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Tobacco or health

Report by the Director-General

In May 1989 the Health Assembly, by resolution WHA42.19, approved a plan of action for "tobacco or health" (1988-1995) proposed by the Director-General and endorsed by the Executive Board. The "tobacco or health" programme, which as a consequence of the restructuring process at headquarters has recently been relocated in the programme on substance abuse, was subsequently the subject of specific requests to the Director-General for additional measures in resolutions WHA43.16 (1990), WHA44.26 (1991) on smoking and travel, and WHA46.8 (1993) on use of tobacco within United Nations system buildings.

The present document reports on developments in the last two years relating to the implementation of the above-mentioned resolutions. It takes into account the discussion of the Executive Board at its ninety-fifth session, to which an earlier version of the report was submitted (document EB95/27). During its discussion, the Executive Board adopted resolution EB95.R9 on an international strategy for tobacco control, recommending a resolution for adoption by the Health Assembly.

CONTENTS

I. INTRODUCTION

1. During the past few years, several Health Assembly resolutions concerning "tobacco or health" have emphasized WHO's main orientations in this area, which are listed in a plan of action for the period 1988-1995[1] proposed by the Director-General, endorsed by the Executive Board, and approved by the Health Assembly in May 1989 (resolution WHA42.19). Subsequent resolutions have formulated specific requests to the Director-General for additional measures and for regular reporting on the implementation of certain activities.

2. This document reports, as requested by the Health Assembly, on the implementation of the following resolutions:

Resolution WHA43.16 (1990) on "tobacco or health" requested the Director-General to monitor and report biennially to the Health Assembly on the progress and effectiveness of Member States' comprehensive tobacco control programmes. The report for 1993-1994 is contained in section II below. The section is organized according to the main programme activities, as outlined in the plan of action approved in resolution WHA42.19.

Resolution WHA44.26 (1991) on smoking and travel requested the Director-General to keep the Executive Board and the Health Assembly informed of the progress made in implementing it as an element of the WHO "tobacco or health" programme. The relevant report is contained in section III.

Resolution WHA46.8 (1993) on use of tobacco within the United Nations system buildings, requested the Director-General to report to the Forty-eighth World Health Assembly on progress in its implementation. A report on progress to date is given in section IV.

Finally, actions that the Executive Board may wish to take on "tobacco or health" matters are outlined in section V.

A report on the implementation of resolution WHA45.20 (1992) on multisectoral collaboration in WHO's "tobacco or health" programme, is given in document A48/33 (provisional agenda item 32.1).

3. In the meantime, in continuing the reform and restructuring process at headquarters, the Director-General decided to relocate the "tobacco or health" programme in the programme on substance abuse, with effect from 1 May 1994. This merger, which is reflected in the Ninth General Programme of Work, recognizes the importance of an integrated and comprehensive approach to problems associated with the use of all psychoactive substances. It is expected that WHO activities in this field will thus be considerably strengthened. A new plan of action for "tobacco or health" (1996-2000) will be prepared accordingly and submitted to our governing bodies for consideration.

II. PROGRESS AND EFFECTIVENESS OF MEMBER STATES' COMPREHENSIVE TOBACCO CONTROL PROGRAMMES

Strengthening national tobacco control programmes

4. Since 1970, the Health Assembly has adopted 13 resolutions on various "tobacco or health" issues. Taken together, they are a clarion call to Member States to adopt comprehensive national tobacco control policies. However, though several of these resolutions, especially those of 1986 (WHA39.14) and 1990

[1] Document WHA42/1989/REC/1, Annex 2, Appendix 2.

(WHA43.16), specify in some detail what should be included in national tobacco control policies, many Member States are experiencing great difficulty in determining how comprehensive national tobacco control programmes and policies are to be achieved.

5. In response to this situation, WHO's regional offices and its "tobacco or health" programme at headquarters have devoted considerable effort to providing on-site advice and assistance to Member States, working along with public health officials in various countries to solve the central problem of tobacco control. In 1993 and 1994, WHO continued to provide on-site advice and assistance in the development of tobacco control policies to Member States (Albania, China, Côte d'Ivoire, Czech Republic, Lao People's Democratic Republic, Latvia, Moldova, Poland, Singapore, Slovakia and Slovenia). Sometimes these were one-person missions; in other cases a team of experts, drawn from WHO, other Member States and/or various international agencies, provided advice and assistance. In all cases, WHO was responding to requests from Member States for support in strengthening their tobacco control policies.

6. In addition to country missions, regional meetings and plans of action have also been developed to encourage strengthening of national tobacco control programmes and polices. A revised *Action plan for a tobacco-free Europe* was issued in 1993 by the Regional Office for Europe, which also sponsored the third and fourth in a series of annual seminars on tobacco control (Austria, 1993 and Sweden, 1994). These seminars brought together WHO "tobacco or health" focal points from most European Member States to plan strategies for national tobacco control. In the Western Pacific Region a meeting was held in the spring of 1994 to develop a regional plan of action, which was reviewed by the Regional Committee and issued in the autumn of 1994; it is noteworthy that the Regional Director has publicly stated that he will be advocating a "tobacco-advertising-free Western Pacific Region by the year 2000" as an important feature of the regional "tobacco or health" policy. The All-Africa Conference on Tobacco Control (Zimbabwe, November 1993) has led to heightened interest in tobacco control issues throughout the African Region. Regional advisers on "tobacco or health" issues in all regions have continued to provide as much assistance as possible to Member States requesting help in strengthening national tobacco control programmes.

7. The potential worth of these activities is beyond dispute. Comprehensive tobacco control involves changes in health-care, social, economic and legal structures. In all these domains, each country has unique structures and systems. General principles derived from international tobacco control experience cannot be applied directly, but must be adapted to each national situation. While publications and international conferences can help, there is no substitute for implementing tobacco control activities where they count the most - in each country. Successful national experiences also serve as good examples for other countries to emulate.

8. As a result of WHO "tobacco or health" missions, policy changes have been tangible in many countries. In others, awareness of how to implement tobacco control policies has increased, and the missions may yet pay further dividends in the form of future policy and programme changes.

9. There are many examples of strengthened tobacco control policies that have been implemented following WHO missions. In most cases, support from WHO probably supplemented national forces that were already at work to promote improvements in tobacco control policy. In Nepal, which benefited from a WHO "tobacco or health" mission in 1992, there are now effective controls on smoking in public places, workplaces and transit vehicles. Tobacco taxes have also been increased, with the new revenue going to finance desperately needed improvements in health care and health protection. In China, a partial ban on tobacco advertising is in force and smoking has been banned on flights on passenger aircraft. New draft regulations have been introduced to extend the current restrictions on tobacco advertising to a near-total ban. Full-time "tobacco or health" policy coordinators have been appointed to the health departments in India (1992 "tobacco or health" mission) and Côte d'Ivoire. India is now attempting to ban all tobacco advertising and extend effective tobacco tax collection to all tobacco products. In Slovakia, a ban on tobacco advertising has been passed by the legislature, and a stepped-up enforcement strategy is now in place to help move

towards full implementation of the law. Lithuania (1992 "tobacco or health" mission) has adopted comprehensive tobacco control legislation. Since the 1993 All-Africa Conference, comprehensive tobacco control legislation has been proposed by the new Government of South Africa. These are only a few of the many examples of tobacco policies that have been strengthened following WHO "tobacco or health" missions to countries.

10. It has been demonstrated that WHO can successfully assist Member States to strengthen their tobacco control policies and programmes. But a great deal of work remains to be done. Tobacco control policies are vigorously opposed, mainly by the tobacco industry, wherever their implementation is attempted. The result is that comprehensive policies that meet all or nearly all of the recommendations of the Health Assembly exist in only a very few countries.

11. Clearly, WHO cannot by itself expect to strengthen tobacco control everywhere by visiting Member States one at a time. It would welcome partnerships with other agencies to ensure that all Member States can get the expert advice and assistance they need from international sources to help them develop and maintain strengthened national tobacco control policies and programmes. Through concerted international collaboration to provide on-site expert advice and assistance in implementing tobacco control strategies, all WHO Member States could eventually take advantage of the opportunity to implement the comprehensive tobacco control policies that have been recommended by the Health Assembly.

Promotion, public information and education

12. The quarterly newsletter *Tobacco Alert*, with worldwide distribution to those concerned with "tobacco or health" issues, continues to be a highly successful tool of health promotion and public education on tobacco issues. In 1993-1994, a series of six issues, each devoted to one WHO region, was produced.

13. Annual observance of World No-Tobacco Day in all WHO Member States is growing in importance as a significant means of health promotion and education. The theme of World No-Tobacco Day 1993 was tobacco-free health services and in 1994 it was the media and tobacco. Planning is now under way for successful celebration of World No-Tobacco Day 1995 on the theme of the economics of tobacco control. Each year, research is conducted on the specific theme selected for the occasion and relevant information is widely distributed.

14. Participation in international conferences such as the Third International Conference on Preventive Cardiology (Oslo, June 1993), the All-Africa Conference on Tobacco or Health (Harare, November 1993), the Fifth International Conference on Reduction of Drug-Related Harm (Toronto, March 1993), the Global Congress on Lung Health (Germany, June 1994) and the Ninth World Conference on Tobacco or Health (Paris, October 1994) has enabled WHO to stimulate health professionals, and others concerned in the fight against tobacco use, to become more effective advocates for strengthened tobacco control policies and programmes.

WHO "tobacco or health" data centre

15. In order to facilitate the monitoring of progress in global, regional and national tobacco control programmes, WHO has established a data centre for routine epidemiological surveillance. Data are systematically collected from a variety of sources on tobacco production, consumption and trade, prevalence and health effects of smoking, and national tobacco control activities, from which WHO has prepared a comprehensive assessment of the "tobacco or health" situation at national, regional and global level in the early 1990s, with trend data for many indicators going back to the 1960s. This assessment, the first in a series of biennial reports, provides a global and regional overview as well as brief country profiles for all Member States, prepared according to a standard format. WHO expects to publish it early in 1995.

16. A summary of trends in cigarette consumption for WHO regions is given in Table 1. 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).

17. The gap is rapidly narrowing, however. In 1970-1972, consumption per adult in the developed countries was 3.25 times as high as 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.

18. There have been very noticeable differences in trends between 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 1900 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*).

19. WHO estimates that there are about 1100 million regular smokers in the world today (see Table 2). About 300 million (200 million males, 100 million females) are in the developed countries, and nearly three times as many (800 million, almost all males) in developing countries. Globally, 30% of all adults (48% of men, 12% of women) are regular smokers. In the 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.

20. These estimates for developing countries are very tentative, since in many cases reliable data on tobacco use, representative of the entire population, are not available. Given the importance of reliable prevalence data for baseline assessment of the extent of tobacco use and their relevance for predicting future mortality from tobacco, methods for rapid assessment are urgently required. WHO is in the process of issuing guidelines to assist Member States, particularly in developing regions, with their data collection.

21. 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, United Kingdom. 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.[1] 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, 4% of female deaths (see Table 3)). 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 compared with average life expectancy. During the 1990s, the report estimates that almost two million people a year will die from smoking in the developed countries (1.44 million men, 0.48 million women). A summary of the trends in deaths from smoking is given in Table 3.

[1] Peto, R., Lopez, A.D. et al. *Mortality from smoking in developed countries, 1950-2000.* Oxford University Press on behalf of the World Health Organization and the Imperial Cancer Research Fund, 1994.

22. In addition to this appalling toll of mortality from active smoking, passive or involuntary exposure to tobacco smoke has been shown to increase the risk of disease in non-smokers. In the United States of America, environmental tobacco smoke is estimated to be the cause of around 3000 lung cancer deaths a year in non-smokers, representing 2% of all lung cancer deaths in that country. In populations with similar exposure patterns for non-smokers, the proportionate mortality among non-smokers is likely to be similar. As a consequence, environmental tobacco smoke has been classified as a Group A carcinogen by the United States Environmental Protection Agency. Exposure to environmental tobacco smoke among children has been shown to increase the risk of lower-respiratory-tract infections, including bronchitis and pneumonia, and to increase the severity and frequency of symptoms in asthmatic children. Exposure to cigarette smoke is a leading cause of the sudden infant death syndrome and is associated with a significant reduction in lung functions. It is also likely that exposure to environmental tobacco smoke increases the risk of other diseases causally related to smoking, particularly major cardiovascular diseases. However, in this case the nature and magnitude of the risk is still uncertain and further epidemiological research is required in order to better document it.

23. The health consequences of tobacco use, particularly cigarettes, are much more difficult to estimate in developing countries owing to lack of data. Currently, it is estimated that tobacco causes about one 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 4). The chief uncertainty is not whether, but rather when these deaths will occur if current trends in tobacco use persist.

24. In order to assist developing countries to monitor more reliably the evolution of their tobacco epidemics, WHO, in collaboration with the University of Oxford, has established a global network of prospective epidemiological studies covering all regions. These studies will yield valuable information on the evolution of mortality risks from tobacco use over the next few decades and should serve as a key information source for national tobacco control programmes. At the same time, WHO has been engaged with IARC in establishing a network of case-control studies in Africa to provide data about the current impact of tobacco use on cancer rates in that region.

III. SMOKING AND TRAVEL

25. As requested in resolution WHA44.26, adopted by the Health Assembly in 1991, the Director-General has been collaborating with ICAO on the question of smoking on aircraft. With some encouragement from WHO, the twenty-ninth session of the Assembly of the International Civil Aviation Organization, in October 1992, adopted a resolution, urging all contracting States:

> *to take necessary measures as soon as possible to restrict smoking progressively on all international passenger flights with the objective of implementing complete smoking bans by 1 July 1996.*

The same resolution also requested the ICAO Council:

> *to intensify its studies into the safety aspects of banning smoking on board aircraft*

and:

> *with the assistance and cooperation of the World Health Organization, to take appropriate measures to promote a smoke-free travel environment on all international flights.*

26. ICAO has now completed a detailed study of the safety aspects of banning smoking on aircraft and will submit to its governing bodies, the conclusion that there is no technical impediment nor legitimate safety concern that stands in the way of implementing a ban on smoking on international flights by 1 July 1996.

27. WHO officials have been working closely with their counterparts in ICAO and with ICAO consultants on promoting smoke-free air travel. At least one Member State has already implemented the smoking ban on both its national and its international passenger flights. Many Member States and many airlines are progressively increasing access to smoke-free air travel. For outstanding progress in this area, a number of airlines have been awarded a Tobacco or Health medal (Aeroflot, 1988; Northwest Airlines, 1988; Civil Aviation Administration of China, 1989; Saudia, 1989; Zambia Airways, 1990; Air Canada, 1991; Egyptair, 1992; Thai Airways International, 1992; Royal Jordanian Airlines, 1993; Zimbabwe Airlines, 1993; Air Botswana Corporation, 1993; Cathay Pacific, 1994; Gulf Air Company, 1994). WHO will continue to collaborate closely with ICAO to do all that is possible to ensure successful and timely implementation of the proposed ban on smoking on all international flights by 1 July 1996.

IV. USE OF TOBACCO WITHIN UNITED NATIONS SYSTEM BUILDINGS

28. In 1993, the Health Assembly adopted resolution WHA46.8, calling on the Director-General to approach the Secretary-General of the United Nations, urging him:

> *(1) to take the necessary steps to ban the sale and use of all kinds of tobacco products in all buildings owned, operated or controlled by organizations and specialized agencies of the United Nations system and that are used to carry out its business;*
>
> *(2) to ensure that the progressive implementation of this ban takes a maximum of two years from the date of this Health Assembly;*
>
> *(3) to encourage and assist employees who are smokers, but who wish to cease smoking, to take part in smoking cessation programmes, and to provide sheltered open-air areas for those who wish to continue smoking.*

The Director-General was further requested to report on progress in the implementation of this resolution to the Forty-eighth World Health Assembly, in 1995.

29. Resolution WHA46.8 has been transmitted as requested, to the Office of the Secretary-General, which has written acknowledging its receipt. In 1994 the Economic and Social Council of the United Nations, in resolution 1994/47, also requested the Secretary-General to coordinate the implementation of resolution WHA46.8. The office of the United Nations Under-Secretary-General responsible for coordination is now seeking to ensure that it is effectively implemented.

30. With some encouragement from WHO, the buildings of UNICEF and the World Bank and the new headquarters of the United Nations High Commissioner for Refugees are now also virtually smoke-free. The Director-General has written to heads of organizations of the United Nations system encouraging them to work with WHO towards smoke-free work environments in United Nations system workplaces. They have also been requested to appoint a member of their staff to collaborate with WHO in examining closely how to achieve smoke-free environments in their office or agency. It is expected that the proposed ban on smoking in workplaces will be implemented by mid-1995 in offices of the United Nations and its specialized agencies.

V. MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

31. The Executive Board, when considering this item at its ninety-fifth session, noted that tobacco control was unquestionably a major global health problem and commended WHO efforts in the field of tobacco or health, despite the shortage of human and financial resources. Recognizing the need to give priority to "tobacco or health", it was recalled that several countries had expressed a desire for the Organization's support in that area. The Health Assembly is invited to consider adoption of the resolution recommended by the Executive Board in its resolution EB95.R9[1] in support of an international strategy for tobacco control and the strengthening of WHO's capacity in the field of tobacco or health.

[1] Document EB95/1995/REC/1.

TABLE 1. GLOBAL AND REGIONAL ESTIMATES AND TRENDS OF CIGARETTE CONSUMPTION, 1970-1972 TO 1990-1992

	Cigarettes per adult			Annual % change		
	1970-1972	1980-1982	1990-1992	1970-1972 to 1980-1982	1980-1982 to 1990-1992	1970-1972 to 1990-1992
WHO regions						
Africa	460	560	540	2.0	-0.4	0.8
The Americas	2 600	2 490	1 870	-0.4	-2.9	-1.6
Eastern Mediterranean	730	930	910	2.4	-0.2	1.1
Europe	2 280	2 470	2 290	0.8	-0.8	0.0
South-East Asia	640	960	1 150	4.1	1.8	2.9
Western Pacific	1 140	1 600	2 000	3.4	2.2	2.8
More developed countries	2 670	2 770	2 400	0.4	-1.4	-0.5
Less developed countries	820	1 160	1 370	3.5	1.7	2.6
World	1 450	1 650	1 640	1.3	-0.1	0.6

TABLE 2. ESTIMATED NUMBER OF SMOKERS IN THE WORLD (MILLIONS), EARLY 1990s

	Males	Females	Total
Developed countries	200	100	300
Developing countries	700	100	800
World	900	200	1 100

TABLE 3. ESTIMATED NUMBER OF DEATHS FROM SMOKING IN DEVELOPED COUNTRIES, 1955-1995

	Males			Females		
	Number (thousands)	% of:		Number (thousands)	% of:	
		All deaths	Deaths at ages 35-69		All deaths	Deaths at ages 35-69
1955	447	10	20	26	<1	2
1965	793	17	28	70	2	4
1975	1 119	21	31	165	3	7
1985	1 369	24	35	317	6	11
1995 (projected)	1 442	25	36	476	9	13
1950-2000	52 million	20	30	10.5 million	4	7

TABLE 4. ESTIMATED NUMBER OF DEATHS CAUSED EVERY YEAR BY TOBACCO

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

FIGURE 1. RELATIVE CHANGE IN CIGARETTE CONSUMPTION (DEVELOPED AND DEVELOPING COUNTRIES)

(Ratio of cigarette consumption per adult in developed countries to that in developing countries)

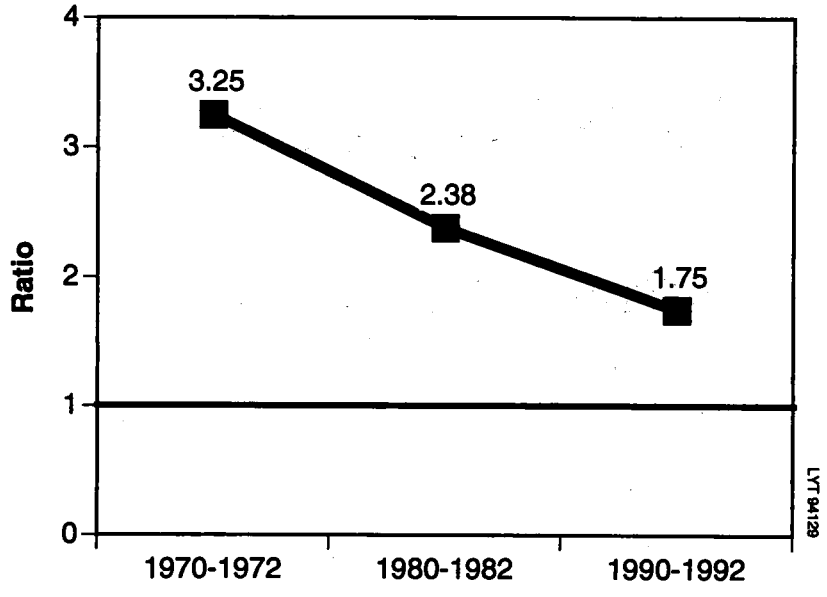
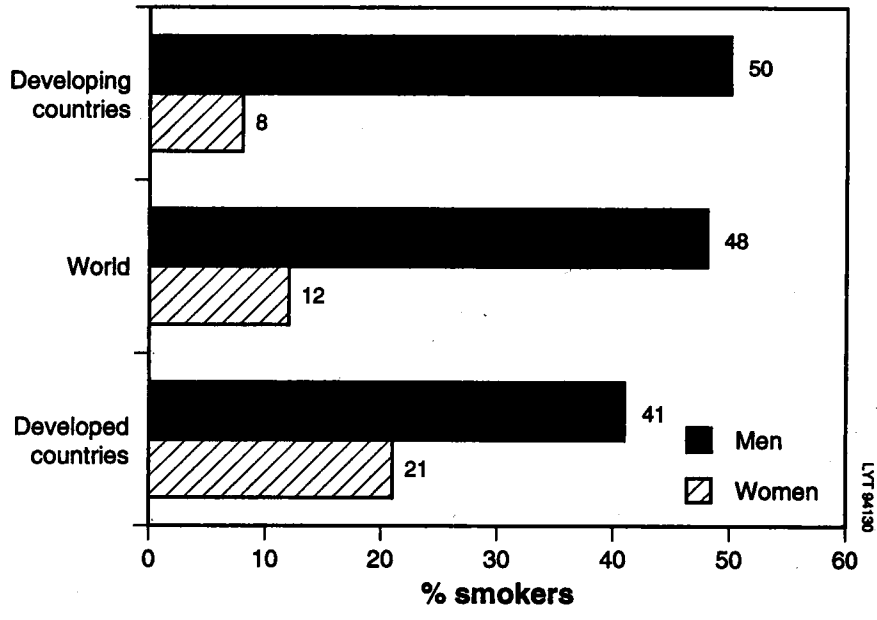


FIGURE 2. SMOKING PREVALENCE IN DEVELOPED AND DEVELOPING COUNTRIES, MEN AND WOMEN, 15 YEARS OF AGE AND OVER, EARLY 1990s



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