

# A worldwide problem: **tobacco**

## The problem

### Tobacco products kill its users

For a good overview of the tobacco epidemic, here is the *WHO World Health Report 1999* chapter on tobacco:

<http://www.who.int/whr/1999/en/pdf/Chapters.pdf>

The current and future health burden of tobacco:

<http://www5.who.int/tobacco/page.cfm?sid=47>

Country-specific information is available on CDC's National Tobacco Information Online System (NATIONS):

<http://apps.nccd.cdc.gov/nations/index.asp>

For a lot of good information about tobacco industry behaviour see

the ASH London site:  
<http://www.ash.org.uk/>

Information about the tobacco industry documents and how to search them is available in

the Denormalization section of the NCTH website.  
<http://www.ncth.ca/NCTHweb.nsf/Menu/129C682000236817852569BD0048C997?OpenDocument>

Another resource comes from the *Journal Tobacco Control*:

[http://tc.bmjournals.com/content/vol11/suppl\\_1/](http://tc.bmjournals.com/content/vol11/suppl_1/)

Spending on tobacco advertising and promotions in the US reached \$9.57 billion in 2000: the FTC report is available at:

<http://www.ftc.gov/os/2002/05/2002cigrpt.pdf>

The use of tobacco is estimated to be the direct cause of about **70 million deaths between 1950 and 2000**. These deaths occurred for the most part among men living in rich countries. But smoking patterns have changed and the deaths now are occurring among both men and women, in both high and low income countries.

Currently, more than 1.1 billion people smoke and hundreds of thousands more use smokeless tobacco. Indeed, if we make no impact on current tobacco use trends, we can expect **450 million deaths over the next 50 years**. Since 1970, women's smoking has grown and tobacco use has expanded dramatically in the other parts of the world. New users are younger. This means that deaths to be foreseen will start occurring when people are in their 30s and 40s.

The victims of tobacco use don't die of something called tobaccoitis – they die of the diseases of modern society: **cancers, heart diseases, respiratory diseases**. In the West, heart diseases cause the greatest number of tobacco-related deaths; in Asia, the greatest number is from respiratory diseases. About a third of all cancer deaths throughout the world are caused by or related to tobacco use.

### Tobacco use is encouraged by a powerful industry

The international tobacco companies have worked on the apparently true premise that influence peddling, obfuscation and deception will allow individuals and communities to support the idea that tobacco use is a reasonable human behaviour, and not to "notice" the deaths that are caused by it. As a result, societies now wring their hands over the dilemma of childhood or adolescent smoking without actually dismantling the processes that cause childhood smoking: positive social values given to tobacco and promoted by the tobacco industry, culturally defined benefits of tobacco use and adult modelling of smoking behaviour.

### Tobacco use defies logic because of addiction

**Tobacco addiction is highly reinforced and does not adversely affect daily functioning**. Tobacco contains nicotine which has proven effects on the central nervous system. It is psychoactive, meaning it stimulates a rewarding sensation, and it produces various perceivable bodily changes such as increased heart rate and increased vigilance.



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For links to tobacco control covering every subject:  
<http://www.tobaccopedia.org/>

Here is information on treating tobacco dependence:  
<http://www.treatobacco.net/>

Together Against Tobacco from INGCAT:  
[http://www.ingcat.org/html/ngo\\_mobilisation.html](http://www.ingcat.org/html/ngo_mobilisation.html)

The press release on the latest report on ETS from the International Agency for Research on Cancer:  
<http://www.iarc.fr/pageroot/PRELEASES/pr141a.html>

The full report on ETS from the WHO:  
[http://www5.who.int/tobacco/repository/stp50/ETS\\_report.pdf](http://www5.who.int/tobacco/repository/stp50/ETS_report.pdf)

The IUATLD Guide for Tobacco Control and Prevention:  
<http://www.iuatld.org/pdf/en/tobaccoguide.pdf>

Risk reduction on stopping smoking:  
[http://www.globalink.org/tobacco/trg/Chapter22/Chapter22\\_CessationPage13.html](http://www.globalink.org/tobacco/trg/Chapter22/Chapter22_CessationPage13.html)

However, all of these effects are small – there is none of the euphoria produced by cocaine. There is no disconnection with reality, as occurs with inebriation from excessive alcohol use. Withdrawal can be stressful and uncomfortable, but does not resemble the extreme bodily harm that results from abrupt abstinence from heroin. However, tobacco addiction is more forcefully reinforced than any of the other substance addictions by a much larger proportion of its users. Unlike other psychoactive substances, tobacco can be and is used in many situations daily. Smokers in particular associate smoking with a broad variety of normal life activities, such as waiting, thinking, appreciating something, finishing an activity, engaging in an activity, feeling happy, sad, frustrated or lonely, etc. The end result is a strong dependence and not only minor social disapproval (as opposed to, say, inebriation).

One of the definitions of addiction is that information of the negative health effects of use do not impede continuing use of the substance. The tobacco industry has been very successful in confusing the issues around health effects but addiction is at work as well. Smokers rationalise (“I’m not smoking enough to hurt me”) or minimise the risks (“It is not that bad or else it would be illegal”), or find reasons why they personally, as opposed to other smokers, are not particularly at risk.

## **Passive smoking: all the old arguments fall apart**

Let us call it passive smoking, second-hand smoke exposure, environmental tobacco smoke (ETS) exposure – the issue of health damage is no longer between a person and his or her tobacco use. The evidence continues to fall into place – **exposing others to your smoke can make them sick, or even kill them.** Parental smoking can damage fertility and add health risks for the foetus, the newborn or the young child. Living or working with a smoker increases the risk of heart disease and cancer for a non-smoker. The rights of people to clean air become very pertinent. The tobacco companies together and separately have fought every inch of progress made in understanding the connections between disease and exposure to others' tobacco smoke, and continue to cloud our understanding of the extent of the problem.

## **Cessation works and reduces risks**

Addiction and positive social values notwithstanding, many smokers want to stop smoking. There may be less demand for stopping among users of other types of tobacco. There is a full panoply of actions that can help people to stop, or help them to get to a stage where they are ready to think about stopping. Policy is the framework for all tobacco control, and normative beliefs give life to social and individual change. Within that, cessation programmes provide the skills and tools for successfully changing this complex



behaviour. We cannot cure tobacco smoking but we can provide medications that ease withdrawal, cognitive and behavioural strategies to understand and confront the difficulties of changing behaviour, social and psychological support to encourage persistence and confidence in reaching the goal of cessation.

Stopping smoking is definitely worth the effort. Overall, the risks of dying prematurely continue to decline even if one stops after the age of 65, or after 40 years of smoking. It is best never to start, and if you start, your chances of having the same risks for chronic diseases of non-smoker levels occur only if you stop by the age of 30. Your chances of maintaining good lung health are best if you stop by the age of 40. Your excess risks decrease for heart diseases and cancers other than lung cancer if you stop smoking at any age.

The World Bank talks about the economic issues in "Curbing the Epidemic:" <http://www1.worldbank.org/tobacco/reports.asp>

## **Are there real benefits of tobacco use?**

Tobacco farming, tobacco product manufacturing, tobacco selling and related promotions all produce jobs. If tobacco use declines it will do so slowly – it has taken more than 50 years for the prevalence rates among men in rich countries to be halved – and the transition to other jobs would occur as it does when one industry declines and other industries grow. But the existence of tobacco-related jobs is not a necessity for a society.

The remarkable progress made in California is available in "The California Tobacco Control Program: A decade of progress. Results from the California Tobacco Survey, 1990-1999." <http://ssdc.ucsd.edu/tobacco>

As for individuals, we know that access to information brings with it for most smokers a great deal of ambivalence about the benefits they feel they get from smoking and the costs that they see accruing to it. The issue is not personal choice. The issue is clearing the air and providing a balanced field for conflicting information about tobacco. When society changes, individuals choose to change their behaviours. One need only look at California, whose smoking population has dropped to about 13% (both sexes) and, on the other hand, Vietnam, where 76% of men smoke and only 4% of women. These two areas are at different ends of the social value continuum. Many more settings resemble Vietnam than California. And the world's health and development will bear the burden.

## **Special populations**

Here is a good source of documents concerning global tobacco issues: <http://www.tobaccofreekids.org/campaign/global/>

Are some sectors of society more at risk than others, needing special emphasis? It all depends on where society is already. Clearly, in Vietnam the at-risk population is principally all the men (and boys), and for the future it is the women (and girls). High or growing social value for smoking is the case for many low revenue countries.

For an excellent look at the issue of poverty and smoking: <http://www1.worldbank.org/tobacco/tcdc/o41TOo62.PDF>

In California, there are social groups that have very few smokers. The children in those groups are much less at risk of starting smoking than other youngsters. People who do not stop smoking in such an environment often come from disadvantaged groups or are themselves more at risk of mental disorders or dysfunctional behaviour.



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In California and other states or countries with a similar history of enormous drops in smoking prevalence special, at-risk populations are pertinent and an essential target of tobacco control initiatives.

Read INWAT Europe's report on women and smoking at:  
<http://www.inwat.org/inpots.pdf>

In many European countries, where men's smoking rates are declining, the at-risk groups are principally located among young people.

In France for example, 48% of the 20-25 year olds smoke, making this a majority behaviour (being more visible than non-smoking). There is a great deal of concern about the large number of women (all ages) who remain smokers but this is still lower than the number of men who remain smokers, so they are both special at-risk populations.

Factsheets on pregnancy and smoking:  
<http://www.lungusa.org/tobacco/smosmpreg.html>

Pregnant women may be a special population in that they are often susceptible to temporary abstinence measures exclusively addressing the health of the foetus and special programmes are needed to extend that concern to health issues for the mother and for the environment of the newborn. But this would of course need to extend to any smoking adults in the family.

For a full understanding of the issues, and links to many other sites, go to Breed's Tobacco Activism Guide:  
<http://www.tobacco.org/Resources/lbguide.html#aa59>

People with smoking-related diseases, and to a lesser degree people with any health condition, can be considered a special population in relation to smoking. Stopping smoking can, for some vascular diseases, stop the progression of the disease more than any medication can. As for cancers, stopping smoking should benefit the effectiveness of treatment. As for respiratory diseases, stopping smoking can stop the accelerated decline in lung function but it cannot bring back the declines that have already occurred.

### **In sum**

The WHO Report on youth and tobacco:  
<http://www5.who.int/tobacco/repository/stp54/singreport.pdf>

**Anyone who is likely to be susceptible to starting smoking is part of a special population.** In most of the world, this means all children. In some special areas, this is reduced to sub-groups of the populations, those children living with disadvantages, or low social skills

For resource papers related to tobacco control in developing countries:  
<http://www1.worldbank.org/tobacco/tcdc.asp>

**Anyone who uses tobacco or is exposed to tobacco smoke needs protection and is part of a special population.** For all smokers, changing to a smokeless tobacco product or reducing tobacco consumption with the aid of nicotine replacement products are being seriously debated as harm reduction measures but no consensus now exists on these issues in the health community.



## Tobacco Control: Responses to the Problem

See the Campaign for Tobacco-Free Kids factsheet on the impact of tobacco taxation at:

<http://tobaccofreekids.org/research/factsheets/pdf/0146.pdf>

Tobacco industry involvement in tobacco smuggling is a major international issue. Here is a report from the Nation magazine in the US on smuggling in Colombia: <http://www.thenation.com/docPrint.mhtml?i=20020506&s=schapiro>

A report from Christian Aid on BAT's treatment of tobacco farmers in Brazil: <http://www.christian-aid.org.uk/indepth/0201bat/index.htm>

Here is a good source of information about policy from Physicians for a Smoke-free Canada: [http://www.smoke-free.ca/eng\\_research/pscresearch\\_papers.htm](http://www.smoke-free.ca/eng_research/pscresearch_papers.htm)

For information about the social meaning of smoking, look at this site: <http://www.ncth.ca>

A report on Denormalization in Canada: <http://ism2000.cba.hawaii.edu/ism-lava.htm>

### Legislation

Legislative measures are the base upon which social change can be built. They must be well crafted so that the spirit of the law can be enforced. The tobacco industry should have no role in the legislative process for it has a strong record of subverting, circumventing, ignoring and changing tobacco control legislation. Policies that are important in regulating the behaviour of the tobacco industry, and to protect both smokers and non-smokers, include:

- Advertising bans
- Taxation policy
- Clean air policy
- Content regulation
- Sales regulation
- Packaging regulation
- Smuggling controls
- Health protection of tobacco workers
- Financial support for tobacco control
- Elimination of subsidies for tobacco growing
- Bans on political contributions or lobbying by tobacco companies
- Fees on excessive profits/elimination of the profit motive in the manufacture of tobacco products

Laws have to be enforced to be of any value. A number of provisions must be foreseen for adequate enforcement of tobacco control legislation:

- Information campaigns about the reasons behind the laws to inform and gain support in the population
- Penalties for non-application of the law, both for individuals and for organisations, companies, etc.
- Specified agents and budgets for enforcement measures

A national tobacco control programme should also include support for international measures. A treaty, the Framework Convention on Tobacco Control, is currently being negotiated which may provide international support for national measures.

### Normative measures

Normative measures and activities influence the transformation of public health goals into health choices by individuals. These include all of the activity that is engaged to provide an environment that facilitates



healthy choices, and in particular regularly available information from multiple sources (including health education campaigns) and advocacy activities, particularly in relation to the media.

People start smoking because other people smoke and **smokers give other smokers social meaning**. As the number of smokers grows, smoking continues to be seen to have a positive value and smokers mutually reinforce avoiding or minimising anti-tobacco information. In this way the environment encourages smoking behaviour. But it can also encourage not smoking and, **as the number of smokers decreases, the social value of smoking decreases and more and more people will want to stop and try to stop**. Treatment and support for stopping will be more effective for successful stopping.

The issue is then to create an environment that gives social value to not smoking. In addition to the legislative measures that emphasise that tobacco use is not a normal, usual behaviour, both information and advocacy need to pass through the media.

**Information is the fuel for any change**, and provides the rationale for giving value to not starting smoking and stopping smoking. Information must be available for a society and the individuals to begin the process of change. As the same information is picked up by more and more sources, it is perceived to be more and more credible. This is why the tobacco industry is actively producing counter-information to limit the effects of research on the causes, costs and consequences of tobacco use in society.

When information is not enough, then advocacy must begin. The objective of advocacy is to maximise support for tobacco control, by presenting information in ways that are resonant and memorable, by invoking similarity with widely supported values of the society. The more advocates there are the better.

## **Programmes**

There are a number of important programmes for tobacco control that fall into the major headings of cessation, prevention and community health promotion.

The treatment options for people who seek help with quitting are now much more successful than in the past. **Nicotine replacement products and bupropion (Zyban) are currently the front-line medical cessation aids**. They reduce the physical discomfort of withdrawal and allow the abstinent smoker to put full effort into the cognitive processes of disengaging from being a smoker. **Cognitive-behavioural techniques** can be useful for dealing with urges to smoke and with relapse episodes. **Social and psychological support** also seem to be an important component of cessation in diminishing the social value attributed to being a smoker. Because of the addictiveness of tobacco, success is difficult to achieve, and many successful quitters will need

This is a good research article about information: [http://tc.bmjournals.com/cgi/content/full/10/2/145?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Pierce+J&titleabstract=quit+rate&searchid=1025773709286\\_25&stored\\_search=&FIRSTINDEX=0&journalcode=tobaccocontrol](http://tc.bmjournals.com/cgi/content/full/10/2/145?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Pierce+J&titleabstract=quit+rate&searchid=1025773709286_25&stored_search=&FIRSTINDEX=0&journalcode=tobaccocontrol)

Quotes from a successful tobacco control advocate: <http://health21.hungary.globalink.org/filteronline/200102/thescience.html>

The US Surgeon General's site on tobacco treatments: <http://www.surgeongeneral.gov/tobacco/>

The site of the tobacco control resource centre: <http://www.tobaccocontrol.org/>



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more than one cessation attempt prior to attaining long-term success. Often smokers try to stop without any support mechanism in place, either in their own environment or through treatment channels, and their success rates are very low.

The US National Cancer Institute Monograph on prevention for young people is available at: [http://cancer-control.cancer.gov/tcrb/nci\\_monographs/](http://cancer-control.cancer.gov/tcrb/nci_monographs/)

The US Surgeon General's Report for 2000 gives an excellent overview of all the issues concerning reducing tobacco use: [http://www.cdc.gov/tobacco/sgr/sgr\\_2000/FullReport.pdf](http://www.cdc.gov/tobacco/sgr/sgr_2000/FullReport.pdf)

Prevention programmes are tempting. Young people, particularly those under the age of 12 years, are very easy to convince about the health damage caused by smoking. However, decades of research have been unable to demonstrate that prevention programmes by themselves have an effect on eventual tobacco smoking. The best programmes at most delay initiation among those receiving the intervention. Nevertheless, **prevention programmes in the context of programmes targeting adults' cessation behaviour** have shown promise.

It has been surprisingly difficult to show successful results in community health promotion campaigns, despite the appeal of such an approach. The difficulty lies in the methodology of evaluation – and more inventive techniques for measuring need to be developed.

## **International activity**

For access to pertinent information and a large number of documents concerning the FCTC: <http://www.fctc.org/>

The tobacco industry works on an international level, with international strategies. Often a national control programme is confronted by international issues, such as cross-border tobacco advertising, smuggling and trade agreements that are in conflict with the national law. As a support base to reinforce national measures and as an instrument to limit the behaviour of the international tobacco industry, the WHO initiated treaty negotiations for the Framework Convention on Tobacco Control (FCTC). The treaty is currently still in negotiation, and the final content is difficult to foresee.

Never underestimate the tobacco industry: here's another site with secret documents: <http://www.tobacco.org/Documents/secretdocuments.html>

NGOs around the world interested in tobacco control formed an alliance to fight for a strong, useful FCTC, the Framework Convention Alliance. The Alliance has prepared position statements and background documents for a number of the issues of international tobacco control, and is actively monitoring the negotiation process. This is an area of great need for much more advocacy at the national level.

