



## New Tobacco Control Era Dawns

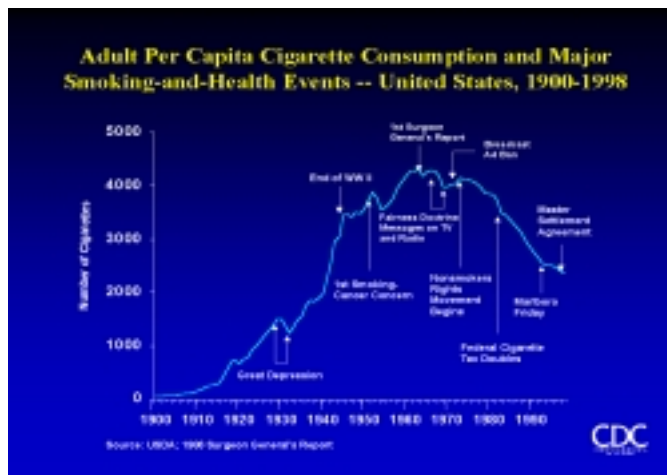
### Global Tobacco Trends Spark Hope, Sound Alarm

by Michael Eriksen, ScD; Lawrence Green, DrPH; Linda Bailey, JD, MHS; Terry Pechacek, PhD, Office on Smoking and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Tobacco control is heralded as one of the 10 greatest public health achievements of the 20th century in the United States. This recognition reflects the dramatic reduction of smoking prevalence among U.S. adults from 42.4 percent in 1965 to 24.7 percent in 1997. But just as the United States, Canada, Australia, New Zealand and several European countries were dramatically reducing their tobacco consumption, the developing world faced a tobacco epidemic. What does experience tell us about effective tobacco control strategies for the future?

#### Industrialized Nations Show Hopeful Signs

Effective programs as well as supportive public policies are needed to curtail tobacco use. The positive trends in U.S. smoking prevalence have resulted not simply from scientific knowledge that tobacco use and environmental exposure to tobacco are hazardous to health, but from a combi-



nation of public education, advocacy for nonsmokers' rights, restrictions on cigarette advertising, improvements in treatment and prevention programs, and an improved understanding of the economic costs

of tobacco. Public policy advances (see chart) have also contributed to the reductions; and legislation restricting smoking in public places, increased taxation and enforcement of minors' access laws have made a substantial impact. And now, the disclosure of tobacco industry documents provides opportunities for a new approach to tobacco control programs and policies—actions that address corporate intent to confuse, mislead, and obfuscate the public's understanding of the harm caused by smoking.

See *Global Trends*, page 2

### BATA Battles BAT In Bangladesh

by Debra Efrogmson, Regional Advisor, PATH Canada, Dhaka, Bangladesh

With a population of about 123 million, Bangladesh is one of the poorest and most densely populated countries in the world. Nearly half the population lives below the poverty line. And while life expectancy has increased over the past decade, it stands at 60.5 for women and 60.7 for men, with diarrhea, cardiovascular diseases and asthma the top three causes of death.

#### Tobacco vs. Food Consumption

Tobacco use has not been well-monitored in Bangladesh. The latest large survey appears to simply study smoking, ignoring the huge issue of smokeless tobacco use. Smoking rates are much higher in men (43.8%) than in women (4.6%), with men aged 35 to 49 having the highest rate—66.1 percent. And, the economic burden of tobacco in Bangladesh is substantial.

In 1996, average yearly expenditure on food for men and women, was just 2.4 times what they spent on tobacco in 1997. Men who smoke cigarettes (rather than cheaper forms of tobacco) spend nearly as much on cigarettes as on food. Since about half the population is malnourished and a large portion of spending goes to food, it is clear that reducing tobacco use could hugely benefit nutritional status.



John Player GOLD LEAF posters adorn a run-down shop-front in Comilla, Bangladesh

#### The Industry's Agenda

Bangladesh is home to several local tobacco companies. In 1998, the Bangladesh Tobacco Company was bought out by British

See *Bangladesh*, page 6

Inside Issues	
• Insider's View	3
• European Advances	4, 5
• Industry Secrets	6
• FCTC	7
• Policy Matters	8

# CECheck-Up

"We've come a long way, Virginia Slims!"...quips veteran anti-tobacco advocate David Simpson in this issue's "Insider's View" as he recounts the tobacco control movement over the decades.

In view of the upcoming 11th World Conference on Tobacco or Health in Chicago, this *Global Health and Environment Monitor* relates the personal stories and official accounts of certain key people and organizations that have been facing major challenges, fighting the tobacco wars and making unprecedented advances. Simultaneously, the issue points to the growing menace of tobacco—especially in the developing world in women and children—the most vulnerable to its hazards.

Michael Erickson and colleagues from CDC lead off with a global dichotomy—progress in the industrialized world, contrasted with the looming epidemic in developing nations, which are least prepared to cope with the challenge, economically or technically. A stark example of the dilemma is shown by Debra Efrogmson's review of the food vs. tobacco struggle in Bangladesh. The Centerfold, effectively covered by Witold Zatonski, Sibylle Fleitman and Hungary's Zuzanna Furesi et. al, highlights European achievements and challenges, in the East and West. It includes Beverly Jensen's update of CECH's World Bank-supported project on tobacco control in the Czech Republic, with the Internet at its service.

Replacing *CECHE In The News*, just this time, are two crucial matters—the cache of tobacco industry documents, dissected by Norbert Hirschorn, and WHO's Framework Convention on Tobacco Control, summarized by Douglas Bettcher and colleagues from WHO.

The issue concludes with Dr. Judith Mackay from China, who gently reminds us that the tobacco control policies of today may have their origin in the 1600s. She highlights the fact that WHO is finally (my emphasis!) taking its rightful place at the head of the table in setting the global tobacco policy agenda in the new millennium. That by itself is cause for celebration at the 11th World Conference in Chicago!

See you there!

-Sushma Palmer, D.Sc.,  
Chairman

Continued from page 1

## ...Global Trends

### Developing Country Trends Signal Alarm

As tobacco control programs and policies succeed—and sales plummet—in industrialized nations, the tobacco epidemic is aggressively spreading into developing countries. The World Health Organization (WHO) currently estimates that about 1.15 billion smokers in the world consume an average of 14 cigarettes each per day. Of these, 82 percent live in low- and middle-income countries. Such patterns of tobacco consumption will have devastating effects on future global health: 10 million people will die annually—11,000 deaths per day—from tobacco-attributed diseases by the late 2020s. In short, tobacco will overtake the pandemics of the present and past as the leading cause of death in developing countries.

Many developing countries face critical barriers to tobacco control. First, tobacco consumption, in parallel with per capita income, is growing in developing countries. Second, the citizens of developing countries are less exposed to education on the health hazards of smoking and, therefore, are less inclined to treat tobacco as a significant threat. Third, many developing countries still suffer from a heavy burden of infectious diseases and malnutrition and accord a lower priority to tobacco-related health effects. Fourth, and perhaps foremost, many developing countries have yet to assemble the political will needed to enforce measures that treat tobacco commensurate with the harm that it causes. In many, the government is tempted by the "smoke ring" of tobacco—specifically employment, revenue and trade. Tobacco marketing is costly in the long run, experience tells us. In California, data show that for every dollar spent on tobacco control, the state realized a savings of \$1.50 in direct medical services and \$4 in the overall cost of tobacco-associated illnesses.

### Effective Strategies Spell Effective Control

World Bank economists recognize that the public health benefits of tobacco control far exceed the costs, and price increases are the most effective strategy for reducing demand for tobacco products both in industrialized and in low- and middle-income countries. Mostly implemented through excise taxes, price increases reduce smoking, especially among youth. World Bank studies show that temporary income loss among producers and distributors may be one consequence, but without a dramatic need for downsizing. Furthermore, the impact of price increases may be significantly enhanced by measures that ban or restrict tobacco advertising and promotion

or increase public awareness of tobacco's harm. For example, cigarette labels may contain prominent health warnings and list ingredients or levels of tars, nicotine and other harmful constituents. In Sweden, Iceland, Norway and Canada, pictures are used or proposed to increase the impact of such warnings.

Nicotine replacement therapy and other cessation interventions are also effective demand-reduction tools. In the United States, proposals are being considered to mandate Medicaid coverage of both prescription and non-prescription smoking cessation drugs, removing current exclusions in the law. Private insurers and managed care organizations are making similar commitments to helping smokers quit.

The recent World Bank report "Curbing the Epidemic" concludes that supply reduction is a less promising approach to tobacco control. Some attention to such policies, nevertheless, is warranted. For example, smuggling becomes a concern when neighboring areas experience cost differentials (i.e., in border areas and special jurisdictions such as military bases and tribal reservations). Measures such as more prominent tax stamps and aggressive enforcement and prosecution can be effective in preventing smuggling. Indeed, trade policies and tobacco control should be complementary. The U.S. Congress recently prohibited the expenditure of tax dollars to support the export and promotion of cigarettes, and U.S. diplomatic posts are now directed to assist tobacco control efforts in host countries.

At the global level, in 1996, WHO member states initiated a Framework Convention on Tobacco Control (FCTC), a legal instrument intended to address the global problem of tobacco use. Once adopted by WHO, the convention and related protocols will be subject to ratification by member states. (See WHO...p.7. Also, visit: WHO's website, <http://www.who.int/toh/fctc/fctcintro.htm>; and the U.S. Government site, <http://www.cdc.gov/tobacco>.)

Non-governmental organizations, research institutes and professional associations also play a critical role in the development of tobacco control programs and policies through their domestic and international activities. For the FCTC, these groups are essential. The U.S. Government will call on such partners to participate in the development and ratification of the FCTC and the implementation of subsequent bilateral and multilateral protocols. The success of these multiple intervention strategies will reshape the tobacco control landscape worldwide for the year 2003 and beyond. § Michele Chang of CDC contributed to this article.

# We've Come A Long Way, Virginia Slims!

by David Simpson, Director, International Agency on Tobacco and Health, United Kingdom

A month after starting work in tobacco control in 1979, I attended the 4th World Conference on Tobacco and Health in Stockholm. Tobacco was already a massive health problem, fast spreading to developing countries, but both the agenda and the attendance were limited by today's standards. Taxation, for example – now shown to be one of the most effective tools for reducing tobacco consumption – was hardly featured; and the vast majority of delegates were from Europe and North America – as we were still talking of “tomorrow's epidemic” for developing countries, and the overwhelming disparity of power and perceived importance of the tobacco industry ruled out any hope of a solution.

## Looking Back

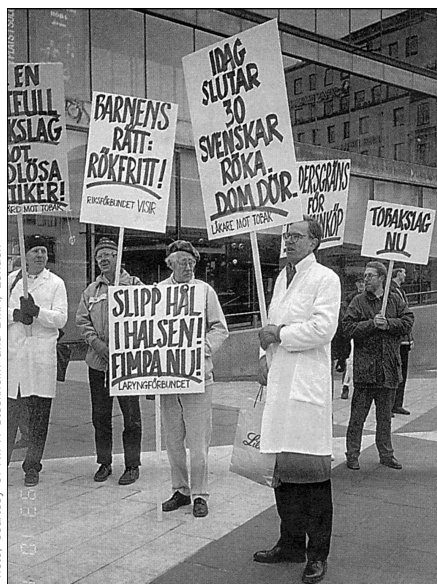
Two memorable speakers in Stockholm were politicians whose subsequent careers neatly demonstrated why the ephemeral nature of politics could not be trusted to deliver an easy, fail-safe solution. Then U.S. Secretary for Health Joseph Califano gave a superb and fiery talk, leaving delegates excited that here at last was the U.S. cavalry riding to the rescue. His British counterpart, Sir George Young, gave an equally inspiring performance, stating that “For prospective patients, the answer may not be incision at the operating table, but prevention by decision at the cabinet table.” Califano left in triumph for a visit to China, but before he got home was sacked from President Carter's cabinet. Political commentators rated his strong stand on tobacco the major factor in his dismissal. Someone coined the term “MyoCalifano Infarction” (MoI): the sudden cutting-off of political life caused by being tough on tobacco. Sir George Young suffered an MoI two years later.

Also in Stockholm was a tobacco industry delegation. A memo written by one of them and later leaked to the press claimed, “The social acceptability issue will be the central battleground on which our case in the long run will be lost or won.” In those days research showed that, except to infants and angina sufferers, passive smoking posed no harm. The valuable insight into industry perceptions showed the importance of making non-smoking regulation a priority, a point effectively grasped by nongovernmental organisations (NGOs) in the United States as evidence of the serious risk of disease to non-smokers began to accumulate in the 1980s.

## Where Are We Now?

What are the most striking changes since those early days? First, the big transnational tobacco companies have become even bigger, swallowing each other until the world's

tobacco markets, apart from China, are dominated by two giants whose annual sales dwarf the entire economic activity of many developing countries. By stealth and joint venture agreements, they have even invaded China, the biggest market of all. In Stockholm, we gasped at the crude cynicism of contemporary cigarette advertising by Western companies in Africa. Now, their subsidiaries in developing countries have wound down support for local products in favour of “international” brands – thanks to increasingly global news media. Industry sponsorship of sports and cultural events, virtually unknown in



Photo, courtesy of NIPH Stockholm and BMA, London

Swedish doctors march in support of the Swedish Tobacco Act of 1993.

developing countries in 1979, is now as ubiquitous and serious a problem there as in the industrialised world.

Another important change is litigation. Tobacco companies have realised they have nothing to lose (and virtually limitless resources to burn) by taking legal action as far as it can go to challenge public health measures. They destroyed Canada's first comprehensive legislation, considered the best in the world; they stopped the U.S. Food and Drug Administration from using its powers to regulate tobacco, a dangerous drug if ever there was one; and they now routinely and boldly pursue legal action against governments and NGOs alike. The disruption to normal life and the massive legal costs are strong deterrents against fighting back.

Ironically, litigation has been a major benefit to health. If information is the main ammunition which our troops use in the tobacco war, the millions of incriminating industry documents forced into the public



David Simpson addresses the 2nd World Conference on Cancer Organizations, Atlanta, GA

domain by trials in Minnesota and elsewhere in the United States represent a cache whose firepower would have seemed the stuff of fantasy 20 years ago. (See Industry...p.6.) The enemy does not obey normal rules, however, and while embarrassed into declaring itself reformed in the West, it shows no hint of changing its practices in developing countries.

## Cause To Celebrate

Despite the industry's might and ruthlessness, there is much to celebrate. A truly international tobacco control movement now exists, and, thanks to the pioneering efforts of NGOs, the concept of tobacco control has been established as a legitimate issue in every country. Twenty years ago only a minority of cancer, heart and lung associations had programmes on tobacco; nowadays few such NGOs ignore the issue. In fact, many have programmes far outstripping the efforts of their governments. My own organisation serves around 200 tobacco control advocates in 108 developing nations – but we know they are a minority of those now active in the developing world. Better still, as the story about Bangladesh (see p.1) demonstrates, such advocates are networking and forming the coalitions so essential for success.

Tobacco control workers are networking internationally, too. The ability of an advocate to put an appeal on GLOBALink and receive active help within hours from every corner of the world must rate as one of the most significant improvements of all. Twenty years ago, this would have seemed a crazy dream.

Changes at WHO (which previously said the right things but had neither the resources nor the political backing to deliver on them) have raised the profile of tobacco control on the political agenda. WHO's flagship Framework Convention on Tobacco Control (see WHO...p.7) has already achieved the most important evaluation of its likely success: the desperate condemnation of the tobacco industry.

We are in the best shape ever for winning the war, but millions will die, many battles will be fought, and a long, hard campaign will be waged before we do. §

## Tobacco Control Gains Ground in Eastern Europe

by Prof. Witold Zatonski, Marie Curie Cancer Center, Warsaw, Poland

Before World War II, Eastern European countries consumed little tobacco. After the war, cigarettes became a symbol of development, widely available and very cheap. Smoking among Eastern European men rose dramatically and became so widespread that in the mid-'70s only about 10 percent of adult men had never smoked. Smoking was less prevalent among women, especially among older and rural female inhabitants.

### Dismal Past

At the dawn of the 1990s, Eastern European males had the highest level of tobacco-dependent disease in the world, WHO estimated. Nearly every second premature death in middle-aged men could be traced to tobacco smoke, and an unprecedented 60 percent of all cancers in young adult and middle-aged men was connected to smoking. Following the political and economic changes of the mid-'90s, smoking patterns became heterogeneous across the region. In some countries, tobacco sales are no longer rising. In Poland, they have fallen 10 percent in the last decade. In the former Soviet Union and other countries with especially difficult transitions, the number of male smokers remains stagnant. Meanwhile, tobacco use is rising among women, especially young women, throughout the region (excluding Poland).

## Hungarians Speak Out on Smoking and Big Tobacco

by Zsuzsanna Fuzesi, MD, Ph.D, Laszlo Tistyan, MA, Monika Tarnok, Fact Institute of Applied Social Sciences Research, Pecs, Hungary

Hungarians are relatively prolific—and tolerant—when it comes to smoking. So reveals a survey of Hungarian smoking (and drinking) habits commissioned by the National Institute for Health Promotion in Budapest and conducted in fall 1999 by the Pecs-based Fact Institute of Applied Social Sciences Research.

This survey of a representative national sample of 1200 Hungarian adults found that 41 percent of the respondents smoked more or less regularly, with 32 percent smoking daily and 9 percent occasionally. Smoking is also predominantly a male habit in Hungary as elsewhere: 44 percent of males and 21 percent of females said they smoke every day.

While the majority agreed that “Smoking can cause serious diseases”, 41 percent believed this applied only to excessive smoking. (Respondents with a family history of smoking-related conditions agreed that smoking can cause serious diseases, whether or not it is excessive.) A considerably lower percentage—38 versus 56 percent—agreed that “Drinking can cause serious diseases.” The majority, 56 percent, said they are not disturbed by others smoking in their presence, underlining the social acceptance of smoking in Hungary. Nevertheless, 70 percent agreed that inhaling the smoke of others is a health risk.

Tobacco control measures received respondents’ overall support, but about half of those who supported smoking restrictions believe the restrictions will not be observed. Meanwhile, about 75 percent of respondents label efforts of health care institutions to restrict smoking as unsatisfactory; and one-third expressed the opinion that doctors and other members of the medical profession are not interested in the problem.

A substantial majority, 67 percent, believe that tobacco manufacturers are not responsible for distributing hazardous products, because nobody forces smokers to consume the products. And while 29 percent claimed that tobacco manufacturers could be sued in Hungary, less than half the respondents (45%) are aware of similar suits in other countries. Ironically, only 15 percent said that they think the government does its best to curb smoking. §



L&M's promise "Discover the taste of freedom" countered by Polish Ministry of Health warning above "Smoking causes heart disease and cancer"

### Recent Success

In the face of these challenges, upon Poland's return to democracy, a health lobby was established to support comprehensive tobacco control. Its work resulted in the 1995 "Law on the Protection of Public Health against the Effects of Tobacco Use." Updated in 1999, this law aimed to create conditions (education, economic conditions, laws and addiction treatment) to limit the health effects of smoking. Its most important provisions are:

1. A ban on radio, television and some print advertising of tobacco until 2000 (A total ban on advertising, sponsorship and donations to political parties by tobacco companies was added in 1999 and will be implemented in 2001.)
2. A ban on the sale of tobacco products to minors (<18 years)
3. A ban on cigarette vending machines and loose cigarette sales
4. A ban on smoking in schools, health care facilities and enclosed workplaces, except in designated areas
5. Health warnings on advertising and cigarette packs covering the top 20 percent of the advertisement and 30 percent of a cigarette pack
6. The creation of a fund for tobacco control activities, consisting of 0.5 percent of the excise taxes collected from cigarette sales (added in 1999).

This law, coupled with Poland's "Gold Standard" tobacco control program, has produced some encouraging results. Cigarette sales fell by 10 percent from 1990 to 1998, and smoking rates have fallen, with the ranks of ex-smokers growing. Decreasing exposure to tobacco has meant better health indicators. Lung cancer, a disease seen almost exclusively in smokers, has been declining among young and middle-aged men in Poland for some time. Nevertheless, youth, especially girls, are smoking more and lighting up younger. And while tobacco control programs are now focusing on smokers most physically and psychologically addicted to their habit, most health care providers are still not familiar with treating nicotine addiction.

### Hopeful Future

Thankfully, networks of tobacco control advocates in Central and Eastern Europe are growing. Efforts and government support vary significantly around the region, with anti-tobacco advocates ranging from health ministry workers to church leaders; but increased Internet access has allowed GLOBALink membership and access to important data, and Eastern Europeans are increasingly participating in international conferences.

Countries like Poland and the Czech Republic have developed health strategies and monitoring agencies, but many others are just beginning tobacco control efforts and have few policies promoting health. In these nations, basic health information may not be available; most health care systems do not offer nicotine replacement therapy; and many health care workers are not trained in treating nicotine addiction (and smoke more than the average person). In some places, smoking is culturally embedded, and the price of cigarettes is relatively low, with multinational tobacco companies eagerly exploiting these factors.

Progress is not impossible, however. Reducing smoking requires concerted effort by medical professionals, scientists, politicians, teachers and parents. It also requires international solidarity. §

## EU Network Promotes Cross-Border Alliances Against Tobacco

by Sibylle Fleitmann, Secretary General, European Network for Smoking Prevention, Brussels

Created in 1957 among five member states as a supranational legislative body to establish a European economic trade zone, the European Union (EU) today comprises 15 member states that are moving towards a united front against the threat of tobacco.

The 550,000 annual tobacco-related deaths in the EU make smoking one of its leading causes of morbidity and mortality. (See table.) Between 1987/88 and 1994/95, the average smoking rates decreased from 44 to 40 percent in men and from 28 to 27 percent in women (thanks in part to the Europe Against Cancer Programme created by the heads of state of the EU in 1987). However, the latest surveys show that the prevalence of smoking in women is rising in several EU countries. In most, smoking among youngsters is also increasing, with girls smoking slightly more than boys.

Percentage of Smokers By Sex and Country  
1987-1995

	Men				Women			
	87-88	89-90	91-92	94-95	87-88	89-90	91-92	94-95
BEL	45	41	41	29	28	24	28	
DEN	46	48	48	44	45	42	44	
FRO	43	44	39	40	27	26	24	
GDR	48	48	42	44	22	26	20	
GRE	62	54	55	49	25	25	28	
ESP	52	51	48	44	27	27	26	
FRA	45	45	49	44	29	28	31	
IRL	38	40	35	36	32	31	27	
ITA	40	38	38	38	27	26	26	
LUX	37	36	40	34	31	23	26	
NET	49	45	46	45	39	34	33	36
POR	46	43	40	38	12	11	12	15
GBR	40	37	35	36	31	30	29	30
EC 12	44	43	42	40	28	28	27	

However, the latest surveys show that the prevalence of smoking in women is rising in several EU countries. In most, smoking among youngsters is also increasing, with girls smoking slightly more than boys.

### Cross-Border Co-operation

Collaboration on tobacco control issues on the European level began in 1987 when the Commission of the European Union formed a working group of

organisations representing national tobacco control activities. The goal was to promote cross-border cooperation aimed at decreasing smoking-related cancer mortality. Between 1987 and 1996, the EU promoted various projects to increase the efficiency and coherence of smoking prevention activities and programs. One milestone was the creation in 1988 of European Bureau for Action on Smoking Prevention (BASP), which assisted the EU Commission on information collection and dissemination. With the support of BASP, several theme-based cross-border networks emerged, including the European Network on Young People and Tobacco (ENYPAT) and a European Smoke-Free Cities Network.

Common goals for increased collaboration, adopted in 1994, encompassed the creation of a permanent pan-European tobacco control structure and the establishment of national coalitions to promote a coordinated approach to tobacco control at a country level. It took three years, several meetings and the EU's threats to abandon its financial support before agreement could be reached among nongovernmental organizations (NGOs) to create a coordinating body for tobacco control — the European Network for Smoking Prevention (ENSP). Building national coalitions proved more difficult, plagued by lack of knowledge of ongoing activities, fear of competition and divergent political interests. For example, of the four kinds of organisations involved in tobacco control in Europe in 1996, professional associations generally favored a more aggressive approach towards policy reform, whereas cancer leagues, hospitals, universities and public health institutes preferred the public health model of smoking prevention. Fortunately, these groups put aside their differences and recognized that a coalition meant enhanced capacity for lobbying and advocacy towards establishing a legal framework for tobacco control on both a national and a European level.

Today, more than 350 organisations work with the ENSP through national coalitions representing the 15 EU member states, Norway, Poland, Estonia, Hungary and the Czech Republic. New theme-based networks such as Interna-

tional Network of Women Against Tobacco (INWAT) - Europe and the Smoke-Free Hospitals Network have joined ENSP, and close collaboration has developed with existing public health-oriented networks on both a European and an international level.

### Policies and Programs

ENSP's main aim is to increase networking among NGOs across Europe. In 1999 alone, ENSP succeeded in creating partnerships among 97 organizations from 15 EU member states, plus Norway, Iceland and Romania, for 10 project proposals amounting to about 3 million EURO. In fact, the ENSP has been among the leading forces behind a number of coordinated tobacco control activities. For instance, organized European lobbying campaigns led by UICC/ECL (the Association of European Cancer Leagues) together with national coalitions and networks were instrumental in the 1998 adoption of the EU directive banning advertising in the 15 member states. Similar campaigns are underway to support a proposed EU directive on tobacco product regulation.

On the international policy level, ENSP is actively working to generate support for the World Health Organization's Framework Convention for Tobacco Control through the Committee for a Tobacco-Free Europe (set up by WHO Europe) and the International Framework Convention Alliance.

Networking between advocacy-oriented coalitions and scientific networks in Europe is increasingly pragmatic and mutually beneficial. The challenge now is to increase public participation in EU decision-making and thereby balance the economic interests and the quality of life of the European citizen. §

## Czechs, CECHE Launch Internet Network

by Beverly Jensen, Senior Project Consultant, Center for Communications, Health and the Environment (CECHE), Washington, DC

On 19 April and 12 June, tobacco control advocates from both sides of the Atlantic descended upon Podedbrady, a resort town on the outskirts of Prague. Their two-fold mission: develop practical strategies to motivate the Czech news media to circulate more stories on tobacco control, and encourage Czech policy-makers to undertake tobacco control reform.

These topics were the subject of a Media Relations Workshop and a Policy Advocacy Workshop—planned for Czech health professionals from government hygiene stations, nongovernmental organizations (NGOs) and international public health groups. (A workshop in October 1999 in Prague addressed Internet skills and featured hands-on training in information technology and electronic networking by CECHE partner Ruben Israel of GLOBALink.) These workshops in part mean a new approach to countering smoking and its adverse consequences on cardiovascular disease (CVD) mortality in the Czech Republic.

In fact, it was the high prevalence of smoking in Czech men (40%) and women (30%) that prompted U.S.-based CECHE and Czech partners to launch an 18-month Internet-based demonstration initiative, the Czech Tobacco-Control Training and Communications Program (TOB-CCP), in 1999. The resulting electronic network, now 42 strong, will seek to ally with the soon-to-be-formed CVD prevention-oriented NGO, The Czech Heart Association, in a population-based tobacco control program that will use the Internet, working with Czech District Hygiene Stations and NGOs.

Meanwhile, experts in information technology and tobacco control from the Czech Republic, other European countries and North America are partnering in this effort to build indigenous capacity, heighten public awareness, catalyze the creation of a tobacco-free environment in the Czech Republic and explore the potential of the TOB-CCP to serve as a model in other Central and Eastern European countries, and around the globe. §

# Tobacco Industry Documents — Secrets Revealed

by Norbert Hirschhorn, M.D., Consultant,  
World Health Organization

Those who saw the movie “The Insider” can appreciate just how recently we’ve discovered what the tobacco industry kept hidden for decades. A few industry secrets emerged from time to time in lawsuits, but hardly anyone outside the companies realized what the industry knew about its product — yet denied or refused to reveal in public. It is now obvious that the tobacco industry knew the health consequences of tobacco, and that it knew that nicotine worked as an addictive drug and manipulated it to increase addiction. Internal industry documents also reveal that the companies deliberately marketed to children, clandestinely recruited and paid consultants, scientists and journalists to front the industry’s case, and even conspired in smuggling.

In 1994, the first major cache of documents, from Brown and Williamson, was sent by a paralegal “whistle blower” to Prof. Stanton Glantz at the University of California San Francisco (UCSF). Within a year, Glantz and his colleagues published five articles in the *Journal of the American Medical Association* (JAMA) exposing the shocking collection. (Recall what Brown and Williamson was doing to “The Insider” Jeffrey Wigand and CBS at this time, and one must admire the courage of the Glantz team, JAMA editors and UCSF.)

Industry documents became publicly available in May 1998 after an intense legal battle that reached the U.S. Supreme Court. In settling the case, which involved the State of Minnesota suing the five U.S.-based cigarette companies and two affiliated agencies for consumer fraud, the tobacco industry was forced to release approximately 5 million documents — some 34 million pages dating from the mid-1950s to 1994 — for storage in warehouses in Minneapolis and Guildford, England. The agreement also stipulated (and was reinforced by the 1998 “Master Settlement Agreement” with U.S. attorneys general) that all additional documents discovered in succeeding lawsuits would be maintained by the U.S. industry on websites and in the two warehouses until June 30, 2010.

The documents may be found electronically through two principal Internet portals: one maintained by the tobacco companies, <www.tobaccoarchive.com>, and one by the U.S. Centers for Disease Control, <www.cdc.gov/tobacco/industrydocs>. Access to the paper documents stored in Minnesota is easy, as the warehouse is managed by a legal services firm; access to the Guildford warehouse, controlled by British American Tobacco, is more difficult.

An international document research network has evolved since 1998 and includes academics, journalists, tobacco control activ-



ists, lawyers and government officials. Their efforts have resulted in numerous collections of documents covering a range of tobacco-related topics. Based on these collections, nearly two dozen analyses of industry secrets have been published — and more are on the way. The most revealing are referenced below.

By court order the documents come only from companies doing business in the United States, but since these companies are transnational corporations, thousands of the documents specifically relate to other nations and global regions. In fact, researchers are starting to assemble national and regional collections covering Asia, Europe, Australia and the Middle East. In addition, a “second generation” of discovered documents begins to show how the tobacco industry has tried to subvert research proving the ill-effects of passive smoke on non-smokers.

The tobacco industry keeps claiming that tobacco use is an adult’s “informed” choice. The documents here, in the warehouses and on the Web disclose how resolutely the industry fought to keep the public ignorant of the truth.

7. Jarvis M, Bates C, “Why low tar cigarettes don’t work and how the tobacco industry has fooled the smoking public,” 18 March 1999, <www.ash.org.uk/papers/big-one.html>
8. Bates C, Jarvis M, Connolly G, “Tobacco additives. Cigarette engineering and nicotine addiction,” 14 July 1999, <www.ash.org.uk/papers/additives.html>
9. Collishaw N, “Imperial Tobacco’s ‘elastic’ cigarettes,” *Physicians for a Smoke-free Canada*, 11 November 1999, <www.smoke-free.ca>
10. Beelman MS, Ronderos MT, Schetzig EJ, “Major multinational implicated in cigarette smuggling, tax evasion, documents show (Part 1 of 2)... Global reach of tobacco company’s involvement in cigarette smuggling exposed in company papers (Part 2 of 2),” *International Consortium of Investigative Journalists of the Center for Public Integrity*, 31 January, 2 February 2000, <www.icij.org>
11. Perry CL, “The tobacco industry and underage youth smoking: Tobacco industry documents from the Minnesota litigation,” *Archives of Pediatric and Adolescent Medicine* 1999;153:935-41.
12. Leavell N-R, “The low tar lie,” *Tobacco Control* 1999;8:433-39.
13. Ong EK, Glantz SA, “Tobacco industry efforts subverting the International Agency for Research on Cancer’s second-hand smoke study,” *Lancet* 2000;355:1253-9.
14. Hirschhorn N, “Shameful science: four decades of the German tobacco industry’s hidden research on smoking and health,” *Tobacco Control* 2000, in press.
15. Walsh B, Chapman S, “Eyes on the Prize: Transnational Tobacco Companies in China 1976-1997,” *Tobacco Control* 2000, in press.
16. Connolly GN, Wayne GD, Lymperis D, Doherty MC, “How cigarette additives are used to mask environmental tobacco smoke,” submitted for publication.
17. Muggli ME, Forstier JL, Hurt RD, Repace JL, “The Smoke You Don’t See: Uncovering Tobacco Industry Strategies Aimed Against Environmental Tobacco Smoke,” submitted for publication. §

Continued from page 1

## ... Bangladesh

American Tobacco (BAT), creating a proliferation of highly promoted BAT products. While cigarette imports have historically been banned in Bangladesh, an exception was made a few years ago for Benson & Hedges, and other imported brands are widely available through smuggling. And, while tobacco ads are banned on electronic media, they are ubiquitous on billboards, in newspapers, as handbills, and as banners advertising a free cigarette for each empty pack. In addition, Bangladesh is flooded with Bengali-language tobacco ads on various satellite TV stations originating in India.

BAT — essentially the only transnational operating in Bangladesh — both widely promotes cigarettes and attempts to portray a positive image through activities such as donating tree seedlings and sponsoring benefit concerts for

See *Bangladesh*, page 7

1. Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE, “The Cigarette Papers,” Berkeley: University of California Press, 1996.
2. Coughlin PJ, Janacek FJ, “A Review of R.J. Reynolds’ Internal Documents Produced in Mangini vs. R.J. Reynolds Tobacco Company, Civil Number 939359 — The Case that Rid California and the American Landscape of ‘Joe Camel,’” February 1998, <www.library.ucsf.edu/tobacco/mangini/report>
3. Hurt RD, Robertson CR, “Prying open the door to the tobacco industry’s secrets about nicotine,” *JAMA* 1998;280:1173-81.
4. ASH/UK, “Tobacco explained,” and “Big Tobacco and women,” 1998, <www.ash.org.uk>
5. Cannon J, “The Y-I papers,” 8 October 1998, <www.tobacco.org> [BAT’s use of high-nicotine variety tobacco plants.]
6. ASH (UK) and Imperial Cancer Research Fund, “The safer cigarette: what the tobacco industry could do...and why it hasn’t done it. A survey of 25 years of patents for innovations to reduce toxic and carcinogenic chemicals in tobacco smoke,” 3 March 1999, <www.ash.org.uk/papers/patent.html>

## WHO Unveils Framework Convention on Tobacco Control (FCTC)

by Dr. Douglas Bettcher and Mr. William Onzivu, Tobacco Free Initiative, WHO, Geneva

Tobacco use kills 4 million people each year worldwide. The World Health Organization (WHO) estimates that, given current trends, by 2030, tobacco-related diseases will cause 10 million deaths annually – with 70 percent of these deaths occurring in low- and middle-income countries. On becoming director general of WHO in 1998, Dr. Gro Harlem Brundtland recognized that the tobacco epidemic cannot be halted by isolated efforts of governments, national nongovernmental organisations (NGOs) or media advocates. This truly international problem requires an international response, she discerned, and designated WHO's development of a Framework Convention on Tobacco Control (FCTC) and related protocols a high-priority step to address this challenge.



The FCTC's success depends heavily on sustained political support from governments, global institutions and society. In May 1999, WHO's World Health Assembly established a working group and an intergovernmental negotiating body to develop and negotiate the Framework Convention. The first working-group meeting from 25-29 October 1999 in Geneva led to a series of broad draft elements and possible protocols for the proposed convention. Convening in Geneva from 27-29 March 2000, the second working group elaborated on these proposals, identified areas of general agreement, and proposed options for consideration by the World Health Assembly and the intergovernmental negotiating body, which will meet for the first time this year in Geneva from 16-21 October. WHO member states and observers, including NGOs, can participate in the negotiating body, whose role is to draft and negotiate the FCTC and possible related protocols.

Among the key issues to be addressed by the Framework Convention and future related protocols are: harmonisation of tobacco prices; discontinuation of duty-free tobacco products; a possible ban on all advertisement and sponsorship; standardisation of test methods; package design and labelling consonant with public health goals; elimination of subsidies for tobacco production; smuggling; and information sharing.

Experts worldwide agree that the central issue in tobacco control is demand reduction to promote public health goals; simultaneously, they appreciate the need to attend to the social, economic and agricultural implications, even though these are long-term issues. Defining strategies that link the global and national dimensions of tobacco control is also important. Such strategies require concerted multisectoral initiatives – with NGOs such as CECHE acting as crucial catalysts both at the national and international levels to promote the development and successful implementation of the FCTC. §

Continued from page 6

### ... Bangladesh

charitable groups. It also engages in disinformation campaigns. At a press conference in March 2000, BAT claimed that there is no sound scientific evidence that tobacco causes serious disease.

#### The Tobacco Control Landscape

Founded in 1997 to increase awareness of the dangers of smoking and prevent its spread, ADHUNIK has been Bangladesh's lead organization in tobacco control, holding the first national seminar on tobacco in 1988. Listed among ADHUNIK's early successes are the ban on tobacco advertising in electronic media, bans on smoking on domestic flights, health warnings on cigarette packs and an increase in tobacco taxes. Other organizations, including the Bangladesh Cancer Society and the National Non-Smokers' Forum, advocated tobacco control in the 1980s and 1990s, but a shortage of resources limited their capacity to influence government action.

The tobacco control movement in Bangladesh began in earnest in the fall of 1999 with the formation of the Bangladesh Anti-Tobacco Alliance (BATA). BATA has 15 members, including health, anti-drug, women's and development organizations. The alliance meets regularly, and its successes include a January 2000 High Court directive requiring that the government pass a series of tobacco control measures in Bangladesh.

Currently, BATA is drafting tobacco control legislation for submission to the government, and it hopes to play a role in the enforcement of

any legislation enacted. Key policies under review are: putting stronger and larger warnings on cigarette packs; banning tobacco promotion and sponsorship; and providing more protection to non-smokers. BATA will also lobby for higher taxes and for various measures to ensure that the public – literate and illiterate – has sufficient knowledge to make an informed choice about tobacco use.

But BATA faces manifold challenges. As the country's single largest taxpayer, BAT has major influence on government action, whereas BATA has a minimal budget, no full-time staff and no office, and cannot afford the media needed to reach a largely illiterate population. (The adult literacy rate in Bangladesh is 50.1 percent for men and 37.6 percent for women.)

One key lesson from the Bangladeshi experience is that networking among different organizations is highly effective. By forming BATA and convening regular meetings, Bangladeshi nongovernmental organizations can now respond far more quickly and effectively than in the past to actions of tobacco companies and to invitations from the government for participation. While coalitions certainly have their problems, they can make the difference between scattered and largely ineffective efforts, and a mass movement capable of mobilizing the public and politicians to control the tobacco epidemic. BATA members hope that tobacco

consumption statistics in Bangladesh will soon reflect the growing importance being placed on sound policies and a strong tobacco control movement. §

The *Monitor* is published by the:  
Center for Communications, Health, and the  
Environment (CECHE)  
4437 Reservoir Road, N.W.  
Washington, DC 20007  
Tel: (202) 965-5990, Fax: (202) 965-5996  
E-mail: [ceche@gc.org](mailto:ceche@gc.org)  
Web Site: <http://www.ceche.org>

**Board of Directors:**  
Dr. Sushma Palmer, *Chairman*  
The Hon. Mark Palmer, *Vice Chairman*  
Dr. C. Wayne Callaway, *Director*  
Mr. Leonard Silverstein, *Director*

**Advisory Board:**  
Stuart Auerbach  
*The Media Development Loan Fund, Washington, DC*  
Ranjit Kumar Chandra, M.D., FRCPC,  
*Janeway Child Health Centre, St. John's, Newfoundland*  
Paula J. Dobriansky, Ph.D.,  
*The Council on Foreign Relations, Washington, DC*  
Stephen Gehlbach, M.D.,  
*University of Massachusetts at Amherst, MA*  
Bernard Goldstein, M.D.,  
*Environmental and Occupational Health Sciences Institute,  
Piscataway, NJ*  
Richard Havel, M.D.,  
*Cardiovascular Research Institute, University of California,  
San Francisco*  
Laurence Kolonel, M.D.,  
*Cancer Research Center of Hawaii, Honolulu*  
Phyllis Magrab, Ph.D.,  
*Georgetown University Child Development Center,  
Washington, DC*  
Antonia Trichopoulos, M.D.,  
*Athens School of Hygiene, Athens, Greece*

Editorial & Design Consultant, Valeska Stupak  
Graphic Artist, Kathy Lewis

# Tobacco Control Policies Build on Centuries of Wisdom

by Dr. Judith Mackay, FRCP, Asian Consultancy on Tobacco Control, Hong Kong, China

The earliest recorded use of tobacco was in America in the first century B.C.; but it was centuries later that “tobacco control” began to surface. One of the first warnings came in the 1600s from Chinese philosopher Fang Yizhi, who said that prolonged smoking “scorches one’s lung.”

The first tobacco control regulation was issued in Bhutan in 1729, banning tobacco use in all religious places. (It is still observed today.) In 1761, the first study on the harmful effects of tobacco took place in England. And, almost 200 years later, in the 1950s, the new scientific era of investigation commenced in England and the United States, followed in 1981 by the publication of the first major study on passive smoking by Takeshi Hirayama in Japan.

## Tobacco Control Faces Challenge

Despite centuries of knowledge, decades of action, multiple World Health Assembly resolutions and numerous global, regional, national and sub-national conferences, the number of tobacco users around the globe is increasing, more children are becoming addicted, more people are dying, and economic costs are escalating. To boot, the epidemic is invading poorly prepared developing countries, which by 2030, will house 85 percent of the world’s smokers.

More optimistically, the systems that will eventually reduce this epidemic are being put into place around the world. In general, tobacco control in developed countries is far ahead of that in developing ones, but not uniformly so (see Global Trends...p. 1). For example, legislation in Singapore, Fiji, Hong Kong, Mongolia, South Africa, Thailand and Vietnam is far stronger than that in several Western countries.

The need for government leadership and tobacco control policies is surprisingly similar worldwide. Even the challenges and obstacles are alike – the focus of health professionals on curative medicine... the hesitation of governments to act firmly... a preoccupation with other illnesses that cause far fewer deaths... lack of funds.

But the most formidable opposition is the tobacco industry, whose global tactics include employing powerful legal firms, public relations companies, lobbyists and front groups to present their arguments, create and place advertising, and facilitate lucrative sponsorships. The industry also recruits scientists to challenge health facts,

funds officials and political parties, and argues for voluntary agreements instead of legislation. In addition, it attacks price increases, bans on tobacco promotion and the creation of smoke-free areas in public places – suggesting that these are highly effective measures. Conversely, the industry ignores (or even supports) health education in schools, health warnings, and bans on sales to minors, indicating that these are largely ineffective measures, albeit useful first-step actions for governments embarking on a tobacco control policy. The industry also invokes “freedom of choice” arguments to oppose restrictions on advertising and marketing in places as diverse as South Africa and Hong Kong.

## Tobacco Control Benefits Economies

The tobacco industry warns that control measures will damage the economy, cause job losses and decrease tax revenue. In fact, tobacco control measures are unlikely to hurt current tobacco farmers, because any reduction in tobacco consumption lies decades ahead, giving ample opportunity for an orderly reduction in production. Other job and tax losses are also unlikely, since when people don’t spend money on tobacco they spend it on other goods and services. Conversely, if no action is taken,

## WHO Leads the Way

In 1998, WHO’s then newly appointed Director General Dr. Gro Harlem Brundtland created the WHO Tobacco-Free Initiative (TFI).

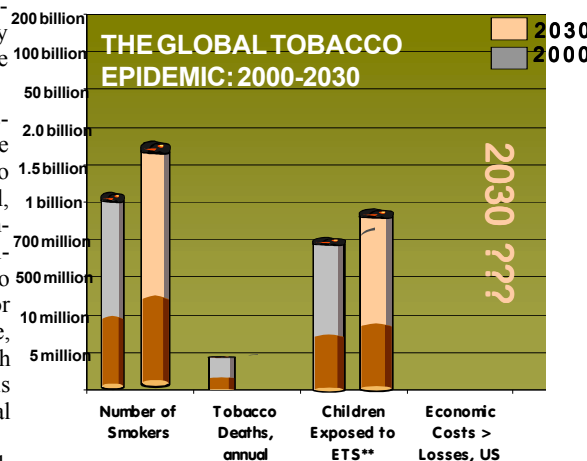
The TFI has increased visibility, staffing and funding for tobacco, and spawned new initiatives relating to legislation, taxation youth programmes, media and nongovernmental organisation (NGO) advocacy. New partnerships have been forged within WHO, and among WHO and the World Bank, UNICEF, the International Monetary Fund, NGOs, women’s groups, the pharmaceutical industry and funding agencies.

Indeed, tobacco has been discussed by WHO at the highest levels – the World Economic Forum in Davos (1999) and the Ninth International Conference of Drug Regulatory Authorities in Berlin (1999). Within the United Nations (UN), an Ad Hoc Intra-Agency Task Force On Tobacco Control has been established. “Tobacco Control for China in the 21st Century,” a collaborative effort of WHO, the World Bank, Centers for Disease Control, Health Canada and Johns Hopkins University with the Chinese Ministry of Health and the Chinese Academy of Preventive Medicine, exemplifies country-level action. WHO’s proposed international Framework Convention on Tobacco Control (FCTC), which signifies the trans-border cooperation required to address the global tobacco epidemic, will be the organisation’s first convention and global agreement devoted entirely to tobacco control within the UN system. (See WHO... p.7.)

Already, the tobacco industry has reacted, arguing that “WHO is behaving like a ‘super-nanny’... and will destroy the livelihoods of farmers in developing nations.” – good signs that the effort is working. Meanwhile, the industry is trying to reposition itself to secure public support, responding to its tarnished image from exposure of internal industry documents. (See Industry...p.6.) Until the industry acknowledges the health hazards of tobacco, accepts regulation and ceases to obstruct tobacco control measures, however, neither governments nor the public health community can risk industry involvement in policy making – in decisions that affect the lives of millions and the future of generations to come. §



...Heard on the Worldwide Web



\* Assuming current tobacco control trends continue

\*\* Environmental Tobacco Smoke

millions of jobs will indeed be lost – by the smokers who die each year, with economic consequences for their families.

The 1999 World Bank report “Curbing the Epidemic” marks the first time a major financial institution has supported policies designed to reduce tobacco demand. The document argues that tobacco control is good for the wealth as well as the health of nations; that it does not lead to loss of taxes or jobs; and that tobacco control measures (e.g., price increases, advertising bans, smoke-free areas, health education and pharmaceutical assistance in quitting) are cost-effective in both industrialized and developing countries.