GUIDELINES FOR CONTROLLING AND MONITORING THE TOBACCO EPIDEMIC

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Guidelines for controlling and monitoring the tobacco epidemic

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Introduction

Each year, tobacco is responsible for the deaths of some 3.5 million people, or one death every nine seconds. These numbers are increasing, and unless current trends are reversed, by the decade 2020–2030, tobacco will kill 10 million people a year, with 70% of these deaths occurring in developing countries. Since the early 1950s, scientific evidence has been accumulating to the point where more than 25 diseases are now known or strongly suspected to be causally related to smoking. However, the costs of smoking extend well beyond the tragic health consequences, encompassing large economic and social costs as well.

Reflecting the concern of the international community, the World Health Assembly has adopted a number of resolutions on tobacco control, including a call for the implementation of comprehensive tobacco control strategies. These measures are urgently needed not only in countries with an already burgeoning tobacco epidemic, but also in countries where the epidemic can still be prevented. This book makes frequent reference to these resolutions and gives guidance on their implementation.

Although countries are working towards implementing World Health Assembly resolutions concerning tobacco and its health effects, lack of knowledge and experience in establishing comprehensive, multisectoral policies may hinder their progress. For those who are interested in or responsible for implementing tobacco control policies and programmes, this book offers practical guidance for setting up and managing long-term, multisectoral, comprehensive tobacco control policies and programmes. The experiences of a number of countries are reviewed, and the results broken down into various subjects that should be addressed as countries develop or improve their tobacco control policies.

Tobacco control is not just a rigid application of guidelines. Countries are encouraged to take the general principles, suggestions and examples in this book and adapt them to their specific needs. It is up to individual Member States ultimately to determine what strategy to take to achieve comprehensive tobacco control.

This book has two parts:

— Part I: Action for tobacco control
— Part II: Monitoring the tobacco epidemic.

Action for tobacco control

Chapter 1 describes briefly the various elements of the tobacco epidemic and the extent of the damage it causes. Chapter 2 discusses how to prepare a national action plan on comprehensive tobacco control, with emphasis on a collaborative approach. The use of a tobacco tax to promote public health is addressed at length. Recognizing that there may be substantial resistance to increased tobacco taxes, specific counter-arguments are offered. Chapter 2 also offers operational suggestions for managing and evaluating comprehensive tobacco policies and programmes once they are implemented.

Chapter 3 provides recommendations on implementing comprehensive tobacco control, based on the experiences of countries that have achieved success in this area. Arguments to counter objections to effective tobacco control measures are also provided.

In developing a comprehensive tobacco control policy, countries will find it useful to assess their current tobacco situation — what has been accomplished and what needs to be done. Chapter 4 deals with groups or institutions that play a key (or supporting) role in tobacco control and those that may oppose these policies and programmes. The information support needed for comprehensive tobacco control is examined in Chapter 5. When relevant information has been collected and documented, it can be helpful to put it into a form that is functional and accessible. Chapter 5 offers guidance in preparing comprehensive country profiles on "tobacco or health" issues. These profiles will be an integral component of the information support used in implementing and monitoring the effectiveness of comprehensive tobacco control policies.

Monitoring the tobacco epidemic

Chapters 6 to 9 focus on data collection and analysis relating to tobacco and its health effects, i.e. epidemiological surveillance. The data, along with additional information suggested in Chapters 4 and 5, will help countries in monitoring and documenting the tobacco epidemic. This information will provide support to strengthening tobacco control policies and programmes.

Reliable data on the epidemic's evolution, particularly among population subgroups, are extremely useful for supporting tobacco control efforts. Chapter 6 explores the principles and issues of surveillance, including the role of disaggregated data for these population subgroups. This chapter provides an overview of the major data collection methods and analytical strategies, and assesses indicators and information sources that will help monitor tobacco consumption and disease occurrence. These principles hold true for both developed and developing countries.

Chapter 7 presents information on how to measure tobacco consumption on the basis of production, sales and trade data. The advantages and constraints of various approaches to measuring tobacco consumption are discussed. For example, indicators such as per capita consumption of cigarettes

can provide information on overall levels of tobacco consumption but do not address the smoking status of population subgroups.

Chapter 8 shows how such information requires population surveys and how to use them to provide tobacco use data that will help to focus tobacco control policies. Revised and updated WHO recommendations for measuring prevalence of tobacco use are provided. In order to promote global standardization in measuring prevalence, all countries are strongly urged to follow these guidelines in conducting surveys of tobacco use prevalence. Surveys of knowledge and opinions are highly dependent on the cultural context in which they are conducted and may lend themselves less well to international standardization. Nevertheless, guidance is given on survey techniques that will elicit policy-relevant information on knowledge of the health effects of tobacco use and public opinions on tobacco control policy options.

Support for tobacco control policy development is greatly enhanced by reliable and timely data on the health effects of tobacco use. Chapter 9 presents an overview of the principal data sources for mortality and morbidity and discusses methods for estimating current and future tobacco-attributable mortality.

The need for action now

It is already known that tobacco is the most important preventable cause of premature death in many countries, and that half of persistent smokers who start smoking in adolescence will die from their use of tobacco. The alarming growth in consumption of tobacco testifies to the powerfully addictive nature of nicotine and the unparalleled ability of tobacco companies worldwide to aggressively market their products, despite strong public health efforts to discourage their use. At the same time, because of the 30–40-year time lag between the onset of smoking and the peak in the deaths that it causes, the health risks of tobacco are still vastly underestimated, even by those authorities responsible for protecting and promoting public health. The need for effective global action against the tobacco epidemic is urgent. This book provides practical guidelines for such action. The sooner this action becomes truly global and effective, the earlier the epidemic will be overcome.

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Part I

Action for tobacco control

Chapter 1

The need for tobacco control

In the early 1950s, widely read and acknowledged scientific reports concluded that smoking is the major cause of lung cancer. Since that time, scientific evidence has accumulated to the point where more than 25 diseases, most of which are life-threatening, are known or strongly suspected to be causally related to smoking. Evidence shows that tobacco use, in all its forms, greatly increases the risk of premature death from a number of chronic diseases.

Even non-smokers are affected by tobacco. Involuntary exposure to tobacco smoke puts them at greater risk of lung cancer and a number of other diseases. Thus, tobacco is a major contributing factor to many diseases and is the largest preventable cause of premature death in many countries.

Each year, tobacco products kill some 3 million people worldwide, and this number is increasing. Unless current smoking patterns are reversed, WHO estimates that by the decade 2020–2030 tobacco will be responsible for 10 million deaths per year, with 70% of them occurring in developing countries. Most of these deaths and all of the millions of potentially tobacco-related deaths before 2020 will occur among people who already smoke. Failure to take serious preventive action now will result in tens of millions of people dying prematurely from an epidemic that is entirely avoidable.

The costs of tobacco go far beyond the tragic health consequences. Tobacco is also a significant economic burden on families and societies. In 1995, a number of international organizations and individuals met at the Rockefeller Foundation's Study and Conference Centre in Bellagio, Italy, under the auspices of the Canadian International Development Research Centre and concluded that:

"Tobacco consumption is a major threat to sustainable and equitable development . . . In the developing world, tobacco poses a major challenge, not just to health, but also to social and economic development, and to environmental sustainability."[1]

[1] Bellagio statement on tobacco and sustainable development. *Tobacco alert*, October, 1995 (available from Tobacco or Health Programme, World Health Organization, 1211 Geneva 27, Switzerland).

A 1994 study by the World Bank estimated that the use of tobacco results in a global net loss of US$ 200 000 million per year, with half of these losses occurring in developing countries. These costs include direct medical care for tobacco-related illnesses, absenteeism from work, fire losses, reduced productivity and foregone income due to early mortality. There are also substantial costs that are not quantifiable but just as real. Among these are reduced quality of life for the smoker and those affected by second-hand smoke, as well as the suffering of people whose lives are affected by the loss or illness of a loved one. The tobacco burden can also be determined on a local scale. For example, in its 1993 report, the United States Congressional Office of Technology Assessment estimated that the total financial cost of smoking to the United States in 1990 was about US$ 2.60 per pack of cigarettes (the cost of a pack in the United States in 1990 was US$ 1.44).

Patterns of tobacco use and mortality

Despite widespread knowledge of the harm caused by smoking, only modest success has been achieved in global tobacco control. Worldwide, consumption of manufactured cigarettes more than doubled from 1967 to 1992, from 2.8 trillion (2.8 million million) to 5.7 trillion (5.7 million million) cigarettes, with per capita cigarette consumption increasing by 25% during the same period.

In developed countries, where smoking became widespread during the 1940s and 1950s, the effects of past smoking trends can now be seen. Almost 20% of all deaths in the 1990s in developed countries are due to tobacco products. In the 35–69-year age group, about 35% of deaths among men and 15% among women are caused by tobacco. Although smoking rates have generally declined among adults in developed countries, they have risen in developing countries.

World Health Assembly resolutions

Reflecting the international public health community's growing concern with the epidemic of tobacco-related disease, the World Health Assembly, the governing body of WHO, adopted 14 resolutions on both national and international tobacco control measures between 1970 and 1995 (see Annex 1). From 1986 to 1995 the Assembly passed nine major resolutions concerning "tobacco or health" issues and continues to reaffirm its commitment to tobacco control.

The World Health Assembly resolution WHA39.14 (1986) is particularly noteworthy in that it calls on WHO's Member States to implement comprehensive tobacco control strategies; these, as a minimum, should contain the following:

(1) measures to ensure that non-smokers receive effective protection, to which they are entitled, from involuntary exposure to tobacco smoke,

in enclosed public places, restaurants, transport, and places of work and entertainment;
(2) measures to promote abstention from the use of tobacco so as to protect children and young people from becoming addicted;
(3) measures to ensure that a good example is set in all health-related premises and by all health personnel;
(4) measures leading to the progressive elimination of those socioeconomic, behavioural, and other incentives which maintain and promote the use of tobacco;
(5) prominent health warnings, which might include the statement that tobacco is addictive, on cigarette packets, and containers of all types of tobacco products;
(6) the establishment of programmes of education and public information on tobacco and health issues, including smoking cessation programmes, with active involvement of the health professions and the media;
(7) monitoring of trends in smoking and other forms of tobacco use, tobacco-related diseases, and effectiveness of national smoking control action;
(8) the promotion of viable economic alternatives to tobacco production, trade and taxation;
(9) the establishment of a national focal point to stimulate, support, and coordinate all the above activities.

Elements one and four of this list were recalled in 1990, with the adoption of WHA43.16, urging all Member States:

(1) to implement multisectoral comprehensive tobacco control strategies which, at a minimum, contain the nine elements outlined in resolution WHA39.14;
(2) to consider including in their tobacco control strategies plans for legislation or other effective measures at the appropriate government level providing for:
    (a) effective protection from involuntary exposure to tobacco smoke in indoor workplaces, enclosed public places and public transport, with special attention to risk groups such as pregnant women and children;
    (b) progressive financial measures aimed at discouraging the use of tobacco;
    (c) progressive restrictions and concerted actions to eliminate eventually all direct and indirect advertising, promotion and sponsorship concerning tobacco.

These and other World Health Assembly resolutions concerned with tobacco and health effects of tobacco are entirely consistent with the *Ottawa*

charter on health promotion,[1] which encourages the adoption of healthy public policies and the creation of supportive environments for health as part of a broad multisectoral approach to health promotion. Major non-governmental organizations (NGOs), such as the International Union Against Cancer (UICC) and the International Union Against Tuberculosis and Lung Disease (IUATLD), as well as the 9th World Conference on Tobacco or Health, have adopted positions similar to that of WHO. In addition, the World Health Assembly has requested WHO to assist countries in implementing comprehensive tobacco control policies and to monitor closely the evolution of the global epidemic of tobacco-related diseases.

The social acceptability of tobacco use

Effective tobacco control begins with the realization that tobacco is powerfully addictive. Researchers have rated nicotine as more addictive than heroin, cocaine or marijuana. Despite their strong desire to quit smoking, smokers often find their efforts futile. They are not helped in their struggle by ubiquitous tobacco advertising and promotion. Tobacco control strategies should consider such personal aspects as self-esteem and self-image, as well as external factors such as peer pressure, pricing and perceived social acceptability. With the exception of social norms in certain cultures and religions that discourage smoking among women, there are few societal taboos on smoking. Hence, since tobacco use is both legal and not widely discouraged, it is permissible to manufacture, market and, in most countries, advertise tobacco products.

It is also permissible to sell tobacco products through wholesale and retail outlets (even in pharmacies and hospitals in some countries), to trade them internationally, and to establish and promote new markets for them. Ultimately, this creates a web of government and economic interests that may be dependent on tobacco for all or part of their income. For example, entities as diverse as ministries of agriculture, advertising firms, small retailers, theatre groups and sports clubs may receive income or sponsorship money from the tobacco industry, and are likely to support continued tobacco trade and consumption. These closely linked interests serve to reinforce the social acceptability of smoking.

The social acceptability of tobacco use contradicts the strong health education and health promotion messages discouraging it. Psychologists have found that teenagers, with still-developing cognitive abilities, are likely to take the contradiction of health education and health promotion messages on the one hand, and publicly sanctioned tobacco advertising, marketing and tobacco use on the other, as licence to believe nothing at all. They are especially prone

[1] Ottawa charter on health promotion. *Health promotion*, 1986, 1:iii–v.

to cite these contradictions in justifying actions that suit their immediate desires, such as smoking.

The importance of effective tobacco control

Many countries have undertaken health promotion programmes and health education programmes to inform people of the hazards of tobacco. However, these efforts are continually undermined by the tobacco industry. Over 40 years of experience with health education and health promotion measures show that these measures alone are insufficient to combat the tobacco problem. If smoking is still perceived as socially acceptable, educational campaigns focused on the health hazards of tobacco use will have but modest results in getting large numbers of adults to stop smoking, or in preventing teenagers from starting. The net effect will be a well-informed population of continuing smokers. For better results, education and health promotion must be accompanied by other actions, particularly legislation and tobacco tax measures, that will reduce the social acceptability of tobacco use.

Favourable results are being seen in countries that have adopted comprehensive tobacco control programmes that ban tobacco advertising, place strong warnings on packages and controls on the use of tobacco in indoor locations, levy high taxes on tobacco, and provide traditional health education and smoking cessation programmes. From 1970 to 1995, comprehensive tobacco control policies were implemented, maintained and upgraded in Australia, Finland, France, Iceland, New Zealand, Norway, Portugal, Singapore, Sweden and Thailand. Tobacco consumption has remained low or is falling rapidly in these countries, providing clear evidence that the more comprehensive the policy, the more effective the solution. In other countries, partial tobacco control programmes and policies have produced only partial solutions to this very serious public health problem.

Effective and comprehensive tobacco control is desirable in every country, whether to reduce already numerous tobacco-related deaths or to prevent the development of a serious public health problem in countries where the use of tobacco is not yet widespread. In many developing countries, particularly among women, there is still time to avoid repeating the experience of the industrialized countries, where tobacco use quickly became widespread, long before the serious health effects of smoking were known. Now that these hazards are acknowledged, this information can and should be used to prevent the appalling global predictions of an epidemic of tobacco-related diseases from becoming a reality. Tobacco control may be a low priority for countries striving for economic and social development, while trying to reduce infectious diseases. But unless strong tobacco control measures are taken now, those lives saved through the prevention of early death from infectious diseases may be lost

in middle age as new generations of adolescents and young adults take up smoking.

Monitoring the tobacco epidemic

Policies and programmes to control tobacco use should be supported by reliable and timely information on the subject, its health consequences and the sociocultural elements which underlie its use. Given tobacco's prominent role as a major health hazard and the likelihood that the health effects will increase dramatically in the future, it is essential that the regular assessment of tobacco use and associated disease trends become an integral part of a country's health information system. Since the epidemic of tobacco-related diseases is constantly evolving, gathering appropriate information at regular intervals will help monitor and control it.

These efforts will be more effective if health promotion policies and programmes are based on internationally comparable information. Standardized approaches make it easier to monitor the global, regional and national tobacco situation and its health effects, and to evaluate the effectiveness of policies and programmes.

Background reading

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