBAL CHALLENGE demanding concerted global and national action. Recognizing that globalization is accelerating the epidemic's spread and perceiving the limits of national action to contain a public health problem with transnational dimensions, Member States of the World Health Organization (WHO) negotiated and adopted a unique public health treaty for tobacco control. Today, the WHO Framework Convention on Tobacco Control (WHO FCTC) contains the blueprint for coordinated global action to address one of the most significant risks to health.

However, national action is critical in order to attain the vision embodied in the WHO FCTC. Building national capacity to carry out effective and sustainable national tobacco control programmes is an urgent priority, and one of the most significant measures required to combat the tobacco epidemic.

The idea for this Handbook arose from the awareness that while various official WHO documents called for developing national capacity for tobacco control, there was no comprehensive publication for the development of such capacity. Conceived as a "How to" manual, the approach is intentionally pragmatic, addressing 'real world' issues and providing practical advice for setting up viable national tobacco control programmes.

OVERVIEW

The Handbook contains three main sections. The Introduction presents the evolving definition of "national capacity", identifies the types of capacities needed for effective tobacco control and outlines the key features of building capacity. Section 1 provides a descriptive overview of the tobacco epidemic, and is further subdivided into four chapters. These chapters address tobacco as a risk factor, with attendant health and economic costs; the global strategies of the tobacco industry; the scientific evidence for effective tobacco control interventions; and the WHO Framework Convention on Tobacco Control (WHO FCTC) as a global solution to a health epidemic with prominent politico-legal and sociocultural attributes. Section 2 focuses on the fundamental capacities necessary to empower countries to take on the tobacco epidemic successfully. The chapters in this section build on early successes in various areas of tobacco control within developed and developing countries that have pioneered the fight against the tobacco epidemic. These chapters apply the lessons learned from the experiences of these countries and offer advice and suggestions to enable Member States to put the theories of tobacco control into practice. This section begins with the development of a national plan of action as the foundation for successful tobacco control at the country level. It addresses the other important elements in national capacity-building, including establishing an effective infrastructure for a national tobacco control programme, training and education, raising public awareness through effective communications and media advocacy, programming specific

tobacco control activities, legislating measures for tobacco control and exploring economic interventions and funding initiatives. Chapters on countering the tobacco industry, forming effective partnerships, monitoring and evaluating progress, and exchanging information and research provide valuable insights to augment tobacco control capacity.

SUMMARIES OF THE CHAPTERS

Part I. Setting the Theoretical Foundation for Tobacco Control

Chapter 1. Tobacco as a risk factor: health, social and economic costs
This chapter reviews the global data on the tobacco epidemic. Tobacco is now a major preventable cause of death in developed and developing countries. Every day over 13 000 people worldwide die from tobacco. Assuming current patterns of tobacco use and intervention efforts, WHO projects that from 2000 to 2030 the number of smokers will rise from 1.2 billion to 1.6 billion and the annual number of deaths will increase from 4.9 million to 10 million. Aggressive promotion by the tobacco industry, and permissive environments that make tobacco products readily available and affordable play a major role in inducing young people to take up tobacco use. The addictive nature of nicotine ensures that majority of tobacco users remain hooked for life. The health and economic costs of tobacco use, however, are borne not only by tobacco users, but by society in general. The chapter examines tobacco consumption trends among adults and youth, presenting cross-country data where available. It illustrates how the costs of tobacco consumption affect tobacco users, non-users, families and communities, businesses, governments and society, making the tobacco epidemic a concern for everyone.

Chapter 2. The tobacco industry: global strategies
This chapter offers insights into the nature of the tobacco industry, and the global strategies it uses to maintain the profitability and widespread use of its deadly product. The tobacco industry documents database, made available publicly as a result of the Master Settlement Agreement (MSA) between the tobacco companies and 46 United States territories and states, is a rich source of information on the industry's formerly secret tactics and plans to deter effective measures to control tobacco use. Actual examples in several countries are cited to illustrate how the industry's strategies have been used to impede progress in tobacco control.

Chapter 3. Tobacco control interventions: the scientific basis
The tremendous adverse impact of tobacco use on health and economic indicators worldwide makes tobacco control a public health imperative. This chapter discusses the evidence for effective interventions to reduce tobacco consumption. Both supply- and demand-side interventions are examined. The impact of these strategies on

smoking initiation and cessation, and their cost-effectiveness, are discussed. Benefits of tobacco control to individuals, families, communities and governments are enumerated. For tobacco control to succeed, a comprehensive mix of policies and strategies is needed. The chapter concludes by urging governments to act quickly, supporting international efforts through the WHO FCTC and establishing solid national programmes to stem the devastating effects of the tobacco epidemic on current and future generations.

Chapter 4. The WHO Framework Convention on Tobacco Control (WHO FCTC): the political solution

Public health protection has traditionally been viewed mainly as a national concern. With globalization, however, many issues related to health no longer respect the geographical confines of sovereign states, and can no longer be resolved by national policies alone. The WHO FCTC was developed in response to the current globalization of the tobacco epidemic. This effort represented the first time that WHO Member States had exercised their treaty-making powers under Article 19 of the WHO Constitution. The idea behind the WHO FCTC and its future related protocols, is that it will act as a global complement to, not a replacement for, national and local tobacco control actions. The chapter reviews the history of the WHO FCTC, the legal approach selected, utilizing a framework convention and related protocols, and the process for the WHO FCTC to come into force. The various core tobacco control interventions contained in the WHO FCTC are introduced, and the features that are unique to the WHO FCTC are highlighted. Finally, the post-adoption process is reviewed.

Part II. Putting Theory into Practice

Chapter 5. Developing a national plan of action

Creating a national plan of action for tobacco control and establishing the infrastructure and capacity to implement the plan of action are key to the successful mitigation of the tobacco epidemic. This chapter provides an overview of the process of developing a national plan of action, starting with building a national coordinating mechanism for developing a plan of action and doing a situational analysis to determine needs and resources. The steps for setting a strategic direction and drafting a plan of action are discussed, and the elements of a national action plan are identified. The chapter also highlights the importance of ensuring legitimacy by securing official approval of the plan, and lists some of the critical issues that national programme officers must address to ensure that the plan of action is sustained and implemented.

Chapter 6. Establishing effective infrastructure for national tobacco control programme

As the process of national action plan development unfolds, it is necessary to begin establishing a national infrastructure to carry out the implementation of the national plan of action. This chapter outlines a model for setting up a national network and infrastructure for tobacco control. It discusses the human, logistic and financial

resources required to establish a viable national tobacco control programme, and the process of creating and sustaining national networks to support the implementation of tobacco control interventions country-wide.

Chapter 7. Training and education
Successful tobacco control depends largely upon having the human resources to develop and implement a range of activities at different levels. This chapter presents an overview of the issues related to training and education of the different groups involved in tobacco control. "Training" refers to the transfer of skills to build capacity to undertake effective tobacco control. "Education" means gaining knowledge and understanding about 1) methods of effective tobacco control and 2) dangers of tobacco and methods of cessation. Determining training and education needs of various groups requires an assessment of the current situation. Results of the situational analysis carried out in preparation for developing a national action plan can provide the critical information for this decision. The selection and development of appropriate materials and effective training methods, and the process of conducting effective training workshops are addressed. The chapter also provides examples of curricula from various types of training workshops, taken from actual sessions carried out in several countries.

Chapter 8. Communicating and raising public awareness
The social marketing of tobacco control requires strategic communication. Communication strategies play a key role, not only in ensuring that accurate information is accessible to the population, but also because well-designed communications campaigns can lead to changes in behaviour that are essential for reducing the prevalence of tobacco use. This chapter presents some key strategies and approaches to designing a social marketing and communications campaign for tobacco control. It draws from the experience of several countries, like Australia, Canada, Thailand, and the United States of America, where effective social marketing and communications campaigns have curtailed tobacco use.

Chapter 9. Working with the media
The media is a key player in any tobacco control campaign. Mass media is often the most practical means to disseminate information and tobacco control messages rapidly to a large population. Media is the vehicle that shapes public opinion, and influences policy leaders. Often, repeated news coverage of an issue can guide the policy agenda of a government. Thus, developing good working relationships with media professionals is essential. This chapter presents practical advice on cultivating good media relationships and obtaining media coverage for tobacco control, even when resources are limited. Characteristics that make an event newsworthy, and that are required of an effective spokesperson, are identified. Practical tips are provided on how to develop several key pieces for media communication, including letters to the editor, opinion editorials and press releases, with actual examples. The chapter ends with a reminder that media can also become an effective advocate for tobacco control, if properly guided and encouraged.

Chapter 10. Programming selected tobacco control activities
This chapter offers a broad overview of the various programme options that are most often included as part of a comprehensive, integrated tobacco control action plan. It examines the roles of prevention through school-based programmes, cessation and protection of non-smokers through the creation of smoke-free environments within a national action plan for tobacco control, and identifies the key elements that determine the effectiveness of these components in reducing tobacco consumption. A crucial element for success in tobacco control is the engagement of communities in the process of understanding the tobacco epidemic more clearly and responding in an appropriate way to control tobacco use. Pointers on effective community mobilization and tobacco control educational resources for communities are outlined. The need to consider strategies targeting key high-risk population sub-groups is discussed.

Chapter 11. Legislating measures for tobacco control
Comprehensive tobacco control legislation is a crucial component of a successful tobacco control programme. The aim of this chapter is to build on previous WHO publications on tobacco control legislation—Tobacco control legislation: an introductory guide, and Developing legislation for tobacco control: template and guidelines—offering practical advice relevant to countries seeking to develop and implement tobacco control legislation. The legislative tobacco control measures that WHO recommends as part of a comprehensive tobacco control programme are summarized, and steps necessary to persuade national decision-makers to support these measures are identified. Legislation should be designed to be self-enforcing and should be supported by a commitment to resource adequately an information, implementation, monitoring and enforcement programme. To this end, tools and strategies to implement and enforce legislation are elucidated. The importance of harnessing the international legislative experience is reinforced, and online databases of tobacco control legislation are provided.

Chapter 12. Exploring economic measures and funding initiatives
The economic aspects of tobacco production and consumption play a critical role in developing strategies for reducing tobacco use. This chapter presents basic information on the key economic issues in tobacco control. It highlights the evidence on price and tobacco consumption, key steps to introduce or increase tobacco taxes and prices, which countries may adapt according to their specific socioeconomic and political situation, and funding initiatives for tobacco control, with examples of successful funding initiatives from Australia, New Zealand and Thailand. Key references from the World Bank, which address these issues in greater detail, are cited.

Chapter 13. Countering the tobacco industry
Tobacco is unique among the risks to health in that it has an entire industry devoted to the promotion of its use, despite the known adverse health impact of tobacco consumption. Predictably, the tobacco industry aggressively blocks any attempt to effectively reduce tobacco use. This chapter focuses on strategies to counter the tobacco industry. Building capacity to face the greatest opponent of successful tobacco

control must be a priority for national and local tobacco control officers. In many cases, tobacco control advocates and nongovernmental organizations (NGOs) are more experienced in this area, and much can be learned from them. The chapter stresses the importance of recognizing the true nature of the tobacco industry and offers guidance in searching the tobacco industry database to learn more about the industry's tactics in a specific country. It also discusses strategies to monitor the tobacco industry and neutralize its efforts to impede or delay tobacco control interventions as a necessary element of building national capacity to curb the tobacco epidemic.

Chapter 14. Forming effective partnerships
In every country with successful tobacco control legislation, NGOs have played a major role in promoting change. This chapter focuses on the contribution citizen groupings can make to tobacco control efforts in the legislative field. In particular, it highlights the role and responsibilities of civil society; focuses on how to build and strengthen national tobacco control movements; and provides suggestions for working with the private sector.

Chapter 15. Monitoring, surveillance, evaluation and reporting
Once a tobacco control policy or programme has been launched on the basis of a thorough assessment of the situation, the evaluation process will consist mainly of assessing its relevance and adequacy, reviewing progress in implementation, and assessing impact and effectiveness for the reorientation and formulation of relevant policies and activities. Surveillance and evaluation play a major role in documenting tobacco control policy accountability for policy-makers, health managers and professionals, and for the general public. Therefore, a comprehensive surveillance and evaluation system should be an integral and a major element of all tobacco control policies and programmes. This chapter introduces the key concepts and issues in tobacco control programme monitoring, surveillance, evaluation and reporting. Selected indicators, methodologies and tools are discussed. Because the topic is a comprehensive one, the reader is provided with a list of earlier WHO publications that examine this topic in greater detail.

Chapter 16. Exchanging information and research
The WHO FCTC provides guidance on surveillance, research and exchange of information on tobacco control. Translating research into public information is essential to assist individuals, communities and governments to take action to reduce tobacco consumption. A mechanism to communicate the evidence for tobacco control is necessary to support a national tobacco control programme. This chapter considers the various challenges to research in tobacco control, and offers practical steps to overcome these challenges. The importance of linking research to policy change is emphasized, and the need to communicate information derived from research effectively to target audiences is highlighted. Establishing a mechanism for information exchange is explored, and as an example, an existing web-based information clearinghouse is presented.

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FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC)

Introduction – International Treaties and Conventions

There is no dearth of international conventions and laws. There are a lot of them around and everyone is directly affected by at least some of them. To give a few examples, there is a Convention on the Rights of the Child, Convention on Climatic Change, Convention for Protection of Ozone Layer, etc.

Such international conventions are first negotiated by government representatives within the United Nations System. The negotiated international convention does not become a law automatically – it has to be ratified by the competent legislative body of the country. In India, for example, international conventions and treaties need to be ratified by the Indian Parliament.

The proposal for starting the process of an international treaty or convention can be initiated by any of the permanent organs of the United Nations System. Until 1998, the World Health Organization (WHO) had not used its constitutional mandate to propose an international treaty or convention. It had no problem in getting its policies and recommendations in the interest of public health accepted by everyone.

Why a Convention on Tobacco?

Smoking has been recognized as a major cause of lung cancer, other cancers, heart diseases and lung diseases for over 40 years. It has been identified as a major global public health problem. Until about 1990, each year tobacco-related deaths numbered 3 million globally of which 2 million occured in developed countries. But since then it has been affecting developing countries far more than industrialized countries. As per current estimates, by the year 2030, tobacco will cause 10 million deaths globally of which 70% will be in developing countries. Despite these well-established scientific facts the recommendations made by WHO and other scientific bodies for the control of tobacco in the interest of public health have not been readily accepted or applied in all countries. As a result, smoking and tobacco use is increasing globally every year.

The reasons are not difficult to identify. Unlike other disease causing agents, tobacco use and smoking are promoted globally by a powerful multinational industry that is a big business in every country in the world. This industry opposes almost every meaningful recommendation for tobacco control even though the validity of such recommendations in reducing tobacco use and improving public health has been well established scientifically. The recommended policies include a ban on advertisement of tobacco products, increase in taxes, no smoking in public places, detailed consumer information, appropriate trade practices and others. Several of these (e.g. advertising, smuggling) are transnational in character necessitating an international approach.

FCTC – Current Status

For these and other reasons, the World Health Organization used its prerogative to propose the Framework Convention on Tobacco Control (FCTC). In response to an invitation from

national leaders to rethink priorities as they respond to an ongoing international process; and, engaging powerful ministries, such as finance and foreign affairs, more deeply in tobacco control;

- Raise public awareness internationally about the unscrupulous strategies and tactics employed by the multinational tobacco companies;
- Mobilize technical and financial support for tobacco control at national and international levels;
- Make it politically easier for developing countries to resist the tobacco industry; and
- Mobilize non-governmental organizations (NGOs) and other members of civil society in support of stronger tobacco control policies.

FCTC and Non-Governmental Organizations (NGOs)

Non-governmental organizations must play a key role in the development and negotiation of the convention to ensure its success. There are several ways in which NGOs can support the FCTC. They can:

- Join some group of NGOs working on FCTC. The largest such group is the Framework Convention Alliance;
- Educate themselves and their constituencies about global tobacco issues and the FCTC;
- Keep the media informed about the FCTC and get their support;
- Provide the media with regular stories on the tobacco problem, suggesting the FCTC as part of the solution;
- Find out what the country's delegates to the FCTC have said so far and meet with them in order to influence their future positions;
- Contact the FCA Regional Contact to find out what regional action is occurring in the region;
- Get resolutions passed in support of the WHO FCTC by the boards of respective NGOs;
- Adopt a declaration modeled after the Kobe Declaration; and
- Meet with and send copies of resolutions or declarations to representatives involved in the WHO FCTC negotiations in respective countries.

More resources and information on FCTC is available at www.fctc.org

Prepared By: Dr. P. C. Gupta, ACT-India

PH-12.

HEALTH HAZARDS OF TOBACCO USE

Tobacco use is a serious and growing problem in India. It is estimated that 65% of all men use some form of tobacco- about 35% smoking, 22% smokeless and 8% both. Prevalence rates for women differ widely, from 15% in Bhavnagar to 67% in Andhra Pradesh. Overall, however, the prevalence of bidi and cigarette smoking amongst women is about 3% and the use of chewing tobacco is similar to that of men at 22%.[1] Since the 1980s use of pan masala and gutka has increased at a phenomenal rate.[2]

This extraordinarily high use of tobacco products is having a devastating impact on the health of the people. The World Health Organization estimates that 8 lakh persons die from tobacco related diseases each year in India alone.[3] Currently, approximately 50% of cancers among males and 20% of cancers among females are caused by tobacco. In a World Bank collaborative research project conducted in Chennai on 50,000 subjects the following key findings were made: 50% of smokers died due to smoking, 25% of deaths among males aged 25-69 years were attributable to tobacco use and the risk of dying among smokers with tuberculosis is about 4-fold higher than the nonsmokers with tuberculosis. Another study showed that smokers have a 3-fold risk of developing tuberculosis compared to non-smokers. This shows that at least 65% of tuberculosis seen among smokers is attributable to the habit of smoking.[4]

Chronic Obstructive Lung Disease (COLD)

Chronic obstructive lung disease (including chronic bronchitis and emphysema) is a progressively disabling disease that is rarely reversible. It can cause prolonged suffering due to difficulty in breathing because of the obstruction or narrowing of the small airways in the lungs and the destruction of the air sacs in the lungs due to smoking.

Smoking is the main cause of chronic obstructive lung disease: it is very rare in non-smokers and at least 80% of the deaths from this disease can be attributed to cigarette smoking.[5] The risk of death due to the disease increases with the number of cigarettes smoked.

Pneumonia

Pneumonia is not only more common amongst smokers, but is also much more likely to be fatal.[6]

Lung Cancer

Lung cancer kills more people than any other type of cancer and at least 80% of these deaths are caused by smoking. The risk of lung cancer increases directly with the number of cigarettes smoked. In 1999, 22% of all cancer deaths related to lung cancer, making it the most common

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5. The UK Smoking Epidemic - Deaths in 1995. Health Education Authority, 1998.
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Peripheral Vascular Disease (PVD)

Smokers have a 16 times greater risk of developing peripheral vascular disease (PVD) (blocked blood vessels in the legs or feet) than people who have never smoked.[16] Smokers who ignore the warning of early symptoms and continue to smoke are more likely to develop gangrene of a leg. Cigarette smoking combines with other factors to multiply the risks of arteriosclerosis. Patients who continue to smoke after surgery for PVD are more likely to relapse, leading to amputation, and are more likely to die earlier.[17]

Stroke

Smokers are more likely to develop a cerebral thrombosis (stroke) than non-smokers. About 11% of all stroke deaths are estimated to be smoking related, with the overall relative risk of stroke in smokers being about 1.5 times that of non-smokers.[18] Heavy smokers (consuming 20 or more cigarettes a day) have a 2-4 times greater risk of stroke than non-smokers.[19] A recent study showed that passive smoking as well as active smoking significantly increased the risk of stroke in men and women.[20]

Reduced Fertility

Women who smoke may have reduced fertility. One study found that 38% of non-smokers conceived in their first cycle compared with 28% of smokers. Smokers were 3.4 times more likely than non-smokers to have taken more than one year to conceive.[21] A recent British study found that both active and passive smoking was associated with delayed conception.[22] Cigarette smoking may also affect male fertility: spermatozoa from smokers has been found to be decreased in density and motility compared with that of non-smokers.[23]

Male Sexual Impotence

Impotence, or penile erectile dysfuntion, is the repeated inability to have or maintain an erection. One study of men between the ages of 31 and 49, showed a 50% increase in the risk of impotence among smokers compared with men who had never smoked.[24] Another US study, of patients attending an impotence clinic, found that the number of current and ex-smokers (81%) was significantly higher than would be expected in the general population (58%).[25]

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16. Cole, CW et al Cigarette smoking and peripheral arterial occlusive disease. Surgery 1993; 114: 753-757
17. Myers, K A et al. Br J Surg 1978; Faulkner, K W et al. Med J Austr 1983; 1: 217-219
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23. Makler, A. et al. Fertility & Sterility 1993; 59: 645-51.
24. Mannino, D et al. Cigarette Smoking: An Independent Risk Factor for Impotence, American Journal of Epidemiology. 1991; 140: 1003-1008.
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Foetal Growth and Birth Weight

Babies born to women who smoke are on average 200 grams (8 ozs) lighter than babies born to comparable non-smoking mothers. Furthermore, the more cigarettes a woman smokes during pregnancy, the greater the probable reduction in birth weight. Low birth weight is associated with higher risks of death and disease in infancy and early childhood.[26]

Spontaneous Abortion and Pregnancy Complications

The rate of spontaneous abortion (miscarriage) is substantially higher in women who smoke. This is the case even when other factors have been taken into account.[8] On an average, smokers have more complications of pregnancy and labour which can include bleeding during pregnancy, premature detachment of the placenta and premature rupture of the membranes.[27] Some studies have also revealed a link between smoking and ectopic pregnancy[10] and congenital defects in the offspring of smokers.[28]

The Hazards of Passive Smoking

Non-smokers who are exposed to passive smoking in the home, have a 25 per cent increased risk of heart disease and lung cancer.[29] A major review by the Government-appointed Scientific Committee on Tobacco and Health (SCOTH) in the UK concluded that passive smoking is a cause of lung cancer and ischaemic heart disease in adult non-smokers, and a cause of respiratory tract infections such as bronchitis, pneumonia and bronchiolitis, cot death, middle ear disease and asthmatic attacks in children.[30] More than one-quarter of the risk of death due to Sudden Infant Death Syndrome (cot death) is attributable to maternal smoking (equivalent to 365 deaths per year in England and Wales.[31] While the relative health risks from passive smoking are small in comparison with those from active smoking, because the diseases are common, the overall health impact is large.

Benefits of Quitting Smoking

When smokers give up, their risk of getting lung cancer starts decreasing so that after 10 years an ex-smoker's risk is about a third to half that of continuing smokers.[32]

Prepared by: Dr. Gajalakshmi Vendhan and Ms. Shoba John
with assistance from Ms. Belinda Hughes

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P11-12

ORAL TOBACCO USE – ITS IMPLICATIONS FOR INDIA AND THE WORLD MEASURES TO PREVENT ITS USE, SALE AND MARKETING

Tobacco-related diseases are now a global epidemic. Each year, about 4 million people die due to tobacco consumption throughout the world. Today, India is the second largest producer of tobacco and also the second leading seller in the world. Most of the tobacco produced in India is used within the country. The percentage of tobacco exported to other countries is very low. However, approximately 2,200 people die of tobacco use every day in India. Yet, the tobacco companies are persisting with their aggressive marketing. They are targeting adolescents as future customers.

Presently, there are 60 cigarette-manufacturing factories, about 1000 gutkha and pan masala manufacturing units and over 1 million women engaged in the hand rolling of bidis. Approximately 600 children between the age group of 10 to 18 are recruited every day by the tobacco industry to keep their business growing.

Smokeless tobacco products are easily available and at a price that even children can buy it from any tobacco or *pan* shop. Children do not simply choose to consume tobacco but are influenced by their environment with the glamorous advertisements endorsing their acceptance. They are influenced by the sports personalities, movie stars and people around them consuming tobacco and because tobacco products are easily available.

What is Smokeless Tobacco?

Smokeless tobacco consists of dried leaves and stems of the plant Nicotinia Tabacum, containing the drug, nicotine. Nicotine is toxic and has been classified as the most addictive drug in existence. In India industrially manufactured chewing tobacco, Gutkha, is easily available in sachets and most popular among youth all over the country. Chewing tobacco is the major cause of oral cancer.

There are mainly two forms of smokeless tobacco used in different parts of the world.

1. Oral snuff – also commonly known as dip available in moist, dry and sachet forms.
2. Chewing tobacco – available in loose leaf, twist and plug forms.

Any form of tobacco used in the world has been established to cause oral cancer, which is the commonest cancers in India among men.

Contents of Smokeless Tobacco

Smokeless tobacco contains dangerous chemicals, which result in addiction leading to death. Nicotine is the main deadly substance in smokeless tobacco. It is directly absorbed in the blood stream and leads to addiction. Smokeless tobacco has similar or higher levels of nicotine than smoking tobacco.

Smokeless Tobacco Causes Cancer

Smokeless tobacco use may increase the risk of oral cancer four times. Smokeless tobacco users, specially those consuming snuff for a long time can develop cancer of the lip, tongue, floor of the mouth, cheek and gum. The chances of oral cancer are higher in users than in the non-users of smokeless tobacco.

Warning Signs:

- A mouth sore that bleeds easily or fails to heal, often appears where the tobacco product is placed.
- A painless lump, thickening or soreness in the mouth, throat or tongue.
- Soreness or swelling that persists.
- A white or red patch in the mouth that persists.
- Difficulty in chewing, swallowing or moving tongue or jaw.

Preventive Measures

There are a number of organizations working for tobacco control worldwide as well as in India. Many preventive measures have been taken and are being planned targeting users as well as non-users. Many preventive campaigns have been carried out to make the general public aware of the dangerous and harmful effects of tobacco use. There is a long way to reach the goal of tobacco control but we must keep making efforts.

1. **Control over Glamorous Advertisements and Marketing of Tobacco Products:**
   Advertisements through the media are one of the effective ways of spreading messages across to the public and tobacco industries have chosen it for the promotion of their products and its sale. It immediately affects the adolescent group as this is a very inquisitive age group and can easily be influenced. Studies have shown that in some countries, tobacco advertising is twice as influential as peer pressure in encouraging children to use tobacco. However, the advertisements are misleading and must be stopped as well as marketing of tobacco to the youth to protect them from becoming future consumers.

2. **Protect Children from Becoming Addictive to Tobacco:**
   The two main smokeless tobacco products, gutkha and pan masala (containing tobacco), are very easily available in India. Children are always interested to try out new products seen in the advertisements. Often, the small and cheap sachets are given free to children in cinema halls, outside schools and colleges and even during some events. There should be an age limit at which tobacco products can be sold legally to children. If someone breaches the law, a heavy penalty should be imposed.

3. **Increase in Taxes on Tobacco Products:**
   The government has to make efforts to increase taxes on tobacco products, to make them unaffordable to children. This will not only reduce sales but also increase revenue generation to be used for other tobacco control activities in the country.

4. **Generating Awareness Regarding the Ill-effects of Tobacco Use:**
   Designing of strong and very clear messages is necessary. Many organizations have done similar work in other health awareness areas very successfully. Equally important is to generate awareness about the dangers and harmful effects of tobacco use specially focusing on adolescents and children. It has been proved that mass media programmes and educational programmes produce better results and a quick impact.

5. **Declaring Public Institutions, Specially Schools and Colleges as Tobacco Free:**
   It is necessary to develop school and college health programmes in order to completely stop the sale and consumption of tobacco within and outside educational institutions.

6. **Involvement of Health Personnel in Awareness Campaigns:**
   Health personnel like doctors, nurses, health volunteers and so on can be of great help in tobacco control activities. They should be appropriately trained as they directly interact with patients and the community.

7. **Eliminate Sponsorship by Tobacco Companies of any Public Events:**
   Tobacco companies sponsor major events like sports, awards, festivals and so on. These sponsorships should be discouraged in order to control the advertisement of tobacco products.

8. **Showing Prominent Warning on Tobacco Products:**
   The statutory warning mentioned on tobacco packets and even on cigarette packets is not prominent. It is necessary that the warnings are prominently depicted on the packets so that they leave some impact on the mind of the user. For example, a picture of a new born with disability, pregnant women, oral cancer pictures and so on.

Conclusion:

Smokeless tobacco is a growing addiction especially amongst the youth of India (as high as 55%). If not effectively controlled, it will soon become an epidemic and also a major cause of deaths in India. It is important to invest in the future - on youth and children. They are being targeted by the tobacco industries for giving employment as well as the future customers. Many organizations are working in the area of tobacco control and legislative measures have also been adopted. **Tobacco Products (Prohibition of Advertising and Regulation of Trade, Commerce and Supply) Bill, 2001** has already been introduced in Parliament and efforts are required to pass the bill. In order to control the tobacco epidemic, effective smoking cessation programmes are required to be implemented along with awareness programmes. Only when this is done will significant progress be made in combating what has become a truly global epidemic.

Prepared by: Ginashri Datta, ACT-India.

P11-12.

Voluntary Health Association of India

SUBMISSION

INTRODUCTION

Presently tobacco contributes to 4 million deaths per year globally. According to the World Health Organization (WHO), tobacco kills more people annually than AIDS and accidents put together. This figure is expected to rise to 10 million tobacco attributable deaths per year by 20 25.

INDIAN SCENARIO

In India, deaths attributable to tobacco are expected rise from 1.4% of all deaths of 1990 to 13.3% in 2020. India, according to the projections of WHO, will have the highest rate of rise in tobacco related deaths during this period, compared to all other reasons/countries.

Tobacco kills between 8-9 lakh people each year in India. This will multiply many folds in the next 20 years. Of the 1000 teenagers smoking today, 500 will eventually die of tobacco related diseases-250 in their middle age and 250 in their old age. Those who die earlier loose on an average 22 to 26 years of productive life compared to non-smokers.

Epidemiological data from developed countries demonstrate an approximate 30-40 year lag time between the onset of regular smoking and smoking-related mortality. Among men aged 35-69 years in developed countries, 30 per cent of all deaths are estimated to be cause by smoking. Specifically, smoking causes:

- 90-95% of lung cancer deaths
- 75% of chronic lung disease deaths
- 40-50% of all cancer deaths
- 35% of cardiovascular disease deaths
- over 20% of vascular disease deaths

As smoking rates in developing countries begin to catch up with those in developed countries, their death and disease rates will also catch up.

FACTS AND REALITIES THE TOBACCO INDUSTRY MUST ACCEPT

- That smoking causes many kinds of cancer, heart diseases and respiratory illnesses which are fatal for many sufferers.
- The annual global death toll caused by smoking is 4 million. By 2030, that figure will rise to 10million with 70% of those deaths occurring in developing countries.

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- That nicotine is a most important active ingredient in tobacco; that the tobacco companies are in the drug business; the drug is nicotine and that the cigeratte is a drug delivery device.
- That nicotine is physiologically and psychologically addictive, in a similar way to heroin and cocaine-rather than shopping, chocolate or the internet. The overwhelming majority of smokers are strongly dependent on nicotine and that this is a substantial block to smokers quitting if they choose to.
- That teenagers (13-18) and children (<13) are in **inherently** important to the tobacco market and the companies are competing for market share in these groups.
- That advertisement increases total consumption as well as promoting brand shares.
- That advertising is one (of several) important and interlocking ingredients that nurture smoking behavior among teenagers and children.
- That current formulation of low-tar cigarettes creates false health reassurance and offers little or no health benefit.
- That second-hand smoke is a real public health hazards including causing childhood diseases such as asthma, bronchitis, cot-death and glue ear, and is a cause of lung cancer and heart disease in elders.

NICOTINE ADDICTIONS

- A UK government scientific committee set in March 1998: *"over the past decade there has been increasing recognition that underline smoking behaviour and its remarkable intractability to change is addiction to the drug nicotine. Nicotine has been shown to have affects on brain dopamine systems similar to those of drugs such as heroin and cocaine"*. (SCOTH, 1998).
- *"Dependence on nicotine is established early in teenager's smoking carriers, and there is a compelling evidence that much adult smoking behavior is motivated by a need to maintain a preferred level of nicotine intake....."* (SCOTH, 1998, Ibid).
- Smokers are compelled to smoke by addiction to nicotine but the harm is largely done by the 4000+ other chemicals in the tar and the gases produced by burning tobacco. It is this combination that makes tobacco so deadly.

MARKETING TO CHILDREN

Publicly the tobacco companies have always maintain that they do not target youth, but the market logic of selling to teenagers is overpowering-teenagers are the key battle ground for the tobacco companies and for the industry as a whole. Internal industrial documents show that they set out to aggressively advertise to youth, and even manipulate peer pressure to make people smoke their brand.

The industry knows that very few people start smoking after their teenage years, and if you can "hook" a youngster early on they could well smoke your brand for life. Independent surveys have shown that approximately 60% of smokers start by the age of 13 and fully 90% before the age of 20. It is both socially and locally unacceptable to

advertise tobacco to under-age teenagers and children-yet it is to this precise age group that the industry advertises in order to survive: ***Studies have shown that teenagers consume the cigarette that most dominate sports sponsorships.***

KEY FACTS ON ADVERTISING AND SMOKING

- Chief Economic Adviser to the Department of Health, Dr. Clive Smee, published the most comprehensive study of the link between advertising and tobacco consumption in 1993. After reviewing 212 'time series' correlating advertising spending and total tobacco consumption, Smee concluded, *"The balance of evidence thus supports the conclusion that advertising does have a positive effect on consumption."* Smee also examined in detail the effects of tobacco advertising bans in four countries and found that banning advertising resulted in reductions in consumption of 4%-9% in the countries surveyed. He concluded: *"In each case the banning of advertising was followed by a fall in smoking on a scale which cannot be reasonably attributed to other factors."*
- A meta-analysis of econometric findings from time series research found a positive association between advertising expenditure and cigarette consumption. The study showed that a 10% increase in advertising expenditure would lead to a 0.6% increase in consumption.
- The US Surgeon General in his 1989 report highlighted the difficulties in designing studies that prove the point definitively, but concluded: *"the collective empirical, experiential and logical evidence makes it more likely that not that advertising and promotional activities do stimulate cigarette consumption."* The Surgeon General suggests seven ways in which tobacco advertising operates to encourage smoking:

US SURGEON GENERAL – HOW ADVERTISING AFFECTS CONSUMPTION

1. By encouraging children or young adults to experiment with tobacco and thereby slip into regular use.
2. By encouraging smokers to increase consumption
3. By reducing smokers' motivation to quit
4. By encouraging former smokers to resume
5. By discouraging full and open discussion of the hazards of smoking as a result of media dependence on advertising revenues
6. By muting opposition to controls on tobacco as a result of the dependence of organizations receiving sponsorship from tobacco companies
7. By creating though the ubiquity of advertising, sponsorship, etc. and environment in which tobacco use is seen as familiar and acceptable and the warnings about its health are undermined.

TOBACCO AND THE RIGHTS OF THE CHILD

The UN Convention on the Rights of the Child was adopted by the UN General Assembly on 20 November 1989 and came into force in September 1990. Interpretation

of the articles of the Convention by the Committee on the Rights of the Child and the practice of States demonstrates that tobacco is indeed a human rights issue. As a legally binding international Convention, ratified States are legally bound to ensure that children can enjoy all of the rights guaranteed under the Convention, including protection from tobacco.

WHO estimates that nearly 700 million, or almost half of the world's children, breathe air polluted by tobacco smoke, particularly at home. Most have no choice in this matter, and as a consequence of their exposure in homes and public places, suffers serious long-term health affects.

Because of the enormous potential harm to children from tobacco use and exposure, States have a duty to take all necessary legislative and regulatory measures to protect children from tobacco and ensure that the interests of children take precedence over those of the tobacco industry. Given the overwhelming scientific evidence attesting to the harmful impact of tobacco use and ETS (Environmental Tobacco Smoke) on child health, implementing comprehensive tobacco control is not only a valid concern falling within the legislative competence of governments, but is a binding obligation under the Convention.

For policy makers, the Convention on the Rights of the Child provides an existing legal framework for implementing and enhancing comprehensive tobacco control policies. Utilising the Convention, human rights and tobacco control advocates have a unique opportunity to identify the problems related to tobacco use and develop in tandem solutions which can be implemented coherently and universal.

Comprehensive, multi-level strategies will be required, including strong public policies. Without such policies, the rights of children will continue to be violated, particularly those relating to guarantees of basic health and welfare, and protection from child labour. States therefore, both individually and collectively, must live up to their obligations under the Convention and protect children from tobacco.

The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution), Bill, 2001 is a social legislation bill that endeavors to protect the health of non-smokers, tobacco users especially children taking to the tobacco habit.

The Bill, is a non-controversial Bill which merely seeks to:

- Ban smoking in public places
- Ban on advertising
- Adequate warning to users
- Ban on sale to minors

The prime beneficiary of this Bill will be the *women and children* who are the most vulnerable to tobacco usage. Public health measures protecting people from harmful effects of tobacco should not be shelved. Simultaneously there has to be a time frame where a shift has to take place from tobacco crops to other alternative cash crops and alternative employment opportunities. In India, we are already burdened with diseases of poverty with a meager health budget and now, we are faced with the additional burden of tobacco related diseases. A developing country like India can not afford the luxury of tobacco related diseases.

It is therefore, the humble submission of the **Voluntary Health Association of India** that the ***"The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution), Bill, 2001"*** be considered by the Standing Committee to be recommended to the Parliament of India for its passage. This will go a long way in protecting the health and lives of millions of people in India and set an example for other developing countries to emulate.

Thanking you,

Yours sincerely,

Alok Mukhopadhyay
Chief Executive

New Delhi
3rd July, 2001

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International Week of Resistance to Tobacco Transnationals (IWR2004) 17-21 May 2004

On 21 May 2003, the World Health Assembly unanimously adopted the Framework Convention on Tobacco Control (FCTC). This groundbreaking treaty will save millions of lives and change the way the tobacco industry operates globally. Throughout FCTC negotiations, Infact and the Network for Accountability of Tobacco Transnationals (NATT) organized five successful International Weeks of Resistance to Tobacco Transnationals that involved thousands of people in events in more than 40 countries. These events helped build global support for the creation of a strong FCTC and counter the aggressive attempts by Philip Morris/Altria, British American Tobacco and Japan Tobacco International to derail it.

The week of 17 May 2004 marks the one-year anniversary of the FCTC's adoption. NGOs around the world are using this critical milestone to build global momentum behind the treaty's swift implementation. In every region of the world, civil society is calling on governments to ratify and implement the FCTC with press conferences, marches, rallies and nationally televised screenings of the film *Overcoming the Odds: A Story of the First Global Health and Corporate Accountability Treaty.*

There is a growing movement calling for swift FCTC ratification and implementation!

IWR2004 actions will span the globe. People are participating in countries such as: Bangladesh, Belgium, Botswana, Burundi, Chile, Colombia, El Salvador, Georgia, Ghana, Hungary, India, Indonesia, Latvia, Lithuania, Malawi, Malaysia, Mauritius, Moldova, Nepal, Nigeria, Pakistan, Palau, Panama, Peru, the Philippines, Poland, Qatar, Romania, Senegal, South Africa, Spain, Sri Lanka, Thailand, Togo, Trinidad, Uganda, Uruguay, Vietnam, and Zambia.

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NATT

PH-12

THE STUDENT CHARTER

TOBACCO : TOWARDS A TOBACCO FREE SOCIETY

Since

- Tobacco is a major cause of death and disability globally and in India.
- Tobacco related death and disability are expected, as per WHO estimates to rise sharply over the next 20 years in India at a rate higher than anywhere else in the world.
- Tobacco injures health in many ways, from childhood onwards, through active as well as passive consumption.
- Tobacco products contain nicotine which is strongly addictive.

We need

- Tobacco control policies which will progressively eliminate the production, sale and use of all tobacco products intended for human consumption.
- A ban on all forms of advertisement (direct and indirect) of tobacco products
- A ban on smoking in all public places
- A ban on sale of tobacco products, in any form, to minors
- Taxation of tobacco at progressively higher levels, to discourage consumption through price-linked disincentives and utilisation of the additional tax revenue for community health education.
- Agricultural policies which will progressively phase out tobacco cultivation in favour of alternate crops.
- Industrial policies which will encourage the switchover of tobacco related industrial capacity to alternate uses

Tobacco Free Initiative

PH-12

WHO

Why is tobacco a public health priority?

Tobacco is the second major cause of death in the world. It is currently responsible for the death of one in ten adults worldwide (about 5 million deaths each year). If current smoking patterns continue, it will cause some 10 million deaths each year by 2025. Half the people that smoke today – that is about 650 million people – will eventually be killed by tobacco.

Tobacco is the fourth most common risk factor for disease worldwide. The economic costs of tobacco use are equally devastating. In addition to the high public health costs of treating tobacco-caused diseases, tobacco kills people at the height of their productivity, depriving families of breadwinners and nations of a healthy workforce. Tobacco users are also less productive while they are alive due to increased sickness. A 1994 study estimated that the use of tobacco resulted in an annual global net loss of US$ 200 thousand million, a third of this loss being in developing countries.

Tobacco and poverty are inextricably linked. Many studies have shown that in the poorest households in some low-income countries as much as 10% of total household expenditure is on tobacco. This means that these families have less money to spend on basic items such as food, education and health care. In addition to its direct health effects, tobacco leads to malnutrition, increased health care costs and premature death. It also contributes to a higher illiteracy rate, since money that could have been used for education is spent on tobacco instead. Tobacco's role in exacerbating poverty has been largely ignored by researchers in both fields.

Experience has shown that there are many cost-effective tobacco control measures that can be used in different settings and that can have a significant impact on tobacco consumption. The most cost-effective strategies are population-wide public policies, like bans on direct and indirect tobacco advertising, tobacco tax and price increases, smoke-free environments in all public and workplaces, and large clear graphic health messages on tobacco packaging. All these measures are included in the provisions of the WHO Framework Convention on Tobacco Control.

The World Health Organization's response to the tobacco epidemic

The Tobacco Free Initiative (TFI) was established in July 1998 to focus international attention, resources and action on the global tobacco epidemic.

TFI's objective

TFI's objective is to reduce the global burden of disease and death caused by tobacco, thereby protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke. To accomplish its mission, TFI:

- provides global policy leadership;
- encourages mobilization at all levels of society; and
- promotes the WHO Framework Convention on Tobacco Control (WHO FCTC), encourages countries to adhere to its principles, and supports them in their efforts to implement tobacco control measures based on its provisions.

TFI's global structure

TFI is part of the Noncommunicable Diseases and Mental Health (NMH) cluster at WHO headquarters (HQ) in Geneva. Regional advisers for tobacco control are based in WHO's regional offices for Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia and the Western Pacific. TFI-HQ works closely with its regional advisers to plan and implement all activities. Its regional advisers, in turn, collaborate with WHO's country representatives and liaison officers to facilitate tobacco control activities at regional and country levels. Most of TFI's major activities are coordinated by its regional offices and decentralized to country level.

TFI's activities

WHO Framework Convention on Tobacco Control (FCTC) interim secretariat

Since the adoption of the WHO Framework Convention on Tobacco Control (see box), the interim secretariat of the WHO FCTC has been concentrating its efforts on ensuring that as many countries as possible sign and ratify the Treaty. Awareness-raising among politicians, policy-makers, health professionals and society at large is essential to this process. TFI is also providing technical support to countries to assist them in their efforts to strengthen their infrastructure and take the necessary steps towards the signature, ratification and implementation of the WHO FCTC.

Research and policy development

TFI collaborates with an international network of scientists and health experts to

promote research on various aspects of tobacco production and consumption and their impact on health and economics. Policy recommendations are developed based on this research and in accordance with the provisions of the WHO FCTC. These recommendations cover different aspects of tobacco control, including regulation and legislation in relation to cessation, second-hand tobacco smoke, smoking and children, smoking and gender, economics and trade.

Surveillance and monitoring

TFI monitors and evaluates international tobacco-related issues by reviewing structural elements (existence of task forces, commissions, nongovernmental organizations (NGOs)), process developments (laws and regulations, economics, behaviour, exposure, advocacy) and epidemiological data (prevalence, morbidity, mortality).

Current surveillance projects include the creation of a **Global Database**, based on a common standard, to maintain tobacco control data worldwide, and the joint WHO/CDC (US Centers for Disease Control and Prevention) **Global Youth Tobacco Survey** (GYTS), which aims to monitor tobacco consumption trends among 13 to 15-year-olds and evaluate youth tobacco control programmes.

Understanding the tobacco industry's practices is crucial for the success of tobacco control policies. In recognition of this reality, WHO's Member States unanimously adopted a resolution (WHA 54.18) calling for transparency in tobacco control. TFI monitors tobacco industry activities so as to provide essential information to countries as they work to develop national tobacco control strategies.

Training and capacity-building

In order to encourage and help countries to sign, ratify and implement the WHO FCTC, TFI is working on projects that aim to strengthen national capacity in tobacco control by building on existing national public health systems. With that objective in mind, TFI is organizing a series of regional, sub-regional and national workshops using evidence-based training materials to help countries develop and implement tobacco control measures tailored to their local needs. A series of case studies from different countries on successful tobacco control interventions is in production.

Communication and media

Public awareness of tobacco's harmful effects is essential to lay the foundations for acceptable tobacco control policies and regulations. TFI works to ensure that tobacco remains in the public consciousness by funding anti-tobacco media campaigns and workshops undertaken by local, national and international groups. World No Tobacco Day, celebrated around the world on 31 May each year, is the culmination of TFI's advocacy activities.

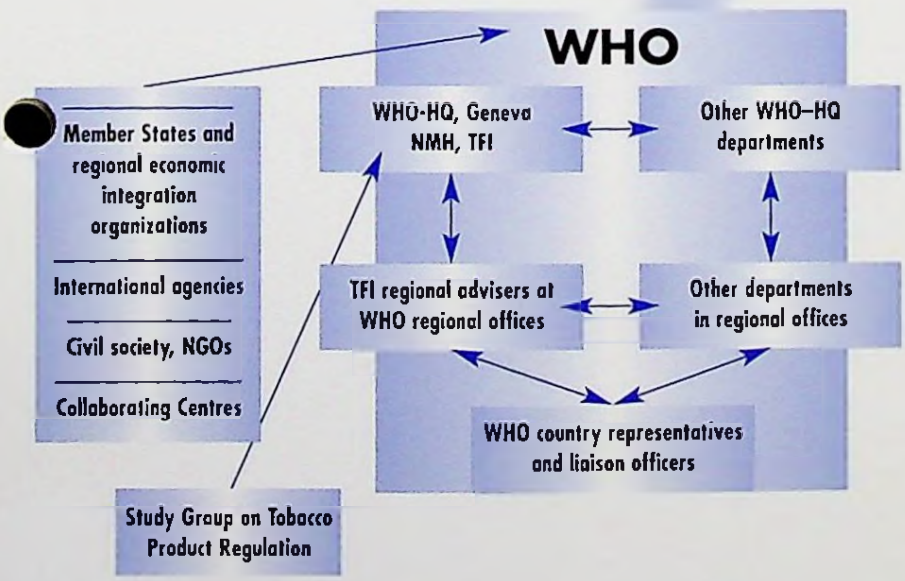
TFI's global network

TFI collaborates closely with other WHO departments at all levels in cross-cluster initiatives to facilitate the integration of tobacco control into other health programmes (e.g. child and maternal health and tuberculosis). Outside WHO, TFI works with **Member States**, other **international organizations** and **civil society** through NGOs working on tobacco control.

The **United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control** was established by the Secretary-General of the United Nations in 1998 to coordinate the tobacco control work being carried out by different United Nations agencies. It is chaired by WHO and comprises 17 agencies of the United Nations system and two organizations outside the UN system.

TFI is expanding its network of **WHO Collaborating Centres**. WHO Collaborating Centres are a network of national institutions designated by WHO that carry out activities in support of its international health work. TFI's Collaborating Centres work on research, training and advocacy. Working with national institutions is an effective way of increasing national capacity and paving the way for self-sustainable programmes at country level.

Tobacco is one of the few openly available commercial products that are virtually unregulated. At the same time, it is the only legally available product that kills one half of its regular users when consumed as recommended by its manufacturer. To address this issue, the Director-General of WHO has established a **Study Group on Tobacco Product Regulation**. The group, which includes leading scientists in the field, carries out research and drafts recommendations for WHO's Member States on how to establish regulatory frameworks for the design and manufacture of tobacco products.



TFI's work is only possible thanks to the collaboration with other institutions and the financial support from several donors.

WHO Framework Convention on Tobacco Control

The WHO FCTC was unanimously adopted by WHO's 192 Member States in May 2003. It is the first public health treaty negotiated under the auspices of WHO. It represents a turning point in addressing a major global killer and signals a new era in national and international tobacco control. The WHO FCTC reaffirms the right of all people to the highest standard of health. In contrast to previous drug control treaties, it asserts the importance of demand reduction strategies, as well as supply issues.

The Convention has provisions that set standards and guidelines for tobacco control in the following areas:

- tobacco advertising, promotion and sponsorship;
- packaging and labelling;
- regulation and disclosure of contents of tobacco products and smoke;
- illicit trade;
- price and tax measures;
- sales to and by minors;
- government support for tobacco manufacturing and agriculture;
- treatment of tobacco dependence;
- passive smoking and smoke-free environments;
- surveillance, research and exchange of information; and
- scientific, technical and legal cooperation.

The WHO FCTC is deposited in the United Nations Headquarters in New York and is open for signature from 16 June 2003 to 29 June 2004. Member States that sign the Convention indicate that they will strive in good faith to ratify it, and show a political commitment not to undermine the objectives set out in it. The ratification of the WHO FCTC binds a Member State to implement its provisions.

Countries wishing to become a party to the Convention after 29 June 2004 may do so by means of accession, which is a one-step process equivalent to ratification. The WHO FCTC will come into force of law 90 days after it has been ratified by 40 Member States.

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PH-12

Action Towards a Tobacco Free World

A workshop at Asia Social Forum, Hyderabad

Date: 3rd January 2003

Time: 2:15 to 6:30 P.M.

Venue: Taj Mahal Hotel, Abids Road, Hyderabad

Facilitated by:

Community Health Cell, Bangalore on behalf of Jan Swasthya Abhiyan / People's Health Movement)

Partner Organizations

Consortium For Tobacco Free Karnataka
PATH-Canada, LIFE

A Report by Dr. Anant Bhan, Community Health Cell

The workshop began with registration of all participants. They were given files with background material about the purpose of the workshop. Around 40 people participated in the workshop.

The workshop began with an introduction to the purpose of conducting the workshop by Mr. S.J. Chander from the Community Health Cell who spoke about the global problem that Tobacco had become and the targeting of Asia and developing countries by Tobacco MNC's and hence the importance of a concerted effort to network for freedom from tobacco.

Dr. Ramesh S. Bilimagga, Radiation Oncologist and member, CFTFK (Consortium For Tobacco Free Karnataka, Bangalore, chaired the first session. He welcomed all the participants to the workshop and reiterated that tobacco was a major problem not just in India but also across the world. He stressed that a small step by everybody in the direction of a tobacco free world would make a big difference. He then invited Dr. Thelma Narayan from CHC to give an overview of the problem.

Dr. Thelma explained that the workshop was being held under the platform of Jan Swasthya Abhiyan (PHM) which was active in more than 92 countries ands was working towards making the govts. and WHO and international bodies accountable to their commitment for Health For All. She stressed that many coordinating and facilitating agencies had helped in organizing the workshop and also enumerated the other events at ASF being facilitated by CHC/JSA/PHM. She said that the workshop would help us understand the tobacco issue especially in regards to dealing with the tobacco industry. It was needed to share our solidarity in the ASF platform and to strategize and reflect. The effect of globalization on public health needed to be studied in depth. Opium had been used in the past by Britain to subjugate China and now the western powers through the tobacco MNCs were using tobacco to subjugate the Asian countries. The US was promoting the global consumption of tobacco and there had been a sharp increase in tobacco usage in many areas; the issue of tobacco advertising was also an important issue. While tobacco use was reducing in the North America and Western Europe, the tobacco market was being relocated with increasing use in Asia and developing countries. Data from different Asian Countries was presented. The

dynamics and intricacies influencing the negotiations of the Frame Work Convention For Tobacco Control (FCTC) led by the WHO (World Health Organization) needs to be more transparent in order to evolve a useful instrument.

A Magic Show and a talking doll show followed this. The magician stressed on the ill effects of tobacco and requested people to not let their lives go up in smoke and to avoid the bad habits. It was well appreciated by the audience. He also wished everybody present a very happy and tobacco free New Year.

Dr.Ramesh then invited Dr. Prakash C. Gupta, an epidemiologist and a public health consultant from Mumbai having 36 years of research experience in the field of tobacco. Dr.Prakash began by saying that tobacco is a public health problem even at the grassroots level. Understanding the problem was not enough and something needed to be done about the problem. There were various organizations working in the field of tobacco control in India-a loose coalition of which was the ICTC (the Indian Coalition for Tobacco Control). Each of the organizations was free to pursue their own agenda but it was an interactive forum for all participating organizations to pool their resources. He expressed hope that more organizations would join the fold. He also mentioned that a death clock had been installed in Delhi that would register the deaths being caused by tobacco usage in India.

After thanking Dr. Prakash, Dr. Ramesh introduced Mr. Sonam, a bureaucrat form the Ministry of Health and Education in Bhutan. Mr. Sonam said that Bhutan had initiated tobacco control regulations as early as 1729; the state religion (Buddhism) did not permit the usage of tobacco. He cautioned that in their experience regulation alone was not enough and there was he need to take undertake aggressive information dissemination and work for anti-tobacco legislation. The Hon'ble Minister of Health had ensured that the sale and consumption of tobacco had been banned in public places. The effort had come through a decentralized approach wherein 18 out of the 20 districts in the country had themselves taken up the initiative to work for local tobacco control. He said that a dilemma that faced the govt. was the continuing sale of tobacco in the duty free shops in the capital city, which could not be stopped because of diplomatic problems- he invited suggestions from the participants on how to deal with the problem. He said that one of the queens in Bhutan was committed to the cause of tobacco control and had been appointed as a goodwill ambassador by the UNFPA and she advocated the tobacco and health issues in various districts that she regularly visited. Appreciating the people of Bhutan, Dr. Ramesh said that it was important to remember that perseverance was the key.

Dr. Ramesh then called upon two members of the Bangladesh Anti Tobacco Alliance to speak about efforts at tobacco control in their country. One of them Mr. Ratan Deb said that sometime ago though there were many groups working in the field not many were working together :only school level programs were being organized to raise awareness about the harmful effects of tobacco and these also not very effective as they were leading to rebellion in many cases. He felt that what would work is strict enforcement, high taxes, controlling of advertising, more elaborate warning in the packs. He said that BATA has little resources compared to other groups and tobacco companies. BATA had filed a case in the Bangladeshi courts and had managed to achieve a significant legal victory which led to decrease in the rampant advertisement of tobacco companies and had also proved that British American Tobacco Company's antismoking campaign was a sham. BATA has been closely working with the Bangladeshi govt. and have been attempting to spread the message of harmful effects of tobacco even in the regional languages. A law for stricter tobacco control is now pending in the parliament. A second writ petition is now pending in the courts under the Right to Life campaign against the Imperial Tobacco company; the court has given a stay order on all relevant advertisements for two months. Many organizations and facilities in Bangladesh are now tobacco free due to the efforts of BATA. He ended stressing that

working together was very important for tobacco control. Mr. Naveen Thomas expressed the view here that one major factor for the success of the campaign in Bhutan was the fact that the political, religious and local leadership had come together to fight the problem and were very much involved.

Dr. Ramesh appreciated the efforts of BATA and raised the fact that the various govts. had a dichotomous attitude towards tobacco wherein e.g. the Karnataka govt. had an anti tobacco cell in the Kidwai Memorial Institute of Oncology, it also had a research wing in the Tobacco Board to try to improve productivity and quality of tobacco crops. He said that in K'taka

- There were 8 million tobacco addicts.
- 6000 children under the age of 15 yrs of age and as many between the ages of 15-24 enter the pool of tobacco users.

There was a need to publicize the tobacco issue among the lay public as they had the right to information.

Mr. Jaggaiah, a security guard from Hyderabad who used to smoke around 48-50 beedis a day for over 40 years presented his medical problems directly related to his tobacco addiction. He used to get cough, dyspnoea and chest pain; he had to undergo surgery (pneumonectomy) for pathology arising from his tobacco usage; he said that he had now stopped smoking and was proud to be free from tobacco.

Ms. Lalitamma from Karnataka, an ex-cultivator then shared her experience .She said that she had been working in the tobacco fields for over 15 years; most of the workers used to be employed as daily wage workers by the rich cultivators and had work for only 3-4 months yr. The workers had very hectic work in the fields everyday and at the end of each day they were so tired that they could not adopt any hygienic methods before consuming food or have a bath before sleeping. They also used to use a lot of pesticides in the tobacco nurseries in their homes and because of all this problems she felt that they used to inadvertently consume a lot of pesticides. During the course of her work, she developed health problems and approached a medical practitioner who advised admission – her treatment bills were in the range of about Rs 30,000. She said that she had resolved to never do that kind of work again and was hoping that other people also left that hazardous work.

Dr. Ramesh thanked all the speakers for giving an insight into the various issues related to tobacco that were affecting their lives and work. He then thanked the organizers for having given him the opportunity to chair the session and handed over the stage to the next chairperson, Ms. Devaki Jain.

Ms. Devaki then chaired the next session, which was distribution of certificates and mementoes of appreciation to

- The people of Bhutan for having shown great collective resolve for the fight against tobacco. This was received by Mr.Sonam Thunsho, secretary, government of Bhutan in charge of health education.
- The members of BATA for their work for tobacco control in their country and for dragging the guilty tobacco companies to court and make them accountable for their unlawful practices. This was received by Mr.Ratan and Mr. Biplob
- Dr. Prakash C. Gupta for his extensive work in research in the field of tobacco.

A short tea break was then announced which gave the opportunity for the audience to interact with the speakers and also for them to view the exhibition of anti tobacco posters that had been put up by Community Health Cell in the hall.

The tea break was followed by a panel discussion on various facets of the tobacco issue. The discussion was chaired by Ms. Devaki Jain. She said that the amount of money the govt. spent on treating diseases arising from the usage of tobacco was more than the money it received through excise. Tobacco related deaths were more than the number of deaths caused due to HIV, Malaria, and T.B. combined. There was a need for campaign mode activists, as knowledge about the ill effects of tobacco did not deter people from harmful habits. Death was a close phenomenon in India especially among the poor and hence morbidity and mortality due to tobacco could not be used as an effective deterrent in that sector. There was a need to work to change attitudes; also important was to fight the tobacco industry, which was targeting the young by using unfair advertising means. There was a need to talk about it in the background of globalization and macro-economic program. The relation between poverty in India and the addiction to tobacco, alcohol and the susceptibility to HIV in poor communities was well known and proven in studies such as one done by NIMHANS. Also, interestingly, the govt. had included Tobacco in the Foods and Beverages list.
Dr. Devaki then invited Dr. Prakash Gupta to give his presentation. Dr. Prakash's presentation had the following salient points:-

1. There were only two causes of death that were increasing worldwide- HIV and Tobacco.

2. Death was an objectively measured event; Tobacco usage was the single most preventable cause of death in the world.

3. Current WHO estimates of tobacco attributable premature deaths are in the range of4.9 million/yr. This is expected to rise to 10 million / yr by the year 2030; already in the 20th century approx. 100 million people had died due to health problems related to tobacco usage.

4. India was the second largest producer and consumer of tobacco in the world; ICMR estimate for the annual attributable mortality from tobacco was 8,00,000.

5. Tobacco causes a lot of medical problems and addiction is a key issue because of the nicotine content

6. Children are the mot severely affected and unfortunately they are powerless to fight against this evil.

7. There were many misconceptions related to tobacco e.g. that it was not a high-risk product and that tobacco users do not have any choice, once addicted.

8. The truth was that more than half of chronic tobacco users would die of health problems arising from that habit.

9. Tobacco smoke had a lot of toxic chemicals and carcinogens and had an effect even on passive smokers; hence there was a need for concerned people to fight for their right for clean air.

10. Tobacco and social justice was also an important issue- as its usage was more among the lower SE strata and the relative risks were also higher in this group; beedis, commonly used by this group were more harmful than cigarettes; also unfortunately, most of the interventions were aimed at the higher SE strata.

11. The rising usage of tobacco among the women was alarming- one study had shown that as many as 10% of college going women in Mumbai were using tobacco.

Dr. Devaki then invited Dr. Srinath Reddy to present his views and experience as the Indian govt. nominee and as a NGO health activist at the FCTC deliberations. FCTC was an attempt by WHO to exercise its treaty making power for tobacco control. The critical issues included stronger action required on the demand and supply sides. There were the issues of trade and public health involved; most country representatives participating in the deliberations were advocating a total ban on all forms of advtg.- direct and indirect. But there had been pressures from some quarters and in the ongoing round the talk was around restriction of advtg; unfortunately the issue of surrogate advtg had not been addressed. The WB and developed countries were of the view that there was a continued increasing demand for tobacco irrespective of control measures (more in the developing countries and lesser in the developed ones). Global resources were lacking for implementation unless a global fund was set up. Also, cross border advertising continued to be an issue and trade v/s public health was a battle that was still being fought out in the FCTC. The recent draft of the FCTC was disappointing. It has been prepared for the next round of negotiation in February 2003.

Ms. Devaki thanked Dr. Reddy and mentioned that the UN precincts and most eateries in the developed countries are smoke free. She then invited Ms. Shobha John of PATH Canada (Programme For Appropriate Technology for Health) based at Mumbai to make a presentation. Shobha spoke about the poor being affected the most by tobacco usage and she presented some data from her PATH studies which showed that the tobacco consumption among the pavement dwellers was 82% and among the street children was 76% - these people were spending less amount of money on food than tobacco. She also raised the issue of misplaced targeting by activists who were not addressing the tobacco problem that was afflicting the poor SE strata and the need to reach out to that group. In Bangladesh, a study had proven that many households were spending 18 times more on tobacco than health. The tobacco issue was causing a loss to the country as the estimated health costs were in the range of Rs 6.5 billion while the excise returns were only Rs 4.5 billion; hence the economic loss to the nation was immense. Also the tobacco industries were themselves promoting smuggling of their products and were using a lot of front groups for surrogate advertisements. The industry's argument that a lot of workers would lose their job had to be viewed with scepticism because the companies as they were getting mechanized were laying off a lot of workers; also experience had shown that the industry was actually quite exploitative: Ms. Devaki mentioned that some traders in B'lore had been subletting the space outside their shops which was actually govt. property to vendors; she then invited Ms. Suvarna to share the findings of her study in Shimoga in Karnataka.

Suvarna mentioned that she had been working in the area for the last 12 yeras and she had noticed that tobacco cultivation had decreased by more than 50% - this had sparked an interest to initiate the study. They had discovered that the cultivators were actually the large farmers as the govt. Tobacco board regulations were that all tobacco cultivators should a possess a minimum of at least 3-4 acres of land .Tobacco cultivation was labour intensive. It also required a lot of wood for curing which had led the farmers to steal wood from the forests. Almost 80% of the forests had been depleted and now the local populace had sometimes to walk a distance of 10 kms to collect firewood. Good quality wood was required for curing wherein temperatures were maintained at 90-120 degrees Fahrenheit for 4 days. The alternative crops that some families had shifted to in the state were maize etc.; they had noticed that the land became more fertile if tobacco cultivation was decreased. As tobacco was a very labour intensive work, the people used to be busy from morning to evening in their work, which had affected families, as there was nobody to look after children and the elderly. This has been shown in falling attendance in school for the children of cultivators and agricultural laborers. The Sanghas and self-help groups discussed this and decided to utilize the govt. programs. Supporting each other, they

cultivation, women were the most affected – they had occupational problems, were made to work hard and do menial jobs; there was gender insensitivity and the women were made to do the most difficult and strenuous work. This had affected the lives of many women and children adversely. Ms. Devaki appreciated the presentation and mentioned the need for linked narratives to help with advocacy issues.

This was followed by a group discussion involving all participants that was chaired by Dr. Srinath Reddy. The main points that were highlighted in the discussion by various participants were: -

- Coronary Artery Disease (CAD) caused by tobacco usage needs to be studied and publicized.
- FCTC needs to advocate strong regulations- local and national.
- Need to sensitize the politicians about the issue.
- Need for effective political lobbying and policy level interventions.
- Need to safeguard the interests of the involved people and to try to bring the larger forces to come together.
- Lesser emphasis to be laid on health and more on the fiscal and the environmental aspects.
- To try to attempt a linkage with the right to food campaign and the environmental issues.
- Promote the usage of the 73rd and the 74th amendments that promote local governance.
- Need for economists to study the long term effects of tobacco usage.
- Promote the ban of tobacco consumption in public places as it gives the right to people to protest tobacco usage.
- Alternate employment strategies to be promoted.
- Need to understand that there was no direct subsidy by the Govt. of India to the tobacco industry but indirect subsidy.
- Legislation against tobacco would be ineffective if people were not informed and convinced about the reasons for legislation.
- Need to approach and convince even the local and vernacular media to cover tobacco related issues.
- Need to convince the film producers and artists to not promote the usage of tobacco in the movies/serials; this was especially relevant as the theme of the World No Tobacco Day this year was '*Free Films from the influence of Tobacco*'.
- The information about tobacco to be integrated into existing health programs and through the educational system in school and colleges.

Mr. Niranjan from the People's Health Movement in Sri Lanka shared that the cost of one cigarette in Sri Lanka was 7-8 rupees and that was an effective deterrent also; it was discussed that Prof. Panchamukhi's study on Karnataka had proven that tobacco farmers were ready to diversify into vegetable cultivation but the market support was not in place. Whereas the tobacco industry was picking up its produce and taking it to the market, this support was not available for the farmers involved in vegetable farming to transport their produce to the distant markets.

The group then discussed the statement to be issued by the workshop participants- certain changes were suggested for incorporation in the statement before finalization and distribution to the ASF organizers and the media. The modified statement and the press release are attached.

Dr. Srinath thanked the participants for their active participation in the group discussion.

A formal vote of thanks was proposed and the workshop ended.

4th January 2003

For Immediate Release

Asian Tobacco Control Activists Suggest Alternatives to Tobacco-Related Work

Hyderabad: Moving out from tobacco cultivation is a feasible alternative, was the message that emanated from the workshop on "Action Towards a Tobacco Free World" at the Asia Social Forum in the citadel of tobacco farming. The workshop held yesterday brought together development workers, researchers, medical and economic experts besides the labourers who were previously engaged in tobacco related work.

Latha, a labourer from Shimoga, Karnataka narrated her experiences working in the tobacco fields, " We used to get a paltry wage of Rs. 30/-a day for 20 hours of back-breaking work in the tobacco farms. Tobacco dust infested my insides and I spent more than Rs. 30,000/- in treatment". She has since become a crusader persuading her co-workers to give up toiling on tobacco farms at the cost of their health. " I will never go back to those fields, even if they offer me Hundred rupees a day", reaffirms a decided Latha.

Tobacco Board officials from the region admit that 80 % of the forest in some of these villages have been depleted due to massive felling of trees to cure tobacco. Their records confirm that many tobacco farmers are therefore leaving tobacco cultivation. Some of these farmers have found safer havens in growing maize and groundnut and tobacco laborers in Shimoga and other parts of Karnataka have shifted to income generation activities like rearing cattle.

Suvarna, a development worker who works with women in tobacco farming relates, " Tobacco work drains them of their energy and health and often strains family relationships to the point of breaking them due to the long hours of work during the farming season. It leaves them with hardly any time to attend to household chores and children". Many of these children eventually drop out of school and are taken to work on tobacco farms.

Several of the workers at the workshop who despise working on tobacco farms pointed out that Government policies in this regard are anti-poor. Government promotes tobacco farming, research and marketing through support institutions and these essentially benefit the rich farmers who own land and resources. They opine that unless these are reversed and alternatives are explored and developed, this exploitative industry would continue to thrive undeterred.

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Statement issued by the participants of the

"WORKSHOP ON ACTION TOWARDS A TOBACCO FREE WORLD"

On 3rd January 2003

ASIAN SOCIAL FORUM, HYDERABAD, INDIA

FIGHT TOBACCO THE KILLER !!!

Realizing that tobacco and its products including cigarettes, bidis, guthka, and chewed tobacco...

- Is one of the biggest killers worldwide and particularly among the poor killing 4.9 million people every year and reducing life by 15-20 years. Tobacco causes cancer of the various organs, diseases of heart, blood vessels, lungs and other organs leading to suffering disability and death.
- Is highly addictive with nicotine being more addictive than cocaine or heroin.
- Is the only freely available consumer product that kills.
- Has an adverse environmental impact, using of millions of tonnes of wood for curing tobacco, excessive use of pesticides and chemicals, depleting soil fertility.
- The tobacco industry results in an overall fiscal loss, with loss of productivity and cost of treating tobacco related illnesses being more than the revenue gainded.
- The tobacco industry indulges in misinformation through aggressive advertisement and sponsorship targeting children, youth and women.
- Affects millions of non-smokers and particularly pregnant women, retarding the growth of the unborn children and causing abortion through passive smoking.
- Tobacco use perpetuates poverty at household and larger levels.

We the participants of the workshop on Action Towards a Tobacco Free World in the Asia Social Forum issues this statement and call upon Government, civil society, media and the people to take up urgent action .....

- On public policies In the context of right to food, right to health and right to work and poverty reduction.
- Work through local government and local bodies, focussing on women and dalits.
- Hold the tobacco companies responsible for the losses incurred and the adverse consequences on individuals and families of tobacco use.
- Ban all direct and indirect advertisement of tobacco and its products including sponsorship of sports and cultural event by the tobacco companies and affiliated bodies.
- Ban the manufacture and sale of chewed tobacco in any form, since minors are especially vulnerable.
- Progressively reduce the area of cultivation of tobacco utilizing the area thus freed for other beneficial crops.
- Prevent the cutting down of trees and denudation of forests for curing and packaging tobacco.
- Increase progressively the tax on tobacco and its products and utilize the revenue thus received for health promotion.
- Introduce legislation and effectively implement laws for prohibition of smoking in public places.
- Use all means to increase public awareness
- Reduce glamorization of tobacco products through films and media.

"WORKING TOGETHER FOR TOABCCO CONTROL"" TOGETHER WE CAN DO IT!