Development Bulletin
No. 54 March 2001

TOBACCO AND DEVELOPMENT: critical issues for the 21st century

Features
Tobacco and the development agenda; poverty, sustainable development and tobacco control; world trade agreements and tobacco use; tobacco control in developing countries; the tobacco transnationals and development; criminal organisations and cigarette smuggling; gender and tobacco; youth smoking and tobacco tax; tobacco and development in Asia and the Pacific; the WHO Framework Convention on Tobacco Control; the Australian experience with tobacco control; experiences with tobacco control in Thailand, Fiji, PNG, Palau, Northern Marianas.

Viewpoint
Tobacco use: whose responsibility?

ACFOA Briefing
Building a secure region: ACFOA's 2001-02 aid budget submission
The Network

The Development Studies Network Ltd is a registered, not for profit, organisation that provides information and discussion on social and economic development issues. It publishes a quarterly journal, Development Bulletin, runs regular seminars on developing policy and annual conferences on international development. Members of the Network are encouraged to contribute information and papers to the Development Bulletin.

Subscription to the Development Bulletin includes membership of the Network. This allows you to publicise in the Development Bulletin information about new development-related books, papers, journals, courses or conferences. Being a member of the Network allows you special discounts to Network seminars and conferences.

Network Office Bearers

National Patron
The Right Honourable Mr Ian Sinclair

Board of Directors
Dr Pamela Thomas
Associate Professor Joe Remenyi, Deakin University
Dr Robert Crittenden, ANUTECH Pty Ltd
Dr Elspeth Young, Australian National University
Dr Gary Simpson, Project Management and Design Pty Ltd
Professor Gavin Jones, Australian National University
Dr Sharon Bessell, Australian National University

Editorial Board
Dr Pamela Thomas, Managing Editor
Dr Penelope Schoeffel, University of Auckland
Dr Elspeth Young, Australian National University
Professor Dick Bedford, University of Waikato
Professor Dean Forbes, Flinders University
Professor R. Gerard Ward, Australian National University
Professor Cherry Gertzel, Curtin University
Professor Joe Remenyi, Deakin University (Book Review Editor)

Advisory Board
Janet Hunt
Dr John Browett, Dean, School of Social Sciences and Development Studies Centre, Flinders University
Professor John Overton, Director, Development Studies Centre, Massey University
Dr Terry Hull, Director, Demography Program, Australian National University
Dr Malama Meleisea, UNESCO, Bangkok
Mr Bob McMullan, MP, Canberra
Associate Professor Mark McGillivray, RMIT University

Editor
Dr Pamela Thomas

Associate Editors
Tanya Mark
Catherine Baird

Correspondence

Development Bulletin
Development Studies Network Ltd
Research School of Social Sciences, Australian National University
Canberra ACT 0200, Australia
Tel: 61 2 6125 2466, 61 2 6125 8257
Fax: 61 2 6125 9785
E-mail: devnetwork@anu.edu.au

ISSN 1035–1132
The Development Studies Network Ltd
A.C.N. 084 750 989
Tobacco and Development: critical issues for the 21st century
Features
Introduction: Including tobacco on the development agenda
Pamela Thomas

Sustainable health development: Negotiation of the WHO Framework Convention on Tobacco Control
Allyn L. Taylor and Douglas W. Bettcher

Trade agreements and tobacco control: How WTO agreements may stand in the way of reducing tobacco use
Neil Collishaw and Cynthia Callard

Tobacco control in developing countries
Prabhat Jha, Frank J. Chaloupka, Hana Ross and Christina Czart

The tobacco epidemic: Some future scenarios
Judith Mackay

Tobacco control and gender: A need for new approaches for the Asia-Pacific region
Martha Morrow

Youth smoking and tobacco tax
Joy Townsend

Challenging tobacco transnationals: Infact's Kraft boycott
Kathryn Mulvey

Special Report: Criminal organizations and cigarette smuggling
The International Consortium of Investigative Journalists

The Australian National Tobacco Strategy
Leanne Wells

Australia's national tobacco campaign: Strong medicine for a big problem
David Hill

The Politics of tobacco control in Australia
John Ballard

Learning from experience: Future directions for tobacco control
Jane Martin, Trish Cotter and Rob Moodie

Protecting young children from environmental tobacco smoke
Trish Cotter

The social and economic impacts of tobacco in Asia and the Pacific
Harley Stanton

Fighting tobacco in Asia
Mary Assunta

Thai tobacco control: Development through strategic alliances
Praakit Vatesatokit

Smoking and development in the Pacific
Harley Stanton

Tobacco control: The Fiji experience
Margaret Cornelius

The current tobacco situation in Papua New Guinea
Paul Freeman

Tobacco use prevention and control activities in the Republic of Palau
Annabel Lyman

Youth tobacco use in the Commonwealth of the Northern Mariana Islands
Abrahams and Norma Ada
Viewpoint
Becoming a professional victim 79
Francis X Hezel

Update
Capacity building in the wake of conflict: Local NGOs in East Timor 82
Ian Patrick

Publications
Books 87
Reports and monographs 92
Newsletters and journals 96

Conferences
Conference reports 97

Courses 101

Resources
Organisations 103
Materials 107
Electronic fora 109

From the press 111

ACFOA Briefing
Building a secure region 115
Editor's notes

It is not often in development research, practice or theory that most current development concerns can be clearly illustrated in a single case study. This special issue of Development Bulletin investigates the way globalisation, world trade agreements, multinational corporations, donor assistance and governance impact on opportunities for poverty reduction and social and economic development. Tobacco provides the case study. If current trends continue, by 2020 tobacco will cause more deaths than HIV/AIDS, malaria and tuberculosis combined. Tobacco is perhaps among the greatest but least recognised causes of poverty and underdevelopment.

This issue was timed to provide information on, and support for, the global meeting of the Framework Convention on Tobacco Control being organised by the World Health Organisation in Geneva at the end of April 2001. Through our extensive network of readers, we hope that the information included here will lead to global strategies that will support poverty reduction and healthful development.

With support from the Australian Commonwealth Department of Health and Aged Care, we have asked economists, medical specialists, lawyers, anthropologists, health promotion experts, social scientists, journalists, marketing specialists and lobbyists to consider the relationship between tobacco and development. We also sought information on effective tobacco control strategies and the experiences of different countries in developing and implementing such strategies.

Support for this special issue

We are very grateful for financial support and encouragement from the Tobacco and Alcohol Strategies Section of the Australian Commonwealth Department of Health and Aged Care. We are also grateful for AusAID's assistance in funding the printing and distribution of an additional 500 copies for distribution in the Asia-Pacific region. The collaborative effort of two Australian government agencies is in keeping with good development principles.

We would like to point out that the views or recommendations in this publication do not necessarily reflect those of the Department of Health and Aged Care, the Department of Foreign Affairs and Trade or the Development Studies Network.

From the field

In keeping with the tobacco theme, Francis Hezel of the Melanesian Seminar considers the growth of the 'victim mentality' in the Republic of the Marshall Islands in relation to litigation between the Marshallese Government and a leading American tobacco manufacturer.

ACFOA briefing

ACFOA Policy Director Jim Redden and Policy Officer Andrew Nette report on the ACFOA 2001 aid budget submission. This report, which provides a concise overview of crucial development issues, incorporates the views of ACFOA's 100-plus member agencies.

Back half

Tanya Mark has put together the back half of this Development Bulletin. She has searched the press, the Internet, libraries and academic bookshelves for up-to-date information on tobacco-related research, publications, courses, materials and websites. Enjoy smoke-free reading and thinking.

Pamela Thomas
Introduction: Including tobacco on the development agenda

Pamela Thomas, Development Studies Network, The Australian National University

Tobacco use is rapidly becoming a critical development issue for the twenty-first century. However, it is still not widely considered to be a developmental problem. In many countries it has low priority as either a health or economic issue. In many developing countries, tobacco production and the manufacture of cigarettes are considered important opportunities for export earnings - approaches that are promoted by multinational tobacco companies. There is limited consideration of the social and economic costs of tobacco use or its long-term impact on health. Currently, 4 million people die each year from tobacco-related illnesses; by the year 2030, it is estimated that this will have risen to 8 million, most of whom will live in developing countries.

This special volume of Development Bulletin provides a chilling case study of the role tobacco plays in social and economic development and in the escalation of poverty and ill health. It provides examples of the ways in which globalisation, trade liberalisation, modern communications and marketing, direct foreign investment and the growth of multinational corporations can impact on the poor, on life expectancy and health status, and on the ability of national governments to legislate for and implement tobacco control policies.

The following papers illustrate how trade liberalisation and reduced trade barriers have led to greatly increased cigarette consumption in low-income countries and how extensive manipulation of modern communications - including the Internet, cable and satellite television, video and film - have encouraged smoking among young people. A major target is the largely untapped market of young women in Asia. Martha Morrow and Simon Barradough highlight the importance of considering gender in tobacco control strategies. Neil Collishaw, Cynthia Callard and Michelle Swenarchuk provide examples of the impact of trade agreements on tobacco use, and Prabhat Jha, Frank Chaloupka, Hana Ross and Christina Crat discuss tobacco use and tobacco control patterns in developing countries. Papers from Australian authors and from Kathryn Mulvey in Boston show how communication channels and inclusive marketing strategies can provide opportunities for international action to control tobacco use.

World Health Organization initiatives

This special issue of Development Bulletin coincides with a global meeting in Geneva to discuss the initiative of the World Health Organization (WHO) for an international legal strategy that will address tobacco control. The Framework Convention on Tobacco Control (FCTC) will provide an integrated global regulatory environment for tobacco control. This will help countries in their attempts to control the marketing and distribution of tobacco products by the large and powerful multinational tobacco corporations and will provide an accepted framework within which small and poorer developing countries can participate in global tobacco control initiatives. WHO has strongly promoted tobacco control for some years through its Tobacco-Free Initiatives and, in the Pacific, its Tobacco or Health programme. The FCTC is the first global tobacco control initiative. Allyn Taylor and Douglas Betcher provide background information on the work of WHO and the development of the FCTC.

In addition, a variety of authors from Australia, Asia, America and Pacific Island countries discuss the latest research findings, the role of international regulatory bodies and the opportunities governments have for addressing the rising tide of tobacco use. They also provide practical examples of successful tobacco control programmes.

Changing patterns in tobacco use

As the following papers indicate, the patterns of tobacco use and tobacco-related deaths are changing. As control measures in industrial countries take effect and tobacco use there declines, tobacco companies are stepping up marketing in developing countries where there are few, if any, controls. From a developmental perspective, issues of governance and transparency, combined with slow legislative processes, competing priorities, low tax, and lack of marketing and content controls, ensure that large, poor, developing countries are attractive markets. The market in China alone is enormous, with an estimated 300 million existing smokers and a huge untapped female market. Tobacco marketing now targets young women. The implications of increased family smoking for development include negative impacts on maternal and child health - with low-birthweights, sudden infant death syndrome, asthma, pneumonia and bronchial problems among infants and small children - and the economic impact of chronic adult ill health.

The Australian experience

In Australia, tobacco use is the leading cause of preventable death and disability. Its social cost is estimated at $12.7 billion a year. But the situation is improving. Since the 1970s, the Australian
Federal and State governments, together with non government organisations (NGOs), have worked together to put in place comprehensive and effective tobacco control strategies. The Ministerial Council on Drug Strategy, which brings together Commonwealth, State and Territory Ministers responsible for health and law enforcement has provided the principal structure for partnership and collaboration on tobacco control. The National Public Health Partnership provides another collaborative forum between Commonwealth and State and Territory governments to address the challenges presented by tobacco. Experience has shown that a number of strategies implemented simultaneously by a variety of organisations have the greatest impact on reducing tobacco use.

The developmental concept of community involvement, with partnerships between government organisations and NGOs, together with extensive consultation and interaction, has been shown to be highly effective in bringing about desired change. The shared strategies have included:

- banning cigarette advertising and promotion of sporting events by tobacco companies;
- the introduction of health warnings on cigarette packets;
- legislation prohibiting tobacco use on Australian airlines and any internal flights;
- restrictions on smoking in work and public places;
- an increase in tobacco prices;
- restrictions on sales to minors; and
- the introduction in 1997 of the National Tobacco Campaign, which included the national QUIT campaign, which provided 24 hour a day support for those wanting to stop smoking.

Leanne Wells, of the Australian Commonwealth Department of Health and Aged Care, discusses the National Tobacco Strategy; David Hill and Kate Hassard focus on the campaign strategies and experiences. Jane Martin, Trish Cotter and Rob Moodie discuss the experience of the Victorian Health Promotion Foundation. Recent research has shown that the Australian experience can be readily adapted to developing countries in the Asia-Pacific region. John Ballard addresses issues of governance and shows that tobacco control in Australia has been a highly political issue. It took some years for Australian politicians to accept that tobacco use was a health problem and that the government had some responsibility for control measures.

**Tobacco use and control in the Asia-Pacific region**

The Asia-Pacific region is currently the major focus of the multinational tobacco companies. The region includes some of the most populous countries in the world. Few women in the region smoke. The Asia-Pacific region therefore provides an enormous potential market for cigarettes. Harley Stanton of the Tobacco-Free Initiative of the WHO Western Pacific Regional Office provides an overview of the Asia-Pacific situation which highlights both tobacco use and existing tobacco control measures. With leadership and technical advice from WHO and/or assistance from AusAID, the Australian aid programme, several countries in the Pacific are introducing tobacco control measures. The most advanced measures have been taken in Fiji, where, over the last five years, a multisectoral Tobacco Control Action Group has worked with the National Health Promotion Council to get tobacco control legislation enacted and a community awareness programme started. Margaret Cornelius points to the importance of having a multisectoral working group and a supportive Minister for Health.

Paul Freeman considers the impact of smoking within the home on Papua New Guinean families and the difficulties in getting control of tobacco-related diseases included in government priorities. The Republic of Palau and the Northern Mariana Islands in the Western Pacific provide examples of different cultural uses of tobacco and different methods of control, as Annabel Lyman, Isamu Abraham and Norma Ada discuss.

Together, these papers point very clearly to the importance of putting tobacco control on the development and development assistance agenda.
Sustainable health development: Negotiation of the WHO Framework Convention on Tobacco Control

Allyn L. Taylor and Douglas W. Bettcher, WHO Tobacco Free Initiative, Geneva

The 'mainstream' development agenda has shifted in recent years from one favouring unbridled and 'trickle-down' economic growth, towards the view that economic growth should be framed by the concept of sustainable development. This view proposes that current economic development should not proceed at the expense of future generations or the natural environment (Thomas 1997:461). In the area of public health, a school of thought has emerged which demonstrates that the 'globalisation of public health' constitutes an increasingly important terrain for development strategies, and that many of these policy issues are core concerns for a sustainable development approach. Questions on how to create a socially regulated global capitalism, rather than an anarchic unregulated system which brings with it, for example, serious health and environmental damage, are becoming part of the global social policy debate (Yach and Bettcher 2000).

Controlling the worldwide tobacco epidemic poses an extraordinary challenge for both public health and sustainable development. The proposed World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC), designed to assist in curtailing the rise and spread of this public health menace, represents the first time that the public health community has ventured into the 'treaty-making' business, a major turning-point for international health development.

The globalisation of the tobacco epidemic

Tobacco use is one of the major public health disasters of the last 100 years (Asma et al. forthcoming). There are over 1.25 billion smokers (0.25 billion female, and 1 billion male) in the world today, representing one-third of the world's population aged 15 and over (Carrao et al. 2000). Cigarette smoking is one of the largest causes of preventable death worldwide and the leading cause of premature death in industrialised countries. Currently, cigarette smoking and other forms of tobacco consumption kill 4 million people a year, with the majority of these deaths in developed nations. However, the epidemic of addiction, disease and death is rapidly shifting to developing and transitional market countries (Murray and Lopez 1996a, 1997).

The majority of smokers today are in developing countries (800 million); most are men (700 million), and 300 million are Chinese. At current levels of tobacco consumption, the epidemic is expected to kill up to 8.4 million people a year by 2020, with 70 per cent of these deaths occurring in developing countries (Murray and Lopez 1996b). Hence, if unchecked, within the early part of this century tobacco will be the leading cause of premature death worldwide.

Smoking has been associated with, inter alia, an increased risk of several different cancers, including lung and bladder cancer, ischaemic heart disease, bronchitis and emphysema, and increased prenatal and perinatal mortality. The health effects of tobacco consumption have strong public characteristics because forced or passive smoking presents health risks to non-smokers, and the financial costs of treating tobacco-related diseases are passed onto the public in countries where health care is provided by the public sector. In industrialised countries alone, smoking-related health care accounts for 6–15 per cent of all annual health care costs (World Bank 1999).

A distinctive feature of the globalisation of the tobacco pandemic is the role of multinational corporations (Yach and Bettcher 2000). Since the beginning of the last century, a few major corporations have controlled much of the world's cigarette market. Today the world market for tobacco is dominated by a handful of American, British and Japanese multinational conglomerates, which have a controlling presence not only in Western countries but also throughout the developing world. China stands out as an exception, with its large production of tobacco products mainly used in the domestic market.

A significant contributor to the increased risk of tobacco-related diseases worldwide is the globalisation of the epidemic through the successful efforts of the tobacco industry to expand its trade in order to achieve market penetration in developing countries and transitional market economies (Bettcher et al. 2000, Chaloupka and Corbett 1998, Taylor 2000, Taylor et al. 2000). Major transnational tobacco companies targeted growing markets in Latin America in the 1960s and the newly industrialising economies of Asia (Japan, South Korea, Taiwan and Thailand) in the 1980s. Since the 1990s they have moved into eastern Europe, China and Africa and are increasingly targeting young persons and women (Connolly 1992). The 'normalisation' of the use of tobacco products, combined with weak regulation of their use in many countries and no regulation of the transnational aspects of tobacco marketing, has led to a public threat of crisis proportions.

The global reach of the industry has been enhanced by the recent wave of international trade liberalisation, particularly the Uruguay Round of negotiations which included for the first time the trade liberalisation of unmanufactured tobacco (Chaloupka and Corbett...
The new multilateral agreements of the World Trade Organization (WTO) have facilitated the expansion of trade in tobacco products through significant reductions in tariff and non-tariff barriers to trade. Regional trade agreements and associations have acted in synergy with the global level by mandating further trade liberalization in goods and services, including tobacco, at the regional level. Further, bilateral trade agreements have facilitated market penetration in developing countries (Roemer 1997).

Trade liberalisation and market penetration have been linked to a greater risk of increased tobacco consumption, particularly in low- and middle-income countries. A recent WHO/World Bank study empirically examined the relationship between cigarette consumption and global trade in tobacco products (Taylor et al. 2000). Estimates from this study indicate that reduced trade barriers have had a large and significant impact on cigarette consumption in low-income countries and a small but significant impact in middle-income countries.

In addition to trade liberalisation, the transnational tobacco industry has also taken advantage of direct forms of market penetration in cash-hungry governments of poor countries via direct foreign investment, either by licensing with a domestic monopoly or through joint ventures or other strategic partnering with domestic companies (World Tobacco File 1998). The globalisation of the tobacco epidemic is not limited to international trade and investment, however.

The epidemic is being spread and reinforced worldwide through a complex mix of factors, including trade liberalisation, global marketing and communications, and foreign direct investment (Asma et al. forthcoming, Chaloupka and Corbett 1998). Processes and practices that transcend national boundaries are fuelling numerous aspects of the epidemic. For example, an estimated 355,000 million cigarettes, or 33 per cent of the world market for exported cigarettes, are smuggled each year in order to avoid taxes: 'Cigarette smuggling is now so widespread and well organised that it poses a serious threat to both public health and government treasuries, which are losing thousands of millions of dollars in revenue' (Joossens 1999).

Advertising contributes to the global spread of tobacco use through worldwide media, such as cable and satellite television and the Internet, and through the sponsorship of worldwide sports and entertainment events. In 1997 in the USA alone, the tobacco industry spent US$5.66 billion on advertising and promotion (FTC 1999), approximately 90 per cent of which went to product promotion. There are currently no figures on the exact amount the industry spends worldwide, although it is clearly substantial.

The dramatic increase in tobacco consumption in the last couple of decades portends public health and economic tragedy for nations worldwide in the twenty-first century. Much of the potential calamity can be averted, however, through effective implementation of tobacco control strategies. In a 1999 report, the World Bank concluded that tobacco control is highly cost-effective as part of a basic public health package in all countries.

Since many, if not all, of the challenges of control increasingly transcend national boundaries, stemming the growth of the pandemic requires global agreement and action. Globalisation restricts the capacity of countries to unilaterally control tobacco within their sovereign borders (Taylor 1996). All transnational tobacco control issues, including trade, smuggling, advertising and sponsorship, prices and taxes, control of toxic substances, and package design and labelling, require multilateral cooperation and effective action at the global level (Joossens 2000). If not attended to, these global problems can unravel the best national tobacco control strategies.

The WHO Framework Convention on Tobacco Control

In order to strengthen international response to the tobacco epidemic, on 24 May 1999 the World Health Assembly (WHA), the WHO governing body, resolved to pave the way for multilateral negotiations to begin on a Framework Convention on Tobacco Control and possible related protocols.

The international legal strategy being used to promote global tobacco control is the framework convention–protocol approach (Taylor and Roemer 1996). The term 'framework convention' does not have a technical meaning in international law. It is used to describe a variety of agreements that establish a general system of governance for an issue area (Bodansky 1999). Framework conventions, unlike more comprehensive forms of treaties, do not attempt to resolve all substantive issues in a single document. Rather, they divide the negotiation of separate issues into separate agreements. States first adopt a framework convention, which creates an institutional forum in which that state can cooperate and negotiate the conclusion of separate implementing protocols containing detailed substantive obligations or added institutional commitments. This approach is, in essence, a dynamic and incremental approach to global lawmaking (Taylor and Roemer 1996).

The idea behind the FCTC is that it will act as a global complement to (not a replacement for) national and local actions. When adopted and implemented, it will represent an important component of a stable and integrated global regulatory environment for tobacco control. It is important to recognise that the FCTC is the only platform for the development of binding global standards and harmonised national policies on tobacco. Mechanisms can be incorporated in the treaty to encourage countries to comply with their international legal obligations as well as to enhance the technical capacity of poor countries to develop and implement strengthened control programmes. The FCTC and its protocols will be binding international law for those countries that adopt and ratify these agreements.
Process and progress in the FCTC negotiations

The 1999 WHA adopted by consensus a resolution that established a two-step political process for negotiating the FCTC. First, it created a working group, open to all WHO member states, to lay down the potential technical foundation of the FCTC and related protocols. Second, it established an intergovernmental negotiating body (INB) to draft and negotiate the FCTC.

The first stage of the process is now complete. During this pre-negotiation period a preparatory working group met twice between May 1999 and October 2000 to elaborate the scientific and policy foundation. This group agreed at its first meeting in October 1999 that substantive tobacco control obligations in the FCTC and related protocols should focus principally on empirically established demand-reduction strategies (WHO 1999a). Hence, during this initial phase WHO member states emphasised that the FCTC should promote global agreement and cooperation on the primary interventions on which there was overwhelming empirical support: tobacco taxes and prices, advertising and promotion, mass media and counter advertising, warning labels, clean indoor-air policies, and treatment of tobacco dependence. Consistent with the World Bank’s recommendations, the working group supported co-ordinated action against smuggling as the one key supply-side area for global agreement and harmonisation of strategies.

The working group met again, in March 2000, to prepare a final report for the 52nd WHA. Working from secretariat papers that analysed the potential elements of the FCTC, based largely on the examples of existing framework conventions and other treaties (WHO 1999b), the final output of the working group was a catalogue of possible draft elements for the FCTC, a menu of possible options, which it forwarded for consideration to the INB (WHO 2000a).

Formal political negotiations on the FCTC commenced with the convening of the first session of the INB in Geneva on 16–21 October 2000. The session was attended by 148 member states and observers from the European Community, 9 other intergovernmental organisations, and 25 NGOs (WHO 2000b). Ambassador Celso Amorim, a senior Brazilian diplomat and former foreign minister with extensive negotiating experience, was elected Chair; the INB also nominated vice-chairs from Australia, India, Iran, South Africa, Turkey and the USA.

The INB began by reviewing and commenting on the working group’s ‘proposed draft elements’ report. There was widespread agreement that it was a useful reference document for initiating negotiations and it was decided to proceed with a detailed reading. The INB agreed that the Chair should prepare a first draft text, indicating possible compromises and a reduced number of options (compared with the report) as well as some reorganisation of the draft elements, on the basis of oral comments and written submissions made during the first session.

The Chair’s text of the FCTC

In January 2001 the negotiations took a giant step forward with the release of the Chair’s text, the first draft of the FCTC (WHO 2001). The formulation of the first draft of an international instrument is a critical step in any treaty negotiation process (Taylor and Bodansky 1998). The initial draft acquires a certain degree of authoritativeness and, as the eminent scholar Paul Szasz (1997) has observed, ‘it tends to focus the necessary negotiations and further studies’. The underlying objective of the FCTC is set down in the Chair’s text as follows:

The ultimate objective of this Convention and of the related Protocols is to provide a framework for integrated tobacco control measures to be implemented through the engagement of the Parties in order to continually and substantially reduce the prevalence of tobacco use and thus protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

In 20 sections, the text sets forth proposed substantive and procedural obligations under the FCTC. With respect to substantive obligations, the draft reflects a comprehensive approach to global tobacco control, addressing a broad array of concerns that includes:

- general obligations to develop comprehensive, multisectoral national control programmes;
- specific control provisions such as: price and tax demand-reduction measures; non-price demand-reduction strategies such as passive smoking, regulation of product contents, regulation of product disclosures, packaging and labelling, and advertising and promotion; demand-reduction strategies related to cessation; and supply measures such as youth protection and control of illicit trade in tobacco products; and
- other potential national obligations under the WHO convention, such as education, training and public awareness, and multilateral cooperation in a number of areas, including surveillance, scientific research and information exchange.

The Chair’s text does not represent a full draft of the FCTC. Rather, it is confined to areas addressed during the first INB session; it does not consider such matters as amending and updating the text and final clauses. In many treaty negotiations, no full initial draft is prepared at all. Instead, the drafters build ‘one, provision by provision, on the basis of debates and of individual proposals considered in the course thereof’ (Szasz 1997).

The Chair’s text will be formally considered by the INB at the second negotiating session on the WHO FCTC, which will take place in Geneva from 30 April to 5 May 2001.

Multisectoral cooperation in the UN system

The establishment in 1999 by UN Secretary-General Kofi Annan of the Ad Hoc Interagency Task Force on Tobacco Control under
WHO's leadership has significantly expanded the horizons for multisectional collaboration on tobacco control across the UN system. Fifteen UN agencies, the World Bank, the International Monetary Fund and the WTO are participating, and much of this multisectional work focuses on the FCTC. The new task force is providing an engine for launching technical work in support of the negotiations, and thereby addressing some of the developmental issues.

This global approach to tobacco control offers a strong illustration of an integrated cross-sectoral policy strategy in a given thematic area. Moreover, the campaign builds upon various areas for action proposed in Chapter 6 of Agenda 21, including strengthening the voice of scientific and non-governmental groups, building capacity in developing countries, and developing international legal instruments to forward sustainable development goals.

The World Bank has been instrumental in gathering evidence on the economics of tobacco control and providing governments with strong policy suggestions which are economically viable. Its study, Curbing the epidemic (1999), has now been translated into 12 languages and is being widely distributed. The Food and Agriculture Organization has taken the lead on a project concerning world tobacco supply, demand and trade by 2010. The project analyses the effect that reduction in demand for raw tobacco will have on agricultural production, employment, household income, and food security. It will also look at tobacco supply, demand and trade under different regulatory scenarios. This study will be especially valuable to various developing countries which are highly dependent on tobacco production and trade.

The UN Environment Programme (UNEP), International Labour Organization (ILO), International Civil Aviation Organization, UN Children's Fund, and WHO are all working to gather evidence and advocate in regard to environmental tobacco smoke, or passive smoking, which has proven to have substantial ill effects on children and non-smokers. Work is also being done to link this with the Convention on the Rights of the Child and the development of national smoke-free legislation.

The UNEP is planning future studies on the impact of tobacco farming on deforestation which is being caused by the need for firewood to cure tobacco leaves. Flue-cured leaves require heat at a given intensity for a period averaging a week to generate the steam that dries them. The heavy demand for wood fuel causes erosion and deteriorating land quality in tobacco-growing areas. Further research is needed to calculate the long-term economic and environmental impact of deforestation caused by tobacco farming. UNEP will examine the environmental implications of pesticide use on tobacco crops, especially downstream.

Other UN projects are under way or planned, including a project on the employment effects of tobacco control (lead agency, the ILO); sharing information on the control of illicit drugs (lead agency, the UN Drug Control Board); and collaboration on the implications of global trade liberalisation for tobacco control (collaboration between WHO and the WTO).

Building these bridges within the UN community and with other international intergovernmental organisations is leading to better coordination, is providing valuable technical work in support of the FCTC negotiations, and has the capacity to generate a more sustainable approach to tobacco control at the global level. Multisectional coordination is also taking place at the national level, with many countries organising formal or informal coordinating mechanisms to prepare for the negotiations and eventual implementation of the FCTC and its related protocols.

**Conclusion**

The FCTC marks a new era in global tobacco control. In an increasingly globalised marketplace, it is not sustainable for a deadly product to be largely unregulated at the international level and also domestically in many countries. The deaths and disability due to tobacco use are entirely preventable. At the moment, the regulation of tobacco products, or the lack thereof, presents a regulatory conundrum. Tobacco products, in a sense, sit in a regulatory no man's land, in that they are neither completely regulated as licit products nor treated as illicit ones (Bettcher 2000).

This unacceptable situation has now fuelled the political will among the community of nations to negotiate and implement a treaty which aims to bridge this regulatory gap and thereby prevent some of the needless millions of deaths due to tobacco use.

While it is generally perceived that the pace of globalisation and emerging interdependence is increasing, it is also evident that the capacity to regulate the negative aspects of this process is falling between the cracks. Regulation of the tobacco epidemic provides a good example of where the spread of a 'global bad for public health' is outstripping the capacity to regulate its untoward effects. Major transnational determinants of ill health, that would qualify as global bads, include the spread of infectious diseases via the food trade and movement of persons across borders; increased trade, marketing and promotion of harmful products such as tobacco; and increased illicit trade in other harmful drugs.

The FCTC as a piece of international law can act as a bridge, an intermediate public good, which makes the attainment of the final global public good, the reduction of the burden of disease, possible. The final public good is an outcome, whereas intermediate public goods, such as the FCTC and related protocols, contribute to the provision of the final public good. Other global conventions have made a difference: the Ozone Treaty/Montreal Protocol have resulted in reduced consumption of ozone-depleting compounds, known as chlorofluorocarbons, by over 70 per cent in just over a decade (Taylor and Bettcher 2000).

The sheer size and rapid globalisation of the tobacco epidemic has created a uniquely important global public health crisis, requiring vastly strengthened national and international action. The WHO FCTC represents one tool in the development of a more sustainable and rational approach to tobacco control and, at the macro level, is one facet of a more sustainable approach to globalisation in the twenty-first century. The recent release of the Chair's text represents a major leap forward in the realisation of this worthwhile goal.
References


Murray, C.L. and A.D. Lopez 1996b, 'Assessing the burden of disease that can be attributed to specific risk factors', in Ad Hoc Committee on Health Research Relating to Future Intervention Options, Investing in health research and development, WHO, Geneva (unpubl. doc. TDR/GEN/96.1).


World Bank 1999, Curbing the epidemic: Governments and the economics of tobacco control, World Bank, Washington, DC.


The Development Studies Network

- The Network offers a forum for discussion and debate of development issues.
- It provides members with up-to-date information and notices of forthcoming events.
- It helps members to inform each other about their work.
- It gives extensive, often annotated, listings of written and other information and education resources.
- Membership is open to anyone interested. Members come from fields as diverse as health, economics, agriculture, administration and human rights.

Membership includes subscription to the Development Bulletin. A year's subscription entitles you to: four copies of the Development Bulletin — news from the field — work in progress reports — international summaries — latest literature — conference reports — conference calendar.

Please find enclosed my annual membership/subscription fee:

<table>
<thead>
<tr>
<th></th>
<th>Within Australia</th>
<th>International</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>D $60.00 + $6.00 GST</td>
<td>D $70.00</td>
</tr>
<tr>
<td>Students</td>
<td>D $35.00 + $3.50 GST</td>
<td>D $45.00</td>
</tr>
<tr>
<td>Institutions</td>
<td>D $160.00 + $16.00 GST</td>
<td>D $170.00</td>
</tr>
</tbody>
</table>

Name _____________________________________________
Address ____________________________________________
Organisation ___________________________ Postcode __________
Phone ___________________________ Fax __________________________
E-mail ___________________________

Payment details:
☐ Cheque Please make payable to The Australian National University.
☐ Money order Please make payable to The Australian National University.
☐ Visa/Mastercard/Bankcard/Amex Name ___________________________
   Card No. ___________________________
   Expiry Date ___________________________

Complete this form and post or fax to:
Development Studies Network
Research School of Social Sciences
Australian National University
Canberra ACT 0200, Australia
Fax: 61 (0) 2 6125 9785
Trade agreements and tobacco control: How WTO agreements may stand in the way of reducing tobacco use

Neil Colishaw and Cynthia Callard, Physicians for a Smoke-Free Canada
Michelle Swenarchuk, Canadian Environmental Law Association

The globalisation of tobacco

As smoking rates decline in wealthy nations, the tobacco pandemic has moved to the developing world. Current projections of increased smoking point to a fourfold increase in tobacco-caused deaths in the developing world between 1990 and 2020. Tobacco use is not only a global problem, it is also a problem of globalisation. Much of the increased spread of use can be traced to the vectors of liberalised trade, more active multinational corporations and increased westernisation (Haj and Chaloupka 2000:32, 343).

In this newly global market, multinational cigarette companies have moved aggressively to establish markets. A decade ago, only 50 per cent of the world’s market was available to international companies; today they have access to almost the whole world (Market Tracking International 1998:15). Smokers rates increased after the introduction of Western brands into Asia (Chaloupka and Laixuthai 1996), and smokers around the world are abandoning traditional cigarettes in favour of US brands (Market Tracking International 1998:988).

This globalisation has been fostered by the policies of the International Monetary Fund and the World Bank to encourage the sale of state-monopoly tobacco companies. Such acquisitions, together with mergers, have helped create a global tobacco oligopoly: more than two-thirds of the world’s cigarette market is now controlled by only four companies (Market Tracking International 1998:1059).

Trade liberalisation and public health are in structural conflict. The benefits of liberalised trade (increased access to improved, more accessible and cheaper consumer products) apply in reverse to cigarettes. Public health is harmed when cigarettes are made more efficiently and inexpensively and are more glamorously promoted, more attractively packaged and more available. Resolving this conflict may be made more difficult in light of the powerful new World Trade Organization (WTO) agreements through which global commercial activity, including the commerce of cigarettes, is governed.

The WTO agreements

The WTO was founded in 1994 after an extensive ‘Uruguay Round’ of trade negotiations, and now has 140 member countries. Unlike its predecessor, the General Agreement on Tariffs and Trade (GATT), the WTO regime expands its reach into non-tariff matters, including standard-setting for public protections, intellectual property laws, corporate investment rights, and trade in services. WTO rules are accompanied by an effective enforcement mechanism: the dispute settlement process.

The members of WTO must agree to abide by the rules of general agreements regulating goods (GATT, and 12 additional agreements, including those on agriculture, textiles and clothing, domestic standards, food and plant safety), services (GATS), and intellectual property (TRIPS) (WTO 1994). Very few products or substances are untouched by WTO agreements (armaments are a notable exception).

Several of the agreements are of particular interest to tobacco control. The Agreement on Technical Barriers to Trade (TBT) sets the terms under which government measures can be used to protect human, animal or plant life, health or the environment. If such measures are challenged as a restraint on trade, the burden of proof is on governments to show that they are ‘necessary’ to protect life, and that there was not a less trade-restrictive option.

The Agreement on Sanitary and Phytosanitary Measures (SPS) governs the use of food safety and animal and plant regulations. It requires that government regulations be necessary for health protection, be science based, be transparent and not be a disguised restriction on trade. The SPS encourages harmonisation with international standards. No WTO panel has yet upheld a health regulation against an SPS challenge.

The General Exception (Article XX(b)) allows governments to protect ‘human, animal or plant life or health’, provided they do not constitute disguised restrictions on trade in goods. The exception has been interpreted narrowly and has been rejected as a defence in all but one of the disputes in which it has been invoked (WTO 1999:27-32). A recent decision against Canada in its challenge against a French ban on chrysotile asbestos was the first example of a positive application of Article XX(b) (WTO 2000).

The Trade-Related Aspects of Intellectual Property Rights (TRIPS) is unlike other WTO agreements in that its purpose is not to liberalise trade but to confer US-style property rights for owners of intellectual property. TRIPS increased global protection for many forms of intellectual property, including trademarks and patents, and is one of the most controversial of the agreements. The TRIPS provides that members may take measures to protect public health and nutrition but the requirement that such measures ‘be consistent with the agreement’ (Article VIII) means there is no general exception to TRIPS obligations.

The General Agreement on Trade in Services (GATS) is a framework agreement adopted in 1994, and currently the subject
of negotiations aimed at increased liberalisation for trade in services. The GATS covers all measures ‘affecting trade in services’ (Article 1). Governments are currently engaged in negotiating further liberalisation in service sectors.

The GATS prohibits governments from placing ‘limitations on the number of service suppliers’ (Article XVI) or ‘limitations on the total number of service operations’ (Article XVI:2(c)). Among other things, this could prohibit limits on tobacco retailing or marketing. Under the agreement, countries must ensure that their domestic regulations (including those controlling tobacco) are ‘not more burdensome than necessary to ensure the quality of the service’ (Article VI). This vague standard invites WTO trade panellists to review, from a strictly commercial perspective, domestic regulations that affect services.

In addition to the WTO agreements, there are regional agreements like the North American Free Trade Agreement (NAFTA) and the Association of South East Asian Nations (ASEAN), which further increase trade liberalisation by extending investment protection and by accelerating tariff reduction, among other things.

**Key elements of trade agreements**

The key provisions and principles of international trade agreements include:

- **National treatment:** This principle requires that foreign goods, once they have been imported, must receive treatment equal to that accorded domestic goods and, more broadly, that governments give to trading partners treatment equal to that given to domestic producers, or ‘even more favourable treatment if that is required to provide effective equality of opportunities for imported products’.

- **Most favoured nation:** This requirement ensures that any trade advantage (such as tariff reductions) that is provided to one trading partner must be provided to all trading partners.

- **Prohibition on quotas:** The prohibition on ‘quantitative restrictions’ in GATT Article XI means that countries cannot use quotas to restrict imports or exports of products, such as might be useful to restrict foreign-made tobacco to a limited share of a market.

- **‘Like products’**: WTO panels have consistently applied these principles to require that products which are used in similar ways must be treated equally, as ‘like products’. This has removed the ability of governments to make distinctions between goods on the environmental or social consequences of their manufacture and marketing. The ‘like product’ requirement forced Thailand to remove a ban on imported cigarettes and required Japan and other countries to abandon high-tax policies designed to discourage consumption of whisky and other imported alcohols.

- **Least trade restrictive**: general application of the principles of national treatment and most favoured nation is the requirement that countries use the least trade-restrictive means of achieving their policy goals. Alternatives which are least harmful to international commerce can be required if they are feasible (even if they are more difficult to achieve or maintain). A US ban on tuna caught with nets harmful to dolphins, for example, was struck down, as GATT ruled that a less trade-restrictive option available to the USA was to work towards international cooperation in fishing practices (WTO 1999).

**Implications for key tobacco control policies**

Public policy measures to reduce tobacco use have been pioneered, implemented, tested and proven over the past three decades. Since 1970 World Health Organization (WHO) member states have unanimously supported 18 resolutions to reduce tobacco use. In 2000, both the World Health Assembly (WHA 2000) and the Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control (INB 2000) approved draft elements for a WHO Framework Convention on Tobacco Control.

These WHO recommendations provide a roadmap for comprehensive tobacco control programmes. Yet the WTO agreements make it possible for the measures endorsed through one international agency (WHO) to be undermined by those of another (the WTO), either through direct challenge or by the chilling effect of threats of trade action.

**Ending tobacco advertisement and marketing**

Governments which try to ban or restrict cigarette advertising may find that they run against WTO agreements on services, technical barriers to trade, and intellectual property.

The GATS may be used to challenge government attempts to regulate cigarette advertising, to impose licensing requirements for tobacco wholesalers and retailers, to ban sales to children, and to require minimum package sizes if these activities are in sectors which are in the schedule of sectors where national treatment and market access provisions apply. Because so many service sectors overlap, it may not be possible to insulate tobacco control measures from challenge by not including such sectors in GATS. For example, tobacco-branded services like Benson & Hedges Cafes or Salem Cool Planet (now operating in Malaysia and some other Asian markets) may fit within classifications of advertising, retail, entertainment or food services, and may be challenged under these classifications.

TRIPS may be used to challenge restraints on tobacco marketing as unjustified restrictions on the use of trademarks. The 1990 GATT decision upholding Thailand’s ban on cigarette advertising gave comfort to some that future WTO panels would support bans on cigarette advertising (Jha and Chaloupka 2000:349). This ruling, however, predated the GATS. The overlapping authorities of GATS and GATT may result in unexpected vulnerabilities to trade challenge, and it is not clear whether Thailand’s ban on advertising would survive new challenges under GATS.
Health warnings and packaging requirements

Intellectual property and investment agreements can provide limits to intended governmental controls on tobacco packaging, as Canada learned when the federal government considered requiring plain (generic) packaging of cigarettes.

The tobacco industry commissioned and delivered a legal opinion from former US Trade Representative Carla Hills to Canadian parliamentarians. Ms Hills’ opinion stated that requiring generic packaging would deprive the owners of their entitlements under NAFTA and WTO. ‘Trademarks would be “encumbered” by “special requirements” on their use. She argued that plain packaging would thus entitle the cigarette company to pursue sanctions through a WTO trade panel at the behest of its government, the USA. (She also warned that the tobacco companies could launch an independent challenge under NAFTA, which provides for direct lawsuits by investors against governments in a number of circumstances.) The initiative regarding plain packaging was dropped, although research showed the clear benefit to public health.

‘Standards’ for tobacco products and exposure to them

Many proposals have recently been made on ways to reduce the harm of cigarettes by setting maximum levels of tar, nicotine or by requiring that cigarettes be self-extinguishing and thus ‘fire-safe’. These and other proposals will be challengeable under WTO. Fire-safe cigarettes and regular cigarettes, for example, would likely be viewed as ‘like’ products by WTO panels, who could then insist on the least trade restrictive measure of reducing cigarette harm. Consumer warnings might be required as a substitute for product regulation as they are less trade restrictive.

Similarly, banning smoking in public places like restaurants or buses affects services under the jurisdiction of the GATS. These public health protections can be challenged as ‘non-tariff barriers to trade’.

Raising prices through taxation of tobacco products

The Thai cigarette case (see Box 2) upheld the right of countries to impose taxes on tobacco products but did not allow different types of cigarettes to be taxed differently. In some countries, taxes are currently applied differently for historic and political reasons: Indian bidis, for example, are not taxed by the national government, while manufactured cigarettes are. If challenged, India could be forced to harmonise taxes between bidis and Western cigarettes, even though the political and economic realities would result in cheaper cigarettes, not more expensive bidis. In numerous WTO cases involving alcohol products, similar tax differentials have been consistently struck down and quite different types of alcohol have been found to be ‘like’ products for trade purposes (Grieshaber-Otto et al. 2000).

GATT and the Thai ban on cigarette imports

In the late 1980s, the US Government began to pressure Japan, South Korea, Taiwan and Thailand to reduce barriers to importing cigarettes, threatening trade sanctions under US law. Japan, South Korea and Taiwan bowed to US demands, but Thailand held firm. The USA challenged both Thailand’s refusal to allow cigarette imports and its ban on cigarette advertising. Thailand defended its ban by appealing to the GATT exception for measures which are necessary to protect human health (Article XX(b)). The panel rejected Thailand’s argument and ruled that imports of US cigarettes should be allowed. The panel did uphold Thailand’s right to ban advertising, and to impose taxes, price restrictions and labelling requirements (GATT 1990). Per capita consumption of cigarettes in the four Asian countries targeted by the US Trade Department was later estimated to be nearly 10 per cent higher than had the markets remained closed to US cigarettes (Chaloupka and Laixuthai 1996).

Banning imports of foreign tobacco products

Health authorities may correctly identify that foreign brands pose a different level of public health risk than less attractive domestic brands. They may even have some evidence that local cigarettes are less likely to be smoked, are less addictive or otherwise less harmful. Banning the import of foreign cigarettes could be a reasonable health measure in such circumstances. The decision on the Thai cigarette case demonstrates that this option is not available under the WTO regime.

State monopolies

The GATT requires that monopolies and state enterprises conduct purchases and sales without discrimination affecting private sector importers and exporters (Article XVII) and that they buy and sell on a commercial basis (Article II:(4)). These restrictions limit the options for countries which may wish to use state monopolies to restrict market penetration by the large tobacco companies, with their accompanying advertising and price-lowering advantages (Grieshaber-Otto et al. 2000). The pressure put on countries wishing to join the WTO to privatise their state tobacco monopolies (as is currently happening with China and Taiwan) further reduces public control of the tobacco market.

Economic alternatives

Governments may wish to implement measures to encourage tobacco farmers to move to other lines of work. If these measures give preference to domestic enterprises over foreign enterprises, they could be subject to a trade challenge. For example, Canada provided subsidies to tobacco farmers to engage in alternative economic enterprises in the late 1980s. Other payments were made to encourage some to leave the tobacco-growing business.

April 2001

13
(Agriculture Canada 1990). In the 1980s, neither of these measures was challenged as contrary to international trade agreements. Were similar measures to be implemented in this century, they could well be subject to challenges under regional and global trade agreements.

**Conclusion**

Although the launch of a comprehensive round of expanded negotiations of the WTO, planned for Seattle in December 1999, did not occur, the 'built-in' agenda of the WTO mandated ongoing negotiations of agriculture and services trade, and these are now in preparation. Concurrent negotiations for increased trade liberalisation through regional agreements (such as the proposed Free Trade Area of the Americas and recent trade liberalisation agreements in ASEAN countries) suggest that trade agreements will play an increasingly important role in the setting of public policy.

Given the broad reach of the trade agreements, and the variety of potential barriers they pose to tobacco control policies, it is essential that those charged with negotiating international instruments resolve the current conflict between tobacco control and trade liberalisation by ensuring that national and international measures to curb tobacco are not undermined by obligations under commercial trade agreements. Treaty and trade negotiators should safeguard the ability to implement public health measures under all international obligations. Current negotiations for a new WTO services agreement and a WHO Framework Convention on Tobacco Control provide these powerful negotiators with opportunities and responsibilities to ensure this is done.

**References**


GATT (General Agreement on Tariffs and Trade) 1990, *Decision: Thailand - restrictions on importation of and internal taxes on cigarettes*, BISD 37S/200, WTO, Geneva.


WTO (World Trade Organization) 1994, *The Uruguay Round final act; General Agreement on Tariffs and Trade; General Agreement on Trade in Services; Agreement on Trade Related Aspects of Intellectual Property Rights; Agreement on Technical Barriers to Trade; Agreement on Sanitary and Phytosanitary Measures*, WTO, Geneva.


**Notes**

1. General Agreement on Trade in Services
2. Trade-related Aspects of Intellectual Property Rights
Tobacco control in developing countries

Prabhat Jha, Frank J. Chaloupka, Hana Ross and Christina Czart, International Tobacco Evidence Network, University of Illinois at Chicago

Introduction

In 1997, the World Bank, working in partnership with WHO, began a systematic examination of the evidence base for global tobacco control, with a focus on economics. The study design involved an international team of 40 economists, epidemiologists and tobacco control specialists. Nineteen detailed background papers containing comprehensive literature reviews and new econometric analyses on a compiled global database of tobacco consumption, prices, taxes, control policies, trade and other economic variables were completed (Jha and Chaloupka 1999, 2000a, b). The setting was global, with an emphasis on the needs of the low-income and middle-income countries where most smokers live. This article summarises some of the key findings from that study.

Scale of the problem

About 80 per cent of the world’s 1.1 billion smokers live in low-income and middle-income countries (Table 1). Smoking prevalence among men in East Asia is 61 per cent, the highest of any region in the world.

While the prevalence of smoking has fallen over the past two decades in high-income countries, it has been rising in most others (WHO 1997). Greater trade liberalisation has contributed significantly to these increases in cigarette consumption, particularly in low-income countries (Taylor et al. 2000). Peto and Lopez (2001) estimate that about 100 million people were killed by tobacco in the twentieth century; for this century, the cumulative number could be 1 billion if current smoking patterns continue. In China alone, 100 million men below the age of 30 will die from smoking on current patterns (Liu et al. 1998).

Many of these deaths could be averted if people alive today quit smoking but quitters are rare in low- and middle-income countries. For example, only about 5 per cent of males in Mumbai, India, are ex-smokers, compared with about 30 per cent of the male population in high-income countries (Gajalakshmi et al. 2000). Smoking appears to be more common among men of low socioeconomic status and accounts for much of the gap in mortality between the rich and poor (Bobak et al. 2000). For women, who have been smoking in large numbers for a shorter period, the relationship between smoking and socioeconomic status is more variable.

Economic criteria for government intervention

Government intervention in tobacco markets is largely justified to protect children from smoking, to inform adult smokers of its risks, and to protect non-smokers (Jha et al. 2000a). Comprehensive approaches to tobacco control are critical. Any control policy whose sole effect was to deter children from starting to smoke would have little impact on global smoking-related deaths for many decades, since most of the projected deaths for the next 50 years will be those of current smokers (Figure 1). Therefore, achieving health gains in the medium term requires encouraging adult smokers to quit (Peto and Lopez 2001).

Table 1 Prevalence of smoking among adults aged 15 and over, by World Bank region, 1995

<table>
<thead>
<tr>
<th>Region</th>
<th>Smoking prevalence (%)</th>
<th>Total smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>61</td>
<td>4</td>
</tr>
<tr>
<td>Europe &amp; Central Asia</td>
<td>57</td>
<td>26</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>40</td>
<td>21</td>
</tr>
<tr>
<td>Middle East &amp; North Africa</td>
<td>44</td>
<td>5</td>
</tr>
<tr>
<td>South Asia (cigarettes)</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>South Asia (bidis)</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>29</td>
<td>9</td>
</tr>
<tr>
<td>Low- &amp; middle-income</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>High-income</td>
<td>38</td>
<td>21</td>
</tr>
<tr>
<td>World</td>
<td>47</td>
<td>11</td>
</tr>
</tbody>
</table>

April 2001
Effective interventions

Tax increases are the most effective and practical way to correct economic inefficiencies in the tobacco market. A 10 per cent tax increase reduces consumption by 4 per cent in high-income countries, and by 8 per cent in low- and middle-income countries (Chaloupka et al. 2000). The young, the less educated, and lower-income groups are the most price responsive. A 10 per cent increase in the real global price of cigarettes or bidis is predicted to cause 42 million of the smokers alive in 1995 to quit and would avoid about 10 million premature deaths in this cohort (Table 2).

A comprehensive set of other tobacco control measures, such as information campaigns, bans on advertising and promotion, prominent warning labels, and clean indoor-air restrictions are also effective (Kenkel and Chen 2000, Saffer 2000, Woolery et al. 2000). Such measures could persuade 23 million smokers alive in 1995 to quit and could avert 5 million deaths. A third strategy, the widely increased use of nicotine replacement therapies (Warner et al. 1997), could persuade 6 million smokers alive in 1995 to quit and could avert 1 million deaths. All three interventions are more cost effective than many other health measures (Warner et al. 1996).

Determining optimal taxes on cigarettes is complex and depends on a variety of factors, including revenue considerations, society values, and what a society hopes to achieve through these taxes. A useful yardstick is the tax level adopted by high-income countries as part of comprehensive tobacco control policies. In most of these countries, the tax is between two-thirds and four-fifths of the retail price of cigarettes. In lower-income countries, on average taxes are less than half of the total price (Figure 2).

In contrast to measures to reduce demand, most measures to reduce supply, including complete prohibition on tobacco products, restrictions on tobacco-related trade, crop substitution programs, and limits on youth access to tobacco products, are largely infeasible or ineffective. The key exception is for strong action to reduce smuggling. Effective measures include prominent tax states and local language warning labels on cigarette packs, aggressive enforcement, and consistent application of strong penalties on smugglers.

The costs and consequences of tobacco control

Several concerns are often raised about the costs of acting to control tobacco. The first is that control efforts will cause permanent job losses. However, falling demand for tobacco does not mean falling employment. Money that smokers once spent on cigarettes would instead be spent on other goods and services, generating other jobs to replace any lost from the tobacco industry. Studies show that most countries would see no net job losses, and that a few would see net gains, if tobacco consumption fell (Jacobs et al. 2000).

A second concern is that higher tax rates will reduce government revenues. We find that a 10 per cent increase in cigarette taxes would raise cigarette tax revenues by nearly 7 per cent on average. In China, for example, conservative estimates suggest that a 10 per cent increase would decrease consumption by 5 per cent and increase revenue by 5 per cent, and the increase would be sufficient to finance a package of essential health services for one-third of China's poorest 100 million citizens (Saxenian and McGreevey 1996).

### Table 2 Potential impact of a 10% price increase and a package of non-price measures

<table>
<thead>
<tr>
<th>Region</th>
<th>Change in number of smokers (millions)</th>
<th>Change in number of deaths (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Price increases</td>
<td>Non-price measures</td>
</tr>
<tr>
<td>Low- &amp; middle income</td>
<td>-38</td>
<td>-19</td>
</tr>
<tr>
<td>High-income</td>
<td>-4</td>
<td>-4</td>
</tr>
<tr>
<td>World</td>
<td>-42</td>
<td>-23</td>
</tr>
</tbody>
</table>

Source: Ranson et al. (2000)
A third concern is that higher taxes will lead to massive increases measured on an index published by the non governmental organisation Transparency International, with experts' ratings of the amount of smuggling, found that corruption within countries is a stronger predictor of smuggling than price. Tax increases appear to decrease consumption and increase government revenue in the short and medium term, even in the face of cigarette smuggling (Joossens and Raw 1995, Merriman et al. 2000).

It is important to note the Canadian experience, which reduced its tax rates as an attempt to counter smuggling (Sweanor and Martial 1994). The result was that consumption rose, especially among youth, and revenues fell. Thus, rather than forgoing the health benefits of reduced smoking, and increased revenue, the appropriate response for governments is to crack down on smuggling.

Conclusion

Countries can prevent millions of premature deaths and much disability if they adopt comprehensive measures to reduce the demand for tobacco products, including tax increases, bans on advertising and promotion, restrictions on smoking, strong health warning labels, increased information on the health consequences of tobacco use, and greater access to nicotine replacement and other cessation therapies. A comprehensive set of tobacco control policies is not likely to harm economies. Given increasing globalisation, some aspects of tobacco control require international or cross-border action. The proposed WHO Framework Convention on Tobacco Control is a particularly promising vehicle for such action.

Note

This paper does not represent the official views of the World Bank or WHO.

References


Jha, P. and F.J. Chaloupka 1999, Curbing the epidemic: Governments and the economics of tobacco control, World Bank, Washington, DC.


Jha, P., F. Paccaud and S. Nguyen 2000b, 'Strategic priorities in tobacco control for governments and international agencies', in Jha and Chaloupka (eds), Tobacco control in developing countries, 449–64.


Woolery, T., S. Asma and D. Sharp 2000, 'Clean indoor-air laws and youth access', in Jha and Chaloupka (eds), Tobacco control in developing countries, 273–86.
The history

The earliest recorded use of tobacco was in the Americas in the first century BC, but the plant did not reach Asia until sometime during the 1500s. Virtually simultaneously, the first warnings came in the 1600s from both King James I in England, and Chinese philosopher Fang Yizhi, who announced that prolonged smoking 'scorches one's lung'.

The first known tobacco control regulation in the world was issued in Bhutan in 1729, banning tobacco use in all religious places, a ban that is still observed today. In 1761, the first study on the harmful effects of tobacco took place in England. Almost 200 years later, in the 1950s, the new scientific era of investigation commenced in England and the USA, followed in 1981 by the publication of the first major study on passive smoking by Takeshi Hirayama in Japan.

In general, tobacco control in developed countries is far ahead of that in developing ones, but not uniformly so. For example, legislation is far stronger in Singapore, Fiji, Hong Kong, Mongolia, South Africa, Thailand and Vietnam than in many Western countries, showing that developing countries can tackle the epidemic.

For example, Singapore banned all advertising 30 years ago, celebrates World No Tobacco Month (not Day) each year, has banned duty-free cigarettes, licenses tobacco retailers, and has the lowest prevalence rates in the world. Thailand has involved monks in the anti-smoking campaign, has a total advertising ban, requires ingredient disclosure, and has strong health warnings, including direct messages such as ‘Smoking causes impotence’.

The future challenge

Despite centuries of knowledge, decades of action, multiple World Health Assembly resolutions, 11 world conferences, and numerous regional, national and sub-national conferences, the number of tobacco users around the globe is increasing, more children are becoming addicted, and economic costs are escalating (Table 1).

The epidemic is spreading to developing countries, which by 2030 will have 85 per cent of the world's smokers.

The obstacles to tobacco control

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, some of which cause far fewer deaths; and lack of funds. But the most formidable obstacle 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.

It attacks bans on tobacco promotion, price increases, and the creation of smoke-free areas in public places – which suggests 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, which indicates that these are largely ineffective measures, albeit useful first-step actions for governments embarking on a tobacco control policy.

The tobacco industry has employed all of these tactics in the Asia-Pacific region.

The 1998 Minnesota lawsuit in the USA against the tobacco industry is now history, but its legacy will continue with profound implications for tobacco control policies around the world. The lawsuit was settled on terms highly favourable to the plaintiffs. The most significant result was not the large financial settlement or the banning of all advertising and promotion within Minnesota, but the disclosure of millions of pages of previously confidential industry documents exposing decades of subterfuge regarding the health risks of smoking, the addictive nature of nicotine and its manipulation by the industry, and marketing to children (Ciresi et al. 1999). The revelations are clear – the tobacco industry has consistently lied or obscured the truth about smoking from governments, the media and smokers themselves.

---

**Table 1 Current and projected estimates of the tobacco epidemic (if control efforts continue at the level in 2000)**

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of smokers (thousand million)</td>
<td>1.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Annual tobacco deaths (million)</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Children exposed to environmental tobacco smoke (millions)</td>
<td>700</td>
<td>770</td>
</tr>
<tr>
<td>Economic cost (US$ thousand million)</td>
<td>200</td>
<td>unknown</td>
</tr>
</tbody>
</table>
The documents brought to light that, in Asia, the industry recruited 'consultants' in China, the Republic of Korea, Hong Kong, Malaysia, the Philippines, Singapore and Thailand to challenge the scientific evidence on environmental tobacco smoke.

In addition, the industry now invokes two principal arguments around the world:

- 'freedom of choice' arguments to oppose restrictions on advertising and marketing in places as diverse as South Africa and Hong Kong;
- so-called economic arguments, which it is now using throughout the Asia Pacific region, where it argues that tobacco control measures will damage the economy, cause job losses and decrease tax revenue. (Coopers & Lybrand 1996)

And some solutions

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, such as price increases, advertising bans, smoke-free areas, health education, and pharmaceutical assistance in quitting, are cost effective in both industrialised and developing countries.

WHO

In 1998, the newly appointed Director-General of WHO, Dr Gro Harlem Brundtland, created the WHO Tobacco-Free Initiative (TFI). The TFI has increased visibility, staffing and funding for tobacco control and spawned new initiatives relating to legislation, taxation youth programmes, media and NGO advocacy. New partnerships have been forged within WHO, and between it and the World Bank, UNICEF, the International Monetary Fund (IMF), NGOs, women's groups, the pharmaceutical industry, and funding agencies.

Tobacco has been discussed by WHO with the Asian Development Bank (1998), the World Economic Forum in Davos (1999) and the Ninth International Conference of Drug Regulatory Authorities in Berlin (1999), and within the United Nations. An ad hoc Inter-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 – the first time that international legislation will be used directly to further public health. It is anticipated that the FCTC will be adopted by 2003.

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', this reaction being a good sign that WHO and the FCTC are effective.

The future of the tobacco industry

Can there be peace with the industry, or at least a truce? Director-General Brundtland has stressed that WHO is not interested in tobacco wars but that, instead, WHO and its member states seek tobacco solutions (Yach 2000).

The battleground will change. At the 10th World Conference on Tobacco or Health in 1997, I made the following predictions:

- The grip of the transnational tobacco companies on the big markets in developing countries will become stronger as they move their growing and manufacturing processes out of the USA; by 2025 there may be no tobacco grown in the USA.
- The 20th World Conference on Tobacco or Health may be discussing the domination of the world tobacco market by the largest exporter (China) and Japan, and the reversal of fortunes of the American and British tobacco companies. (Mackay 2000)

The timing was too conservative. Since then, Japan has bought the international arm of RJ Reynolds, which is already becoming one of the world's top three tobacco companies, and is currently tipped to set its acquisition sights on Britain's Gallaher, the company that produces Silk Cut and Benson & Hedges. It is also expanding in Asia, for example signing an agreement in November 2000 to develop jointly a new product with Korea Tobacco & Ginseng Company.

China is rapidly moving towards becoming a major exporter of tobacco, as well as establishing factories around the world. In November 2000 it announced an agreement with Iran to establish a cigarette manufacturing factory in one of Iran's free economic regions. In December 2000, Hefei cigarette factory ceremoniously sent its first shipment of cigarette exports to Sierra Leone, giving it further access to 16 countries in West Africa. In December 2000, the Beijing Famous Brand Asset Evaluation Company predicted that, within three to five years, China's elite tobacco companies would rank in the world's top 500 companies.

One advantage of the shift of power to Asia will be that the US-based tobacco industry will lose political clout, with the US Government and NGOs stepping up their efforts globally to combat the tobacco epidemic.

An ex-tobacco industry executive based in Asia has made the interesting prediction that tobacco production could be reduced by the global demand for food, and that many of the tobacco companies are involved with the transnational food business.

Future scenarios

There are several possible scenarios for the future (World Conference 2000):
Scenario 1: The present extended – the fight against tobacco continues

If we continue to do ‘more of the same’, with the addition of a relatively weak FCTC, the number of smokers in the world will increase from the current 1.2 billion to 1.64 billion by 2025. There is a danger that a major distinction will evolve between nations which have or have not made the transition to committed and vigorous preventive health measures and practices (Kaplan 1997).

‘Pre-transition’ nations will be grappling with deteriorating health status, an unabated epidemic of cancer/heart disease/obesity/industrial and road accidents. They will struggle with deeply entrenched tobacco interests that manipulate their governments, the media and public opinion. They will have made an extremely costly mistake by missing the opportunity to build significant barriers to tobacco in the early twenty-first century.

Scenario 2: Worst case scenario – tobacco triumphant

If the industry continues its expansion into developing countries, if its profits continue to allow it undue influence, if litigation is abandoned, if governments are persuaded that voluntary agreements are a good idea, if activism recedes – the future health consequences are almost unthinkable.

This could also come about through external causes, such as a severe economic depression, war, or a completely new global viral pandemic that pushes tobacco control completely off the agenda.

Scenario 3: Best case scenario – when tobacco use is history

‘Post-transition’ nations will have robust health education programmes and extremely restrictive tobacco policies, along with the active promotion of and increased support for physical activity and a healthy diet.

How might this happen? The following will need to be done if any possible success is to occur.

Globally

• A strong, binding FCTC and robust protocols are adopted by all WHO member states. China and Japan are critical in making this a success.
• The World Bank’s analysis of the economic benefits of tobacco control is accepted. A global consensus emerges on the cost effectiveness of health promotion and disease prevention targeted towards tobacco.
• Other UN agencies all have a role in tobacco: the IMF and WTO consider the health implications of loans; the FAO considers the broader implications of tobacco farming; the ILO analyses tobacco workers.
• Highly tobacco-dependent economies are assisted in diversifying.
• Alternative, commercially profitable uses of tobacco are found.

The tobacco plant becomes the key to producing vaccines and other beneficial medical products.
• Research: vaccines are also produced to switch off the nicotine receptor.
• Quitting: the use of nicotine replacement therapies becomes widespread. Unless there is a massive emphasis on cessation, there will be no impact on the predicted death rates to 2030 as these will be in people who already are smokers.
• Cures are found for many tobacco-related conditions.
• Smuggling is checked, although tobacco will have become a predominantly illegal product in many markets. The tobacco industry may have been hit by several spectacular legal cases proving their involvement with smuggling their own cigarettes.
• Tobacco control spreads to environmental movements, human rights, gender, and corporate accountability movements, and to community, social and grassroots health movements that enable control efforts to flourish.

Nationally

• Core funding for tobacco control and health promotion available from government and tobacco tax, with contributions from big business, in the same way it is beginning to contribute to environmental issues today.
• The tobacco industry becomes a fully regulated industry, with the licensing of nicotine as an addictive drug and with manufacture, promotion and sale under strict regulatory control by government agencies. Specifically:
  • the production of progressively less hazardous, less addicting tobacco products, whose use is mandated and no advertising claims allowed. Tar levels will be below 10 mg all over the world.
  • cigarette packets will be plain black and white and contain only brand name, tar and nicotine levels, and explicit health warnings.
• Tobacco advertising and promotion will be completely eliminated in all countries.
• Prices will be regulated; duty-free tobacco will have long disappeared.
• Smoke-free areas will be exchanged for non-smoking being the norm. ‘Smoking rooms’, popular 100 years ago, will make a comeback.
• Health education will be carried out by all nations, and the failure of school programmes last century will force health educators to turn to social marketers for professional help.
• Incentives for cessation will include monetary savings through rebates and lower health insurance premiums.
• The litigation flurry will have run its course. Much of the developed world will have moved to a managed tobacco industry, with liability automatically paid for tobacco-attributable health care costs and to individual smokers and non-smokers who have been harmed by tobacco.
• Medical schools will have systematically incorporated tobacco issues into the curriculum, and health professionals will be competent and effective in advising patients on quitting smoking.

April 2001
Special attention will have been given to the emerging tobacco epidemic among women, particularly in developing countries. If this is neglected, there will be major consequences on health, income, the foetus and the family.

Conclusion

Even holding global and Asian tobacco consumption to its present level will be nothing short of a minor miracle, given present trends and global population increases of more than 2 billion more people by 2030. We simply have to do more.

References


Coopers & Lybrand 1996, 'A study of the economic impact of a ban on cigarette advertising in Hong Kong', prepared for Association of Accredited Advertising Agencies, 3 June.


Yach, D. 2000, Address by Yach, Executive Director, Non-communicable Disease and Mental Health, and Programme Manager, Tobacco Free Initiative, to selected missions in Geneva, 25 September.
Tobacco control and gender: A need for new approaches for the Asia-Pacific region

Martha Morrow, Key Centre for Women's Health in Society, University of Melbourne
Simon Barraclough, School of Public Health, La Trobe University, Melbourne

The Western Pacific Region of the World Health Organization has voiced special concern over the increasing prevalence of tobacco use among females and youth, and has called for further regional and national action, including 'targeted and timely health promotion and advocacy initiatives' (WHO 1999b:3).

'Gender' is often used as a proxy for 'women'. It is crucial to retain the broadest definition of gender (that is, the social construction of normative roles for the sexes) in order to address the issue of tobacco control. Being born male is the single greatest risk marker for smoking in most of the Asian region; conversely, being female is the strongest marker in some Pacific Island states. The enormous sex-linked differentials in the region can only be explained by gender expectations which, in most countries, make smoking normative for men but anathema for women. This situation poses grave dangers for both sexes: for men in the immediate future, but potentially for women if gender roles alter and they begin to take up the habit. There is preliminary evidence that this is already happening among some groups.

Although smoking is harmful to everyone, men and women face specific sex-linked threats. There is increasing evidence that male smokers risk deleterious impacts on fertility as well as sexual potency (American Council on Science and Health 1996), the latter concern now being highlighted in Canadian warning labels on tobacco packaging.

Recent studies suggest that women are more vulnerable to lung cancer than men, given similar tobacco consumption over time. Female smokers face enhanced risks of cardiovascular disease in combination with oral contraceptives, and higher rates of infertility, premature labour, low-weight infants, cervical cancer, early menopause, and neck, hip and arm fractures. Non-smoking women are routinely exposed to risks from environmental tobacco smoke, such as higher rates of lung cancer and heart disease, than for women not exposed, and the burden of caring for partners with smoking-related illnesses (Ernst et al. 2000, Vierola 1998).

Social factors and tobacco use

To be effective, health policies and programmes must be formulated appropriately to address the social norms, roles, cultures and communication styles of the different target populations (WHO 1994, Yach et al. 1998). Smoking, like other health behaviours, is practiced within a wider social context. Variations in rates are found particularly by age, ethnicity, sex and social class (WHO 2000a, World Bank 1999). The Global Commission on Women's Health has argued that 'it may be more appropriate to consider smoking as an individual response to a social environment than to see it as a voluntary lifestyle choice' (WHO 1994:27).

Smoking differs from most other health behaviours because of its addictive nature. Thus, in understanding initiation we must investigate the specific social context, but the subsequent physiological addiction creates its own momentum, largely explaining continuation. Smoking cessation stands at the intersection of these personal, social and physiological influences. Initiation and cessation alike are complex issues that continue to confound health promotion experts.

Overwhelmingly, smoking is embarked upon during adolescence (Warren et al. 2000), a time when curiosity and a sense of invulnerability place this population at particular risk. Aggressive advertising that glamorises tobacco use or renders it normative is more difficult for young people to resist (Rainey and Lammers 2000, Seimon and Mehl 1998, World Bank 1999).

In earlier decades, smoking was more prevalent among the rich. However, recent surveys among males have confirmed that in high- and low-income countries alike, poor, less educated men are more likely to be smokers, and to smoke more cigarettes daily, than their affluent peers (World Bank 1999). Co-morbidity studies have found the highest female smoking rates in developed countries among the most socioeconomically disadvantaged (WHO 2000b).

Internationally, associations between sex and tobacco use are changing in many countries (WHO 2000a, World Bank 1999). Smoking in Western countries was predominantly a male activity until the Second World War; shortly afterwards, brands targeting women began to be produced for the US market (Vierola 1998, Worth 1999). The lag time in disease manifestation is reflected in higher lung cancer rates among men in most countries. Today, however, there is little sex-linked difference in prevalence among young people in the USA, many parts of Western Europe, New Zealand, Australia, and parts of Latin America (Hill et al. 1999, Reeder et al. 1999). Significantly, lung cancer deaths among women have increased fourfold in developed countries over the past 30 years, and have overtaken breast cancer as the main cause of cancer mortality among women in the USA, where female smoking first became commonplace (WHO 1998).

Smoking in the Asia-Pacific region

It is estimated that 59 per cent of males and 4 per cent of females in East Asia and the Pacific smoke, although there are wide variations between countries (World Bank 1999). Rates for some countries appear in Table 1.
Table 1 Prevalence of smoking among males and females in selected countries of the Western Pacific Region (%)

<table>
<thead>
<tr>
<th>Country</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>29.9</td>
<td>24.2</td>
</tr>
<tr>
<td>China</td>
<td>66.9</td>
<td>4.2</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>34.4</td>
<td>71.1</td>
</tr>
<tr>
<td>French Polynesia</td>
<td>36.0</td>
<td>36.0</td>
</tr>
<tr>
<td>Laos</td>
<td>41.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Philippines</td>
<td>53.8</td>
<td>11.0</td>
</tr>
<tr>
<td>Singapore</td>
<td>26.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Vietnam</td>
<td>50.0</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Source: WHO (2000a)

China, Singapore and Vietnam have the region's lowest female rates, but Chinese and Vietnamese men are among the heaviest smokers. Of concern is a trend towards higher tobacco use among young women, as evident in Australia, the Philippines, Singapore and Japan. A 1996 survey of Australian secondary school students (aged 12–17) found rates for both sexes were lower than in the early 1980s, but had risen since the late 1980s. Girls were more likely to be current smokers than boys for all age groups over 13, with the highest contrast in the cohort at age 17 (34 per cent for females versus 28 per cent for males) (Hill et al. 1999). Australia's current National Tobacco Strategy makes no mention of gender in its strategy objectives or areas. Its targeted populations include Indigenous people, but gender is not cited except in relation to pregnant women (DHAC 1999:2–3).

In Japan, rates for women aged 20–29 have risen from 12 per cent to 22 per cent over the past 30 years (Tominaga 1999), while, in Singapore (the region's showcase in terms of successful tobacco control), the percentage of female smokers aged 20–24 grew from 2.5 per cent to 6.7 per cent between 1992 and 1998. This increase is the more striking in contrast to the decline found among males—from 30.1 per cent to 27.7 per cent—in the same age group in the same period (Ministry of Health, Singapore 1999:18).

The impact of gender

Similar sex ratios should not lead us to conclude that gender plays no role in smoking initiation, maintenance or cessation. North American and British studies have found that females and males begin to experiment, become habitual users of tobacco, and consider quitting, within social milieus strongly influenced by gender norms (Michell and Amos 1997, Royce et al. 1997, Seguire and Chalmers 2000). Historical sex-linked smoking patterns and trends in Western countries show that gradual shifts to higher levels of female smoking occurred simultaneously with shifts in normative female roles. Recent evidence suggests that women around the world are drawn to smoking for varied reasons, including associations with peer acceptance, modernity, independence, female 'bonding', and desire for weight control, all of which are effectively exploited in advertising (WHO 1999b).

Tobacco smoking in Indonesia is strongly gendered. National survey figures for Indonesians aged 20 and older were 68.8 per cent for males and 2.6 per cent for females. A significant proportion of the household budget is spent on what is a predominantly male habit, often to the detriment of women and children. Cigarette advertisements often show 'macho' images of men, while social disapproval of female smoking is strong. Nevertheless, concerns about the weakening of cultural disapproval and the growth of 'modernity' have led health promoters to fear the spread of the Western female smoking phenomenon to Indonesia (Barraclough 1999).

Qualitative investigations in Vietnam have found that traditional roles appear to draw boys into smoking as a sign of adulthood and masculinity, while females eschew smoking primarily as 'inappropriate' (Do Hong Ngoc 1995, PATH Canada 1998). Whether this constitutes robust 'protection' against smoking is called into question by results from a recent survey which found that non-smoking was attributed overwhelmingly to smoking's 'inappropriateness for Vietnamese women', rather than to its risk to health. It also found a moderate level of ambivalence in non-smokers about the possible future uptake of smoking, particularly if they find themselves 'unhappy' or if mores change for Vietnamese women (Morrow et al., unpublished).

We should remember that tobacco use, particularly for women, does not always mean smoking. Chewing tobacco (on its own or mixed with betel and other ingredients) is a tradition favoured most by women in South and Southeast Asia. Studies in Kerala, India, found that 22 per cent of rural women chew tobacco in this way (WHO 1999c). In Indonesia, the chewing of sirih (betel), which involves the use of tobacco mixed with other ingredients, is predominantly a female habit (Barraclough 1999). This means that warnings about 'smoking' may not alert those who chew to the health risks they face, which include higher rates of oral cancers.

The impact of gender is all too apparent from any critique of tobacco advertising (where still permitted), which plays on both obvious and more subtle gender-based fantasies and anxieties. Advertisements link male smoking to risk-taking and to financial success. A bevy of handsome men surround the smoking female, an obvious and more subtle gender-based fantasies and anxieties. Advertisements link male smoking to risk-taking and to financial success. A bevy of handsome men surround the smoking female, while others she is alone, confident and svelte (always slim), or sharing a private joke with a close female friend (Philippine Senate 1999, Robert Wood Johnson Foundation 2000).

There is evidence that concern about gender influences on smoking is beginning to emerge in the region. In Malaysia, the issue was raised in the 1996–97 National health and morbidity survey, despite a lack of data indicating any rise in female smoking rates. It suggested that:

... modernization, changes in women's role in society, social interest and smokers' perception and experience regarding the maintenance of lower body weight through smoking, which had resulted in the higher prevalence of smoking elsewhere, may change the future pattern of smoking in Malaysian women. (Ministry of Health, Malaysia n.d.:25)
The gender factor in men’s smoking was also recognised, with a call for prevention programmes to seek to reverse the traditional and inappropriate perception that smoking was a sign of masculinity and maturity among men.

The ‘westernisation’ of cultural practices cannot be assumed as an inevitable concomitant of economic development. It is impossible to predict future patterns among Asian females, but it may be instructive to recall the historical shift in Western countries noted above. Moreover, it must be remembered that in absolute terms many millions of Asian women already use tobacco, even though prevalence is comparatively very low in most countries. The fact that Asia’s populations are relatively young means that the number smoking will increase even in the absence of higher female rates.

**National action on gender and tobacco control**

There are challenges here for tobacco control. National health programme design and policy formulation should take gender into consideration, no matter what the relative smoking ratios are. Ways in which to incorporate the actual and potential role of gender into tobacco control efforts include:

- conducting broad, qualitative and quantitative research that explores the complex interactions between health behaviours and the ever-changing social context of people’s lives, and then utilising the findings to develop appropriately targeted interventions;
- increasing awareness among health programme designers and health educators about the impact of gender and the need to raise the issue (in relation to both men and women) within public health debates;
- better understanding the ways in which poverty, lack of education, and socio-cultural influences can coalesce to render specific groups, such as young, low-income youths (of both sexes), at particular risk of smoking;
- supporting the incorporation of gender issues in the development of WHO’s Framework Convention on Tobacco Control. The 1999 WHO Kobe Conference on Tobacco and Health has spearheaded these efforts. Now is the time to reflect upon their relevance for individual countries in the Asia-Pacific region.

**References**


Do Hong Ngoc 1995, ‘Smoking in women: A survey in Ho Chi Minh City’, Health Information and Education Center, Ho Chi Minh City.


Philippine Senate 1999, ‘A white paper on tobacco and smoking’, Philippine Senate (Committee on Health and Demography), Manila.


Royce, J., K. Corbett, G. Sorensen and J. Ockene 1997, ‘Gender, social pressure, and smoking cessation: The community intervention trial for smoking cessation (COMMIT) at baseline’, *Social Science and Medicine*, 44(3), 359–70.


WHO 1999c, 'Avoiding the tobacco epidemic in women and youth', Discussion Paper, International Conference on Tobacco and Health, Kobe.


Notes

1. Martha Morrow and Simon Barraclough are currently analysing data from their research project ‘Tobacco control policies and gender in Singapore, Indonesia, Malaysia, Vietnam and Philippines. For further information email martham@unimelb.edu.au
Youth smoking and tobacco tax

Joy Townsend, Centre for Research in Primary and Community Care, University of Hertfordshire, UK

Introduction

Tobacco smoking is heavily influenced by economics. The massive profits of the industry motivate its promotion. Economic concerns determine and qualify its use by individual smokers. Tobacco products are cheap to produce; the base cost is low; and tobacco is addictive. The combination of these factors results in the high prevalence of its use in each country and its pervasiveness across the globe. Even in countries where the price is relatively high, a cigarette will still cost considerably less than a snack item or a drink, so smokers can afford not just the odd one or two, but usually 20 or so a day.

One of the clearest and most immediate influences on tobacco use is its price, and tobacco control policy influences this price through the medium of tobacco taxation. Cigarette consumption has varied inversely with the real price of cigarettes in the UK over the last quarter of a century, increasing during periods when the price of cigarettes fell in real terms, during the early 1970s and late 1980s (Townsend 1996), and falling when real cigarette prices rose in the mid-1970s and during the early 1980s and 1990s. Similar counter-movements of smoking with relative cigarette price are shown for several countries, including Canada, South Africa and France (INSEE 1990, Saloojee 1995, Sweanor 1991). Increasing cigarette taxation is clearly an effective tobacco control policy.

There are many issues to consider around price and taxation, but the basic message is clear – increase the price and tobacco use will decline. Let the price fall and tobacco use will increase. Because the price of tobacco can have such a major effect on smoking and health, it is important for tobacco control interests to know the trends and their effects. Data are available for many countries in the form of routine national economic statistics, but are seldom monitored closely or analysed. The World Bank is now collating this material.

Tobacco tax largely determines the price of tobacco products and has two major effects:
• it reduces smoking and so tobacco-related illnesses and deaths, and
• it provides government tax revenue.

There can be a synergy between taxation and health campaigns, in that health publicity can make tobacco tax acceptable. Tax revenue can provide funds for health campaigns and cessation support.

Current trends and young people

Young people may be less aware than adults of the risk to their health that smoking poses. Most new recruits and would-be smokers also underestimate the risk of becoming addicted to nicotine. As a result, they seriously underestimate the future cost – that of being unable in later life to reverse a youthful decision to smoke. Societies generally recognise that adolescent decision-making capacity is limited and so restrict young people’s freedom to make certain choices, for example by denying them the right to vote or to marry until a certain age. Likewise, societies may consider it valid to restrict young people’s freedom to choose to become addicted to smoking, a behaviour that carries a much greater risk of eventual death than most other risky activities in which young people engage. In the USA, studies among final-year high school students suggest that fewer than two out of five smokers who believe they will quit within five years actually do quit. About seven out of ten adult smokers in high-income countries say that they regret starting and would like to stop. Over decades and as knowledge has increased, the high-income countries have accumulated a substantial number of former smokers who have successfully quit. However, individual attempts to quit have low success rates: of those who try without the assistance of cessation programmes, about 98 per cent will have started again in a year. In low- and middle-income countries, quitting is rare.

The effects of price on tobacco use at young ages

The price response of young tobacco users and young potential tobacco users is of special interest, as this is the age of recruitment to tobacco, and there has been an apparent lack of success in health education in reducing teenage smoking. Lewit and Coate (1982) studied teenage smoking in the USA and concluded that teenagers are highly responsive to cigarette prices (elasticity –1.4). There has been differing US evidence, suggesting a much lower price elasticity among teenagers (Wasserman et al. 1991), not significantly different from the estimate of –0.23 for American adults; however, more recent work by Chaloupka and Wechsler (1997) confirms the earlier reports of high elasticities when other confounding factors, especially income, are taken into account.

A UK study during 1972–90 reported that the most price-sensitive smokers were women and men aged 25–60 years (Townsend et al. 1994). Young men, on the other hand, were more influenced by income than price, showing a high response
to income changes and a non-significant response to price. Young people generally have relatively low incomes but with a high proportion available for discretionary expenditure, so changes in income are likely to have a relatively greater effect on their smoking patterns. These results do not confirm the findings of Lewit and Coate (1982). They do, however, suggest that cigarette consumption in teenage women may be significantly affected by price rises, although for them the effects of price and income appear to be interrelated. There will be an indirect longer-term price influence also via effects on parents, as it is well established that the probability of a young person becoming a regular smoker is positively related to parental smoking.

Recent research by Emery and others (2001) has looked at whether young people's decisions to experiment with cigarette smoking were affected by price. As young people typically are given cigarettes or other tobacco products at the experimentation stage, rather than buying them, it is not surprising that they found that price was not significantly associated with experimentation. However, they did confirm other findings that price is an important factor in more advanced smoking behaviour of young people. The authors concluded that raising tobacco prices may slow progression from higher levels of experimentation to established smoking patterns, and that cigarette prices are a critically important policy tool in reducing adolescent smoking beyond experimentation.

**Conclusion**

The 1999 World Bank report, *Curbing the epidemic*, states that:

... evidence from countries of all income levels shows that price increases on cigarettes are highly effective in reducing demand. Higher taxes induce some smokers to quit and prevent other individuals from starting. They also reduce the number of ex smokers who return to cigarettes and reduce consumption among continuing smokers. On average, a price rise of 10 per cent on a pack of cigarettes would be expected to reduce demand for cigarettes by about 4 per cent in high income countries and by about 8 per cent in low and middle income countries, where lower incomes tend to make people more responsive to price changes. Children and adolescents are more responsive to price rises that older adults.

The report notes that, in lower-income countries, cigarette or tobacco tax tends to be lower (not more than half of the retail price) than in higher-income countries, where it is typically two-thirds to four-fifths of the price. It recommends the raising of taxes to this latter level as the most effective disincentive to smoking, particularly for young people.

**References**


Challenging tobacco transnationals: Infact's Kraft boycott

Kathryn Mulvey, Infact, Boston

'The poorest of smokers today are in the developing world, where countries are struggling with the issues of poverty, drought, famine and wars. Tobacco use is a man-made problem, and this is something that developing countries cannot afford at all' (Mary Assunta, Consumers Association of Penang in Infact's documentary Making a killing)

The health crisis created by tobacco use is spread internationally by a handful of giant corporations, led by Philip Morris, British American Tobacco (BAT) and Japan Tobacco. Their active, deliberate and planned marketing and promotion have brought on the sharp expansion in tobacco addiction.

The July 2000 report by a WHO Committee of Experts on Tobacco Company Strategies to Undermine Tobacco Control Activities concluded 'that tobacco is a case unto itself, and that reversing its burden on global health will be not only about understanding addiction and curing disease, but just as importantly, about overcoming a determined and powerful industry' (WHO 2000: 244).

The tobacco transnationals have used their political influence to water down or defeat public health policy, even in the wealthiest countries, and they have launched an international lobbying campaign targeting the WHO-initiated Framework Convention on Tobacco Control (FCTC). In 1998 in the USA, for example, Philip Morris had over 300 lobbyists, and the tobacco industry spent more than US$60 million on direct lobbying to defeat US tobacco control legislation.

Philip Morris, the world's largest and most profitable tobacco corporation (worth US$62 billion), confronts other countries as a veritable leviathan: its annual revenues are larger than the GDPs of Ecuador, Guatemala, Kenya, Kuwait, Malaysia or Peru, and roughly equivalent to the economies of Ireland, Singapore or Hungary. Japan Tobacco is a US$19.5 billion corporation and BAT a US$19.3 billion one. Together with Philip Morris, they hold an estimated 42 per cent of the world market share for tobacco.

Philip Morris has ridden to the top on the strength of the Marlboro Man advertising and promotional campaign. Designed as 'the right image to capture the youth market's fancy...a perfect symbol of independence and individualistic rebellion' (USDHHS 1994:177), the cowboy has made Marlboro the top cigarette brand among US teens – and worldwide. The corporation is now the most diversified of the three leaders, owning Kraft Foods and Miller Beer. Kraft Foods provides Philip Morris with a more credible front, and thereby more clout with consumers and policy makers.

Launching the campaign

Economic problems require economic solutions. Since 1977, the US-based non government organisation Infact has been exposing life-threatening abuses by transnational corporations and organising successful grassroots campaigns to hold them accountable to consumers and to society generally.

Infact launched its tobacco industry campaign in May 1993, working with allies in the USA and globally to pressure Philip Morris to stop addicting new customers around the world, and to stop manipulating public policy in the interests of profit. In April 1994, Infact issued the following public challenge to the tobacco industry:

• Stop tobacco marketing and promotion that appeals to children and young people.
• Stop spreading tobacco addiction internationally.
• Stop influence over, and interference in, public policy on issues of tobacco and health.
• Stop deceiving people about the dangers of tobacco.
• Pay the high costs of health care associated with the tobacco epidemic.

A key strategy in Infact's campaign has been a widespread boycott targeting Kraft Foods: letter-writing campaigns, petition drives, call-in days, in-person deliveries to corporate offices, visibility actions, leafleting blitzes, counter-recruitment protests, shareholder meeting demonstrations, and direct dialogue with corporate decision makers.

Revealing the truth

In May 1998, the US tobacco corporations agreed to settle a lawsuit filed by the state of Minnesota to recover the costs of treating tobacco-related illnesses. As part of that lawsuit, the corporations, including Philip Morris, were forced to turn over millions of internal documents dating roughly from the 1950s onward. These documents are now publicly available on the Internet as well as in documentation centres in Minneapolis, USA, and in Guildford, United Kingdom (Press Release 1998).

The documents provide an important glimpse into the inner workings of transnational companies, and the seriousness with which they view well-organised consumer campaigns.
Measuring boycott impact

Infact's campaigns alter the cost–benefit ratio for a corporation to continue engaging in the dangerous practices being targeted. Prior to the launch of a boycott, benefits are generally high and costs low or nonexistent.

Infact's boycotts are one strategy within a broader public education campaign. As abuses are widely exposed, public and policy-maker tolerance of misconduct erodes and so benefits are reduced. As boycott pressure cuts into sales, corporations are concerned not only about current losses but also about future business impact. In fact, lost sales are only a small fraction of the overall financial impact of a strategic consumer campaign. Other boycott-attributable costs include:

- *direct expenses of salaries* for management time spent dealing with the boycott and its impact;
- *lost management time* that could have been spent on acquiring new sales and increasing shareholder value;
- *public relations, advertising, and corporate giving* to maintain goodwill with consumers, the media, and political leaders;
- *reduced stock value*, for, as public relations giant Burson-Marsteller advised Philip Morris in its analysis of consumer boycotts, 'boycott announcements have an immediate and pronounced effect on boycott target firms' stock prices';
- *harm to the corporate name, reputation and image*—among the most valuable assets of any corporation; and
- *internal conditions* created within a corporation when one business segment is dragging down another.

Together these factors change the cost–benefit ratio, providing incentive for behaviour change. Because of Infact's Kraft boycott, the costs for Philip Morris are rising.

The Kraft front

Philip Morris purchased General Foods in 1985, acquired Kraft in 1988 and in 2000 bought Nabisco, formerly partnered with RJ Reynolds as RJR Nabisco (Chakravarty and Santelmann 1990:96, *Wall Street Journal* 2000). These acquisitions gave the corporation greater credibility with the public, who might interpret these moves as steps towards phasing out tobacco, and with policy makers, by vastly increasing its size and political muscle. The food businesses 'contribute their image, legitimacy, and constituency to the tobacco industry (Marcus and Connolly 1998). Former Kraft CEO Robert Eckert cited the threat of proposed tobacco legislation in soliciting contributions to Philip Morris's Political Action Committee from Kraft employees, and sent letters to state representatives touting the philanthropic good works of Kraft and Philip Morris. At least one Philip Morris internal document demonstrates that a key objective of charitable contributions is 'to enhance understanding among opinion leaders about the extent of the company's giving programs'. Another is to try to limit the ability of organisations working on tobacco control to build strategic alliances.

Kraft's influence is not limited to the USA. The WHO Committee of Experts found that Philip Morris has tried to influence national and international policy through Kraft. For example, current Chair and CEO Geoffrey Bible (as president of the corporation's international tobacco division in 1988) noted that 'this organization [WHO] has extraordinary influence on government and consumers and we must find a way to diffuse this and reorient their activities to their prescribed mandate', and 'in addition, we need to think through how we could use our food companies, size, technology, and capability with governments by helping them with their food problems'.

Philip Morris uses Kraft as a front. When we expose and challenge Kraft, we threaten the efficacy of that very valuable front. So, when Infact began the boycott, Philip Morris had to respond.

Covert operations

'The bad news is that this has the potential to go beyond the tobacco products and into our other operating divisions . . . namely food and beer products. That's one area where the Philip Morris corporate name has kept many people away from our other companies' products' (Philip Morris internal memo 1993)

Within weeks of Infact announcing its campaign, internal memos were flying between Philip Morris's top executives. A handwritten note across the top of one of the first ones about Infact bears the initials of then-CEO Michael A. Miles and reads: 'This group could be real trouble. We are gearing up to defend.' Nearly every postcard, phone call, news release and letter from activists is tracked, counted and used to develop a coordinated response, demonstrating the degree to which grassroots campaigns create internal pressure for a corporation.

What Philip Morris says publicly—or, more importantly, doesn't say—about the impact of such pressure is in sharp contrast to the flurry of activity created inside the corporation. This activity involves top executives and includes regular briefings of the CEO as well as training for the corporation's entire food and tobacco structure, including international management. Philip Morris developed and implemented a plan which included the following:

- conducting information/intelligence gathering about Infact and monitoring its allies;
- avoiding publicly acknowledging or mentioning the word 'boycott', while intently monitoring boycott activity;
- emphasising Kraft's independence from the rest of the corporation;
- reassuring representatives at all operating divisions and shareholders that the boycott will have little effect, while privately fighting 'with everything we have';
within a few months, Infact activists and allies had shown the documentary, lived up to these fears with the release in was the executive producer of the documentary • film to thousands of people in more than activate a larger segment, particularly outside the corporation's image is in trouble. Between 1998 and 1999, as would benefit Philip Morris, but harm Kraft.<ref>14</ref> Infact escalated the boycott by focusing on Kraft Macaroni advertising in the <ref>corporate</ref> images made a big impression on Philip Morris. Infact documents include polls showing that linking the corporate names publicly downplaying Kraft's connection to tobacco, the corporation is risking Kraft's image to boost Philip Morris'. Internal documents include polls showing that linking the corporate names would benefit Philip Morris, but harm Kraft.<ref>14</ref>

As a sign that this new approach may be backfiring, a Harris Interactive poll released in February 2001 found an astounding 16 per cent of respondents familiar with Philip Morris had boycotted its products in the past year (Wall Street Journal 2001:1B). Boycotts can achieve their objectives with only a small proportion of consumers actively participating. The late Cesar Chavez, leader of the United Farm Workers, found that boycotts work when they enjoy 5 per cent support.

Kraft's brain drain

In a 1999 cover story in Business Week, Eckert (then President and CEO of Kraft) admitted that the 'notoriety' of the tobacco business was being felt at the food business. The article noted that a group (Infact) 'is waging a boycott of Kraft brands, and this year, activists at the University of North Carolina at Chapel Hill and the University of Wisconsin staged protests when Kraft tried to recruit on those campuses'.

Philip Morris clearly recognises the threat to employee morale posed by public exposure and pressure. In the proxy statement distributed to shareholders for its 2000 annual meeting, management cited 'increased employee retention and motivational issues' and the impact of 'the current litigation and regulatory environment . . . on all company executives (including those executives in non-tobacco areas of the business)' as part of its rationale for granting special bonuses to thousands of employees.<ref>15</ref> Despite this sweetheart deal, and despite speculation that he was a potential successor to Bible, Eckert unexpectedly resigned in May 2000 in order to take over the toy maker Mattel (Advertising Age 2000b:6). Less than a month before, he had received an Open Letter, organised by Infact and signed by 58 US religious leaders, urging him to use his influence to stop Philip Morris' abusive practices or to separate Kraft from the tobacco giant.

At least two of Eckert's top deputies followed him out the door. According to food industry analyst Erika Gritman Long, 'it's absolutely essential [to retain employees] because this is an incredibly execution-sensitive business'. Long says that 'losing talent is a tremendous' earnings risk (CBS 2000, PRNewswire 2000).

A look towards the future

Clearly, Infact's tobacco industry campaign and Kraft boycott have forced Philip Morris to respond in numerous and costly ways - and have thus contributed to life-saving gains. Since May 1993, the tobacco corporations have been forced to admit the addictive and deadly effects of their product, they have begun to pay some of the enormous health care costs associated with it, their once-powerful lobbying arm, the Tobacco Institute, has been shut down, and they have given up some of their most outrageous promotional tactics in the USA. People around the world are beginning to hold these corporations accountable for the harm they cause.

Yet Philip Morris continues its aggressive promotion with tactics like Marlboro Man, arguably the world's leading source of youth tobacco addiction. The continuing prevalence of this image underscores the lack of independent government authority to regulate the tobacco giants. Meanwhile, the corporation employs increasingly expensive and sophisticated public relations to cover its tracks, even going so far as to stake out a 'reasonable' position in favour of 'sensible' regulations.

Actions speak louder than words: the experience of Infact and other organisations has long proven that concerted grassroots campaigning can and does change corporate behaviour. By providing an unprecedented view inside a transnational corporation, Philip Morris's internal documents enhance our planning and analysis. Growing Kraft boycott pressure on Philip Morris, using organising tools like the documentary Making a killing, will curtail specific abuses like Marlboro Man.

While we make it more difficult and costly for Philip Morris to go on with business as usual, Infact is also working with allies in the Network for Accountability of Tobacco Transnationals to secure...
public policy advances that will protect the health and lives of future generations. As well, the FCTC has the potential to prevent the further spread of tobacco addiction, to limit the political power of tobacco transnationals, and to set global standards affecting other industries whose policies, practices or products endanger health or the environment. Together, environmental, consumers, human rights, and corporate accountability organisations are forging new ground in international law to prevent life-threatening abuses by these corporations.

Notes
5. 'INFACT initial research', Barry Holt, spokesperson, to Craig Fuller, Senior Vice-President for Corporate Affairs, #2047904454, 29 June 1993.
8. Memo regarding InFact to Wendy Burrell (Philip Morris International) and Richard Collins (Kraft General Foods International), #2504093017/9306, 27 May 1994; Memo from Holt to Fuller regarding InFact, #2045994894, 6 January 1994.
9. Memo from Holt to Fuller states: 'My office is monitoring the critic group's activity...'. #2045664894, 6 January 1994; Memo from Sheila Raviv and Roy Perkins (Burson-Marsteller) to Holt states: 'Determine which groups have been solicited to by the critic to join campaign', and 'intensify monitoring of third-party groups', #2045994612, 12 April 1994.
10. 'Critic boycott: History and strategic recommendations', #2046019682, 1 August 1994; Memo from Holt to Fuller regarding InFact, #2045994894, 6 January 1994; Note regarding InFact activists for Darienne Dennis at Philip Morris, #2045994612, 24 March 1994; RJR Nabisco letter to retailers to call toll-free number regarding InFact activity, #509926449A/6450, 28 April 1994.
11. Memo from Sheila Raviv and Roy Perkins to Holt regarding the boycott, #2045994611/4612, 12 April 1994; 'Critic ally targets tobacco companies' promotional campaigns and marketing methods in spring publication', #2023437008, 12 May 1994.
12. Memo, 12 April (#2045994611), states: 'The key to handling this situation will be reassuring key contacts at the various companies that the effort against PM will have little, if any, impact financially and the best policy — at least for now — is to "wait it out"'; INFACT update, #2047904453, 5 August 1993, states: 'We will have to fight with everything we have'.

References
Advertising Age 2000a, '100 leading national advertisers', 25 September, p48; 'Top 100 megabrands', 13 November, 66.
Advertising Age 2000b, 'Eckert to craft makeover for troubled toy marketer', 22 May.
Business Week 1999, 'Philip Morris: What it's like to work at America's most reviled company', 29 November.
Chakravarty, S.N. and N. Santelmann 1990, 'Philip Morris is still hungry', Forbes, 2 April.
Philip Morris 1999, 1999 annual report, Philip Morris Companies, Inc.
USDHHS (US Department of Health and Human Services) 1994, Preventing tobacco use among young people: A report of the Surgeon General, Centers for Disease Control and Prevention, Atlanta.
Wall Street Journal 2001, 'Survey rates companies' reputations, and many are found wanting', 7 February.

Development Bulletin 54
Criminal organisations and cigarette smuggling,

The International Consortium of Investigative Journalists

Tobacco manufacturers have often blamed the international smuggling of their products on organized crime. But a year-long investigation by the Center for Public Integrity shows that tobacco company officials at BAT, Philip Morris and R.J. Reynolds have worked closely with companies and individuals directly connected to organized crime in Hong Kong, Canada, Colombia, Italy and the United States. One Italian government report obtained by the Center states that Philip Morris’ and R.J. Reynolds’ licensed agents in Switzerland were high-level criminals who ran a vast smuggling operation into Italy in the 1980s that was directly linked to the Sicilian Mafia. Corporate documents, court records and internal government reports, some of which go back to the 1970s, also show that BAT, Philip Morris and R.J. Reynolds have orchestrated smuggling networks variously in Canada, Colombia, China, Southeast Asia, Europe, the Middle East, Africa and the United States as a major part of their marketing strategy to increase profits. The corporate documents refer to this black market business as ‘duty not paid’, ‘parallel’ markets, ‘general trade’ or ‘transit’. But these same documents often clearly delineate between this aspect of the business and legal trade. For example, one BAT official, in a 1989 letter to associates in Taiwan, said, ‘With regard to the definition of transit, it is essentially the illegal import of brands from Hong Kong, Singapore, Japan, etc. upon which no duty has been paid.’

Reasons for smuggling

The companies have sought to undercut rising government taxes, which studies show are the main reason most smokers quit, as well as to gain market share on their competitors or on government-controlled tobacco monopolies by offering competitively priced popular international brands on the black market. The result has been tax evasion on a global scale that has greatly depleted government treasuries, especially in Third World countries. Cigarette smuggling has also fostered international crime and money laundering and alarmed growing numbers of law enforcement officials worldwide. Attracted by huge profits, quick turnovers, a captive market and relatively light penalties if caught, organized crime now controls large sectors of the smuggling.

‘Organized criminals, who have traditionally been involved in smuggling illicit narcotics, are suddenly realizing that tobacco is a good thing to get into, as you make just as much money, and it’s perhaps not quite as anti-social’ Douglas Tweddle, the outgoing director for compliance and facilitation at the World Customs Organization in Brussels, told the Center. ‘The public generally aren’t against you if you’re selling smuggled cigarettes; in fact, they rather appreciate you. And if you get caught, in virtually all countries, the penalties for smuggling tobacco are a great deal less than smuggling heroin or cocaine’.

In the United States, cigarette imports have risen so dramatically that investigators are looking into whether the country is being used as a way station in the global smuggling trade. ‘Profits from cigarette smuggling rival those of narcotic trafficking’, then-U.S. Customs Commissioner Raymond Kelly told congress last year. ‘The United States plays an important role as a source and transshipment country’.

The black market trade

It is estimated that about one in every three cigarettes exported worldwide is sold on the black market. This enormous business is operated through a web of offshore companies and banking institutions that often employ the same routes and distributors. Russian and Italian mafia use Cyprus and Montenegro. The drug cartels and U.S. mafia use Aruba and Panama. The same names turn up in smuggling networks into Colombia, Canada and Europe. In Southeast Asia, the same distributors who smuggle out of Hong Kong to China also control distribution out of the Philippines and Singapore.

The Center investigation shows that the manufacturers funnel massive amounts of their brand name cigarettes into these smuggling networks, often employing circuitous routes in an apparent attempt to shield themselves from accusations of wrongdoing. Distributors and manufacturers work hand in hand to feed this market. But, in some cases, the manufacturers have worked directly with organized crime figures.

A Colombian lawsuit against Philip Morris and BAT accuses them of involvement in drug-money laundering through what is known as the "black market peso exchange," a circuitous system by which drug dollars are laundered for clean pesos through the purchase and importation of such goods as cigarettes and alcohol.

In a federal civil racketeering lawsuit launched in 2000, Colombia’s governors accused tobacco company executives of illegally entering the country to organize smuggling networks and retrieve cash payments, which were then smuggled out for deposit in offshore banks. Company employees are also alleged in the lawsuit to have bribed border guards. And their agents have been implicated in illegal cash campaign contributions to Colombia’s former president Ernesto Samper.

April 2001
In Italy, court cases and police and government reports reveal an intricate web of Mafia families that through bribery, intimidation and murder control the smuggling of billions of Philip Morris and R.J. Reynolds cigarettes into Europe through Cyprus, Albania and Montenegro.

In Spain, at least one major distributor for RJR is allegedly a black market distributor linked to illegal drug trafficking.

In Canada, RJR sales executives dealt directly with smugglers linked to the American and Canadian mafia.

In some cases, tobacco industry executives actively played various gangs off against each other and solicited and received millions of dollars in kickbacks or bribes in return for selling to preferred criminal syndicates, according to court records and sources.

Involvement of tobacco company executives

The Center investigation also shows that when senior or mid-level executives have been charged criminally with aiding and abetting smuggling, tobacco companies often don’t cooperate with investigators. In a Louisiana case, for example, lawyers for one tobacco company used their connections in the administration of former President Bill Clinton to force the removal of a prosecutor pursuing a Brown & Williamson sales executive for smuggling into Canada.

The major tobacco companies all vigorously deny any involvement in the smuggling of their products. In a statement to the Center, BAT also said it knew of no evidence to substantiate allegations that some of its employees or distributors have worked with criminal organisations and/or organised crime.

The impact of criminal investigations

Top BAT executives, at a meeting last summer, considered the company’s marketing strategy in light of expanding investigations, media reports and civil lawsuits. An industry source told the Center that BAT executives discussed halting all ‘transit’ business but worried that shareholders would be furious at the resulting drop in profits, which one government source estimated to be as high as £500 million (US$720 million) annually. BAT decided to continue the ‘transit’ business, the industry source said, but no longer to refer to it as transit, DNP or GT. The new company term is ‘WDF’ for Wholesale Duty Free.

The executives also discussed taking steps to counter any civil and penal actions that could threaten the company’s survival, the source said. Massive smuggling has sparked a growing number of lawsuits. In a 12-month period ending last year, Canada, the governors of Colombia, Ecuador and the European Union all filed separate racketeering suits in the United States against the tobacco giants. Germany, Spain, France, Italy, Belgium, the Netherlands and Finland have since joined the EU suit. Among the charges, the EU accuses the tobacco companies of aiding and abetting smuggling, involvement in organized crime, defrauding state treasuries of billions of dollars, laundering drug money and committing wire fraud and mail fraud.

In addition, criminal investigations have multiplied. In the United States, several grand juries are examining the allegations of tobacco company involvement in cigarette smuggling, including one in Raleigh, N.C., and another in New York. A multi-agency investigation, coordinated out of Atlanta, is also looking into possible corporate involvement in cigarette smuggling and its related crimes, such as money laundering, according to federal government sources.

Canada, Italy and Britain have also launched criminal investigations. Still, with the exception of one case in Syracuse, N.Y., where a unit of RJR called Northern Brands International pleaded guilty in 1998 to smuggling-related charges, the tobacco industry has not faced criminal prosecution.

The growing list of civil cases, however, could prove devastating. Faced with possible treble damages under the U.S. Racketeering Influenced and Corrupt Organizations Act, the tobacco companies are vigorously fighting the lawsuits. Already, allegations have surfaced in the Colombian lawsuit that Philip Morris is corrupting the legal process through threats and the destruction of documents. BAT is alleged to have engaged in influence-peddling by putting political and government officials in Colombia on paid consultant contracts.

An affidavit sworn in September 2000 by José Manuel Arias Carrizosa, the executive director of the Colombia Federation of Departments (or states) says that Philip Morris Vice President J. Armando Sobalvarro tried to persuade Arias, in an October 27, 1999, meeting, that a lawsuit against Philip Morris was ‘not in the Departments’ best interests.’ Sobalvarro noted that Philip Morris was lobbying Washington for a large aid package for Colombia and concluded the visit by threatening Arias that if the lawsuit against Philip Morris proceeded, ‘there would be blood.’

For investigators like Hong Kong’s Godfrey, there is absolutely no doubt that BAT knew its cigarettes were being smuggled into China and Taiwan. ‘(BAT) is a very sophisticated company’, he said in an interview, ‘There’s no reason why they shouldn’t know.’ Godfrey also said he believes that bribery became institutionalized at BAT-Hong Kong.

Blood, threats, bribery and corruption are no strangers to cigarette smuggling. Tobacco companies seem to know that as well as anyone.

Notes

1. Reported by Maud S. Beelman, Bill Bimbauer, Duncan Campbell, William Marsden, Erik Schelzig and Leo Sisti and written by William Marsden. This is an investigative report of the Centre for Public Integrity, March 5, 2001 and is taken from the website http://www.publici.org/story
The Australian National Tobacco Strategy

Leanne Wells, Director, Tobacco and Alcohol Strategies Section
Australian Commonwealth Department of Health and Aged Care

This paper introduces the Australian National Tobacco Strategy and provides an overview of the environment in which the strategy was developed. It reviews the policy frame in which tobacco control is located in Australia and discusses the relationship between Australian tobacco control policy, the ten-point plan for tobacco control of the World Health Organisation (WHO) and broader global policy developments. The paper discusses the networks and partnerships that have been established at national, state and regional levels and the role these play in implementing the strategy. It concludes with an overview of action taken or planned by Australia to assist our regional neighbours to strengthen their tobacco control capacity and to participate in the Framework Convention on Tobacco Control (FCTC) negotiations.

The global agenda

WHO, the World Bank and many governments agree that policies to reduce smoking will work only if they are comprehensive, coordinated and sustained. Since 1970, through the World Health Assembly, WHO member states have supported resolutions to reduce tobacco use. Based on these resolutions, WHO has recommended a ten-point plan for comprehensive tobacco control. The measures include:

- use of fiscal policies to discourage the use of tobacco;
- health promotion, health education and smoking cessation programs;
- protection from involuntary exposure to environmental tobacco smoke;
- elimination of direct and indirect tobacco advertising, promotion and sponsorship;
- controls on tobacco products, including prominent health warnings on tobacco products and any remaining advertisements; and
- limits on and mandatory reporting of toxic constituents of tobacco products and tobacco smoke.

The broader global agenda provides added impetus and renewed interest in exploring best-practice tobacco control and its place within health and economic development policy. In the next two decades, non-communicable diseases will increase to over 70 per cent of the global burden of disease.1 Numerous factors influence this new 'epidemic' of non-communicable disease, but one risk factor overshadows all others: tobacco use. There will be increasing health problems linked to non-communicable disease and injury, many associated with ageing and the tobacco epidemic. Mental illness, cardiovascular disease and road traffic accidents are all in the top five predicted causes of the global burden of disease in 2020. But tobacco is set to be the biggest killer of them all – causing more deaths than malaria, HIV/AIDS and tuberculosis together.2

The tobacco epidemic is the driving force behind the FCTC, which will represent a collective international response to common concerns related to tobacco and will be the first-ever treaty on a public health issue. Australia has been actively involved in treaty negotiations to date and is the Western Pacific member of the six-person bureau overseeing it.

Australian Government involvement in tobacco control

The Australian experience is not unlike global trends. Tobacco use is among the leading health indicators and is the leading cause of preventable death and disability. It is responsible for about 12 per cent of the total burden of disease in males and 7 per cent in females (Mathers et al 1999). It is a serious risk factor for a range of chronic diseases, including cancer, cardiovascular disease and asthma, and is a significant burden on our health systems and communities. In 1998, an estimated 19,019 people died in Australia as a result of tobacco smoking (Ridolfo and Stevenson 2001). The social cost of tobacco use in Australia in 1992 has been estimated at $12.7 billion but this does not include the impact of passive smoking.

Australia has been active since the 1970s in promoting and working towards the implementation of comprehensive tobacco control strategies. Tobacco control measures were strong and effective, but could be regarded as a series of sequential, single-measure interventions. Our most recent developments recognise that there is no single solution to this major health dilemma. Smoking is unlikely to be reduced to acceptable levels without consistent, coordinated and comprehensive measures across all sectors that address supply, demand, tobacco product promotion and community acceptance.

As a result, Australia's more contemporary tobacco control results can be attributed to a range of strategies that have acted together to contribute to overall success. The precise impact of any one of these strategies is difficult to assess, as many have been implemented simultaneously with other measures. However, there has been an undeniable reduction in smoking prevalence (NHMRC 1995).

From 1945 to 1992, the prevalence of smoking among Australian males fell from 79 per cent to 28 per cent.3 This period saw some landmark tobacco control policy developments. The
1970s saw the first health warnings introduced; the 1980s marked the beginning of a period of significant regulation which banned smoking on domestic flights, saw the phase-in of almost complete bans on advertising on television and radio and in the print media, and saw the growth of legislation in Australian States and Territories to restrict smoking in work and public places and to restrict point-of-sale advertising and sales to minors.

Health promotion foundations are in place in one Territory and two States. They provide funding to arts and sporting bodies to replace tobacco sponsorship; some also provide resources for health promotion and research infrastructure.

Australia's first National Tobacco Policy was developed in 1991. It provided the framework for further tightening of advertising under the Tobacco Advertising Prohibition Act 1992; and it also led to a nationally agreed system of strengthened health warnings on tobacco products, resulting in some of the strongest and most prominent health warnings in the world at the time.

More recent tobacco control effort in Australia was spearheaded by changes to the excise treatment of tobacco; the changes have provided further price disincentives to smokers, closed the last remaining avenues that have permitted an association between tobacco advertising and sport, and established the internationally recognised National Tobacco Campaign.

The National Tobacco Campaign, launched in June 1997, has grown to be the most collaborative, intense and sustained anti-tobacco campaign ever seen in Australia. The campaign has achieved a high public presence, with strong relationships between and support from the Commonwealth, State and Territory governments, QUIT campaigns, and key non-government organisations (NGOs) involved in tobacco control. It has also had a measurable impact on smoking prevalence, which is estimated to have dropped by about 1.4 per cent (190,000 smokers) in the first six months of the campaign. This reduction was sustained over the following year. The campaign's focus is adult cessation and the message 'Every cigarette is doing you damage'. The campaign is supported by a range of nationally coordinated cessation services.

The National Tobacco Strategy

In federated countries such as Australia, various levels of government have responsibility for different aspects of public health. While the provision of health services is traditionally and constitutionally the province of State governments, the issues of health and health outcomes transcend boundaries. The Federal government is responsible for Medicare (Australia's universal health insurance system), for the Pharmaceutical Benefits Scheme, and for the cost burdens placed on these systems by preventable chronic disease. However, Federal and State governments work together to respond to health challenges; major governance structures have emerged to foster partnership and collaboration, strengthen infrastructure, and improve capacity in public health effort. These structures include the National Public Health Partnership and the Ministerial Council on Drug Strategy (MCDS).

The MCDS is the peak policy and decision making body for licit and illicit drug issues in Australia. In 1999, it endorsed the National Tobacco Strategy, the first comprehensive national approach to tobacco control in Australia. The strategy is a commitment by all governments in Australia to take action on tobacco control across a range of agreed key strategy areas and is a model suited to a federated country such as Australia. The strategy articulates the priorities, capacities and responsibilities of different jurisdictions and NGOs to ensure that targets for tobacco control are achieved. It is regarded as essential to maintaining a comprehensive approach to tobacco control into the twenty-first century and to ensuring a firm commitment to meet Australia's goals and targets for tobacco control.

The Australian National Tobacco Strategy 1999–2002/03 is the first action plan under Australia’s National Drug Strategy to be developed and to commence implementation. The strategy represents a collaborative framework for national action on tobacco control issues, providing national leadership while allowing flexibility for each jurisdiction and the non-government sector to ensure that tobacco control action is responsive to local needs and priorities as well as national imperatives.

The strategy is framed around the goal of improving the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms. It has four main aims:

- prevent the uptake of tobacco use in non-smokers, especially children and young people;
- reduce the number of users of tobacco products;
- reduce the exposure of users to the harmful consequences of tobacco products; and
- reduce exposure to tobacco smoke.

There are six key strategy areas designed to address supply, demand and promotion of tobacco products:

- strengthening community action;
- promoting cessation of tobacco use;
- reducing availability and supply;
- reducing tobacco promotion;
- regulating tobacco; and
- reducing exposure to environmental tobacco smoke.

Within this framework, each tier of government in Australia is developing tobacco control plans; there are also national initiatives. Highlights or achievements from the first year of implementation include:

- the launch of the third phase of the National Tobacco Campaign;
- work with the Australian Indigenous community, where smoking prevalence is double that of the general population;
- the development of smoking cessation guidelines for health professionals;
- education and training measures for health professionals;
- the Tobacco Advertising Prohibition Amendment Bill 2000;
- a review of health warnings on tobacco products;
- a voluntary agreement for ingredients disclosure;
• new or strengthened legislation in many jurisdictions to reduce and control point-of-sale promotion of tobacco products and to impose bans on smoking in most enclosed public places; and
• an inaugural National Tobacco Control Conference.

Other relevant areas of policy
A great deal of tobacco control activity occurs outside the national drug strategic framework, and a number of other national public health strategies influence the control of tobacco in Australia. An imperative for the National Tobacco Strategy is to establish links with other national strategies to ensure that tobacco control is being addressed in an integrated and consistent manner.

Two contemporary initiatives in particular serve to highlight the importance of effective tobacco control in preventing disease. The National Health Priority Areas Initiative is an important collaborative mechanism involving Commonwealth, State and Territory governments, the National Health and Medical Research Council, the Australian Institute of Health and Welfare, NGOs, appropriate experts, clinicians and consumers. The initiative targets and reports on five priority groups of diseases or conditions (cancer control, cardiovascular health, mental health, diabetes mellitus and injury prevention and control) across the continuum of care (from prevention through to treatment, management, maintenance and research). This provides an integrated approach to tackling health determinants and major risk factors such as smoking that are common across several priority areas.

The National Public Health Partnership is an Australian public health reform which has introduced a new working arrangement to plan and coordinate public health activities via jointly developed policies, funding agreements and work programs. It provides a further avenue through which to advance tobacco control. For example, the partnership has supported the development of a national best-practice response to passive smoking, providing State and Territory legislators with a 'tool kit' of model principles and legislative clauses to help build or strengthen legislation designed to limit smoking in enclosed public places. It has also supported, in conjunction with the general practice sector, the development of a framework for enhancing the role of general practice in population health. A consensus statement has been developed; eventually, there will be an action plan for the management of behavioural risk factors, including smoking, in general practice.

Wider public policy trends
The National Tobacco Strategy also reflects wider public policy trends. The concepts of 'joined-up thinking' and 'joined-up solutions' (terms that were coined initially in the UK) have been paramount in some recent public policy thinking. In the health community, this sentiment can be seen in the increased attempts to share information, to network and to improve collaboration and joint action across strategies. It is also evident in the increasing attempts to break down the boundaries between 'single-issue' health strategies, particularly with strategies which are concerned with health issues that have common risk and protective factors. This particularly applies to the four behavioural risk factors—tobacco use, alcohol use, nutrition and physical activity—where Australia is beginning to think about how we can take better, more integrated approaches.

The term 'social coalitions' is also used in the current policy environment, mainly to describe avenues through which joint action can be taken to solve community problems. In essence, it recognises the specialised knowledge and expertise of volunteer and community organisations working with social issues 'on the ground'. In practice, it is evidenced in the emergence of more inclusive infrastructure to guide and recommend policy in provinces that have traditionally been exclusively government. In the tobacco arena, for example, we have a National Expert Advisory Committee on Tobacco, comprising government and community members and chaired by an NGO.

Similarly, we have an active and influential non-government sector with a broad constituency ranging from academia to health organisations such as the National Heart Foundation, Australian Cancer Society and Action on Smoking and Health. Such organisations are well informed and engaged players in the policy process and are increasingly regarded as partners in policy and program development.

Australian Government involvement in promoting tobacco control capacity in the Western Pacific region
The WHO Tobacco Free Initiative is a project established in 1998 by the Director-General of WHO to reinvigorate and give greater priority to work on tobacco control. FCTC forms the cornerstone of the initiative. The Framework Convention will be an international legal instrument intended to circumscribe the global spread of tobacco and tobacco products.

At the first meeting of the Intergovernmental Negotiating Body of the World Health Assembly in 2000, Australia secured one of the six vice chair positions on the Bureau of the Negotiating Body as the representative of the Western Pacific region. At the time, several countries in the region indicated they would be seeking support, guidance and leadership from Australia throughout the FCTC process.

Australia's leadership in the area of tobacco control in the region is demonstrated by:
• the negotiation of a memorandum of understanding between the WHO Western Pacific Regional Office, AusAID and the Department of Health and Aged Care to fund a project to build capacity in the Western Pacific region in tobacco control;
• Australia's attendance at the National Focal Persons on Tobacco or Health meetings convened by the WHO Western Pacific Regional Office in Manila in August 1999 and August 2000. The forum was established in 1999 by the WHO Western Pacific Regional Office to assist member states in the region to
share experiences regarding efforts to control tobacco use, particularly in relation to the development and implementation of the international FCTC; and

- planning currently under way to conduct a seminar and workshop on tobacco control issues, in collaboration with the National Centre for Health Promotion, for regional participants sponsored to attend Australia's inaugural National Tobacco Control Conference in June 2001.

Some reflections on tobacco control in Australia

The National Tobacco Strategy brings a number of strengths to public health action for tobacco control in Australia. The strategy is underpinned by a comprehensive approach, seeking to advance action across a number of key strategy areas. The multivariate approach adopted can be considered world best practice in accord with WHO standards. The strategy has the capacity to leverage 'minimum' action and commitment by all jurisdictions, and to ensure a degree of national consistency and action directed toward common goals across jurisdictions without rigidly imposing uniformity; it retains scope to address local needs and circumstances. This is why the model is particularly suited to a federation.

The strategy has enjoyed a strong 'public face' in the form of the National Tobacco Campaign, which has spearheaded other action under the strategy and served to keep tobacco on the public agenda. Tobacco use is dealt with mainly through the National Drug Strategic Framework; however, because tobacco use is a key behavioural risk factor, it rightfully spans other areas of public health policy. This offers the capacity for tobacco control action to be pursued via a range of avenues.

The strategy builds on a tradition of partnership and collaboration around drug and public health policy in Australia by bringing together governments, the public health community and tobacco control experts to collectively determine and act on national priorities in tobacco control. A key element is the National Expert Advisory Committee on Tobacco, which provides an important source of guidance on strategic direction and advice.

While the scope for innovation and pursuing emerging opportunities is recognised and valued, responsible public policy faces the imperative of delivering 'best buys' from limited funding. Evidence-based action is a hallmark of the strategy. Strategy implementation has followed a planned approach, beginning with the establishment and endorsement of national priorities by all jurisdictions. Activity in the first year of strategy implementation has concentrated on the formative work necessary to advance these national priorities from a sound research base. For example, the strategy contains a commitment to develop and disseminate Australian smoking cessation guidelines. Our first step has been to commission the National Heart Foundation to compile a literature review of evidence for the efficacy of particular smoking cessation interventions. They will also review and appraise existing smoking cessation programs against that evidence in order to lay the foundation for Australian guidelines - their development, dissemination and promotion. The National Heart Foundation study will also review guidelines in countries such as New Zealand, the UK and the USA and explore their applicability and adaptability to the Australian context.

The National Tobacco Strategy is Australia's first truly national collaborative strategy in tobacco control. It captures input and support from a range of Federal government agencies and from both government and non-government sectors in all States and Territories. It is a partnership model where stakeholders are involved in conception and priority setting and are committed to implementation towards common goals. The strategy positions Australia well in terms of meeting future tobacco control challenges, responding to emerging trends, responding to and participating in international and regional initiatives and ensuring leadership in the Western Pacific region.

Further information on the Australian National Tobacco Strategy can be found at <www.health.gov.au/tobacco>.

References


NHMRC (National Health and Medical Research Council) 1995, Health Australia: promoting health in Australia, Discussion paper, NHMRC, Canberra.

Notes

2. Dr Gro Harlem Bruntland, Director General, World Health Organization, 'Why Invest in Health', address to the Third International Conference on Priorities in Health Care, Amsterdam, November 2000.
Australia's national tobacco campaign: Strong medicine for a big problem

David Hill, National Expert Advisory Committee on Tobacco
Kate Hassard, Centre for Behavioural Research in Cancer, Melbourne

In her book The March of Folly, Barbara Tuchman documents episodes in history, from the siege of Troy to the Vietnam war, in which governments pursued policies that were clearly against their own interests in the face of clear, available evidence and insistent advice that those policies were not in their best interest. Tuchman might well have added a final chapter on the way rich, developed countries have treated the tobacco epidemic.

How can it be that we in developed countries do so little to prevent the preventable deaths from tobacco which, in our country, total about 19,000 a year, compared with about 1,000 for illicit drugs (Ridolfo and Stevenson 2001)? How can it be that we are so soft on an industry whose product, when used as intended, kills about half of its continuing users?

It is clearly a responsibility of developed countries to assist developing countries to avoid the ravages of tobacco, particularly as it is the aggressive economic, political and marketing strategies of Western tobacco companies that have created this deadly new market of manufactured cigarettes. We report here on a recent Australian campaign to promote smoking cessation in adults that appears both effective and transferable to other countries and cultures.

Developing a national anti-smoking campaign

In Australia, in 1996, the Minister for Health provided money for the first truly national anti-smoking campaign. There were adequate funds for the creation of high quality, new advertising material, together with a reasonable budget to ensure good reach and frequency of exposure for the campaign.

While Government would probably have preferred a campaign transparently targeting adolescents, since this would have brought the most political kudos, this was not the recommended strategy as teen campaigns are often ineffective and carry risks of backfiring if perceived by teenagers as an attempt to control inappropriate behaviour. The message can be seen as a double standard, as 'picking on kids' even though so many adults smoke.

There is greater potential to achieve health gains in the short and medium term through a cessation message targeting adults. Our best chance of saving lives is through getting current smokers to quit (Peto et al. 2000:452). As starting smoking in adolescence is partly determined by parental example, the more adults who quit the fewer teenagers will begin (Farkas et al. 1999). Therefore, the target market for the campaign launched in 1997 was, and remains, adult smokers aged 18–40 years. Total expenditure over the first year represented about $US0.35 cents a head.

Having decided that the aim was to persuade and assist pre-middle aged smokers to quit, and having decided that the bias should be towards lower socioeconomic groups, the next major strategic decision concerned the framing of the messages. The major channel of communication was to be television, because of its wide reach and ability to convey high-impact messages.

Developing effective messages

Through qualitative research and careful analysis of the smoker's perspective, we concluded that smokers were not much interested in the statistics on the harm of smoking. To the extent that they are interested at all, it is in the concrete ways in which smoking harms their bodies, and so messages that emphasise risk, even if it is a very high risk, simply invite them to take a chance as a gambler does. They translate the public health professional's dire statistics into rationalisations such as 'Smoking is like buying a ticket in a lottery that is drawn when you're 70. I'll chance that.'

A review of qualitative research from previous quit campaigns and further qualitative studies commissioned specifically during development of this campaign suggested that most smokers want to quit in the future, want new information about smoking (not things they think they already know), and need to be shocked into quitting. This raised the possibility that the most effective messages would best be negatively framed—that is, would focus on the negative consequences of failing to accept the recommendation to quit smoking rather than on the positive consequences of quitting. In particular, it raised the issue of the effectiveness of fear arousing communications.

Most people trained in behavioural science, psychology or health promotion have been taught that such communications are ineffective. There are some classic early research studies that seemed to indicate an inverted U relationship between the fear content of communications and response to recommendations. The claim is that, at the low end of the continuum where the communication does not even make people vaguely anxious, it will have little effect; where it makes them moderately anxious or fearful, it will have maximum effect; but where it is very frightening, the effect will be weak or nonexistent. The hypothesised reason for this is that people defend themselves against the negative emotions engendered by the message with denial and repression—they shut it out.
The inverted U is probably a good representation of the relationship of the fear response and behaviour change, but it does not mean we should not use 'scare' messages in anti-tobacco advertising (Sutton 1992). No matter how hard we tried, it would probably be impossible with mass communication channels like television to engender a truly highly fearful response. Is it conceivable that you could ever be made highly fearful (in the way that physical danger does) by a TV commercial? For all practical purposes, we think it is likely that mass communications operate in that zone where increasing the fear content increases the likelihood of response in the target population as a whole.

In developing the Australian campaign, we were very committed to making an explicit statement about how we thought the messages would affect an individual's smoking behaviour (Hill et al. 1998). The way the advertisements should work is that, having engaged the viewer's attention and interest, a conditioned association is formed between the act of smoking and a visceral (or emotional) response to depictions of its harmful effects. Thus, in the minds of smokers, images of damaged organs are substituted for, or at least compete with, the attractive associations with smoking that already exist in their minds. Because advertising campaigns are repetitive it is reasonable to expect these associations to be built up through repeated exposure. The psychological mechanism postulated to drive behaviour change is the motivation to reduce the discomfort and anxiety caused by contemplating the damage that smoking even a single cigarette can do.

The communication brief to our advertising agency called for the creation of advertisements which would put quitting on the smoker's personal agenda for today. The television advertisements had four main stimulus elements and four intended responses.

Structure of advertisements

First, there was what we called the 'empathy device'. In this was depicted a typical moment in a smoker's life. This was based on indications from smokers in qualitative research that what would strike a cord with them were slightly 'desperate' situations that mildly deprecated smoking. These were intended to elicit a response in smokers such as 'the people who made this advertisement understand me'.

Next was the 'conditioning device' designed to form strong associations between the act of smoking and images of the damage smoking causes. The purpose here was to achieve emotionally loaded, intrusive thoughts about the harm that would replace, or at least compete with, the good feelings. We also had indications from qualitative research that smokers intent on quitting needed a memory bank of 'strong stuff' to draw upon when suffering the hardships of quitting. New news about smoking was needed to overcome the smoker's defence that they have heard it all before. There needed to be novelty in the message. As well, we wanted to achieve what we came to call the 'yuck' factor – the thought that 'I can't bear to think I'm doing that to myself'.

Finally, there was focus on the immediate and certain effects of smoking rather than on the less probable, if more dire, consequences, such as death from a smoking-related disease. There is plenty of evidence in the more general field of behavioural research that the certainty of consequences is a greater deterrent than the severity of them. Underpinned by this rationale of behaviour change, a suite of six advertisements was produced over three years. During this time, there were a number of waves of media advertising concentrated very strongly on television. The greatest intensity was at the launch in June 1997. This included Artery, showing the build-up of fatty deposits on the artery wall, and Lung, depicting damage to the air sacs in the lungs. These were followed by Tumour, showing the growth of a tumour in the airway. In May 1998, two additional advertisements known as Brain and Call for help were added to the suite, and the campaign was re-launched around them. Brain dealt with stroke as a tobacco-related disease, and Call for help modelled a smoker calling the Quit counselling line for assistance. In May 2000 the final two advertisements were launched. Eye showed damage to blood vessels behind the eye resulting in blindness, and Tar depicted tar accumulating in the lungs. Each of the advertisements finished with the national 'Quitline' number, encouraging smokers to call for advice on quitting.

TARPS and Quitline calls

By superimposing calls to the Quitline on the level of media buy (TARPs, or target audience rating points), there is a strong relationship between television advertising activity and the response of smokers wanting help in quitting. There was an additional effect in June 1997 and April 1998, presumably due to public relations activity generating news coverage at the time of campaign launches.

What is particularly interesting about these figures is that even after 18 months, by which time saturation might have occurred, 'switching' on the television advertising campaign 'switches' on calls to the Quitline in the same way as it did at the beginning of the campaign. It suggests that smokers are cycling in and out of a readiness to quit which makes them differentially responsive to anti-smoking advertising at different times. The implication is that, if advertising is stopped over long periods of time, there will be many smokers who cycle in and out of a readiness to quit without being helped by the campaign at the optimal moment – possibly a missed opportunity to save lives.

Evaluation of the campaign

It was necessary to devise a comprehensive matrix of measures from which to judge the effectiveness of this campaign. Because the advertising was based on an explicit model of how the messages would be processed and acted upon by smokers, it was possible to frame evaluation measures to test for specific hypothesised effects.
Two publications report the results of the evaluation and can be viewed, together with images of the creative material, at <www.quitnow.info.au/Hotspots.html>. The following evaluation results focus only on large telephone sample surveys conducted immediately before the campaign began, six months into the campaign and after 18 months (Hassard 1999, 2000).

By the end of six months the population survey showed:

- 87 per cent of the adult population were aware of the campaign;
- 50 per cent of smokers said the ads were 'very thought provoking';
- 59 per cent of smokers said they were 'very believable';
- 44 per cent of smokers said they were 'very relevant to me';
- 76 per cent of smokers said they 'encouraged me to quit'; and
- 60 per cent of recent quitters said the campaign made them 'more likely to stay quit'.

Although the campaign was intended to engender negative emotions about smoking, it also operated at a cognitive level, conveying new knowledge. It produced change in health beliefs on topics dealt with in the advertisements but did not produce change in beliefs about topics not targeted. Such specific effects strengthen confidence that campaign effects are 'real' and not spuriously correlated with some extraneous factor.

We were concerned by the possibility that such a strong and confronting campaign might have counter-productive effects, provoking people to discount the message. One survey item checking on this possibility asked people to agree or disagree with the statement 'The dangers of smoking have been exaggerated'. Reassuringly, the proportion of people who thought the dangers had been exaggerated actually fell significantly after the campaign, as did the proportion who thought 'the occasional cigarette does not do any damage to your health'.

In the first six months, the campaign also affected smokers' personal beliefs and feelings. There was an increase in the proportion who thought they had already damaged their body by smoking. Importantly for our model of behaviour change, we found an increase in the percentage who felt 'bad' about being a smoker, which suggests an unease about their smoking which might seek to relieve by trying to quit.

### Stages of behavioural change

Through the work of Dr Prochaska, his colleagues and others, we understand that quitting smoking is a process, not an event, and there are likely to be stages through which people pass before they become successful long-term quitters (Prochaska and DiClemente 1983). This being the case, we would expect an effective campaign to reduce the proportion of smokers not yet contemplating giving up smoking and to increase the proportion contemplating or preparing to quit. This was the pattern we found after six months.

The most important evaluation questions were: did smokers try to quit and did they succeed? After six months there was an increase of 18 per cent compared with baseline in the proportion thinking at least daily about quitting. More had tried to quit in the two weeks immediately preceding the survey and more had actually quit—an increase from 8.3 per cent to 11.4 per cent.

### Benchmark and follow-up

After 18 months, most of the gains had been sustained or further improved. There were two measures of population prevalence, based on large telephone surveys. The "enumerated" household sample was information about all members of the household based on a proxy report by the person answering the telephone, whereas the "informant sample" was based only on data about the person answering the telephone. Both samples gave very similar results, indicating that there were around 1.8 per cent fewer people smoking 18 months after the campaign than before it started. Prior to the start of the campaign, the prevalence of smoking had not been falling for several years, so this result represents a change in the trend line which we believe is at least partly attributable to the effects of the campaign.

### International applications of the campaign

The advertisements are now being used beyond Australian shores. The USA (Massachusetts, California), United Kingdom, Canada (British Columbia), Singapore, New Zealand, Poland, Iceland and Cambodia are some of the countries using the campaign material. Cambodia and Singapore have adapted the scenes depicting smokers by reenacting them with local actors in culturally relevant environments, while keeping the health effects images and structure of the advertisements unchanged. It is enormously satisfying that the health benefits of this campaign may be experienced within the international community.

### References


The politics of tobacco control in Australia

John Ballard, The Australian National University

In Australia, smoking is a health issue. There is almost universal acceptance that smoking causes disease and a very effective anti-smoking movement has a willing audience to which it appears credible and reasonable. In contrast, the industry suffers from negative perceptions and cynical audiences. The industry and our smokers are isolated. The isolation is exacerbated by significant legal exposure. Australia is a template for anti-smoking groups in other countries. David Davies to A. Daw, 30 Nov 1993

This statement from the Chief Executive Officer of Philip Morris in Australia probably exaggerates the significance of Australian policy and activism on the international scene. It does, however, capture the frustration of the tobacco industry, accustomed to unfettered markets, in a country which by 1993 had established controls over advertising and was beginning to take seriously the effects of passive smoking. In any event, an examination of the Australian experience may prove instructive for those countries on which the tobacco industry has focused its examination of the Australian experience may prove instructive for those countries on which the tobacco industry has focused its attention after finding Western markets increasingly restricted.

Tobacco politics is a unique species of policy making. On no other issue of public health and wellbeing has there been a powerful industry committed for 40 years to denying its own evidence concerning the health impact of its products. This fact, widely believed by health authorities and activists for many years and recently confirmed by the exposure of internal industry documents, has shaped the nature of policy debate and has led to much greater willingness to invoke stringent government regulation, rather than rely on self-control by the industry and by smokers.

As Australia emerged from an extended period of economic restriction in the mid-1950s, the longstanding monopoly held by British Tobacco (WD & HO Wills) was broken by the establishment of new factories by Philip Morris and Rothmans, who introduced aggressive marketing for a proliferation of new brands. Cigarette consumption, which had been rising since World War II, attained new heights, and women for the first time took up smoking in substantial numbers. The establishment of factories in the mid-1950s was welcomed by governments eager to substitute local production for imports. From 1949 to 1972, conservative Federal governments were committed to national industrial and agricultural development, and State governments, including those controlled by Labor, were equally committed.

During the 1960s, an increase in Australia's tobacco growing to meet new demand received strong government support. The three manufacturers agreed to purchase 50 per cent (57 per cent from 1977) of their leaf domestically in exchange for a concessional tariff on equivalent imported leaf, producing a premium for local growers of 36 per cent, or $20 million, by 1993. However, the shift towards economic rationalisation brought a gradual phasing out of support for what had become the most highly assisted agricultural industry in Australia.

At the time the tobacco industry became a focus for government support in the 1950s, the discourse of tobacco as an engine of development began to be challenged by an anti-tobacco discourse of health. From early in the twentieth century, a few doctors had been active in warning of the effects of smoking, but their impact was limited and a large proportion of doctors smoked tobacco. The first results of British and American research on tobacco and lung cancer were published in 1950, and by the mid-1950s the National Health and Medical Research Council was calling for anti-smoking education campaigns and a prohibition on tobacco advertising to the young.

Medical groups were the first to mobilise anti-tobacco campaigns. The medical director of the Anti-Cancer Council of Victoria was a mobilising force behind the policy adopted by the National Health and Medical Research Council (NHMRC), and other state cancer councils became active. In 1966, Dr Cotter Harvey, President of the New South Wales (NSW) Medical Board and of the National Tuberculosis and Chest Association, helped set up the Australian Council on Smoking and Health (ACOSH), with a few active State branches. Under pressure from the medical profession, ministers for health at both State and Federal levels sought support for health warnings, advertising restriction and education campaigns, but they carried no weight against forces protecting the industry.

Controls on advertising

By the late 1960s, a causal relationship between tobacco and lung cancer had become medical orthodoxy. Public and political consciousness rose despite the mobilisation of counter-arguments by the tobacco industry and the scientists whom it subsidised. In the absence of Federal government action, the states began to move, adopting health warnings on cigarette packs. Federal regulations required warnings to be included in radio and television tobacco advertisements, but under industry pressure they were watered down from 'smoking is dangerous to health' to 'smoking is a health hazard'. Nonetheless, the adoption of health warnings was the first evidence of a conversion of governments from a pro-smoking stance, and it provided anti-tobacco groups with political respectability.
While public opinion favoured health warnings and education campaigns, there was initially reluctance to support a ban on advertising. The UK had banned cigarette advertising on television from 1965, and the US from 1971. A voluntary code of advertising adopted by the industry enabled coalition governments to deny the need for regulation; in 1973, a new Labor government backed away from its electoral pledge to ban radio and television advertisements and implemented instead a three-year phasing-out period. By 1976, the coalition was back in office. A cabinet vote resulted in a majority opposing the implementation of the ban, but the Prime Minister, Malcolm Fraser, declared the motion carried anyway. During debate in Parliament, however, the leader of the National Country Party succeeded in adding a seemingly innocuous industry-sponsored amendment permitting 'incidental and accidental' display of advertising. This was proclaimed necessary for the broadcast of anti-tobacco advertisements, but it effectively opened the gate to the continuous display of perimeter advertising in televised sport.

Sports sponsorship

The tobacco industry had begun supporting sports and cultural events in the 1950s, but after the 1976 ban the industry's substantial television advertising budget was diverted to much less expensive print media and sports sponsorship. Major Australian sporting fixtures were taken over by tobacco: test cricketer by Benson and Hedges, the Australian Open tennis tournament by Marlboro, and NSW Rugby League by Rothmans Winfield, the most popular brand of the 1970s and 1980s. The industry claimed that it was interested only in competition for brand loyalty, denying allegations by anti-tobacco forces that sports sponsorship was a blatant appeal to the young, allegations later justified by revelations from industry documents. In 1976, Philip Morris organised the Confederation of Australian Sport, which became the main representative body for sport, successful in obtaining substantial government funding for sports. From the start, the industry covertly paid the salary and office expenses of its president.

In 1977, a report of the Senate Standing Committee on Social Welfare (Drug Problems in Australia – an Intoxicated Society) provided the first overview of tobacco policy and recommendations for reducing consumption, including curbs on advertising and sports promotion, and an end to subsidies. The Australian Medical Association responded with more radical proposals: a ban on vending machines, taxation by tar content and a levy on tobacco sales to fund a public information programme. The industry, aided by media and advertising bodies, lobbied vigorously against all these proposals, and the Federal government took no action.

In 1979, on the eve of setting up a Tobacco Institute of Australia to coordinate public relations, a Philip Morris review of industry strategy noted that lobbying by sporting groups had succeeded in defeating proposals in the States to make health warnings compulsory on all advertising. "We had little trouble in persuading sports writers to defend our sponsorship, as many of them are closely involved in corporate promotions." Contracts with sporting associations contained escape clauses allowing withdrawal in the event anti-tobacco legislation interfered with advertising.

Tobacco control activism

Medical groups in Victoria, Western Australia and South Australia maintained the battle for further restrictions on advertising, and other more activist anti-tobacco groups formed during this period. The Non-Smokers Movement of Australia (NSMA) was organised in Sydney in October 1977 to protest against the failure to implement rules on smoking in public transport; the industry's response was covert sponsorship of a Smokers' Rights League and its publicity. The NSMA developed a tradition of embarrassing public officials and supporting occupational health litigants, achieving substantial media coverage for its cause.

A younger generation of activists, graduates of the movement against the Vietnam war, took a more radical stance in opposing the industry. In 1978, a small group of public health activists organised a Movement Opposed to the Promotion of Unhealthy Products (MOP UP). It succeeded, through a complaint to the Advertising Standards Council, in getting withdrawal of Winfield advertisements featuring Paul Hogan on the grounds of his appeal to children and adolescents. Annual MOP UP protests in Melbourne were also credited with the termination of Marlboro's sponsorship of the Australian Tennis Open Championships.

Initially an offshoot of MOP UP, the more anarchic BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions) achieved greater notoriety, becoming an international model for effective civil disobedience. Over a period of eight years, BUGA UP was best known for its spray-paint 're-facing' of tobacco advertising billboards, most often altering their lettering: 'Mild and Marlboro' became 'Vile and a Bore', 'Dunhill' became 'Dunghill', and 'Anyway, Have a Winfield' was transformed into 'Anyway, Have a Wank, It's Healthier'. BUGA UP's messages politicised the issue of tobacco control by catching the public imagination and were credited with swaying opinion towards regulation of advertising.

Health promotion approaches

Meanwhile the North Coast regional office of the NSW Health Department, taking seriously the new concept of health promotion, set up a community intervention project involving the social marketing of healthy lifestyles, including tobacco education. Its Quit for Life smoking campaign proved highly effective and served as the basis for a State-wide campaign in 1983, the first of its kind and widely emulated. The programme was heralded as a turning point in the reorientation of Australian public health policy towards health promotion, with significant impact not only in the approach to tobacco education but also in Australia's response to AIDS.

A series of attempts were made in South Australia and Western Australia to introduce legislation banning forms of tobacco advertisement subject to state control. In each case, industry
lobbying of conservative parties succeeded in blocking action. Then, in 1987, the well-funded Anti-Cancer Council of Victoria succeeded in pushing through a most significant innovation. A campaign carefully orchestrated in conjunction with the State Minister for Health won bipartisan support for a substantial tax increase on tobacco products, an increase dedicated to the funding of a new Victorian Health Promotion Foundation (VicHealth). The foundation was given responsibility for tobacco education programmes; it succeeded in displacing the tobacco industry's subsidies for sport and the arts. The foundation provided an innovative model which was copied by South Australia, Western Australia, California and Massachusetts. The Tobacco Institute of Australia, which had proved successful in stifling earlier attempts at legislation, was caught off guard in Victoria, with insufficient time to mount a counter-campaign.

There was then increasing pressure on the Commonwealth Labor government to close the loophole in the Broadcasting Act 1976 and ban print advertising, which lay within its jurisdiction. The government was loath to offend Australia's media barons, Rupert Murdoch and Kerry Packer, because tobacco provided ten per cent of Packer's advertising income and Murdoch was closely affiliated with the industry. However, in August 1989, a small minority party, the Australian Democrats, forced the government's hand by declaring that they would table legislation banning all remaining forms of tobacco advertising. Public opinion polls showed strong support for a ban, and the government, about to face an election in which it sought Democrat preferences, decided to support their bill.

By this time, a federation of anti-smoking groups, Action on Smoking and Health, had been established, with offices in the NSW Cancer Council. The group coordinated the first national lobbying campaign against tobacco. The Tobacco Industry Association presented its usual case: that advertising neither affects were forced to abandon a filibuster and accept the bill.

Smoking and Health, had been established, with offices in the
showed strong support for a ban, and the government, about to
face an election in which it sought Democrat preferences, decided
to support their bill.

By this time, a federation of anti-smoking groups, Action on Smoking and Health, had been established, with offices in the NSW Cancer Council. The group coordinated the first national lobbying campaign against tobacco. The Tobacco Industry Association presented its usual case: that advertising neither affects children nor increases consumption, but merely affects brand
market share, and that bans are a form of censorship restricting commercial and individual freedom, a precedent for further incursions. Government amendments effectively rewrote the Democrat legislation, deleting reference to peripheral television and sports sponsorship and focusing only on the issue of print advertising; the print media were quietly assured of continued self-regulation on alcohol advertising. The coalition parties were badly divided on the issue, but, under intense media scrutiny, were forced to abandon a filibuster and accept the bill.

The issue of sports sponsorship remained on the agenda. By the time the Commonwealth Government came to act on the issue in 1992, there were several precedents on which to draw, including recent legislation in Hong Kong. Two pieces of research were of considerable importance in persuading the Labor cabinet to support removal of the exemptions implanted in the 1976 broadcasting ban. The first showed that consumption of tobacco and alcohol carried greater social costs than illicit drug use; this received wide publicity. The second was research by the Anti-Cancer Council of Victoria that undercut industry claims by showing that, among school-age smokers, brand preference varied markedly according to football sponsorship in each state. This evidence was crucial in swinging the support of some ministers. Written into the legislation, however, was authorisation for granting exemption for international sporting events which Australia might lose if tobacco sponsorship were cut off; only in 2000 was further legislation passed specifying that this exemption would end in 2006.

Since the 1992 act, further control of advertising has occurred in the form of expanded warnings on cigarette packs and limitation of point-of-sale displays. NSW introduced stringent restrictions on the size, placement and format of point-of-sale advertising, and in 2000 the Tasmanian Government proposed comprehensive tobacco legislation which would make it the first State, and perhaps the first jurisdiction globally, to ban all advertising at point of sale.

Environmental tobacco smoke

Historically, smoking indoors has been traditionally confined to specified spaces – for example, the smoking room and the public bar. Only after World War I did it become the norm for smoking to occur in workplaces, restaurants and public transport. Complaints by non-smokers led to the segregation of non-smoking spaces in public transport, but only in the 1970s were entire trains and buses declared off-limits for smoking, in part because of cleaning costs.

Litigation for compensation for the effects of passive smoking was unheard of until the mid-1980s, while lawsuits for damages from active smoking remained unsuccessful. In 1986, a number of authoritative reports on the harmful effects of passive smoking were published, and the NHMRC, referring to US precedents, called for the restriction or prohibition of smoking in workplaces and in enclosed public spaces, hospitals, restaurants and transport.

In July 1986, a month after a ban on smoking in Commonwealth government offices, the Tobacco Institute of Australia published in major newspapers an advertisement headed 'A message from those who do . . . to those who don't', claiming that 'there is little evidence and nothing which proves scientifically that cigarette smoke causes disease in non-smokers'. When the institute refused to give an undertaking not to repeat this claim, the Australian Federation of Consumer Organisations (AFCO) sought an injunction. Their lawsuit became a marathon public interest test case, with 6,000 pages of evidence, 20 Australian, US and British expert witnesses, and a 211-page judgment issued in February 1991. The Federal Court of Australia ruled that passive smoking is a cause of lung cancer, asthma attacks and respiratory diseases, and thereby set a global legal precedent which received wide publicity.

After this judgment, state legislation on workplace health could be deployed. In 1992, a NSW court awarded $85,000 damages for asthma resulting from non-enforcement of an office smoking ban. By this time, most large companies had instituted either total or partial bans on workplace smoking. As regulations increasingly banned smoking in all forms of public transport, including taxis, and as both fast-food chains and upmarket restaurants became
smoke free, the Tobacco Institute and its subsidised partner, the Australian Hotels Association, concentrated on promoting air quality standards as an alternative solution.

The first jurisdiction to introduce comprehensive legislation banning smoking in enclosed public spaces, including restaurants and hotels, was the Australian Capital Territory, which did so in 1994, with a year's grace for restaurants and three years for licensed premises such as pubs and bars. As polling showed a shift in public opinion, the States followed, most of them in 2000. NSW seized on the Sydney Olympics as the occasion to introduce an immediate ban on smoking in enclosed public spaces. Even tobacco-growing Queensland, which had refused to regulate smoking and which lacked a strong advocacy group, used the National Tobacco Strategy of 1999 as a basis for proposals to catch up with the other States by 2001. Each of these initiatives was welcomed by the unions, which had fully accepted passive smoking as a health risk, and opposed by the Hotels Association with claims that business, especially tourism, would suffer.

Recent developments

The conservative coalition government which took office in 1996 greeted a Senate committee report which recommended a wide range of further controls with Prime Minister Howard's reference to the dangers of the 'nanny state'. His government implemented two of the report's recommendations, by changing the basis of excise from 'per weight' to 'per stick' and by setting a terminal date for the exemption of international motor racing from the ban on sports sponsorship. It has also funded the first National Tobacco Campaign, a collaborative effort among Federal and State governments and non government organisations, and has sponsored formulation of a National Tobacco Strategy 1999-2000 through the National Council on Alcohol and Drug Control. Nonetheless the Liberal Party is seen to be close to the tobacco industry; most notably in NSW, where Nick Greiner became chairman of Wills (and then of British American Tobacco after the fusion of Wills and Rothmans) after being forced to resign as Premier of the State. The Liberal Party has also engendered controversy by allowing Philip Morris to host luncheons at its national conferences, and both Liberals and Labor continue to receive substantial donations from the industry.

Taxation is one area in which substantial recent change has taken place. Since Federation in 1901, the Federal Government had charged excise duties, which were particularly favoured for their low administrative cost relative to income generated. The States began to raise substantial revenue from tobacco licence fees from the mid-1970s; there were substantial increases in rates from then through the 1990s, apart from their linkage to the consumer price index since 1983. In 1999, the Federal Government changed its tobacco excise assessment from a 'per weight' to a 'per stick' basis, in line with anti-tobacco arguments that the industry was producing high-volume, low-weight brands to escape tax.

The success of litigation in the United States led to several initiatives in Australia. In March 2000, a class action by smokers was struck out by the Federal Court, which ruled that claims for damages for tobacco-related disease could not be grouped together. The US Attorneys General settlement led to consideration of similar action in Australia, but the State Attorneys-General apparently decided that the relatively high level of tobacco taxation was considered to have more than covered publicly funded health costs incurred from tobacco.

In Australia, the small number of discrete political cultures in a federation of six States and two Territories has encouraged both the development of different approaches and frequent opportunities for cross-pollination. Much of the credit for maintaining continued pressure for improved tobacco control is owed to the medical, public health and activist organisations which have learned to use media coverage to change public opinion. The capacity for producing significant epidemiological and social research, fostered particularly by the Anti-Cancer Council of Victoria and VicHealth, has also been of major importance in convincing governments of the need for action.

The most celebrated Australian innovations, which might deserve the title 'template', are the North Coast Quit-for-Life campaign and the Victorian tobacco control legislation establishing and funding VicHealth to displace tobacco sports sponsorship. Together they are claimed as the source of inspiration for California's programmes since 1988. But the precedents set by BUGA UP and by the AFCO case should not be overlooked.
Unlike other areas of public health, there is little debate about the best way to tackle the tobacco problem. Large-scale and sustained comprehensive control programmes are effective in reducing tobacco use. The efficacy of these efforts is shown by the sustained declines in use in the US states of California and Massachusetts (Table 1), where such programmes have been in place for a number of years.

In Australia in the late 1980s, the state of Victoria was leading the nation and the world with its tobacco reduction strategies. The declines in prevalence witnessed around this time reflected the state's leadership in control initiatives. The Victorian Tobacco Act 1987 provided the model for legislative reform in other Australian states and territories, as well as for other countries. However, if there was one single cause for the plateauing of smoking rates in Victoria in the mid-1990s, it was the decline in resources applied to addressing the problem (Hill et al. 1998) (Figure 1). Now, with a modest increase in resources, the smoking rates have once again started to decline (Hassard 2000). But the lessons of the 1990s were hard to learn and serve as a warning to all governments that there is a need for on-going and adequate resources for tobacco control programmes.

The US Center for Disease Control and Prevention has recommended that US$7-20 a head be allocated annually to fund comprehensive control programmes, depending on the size of the population (USCDC 1999). Evidence that smoking prevalence would decline in Australia with increased funding is persuasive as declines have been greatest during periods when expenditure was highest, both in adults (Figure 1) and in young people (M. Scollo, pers. comm.).

In Australia, the National Tobacco Campaign (NTC), a collaborative partnership between all states and territories and the federal government, was implemented in 1997 as a result of concern over a stalling in the declines in smoking prevalence. The campaign was targeted towards low income smokers in the 18-40 age group, where prevalence is highest.

Evidence suggests that the first phase of the NTC successfully reduced smoking prevalence by 1.4 per cent. The second phase has resulted in declines but has not been as successful because of the reduced funding available, particularly for mass media advertising (Hassard 2000). These results underscore the importance of sustained and targeted campaigns.

Table 1 Comparison of per capita cigarette sales in Massachusetts and California with other US states and District of Columbia, 1990-97 (packs purchased per adult per year)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>125</td>
<td>120</td>
<td>117</td>
<td>*102</td>
<td>101</td>
<td>98</td>
<td>93</td>
<td>78</td>
</tr>
<tr>
<td>% change since 1990</td>
<td>4</td>
<td>6</td>
<td>18</td>
<td>19</td>
<td>22</td>
<td>26</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>California (1989*)</td>
<td>100</td>
<td>92</td>
<td>89</td>
<td>89</td>
<td>73</td>
<td>76</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>% change since 1990</td>
<td>8</td>
<td>11</td>
<td>11</td>
<td>27</td>
<td>24</td>
<td>25</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>48 remaining states</td>
<td>139</td>
<td>135</td>
<td>131</td>
<td>125</td>
<td>126</td>
<td>124</td>
<td>124</td>
<td>124</td>
</tr>
<tr>
<td>% change since 1990</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

Note: *indicates year that large-scale campaigning commenced

Who will die?

The 1998-99 figures for Victoria show that smoking prevalence is inversely related to education and socioeconomic status (Centre for Behavioural Research in Cancer 2000). Those with a tertiary education are least likely to smoke (14 per cent); prevalence is highest at the low end of the occupational scale. People from blue-collar households have the highest rate (27 per cent), and those who are not working or who are looking for work are much more likely to smoke and their quitting rate is low.

If smokers quit before they reach the age of 35, they avoid more than 90 per cent of the risk attributable to tobacco. Even those who quit at around 50 or 60 avoid most of their subsequent risk of developing lung cancer (Peto et al. 2000). Unless current smokers quit, the disease burden for tobacco will remain high for another 30-40 years.
Who will benefit?

The benefits of stopping smoking are greatest for those at greatest risk and can reduce death rates in as little as two years. The US CDC (1999) has stated that smoking cessation is more cost-effective than other commonly provided clinical preventive services, including mammography, colon cancer screening, Pap tests, and treatment of mild to moderate hypertension, and high cholesterol.

Some smoking-related illnesses are affected relatively quickly, with excess risk from cardiovascular disease reduced by half in the year after quitting (USDHHS 1990). These figures translate into reductions in morbidity and cardiovascular mortality as well as reduced demand for health services. Cessation of maternal smoking before the end of the first trimester yields immediate short-term health and economic benefits by reducing the number of low-birthweight infants. Recent research estimates that, if pregnant women stopped smoking, this would prevent 5 per cent of hospital admissions in babies under the age of 8 months (Wisborg et al. 1999).

In Victoria, for example, a sustained 1 per cent a year decline in smoking rates would achieve reductions in hospital admissions (1,255 a year), bed days (210,259 a year), and sundry medical services and consequent financial savings of $8.5 million a year (Ministerial Tobacco Advisory Committee 2001).

Programme initiatives

The US experience shows that declines in cigarette consumption have been much greater in states with large, well-funded and sustained anti-smoking campaigns (Table 1). To achieve these reductions, a number of elements have worked in parallel (Gray and Daube 1980):

- legislation and regulation to control the content, manufacture, supply, promotions, sale and price of the product;
- identifying and eliminating the disparities related to tobacco use and its effects among different population groups;
- promoting cessation among young people and adults;
- preventing the uptake of smoking by young people; and
- reducing exposure to environmental tobacco smoke.

It is generally quite difficult to attribute a reduction in tobacco use to any single factor, as many factors often work in parallel. The underlying message is quite clear, however: multifaceted control programmes are effective in reducing tobacco use and can be applied in any country.

Mass media campaigns

Mass media campaigns have become essential elements of tobacco control, although their funding levels and effectiveness vary considerably.

The current NTC ‘Every Cigarette is Doing You Damage’ campaign is nearly four years old. It has indicated positive effects upon knowledge/beliefs, attitude and behaviour, and shown favourable cost-effectiveness. The influence of the campaign applied to males and females, older and younger participants, and smokers and recent quitters at all levels of educational attainment.

One of the unexpected effects of the campaign was the influence on teenage smokers, who were not a specific target. The cessation-focused NTC advertising had more impact on young teenagers than another campaign specifically designed for them (Hasard 1999).

Free-to-air television advertising is still the most effective mass medium for reaching smokers, particularly lower socioeconomic groups. However, other advertising media are becoming more important and could be exploited to broaden the current reach of the campaign to access harder-to-reach groups, such as people in rural areas and young people. Media utilised must include the Internet and pay television, and more targeted initiatives such as pay slips and public transport tickets.
Education campaigns

School-based prevention programmes are also part of state tobacco control programmes, but their effectiveness varies. Evidence indicates they are more effective when combined with community programmes and mass media campaigns. They should therefore be part of a comprehensive strategy, because educating school-age children and adolescents about the consequences of tobacco use is clearly important in sustaining a smoke-free norm.

There is also the opportunity to work with the broader community in the development of evidence-based education programmes and increase the strategies, programmes and guidelines that support state tobacco education and primary prevention initiatives.

Establishing smoke-free workplaces, public places and homes

Concerns around the health effects of passive smoking and the risk of litigation have resulted in many workplaces and public places being declared smoke-free. This is a powerful strategy because it protects non-smokers, increases quit rates and reduces consumption. It has been estimated that in Australia smoke-free policies were responsible for 22 per cent of the substantial fall in cigarette consumption between 1988 and 1995 (Chapman 1998).

There are still 30 per cent of workplaces in Victoria with either no or inadequate smoke-free policies (Centre for Behavioural Research in Cancer 2000). In the absence of legislation, workplaces and public places need to be supported and encouraged to introduce such policies, to supply cessation support and advice, and to meet their obligations under the Occupational Health and Safety Act. Where legislation does apply, it should be supported through on-going public education programmes. Although homes are increasingly being made smoke-free, nearly 500,000 Australian children under four live in a home with one or more smokers (ABS 1995). Farkas and colleagues (2000) have found that smoke-free homes and workplaces play an important role in reducing adolescent smoking, and initiatives to encourage smoke-free homes should be on-going.

Cessation programmes

Nicotine addiction is treatable and there are clinically effective programmes available. Most people who use tobacco have attempted to quit, but only a small fraction succeed on their own. Although many do so without formal treatment, treatment clearly improves quitting rates. Among health programme-spending options, smoking cessation programmes are called the 'gold standard' of cost-effective interventions (Centre for Behavioural Research in Cancer 2000, USCDC 1999, USDHHS 2000).

Community-based resources such as centralised 'quitlines' and workplace cessation programmes can increase access to treatment and advice. State and local media campaigns that reinforce non-smoking norms also enhance motivation to quit, reduce tobacco use among those who continue to smoke, and prevent relapse.

Evaluation of the Quitline nationally found that around one in 25 smokers called the Quitline during phase one of the NTC. Smokers who call the Quitline have a much greater chance of successfully quitting. The quit rates (point prevalence quit rate of 29 per cent at 12 months) compare favourably with data from similar surveys of other Quitline services (Hassard 1999). Evaluation also shows that they are accessed by the campaign target groups and, in particular, heavy smokers.

Much can be done to improve access to and the effectiveness of treatment programmes within medical systems. More than 80 per cent of adults see a doctor at least once a year (Deeble 1991). Routine, repeated advice and support can increase smoking cessation rates two to threefold. Doctors, nurses, psychologists, dentists and other health professionals are more likely to give such advice and support if they practise in a system that encourages such behaviour through practice-based systems for tracking smoking status, office-based written materials for smokers to take home, training of health professionals in screening and advising patients, coverage of cessation programmes by health plans, and reimbursement for treatment.

Evidence-based guidelines recommend that all smokers be offered behavioural therapies with pharmacotherapies (such as nicotine replacement products) and that these, in combination, produce the best results (ACHPR 1998). Treatment works, but there is ample room for improvement. Despite evidence of its effectiveness, relatively few smokers seek out formal treatment, and relapse rates are high. Improving smoking cessation success rates is especially important in certain target populations, for example, pregnant women and the unemployed.

Laws regulating sales to children

Laws regulating tobacco sales to young people under 18 will not achieve their full potential impact until retail compliance rates are high. Several reports have shown that enforcing such laws can reduce tobacco consumption. Active programmes of retailer education and enforcement can dramatically increase compliance. There is strong public support for the enforcement of legislation: 90 per cent supported the strategy in the 1998 Australian National Drugs Survey (Williams 1999).

Monitoring performance and evaluating programmes

Tobacco control can improve over time only if:
- baseline data exist;
- the elements are assessed — the effectiveness of each component must be monitored and assessed both separately and in combination; and
- research to improve the programmes is carried out.

This is not to imply that results will be quick; significant reductions in tobacco use take years, even in states where control has clearly been effective.
Funding mechanisms

Based on international best practice, the optimal level of investment has been estimated to be around US$7 a head. Expenditure in Massachusetts since 1993 has been US$6 a head. The UK recently committed £100 million to anti-smoking programmes over five years, and South Australia a reasonable investment of $A3 a head over three years ($A3.9 million total).

Significant government commitment is necessary in order to achieve anything like the US declines in smoking prevalence. However, these costs could be offset by savings in avoidable health care costs and by the introduction of tobacco retailer licence fees. For example, an annual fee of around $A500 in Victoria would raise $A5 million, which could be used for monitoring, enforcement and education. There are other possible funding opportunities for the future sustainability of control programmes:

- **Hypothecated federal excise**: Similar to the early hypothecation of state franchise fees for health promotion foundations, the precedent for hypothecating federal excise has been set with part of the petrol excise directly funding infrastructure. Revenue from this source would be a small fraction of the total collected and could be dedicated to federal tobacco control initiatives.

- **Tobacco wholesaler, manufacturer and importers' licence**: Governments could consider imposing fees on others involved in the production and distribution of tobacco products. This revenue could then be used to reduce retailer licence fees and to help finance the rest of the state's control strategy.

- **Cost recovery by the state from tobacco companies**: Governments could investigate the feasibility of direct cost recovery litigation by the Victorian Government against Australian tobacco companies.

- **Legislation for state governments to recover costs**: Introduce legislation to compel patients making compensation claims (including those against the tobacco industry) to seek to recover state public hospital treatment costs, and to enable the state government to recover those costs from successful claimants.

- **Public interest litigation**: Sponsor public interest litigation aimed at compelling the tobacco industry to fund a public education campaign to warn consumers about health risks not adequately explained or covered in current health warnings.

- **Health Insurance Commission and health insurance companies**: Recently, one major insurance fund has spoken publicly of the need for greater investment in tobacco control. Negotiations could also occur with the Health Insurance Commission and health insurance funds to invest a proportion of the payment they, similarly, would receive as a result of successful claims by individuals who received compensation for smoking-related diseases. This provides for the reimbursement of payments made by Medicare and nursing home benefits supplied to individuals as a result of an injury in respect of which a judgement or settlement is subsequently made.

Conclusion

Tobacco control programmes are good value for money compared with other prevention strategies and are also cost-effective. This has been the experience overseas in countries that have implemented aggressive, multifaceted and sustained programmes. The evaluation of the Australian National Tobacco Campaign found that it was cost-effective, but it also found that, when NTC spending on media declined, there was a concomitant reduction in quitting activity (Hassard 2000).

Public health agencies agree that tobacco smoking is an issue that deserves priority. Evidence-based strategies are available. We know what to do, and there are qualified people and the infrastructure to do it. Smokers deserve to have more than the current level of funding returned in the form of programmes and assistance to quit. Children also deserve to be protected as much as possible from an addiction that is usually taken up in childhood, before they are able to make other adult decisions like voting, drinking and gambling.

References


Deeble, J. 1991, Medical services through Medicare, Background Paper No. 2, National Health Strategy Unit, Canberra. Cited in C. Silagy, A review of literature into smoking cessation services and nicotine replacement therapies, Department of General Practice, Flinders University, Adelaide, 1996.


Protecting young children from environmental tobacco smoke

Trish Cotter, Victorian Health Promotion Foundation

While the harmful effects of active smoking have been known since the late 1950s, the dangers of exposure to environmental tobacco smoke (ETS) were not widely acknowledged until the mid-1980s. Since then, evidence has continued to mount and a number of scientific reviews have concluded that passive smoking causes disease, including lung cancer in non-smokers, and that children whose parents smoke are more likely to suffer respiratory problems than are children of non-smoking parents.

In Australia, there is public recognition that passive smoking is harmful to health. For example, 80 per cent of those living in the state of Victoria recognise that passive smoking can damage non-smokers' health (Mullins et al. 1999). Health knowledge, coupled with the fear of litigation under workers' compensation, common law and discrimination law, has been the impetus for governments and business to implement significant restrictions on smoking in workplaces, such as in public transport, in cinemas and in many workplaces. Public opinion is also supportive of further restrictions. This is particularly evident in a study of Victorian restaurant patrons that showed 92 per cent supported restrictions on smoking in restaurants (Mullins and Morand 1995).

Despite the current weight of evidence about the effects of ETS on child health, there has been much less attention directed at domestic exposure, particularly to children. Children are afforded less protection by law from ETS exposure from their parents than from strangers smoking in public places.

Health effects

The most important reviews of the scientific evidence were conducted by the US Department of Health and Human Services (1986), the US Environmental Protection Agency (1992), Australia's National Health and Medical Research Council (1992), the UK Scientific Committee on Tobacco and Health (1998), and the WHO International Consultation on Environmental Tobacco Smoke and Child Health (1999). All concluded that in children passive smoking:

- Increases risks of lower respiratory tract illnesses, including bronchitis and pneumonia, in the first years of life;
- Increases chronic respiratory symptoms in school-aged children;
- Increases risk of acute and chronic middle ear disease;
- Reduces lung function (the predominant effect may be from maternal smoking during pregnancy);
- Results in small reductions in birth weight, because of exposure of non-smoking mothers to ETS during pregnancy;
- Increases risk of sudden infant death syndrome (SIDS), because of maternal smoking (the predominant effect is believed to be from in utero exposure). There is also some evidence that postnatal ETS exposure contributes to the risk of SIDS;
- Increases learning difficulties, behavioural problems and language impairment, associated with paternal smoking. There is some evidence that both ETS exposure to non-smoking women during pregnancy and children's postnatal ETS exposure may contribute to small impairments;
- Results in physiological changes that may increase the risk of cardiovascular disease; and
- Increases a possible risk of some childhood cancers. However, the potential roles of pre-conceptional, in utero and postnatal exposures are unknown (WHO 1999).

In a country of high asthma prevalence such as Australia, it is important to note that passive smoking is also a significant factor in the development of childhood asthma (Landau 1991). When exposed to tobacco smoke, children are more likely to develop sensitive airways, which makes them more susceptible to asthma attacks. Children who live with smokers have higher rates of asthma, develop asthma at a younger age and have an increased need for medication (Weitzman et al. 1990). The National Health and Medical Research Council (NHMRC) (1997) estimates that around 8 per cent (46,500) of childhood asthma cases are attributable to passive smoking.

Exposure and impact

Cigarette smoke is more dangerous for young children than adults because their developing lungs are smaller and more delicate (RCP 1992). Children of smokers are around 60 per cent more likely to have serious chest infections, such as bronchitis, croup and pneumonia, especially during the first years of life (NHMRC 1997). Exposure to tobacco smoke has a major health impact, even if for some diseases the attributable risk is only slightly increased, because almost half of the world's children are exposed (WHO 1999).

Young children's exposure to ETS comes mainly from parental smoking within the home. In 1993 in Western Australia, 32 per cent of children ages 4–16 lived in households where they may have been exposed to passive smoking (ABS 1995) and Australia-wide over 547,000 children aged 4 and under live in households with one or more smokers. This is more than 40 per cent of all children in this age group. These figures are comparable with
those of other Western countries. For instance, in 1998 in Canada, nearly 50 per cent of children were found to be exposed to ETS in the home (Couts 1998).

If one views the family car as an extension of the home, it is interesting to note that the 1995 NHMRC draft report on ETS suggests that smoking should be illegal in cars where children are passengers. A survey in South Australia found that nearly two-thirds of smokers with children under 15 years allowed smoking in their car. However, smokers with children were less likely to allow smoking in cars than those smokers without children (Roberts et al. 1996). A New South Wales survey found support for legislation to ban smoking in cars: 72 per cent of adults overall, and 63 per cent of adults who smoked, thought that it should be illegal when children are present (Bauman et al. 1995). Parents who smoke may also increase the risk of their children becoming smokers (Farkas et al. 1999).

There is little if any published research on the social and economic impacts for children exposed to ETS. One could hypothesise that repeated minor illnesses would be a real barrier to a child's progress, academically and socially. It is also conceivable that frequency of illness would place a further strain on a family's financial resources, as well as health care costs on a population level. More research is required in this area.

Policy context

The UN Convention on the Rights of the Child obligates us to guarantee the child's right to the highest attainable standard of health and a protective environment. Community attitudes reflect this and support the care and nurturing of our young children.

The health of Australia's young children is also governed and guided by a national policy which sets a clear direction for the future development of health and health-related services for our children and young people. It aims to ensure that appropriate services are readily accessible to all children, young people, and their families or other care-givers. The policy makes special reference to the influence of tobacco in infancy and early childhood (DHSH 1995).

The Public Health Association of Australia has published its policies on passive smoking, tobacco control, and smoking and children. It does not have a policy that addresses the specific issues relating to the effects of ETS on children.

Smoking is banned voluntarily in most 'family' restaurants, for example McDonald's, and Commonwealth regulations prohibit smoking in child care centres.

In Victoria there is no current state-wide programme that addresses the protection of children from passive smoking. The only Victorian initiative was conducted in 1992 by the Quit Campaign, which followed a ruling in the Federal Court of Australia in February 1991 which concluded that 'there is compelling scientific evidence that cigarette smoke causes lung cancer in non-smokers' and that 'the evidence, epidemiological and clinical, establishing a causal relationship between passive smoking and respiratory disease in very young children was overwhelming. The evidence was of such strength that it constituted scientific proof' (Everingham and Woodward 1991). The mass media and community-based campaign aimed to discourage people from smoking around children. It was most successful among non-smoking parents. After the campaign, 16 per cent more non-smokers with children said that they usually discouraged their visitors from smoking inside the house. There was no change in behaviour among smokers.

Issues for consideration

Community attitudes support nurturing and protection: we have school attendance regulations, immunisation protocols, infant restraint laws, and laws to protect children from physical and sexual abuse. However, several factors contribute to a lower level of support for ETS control measures in homes, compared with workplaces and public places. Many people believe that the government should not interfere with behaviour in the private setting.

Social pressures and customs are also involved. One study suggested that some people have difficulty asking others not to smoke, such as a parent-in-law, or, in some cultures, where cigarettes are given as gifts as a sign of respect and welcome when visitors enter the home.

If smoking were restricted in the home, some groups might encounter more real difficulty in providing a smoke-free environment and might fear that children might be removed from homes that were not smoke-free (Ashley and Ferrence 1998). There is still strong support for the view that smoking is one of the few breaks that mothers of low income allow themselves and that it provides some solace in an otherwise stressful and unrewarding life. Low-income parents are more likely to smoke and to have friends who smoke. They are also more likely to live in small housing units or flats with limited access to the outdoors. Many single parents would have to leave their children on their own or else take them along every time they went outside to smoke.

Even without explicit regulation of home environments, court cases have already brought the issue of ETS in the home to public attention as part of child custody cases in the USA and to a much lesser extent here in Australia. The involvement of health professionals in the identification of ETS exposure, particularly for children with respiratory disease, raises issues regarding interference, on the one hand, and failure to act, on the other. Given the complexities of this issue, which range from political to individual rights, it is clear that a comprehensive approach would be a wise one.

With the notable exception of Borland et al. (1999), Australian data are limited. More research is needed in the area of:

• social and economic impacts of childhood exposure to ETS;
• data on levels of exposure;
• understanding of the knowledge and beliefs of those smoking around children;
• understanding of parents' intention to quit smoking; and
• the barriers to providing a smoke-free home/environment.
Proposed draft policy statement

The scientific evidence shows that ETS is a danger to the health of young children. It is therefore recommended that:

- immediate action be taken to further restrict smoking in places (indoor and outdoor) where young children are cared for and play and where one would reasonably expect them to spend significant time with their primary carer (including shops, especially toyshops, family restaurants, shopping malls, child care centres/creches, including after-care, in cars when children are present);
- parents and carers who smoke be given encouragement and support to quit, particularly in environments where they are likely to be receptive to such information (for instance, when visiting health professionals with their children);
- governments lend support to a mass media and communication strategy to capitalise on broader social change and encourage parents to quit;
- cigarette packs carry a more specific warning about the effects of ETS on children (for example, 'Smoking around young children can lead to asthma attacks, SIDS and respiratory diseases such as croup and pneumonia');
- the cigarette pack carry specific information on ETS and provide a link to a smoking cessation counselling service;
- health insurance funds provide financial incentives on premiums for parents who declare themselves (and their homes) smoke-free;
- information materials (including a smoke-free home sticker) be provided to every new mother before she leaves the hospital; and
- quit packs and information on ETS be available in supermarkets and pharmacies (where baby needs/nappies are sold).

The fundamental issue about ETS and young children is that exposure is not just a priority based on the evidence; we are also obligated to do so as a signatory to the UN convention on children's rights, by community expectations and by federal policy to protect the health of young Australians.

While there is sufficient evidence on the health effects of ETS to warrant specific action to restrict exposure in cars and the family home, such initiatives cannot be taken in isolation of the social environment.

More socially acceptable, and arguably more effective, smoking cessation by pregnant women, mothers, fathers and carers provides a way for the public health dollar to 'double its money' by protecting children and saving their parents' lives. If this approach were to be successful, it would create a platform for long-term social change in which smoking around children would not be an acceptable behaviour.

References


NHMRC (National Health and Medical Research Council) 1995, 'The health effects of passive smoking', draft report of the NHMRC working party, NHMRC, Canberra, November.


WHO (World Health Organization) 1999, International consultation on environmental tobacco smoke (ETS) and child health, report, WHO.
The social and economic impacts of tobacco in Asia and the Pacific

Harley Stanton, Tobacco Free Initiative, World Health Organization, Western Pacific Regional Office

Introduction

"Tobacco is a dirty weed, I like it. It satisfies no normal need, I like it. It makes you thin, it makes you lean. It takes the hair right off your bean. It's the worst darn stuff I've ever seen, I like it."

Tobacco has played an ironic role in society, as highlighted by this verse. It has been hailed as a blessing and a curse. Until recent times it was promoted as a cure for lung complaints. Now it is the leading cause of lung cancer globally, and a major cause of heart disease. Tobacco is legal in every country in the world and is arguably the most widely distributed and used drug.

History of use and development

The use of tobacco was known in China and parts of Latin America for over 2000 years. However, its spread in the Americas began only after the 1540s when the French Ambassador to Portugal, Jean Nicot, joined in research on the plant, to which his name was given. Tobacco use over much of the ensuing three centuries was limited until the development by Bonsack of the cigarette-manufacturing machine in 1881. Machines now produce 12,000–15,000 cigarettes a minute at extremely low cost. The tobacco business is very profitable, few other products offering such potential for returns on investments.

The role of tobacco in development and health received scant attention until the last half of the twentieth century. The combined economic role of tobacco in the national and global economies is greater than that of all but the top 10 or 12 economies, accounting for around US$400 billion of business. The profits flow particularly to the producers, and secondary benefits flow to the satisfaction derived by customers. However, recent calculations published by the World Bank show that consumption of tobacco products leads to a net decline in economic welfare (Peck et al. 2000) - a situation of particular concern in the countries of Asia and the Pacific where tobacco use is increasing rapidly.

The consequences of tobacco use

Since the first major studies of health effects in the 1960s, there has been a growing awareness of the risks associated with smoking. Upwards of 100,000 papers in medical and scientific journals show the impact of tobacco use, particularly in its popular form as a cigarette.

Already in China there are 2,000 deaths per day from smoking and this is expected to rise to around 8,000 by 2030 (World Bank 1999). Tobacco use will cause around one in six deaths globally, exceeding the toll from AIDS, tuberculosis, automobile crashes, maternal mortality, homicide and suicide combined.

The Western Pacific Region has shown the highest rise in tobacco use of any WHO region (WHO 1999, 2000a). The prevalence rates are 62.3 per cent for males and 5.8 per cent for females, accounting for 422 million smokers, or 34.4 per cent of the total number of smokers in the world (Carrao et al. 2000).

In most developed countries increased funding and effort is being concentrated on tobacco control in order to reduce current use, and to reduce the uptake of smoking. In the Western Pacific Region and other developing countries a number of factors work against these trends, including the privatisation and globalisation of tobacco companies, and the role of image and the media in expanding markets. Many of these economies are still heavily dependent on tobacco, which governments and communities see as a significant revenue source.

Poverty and tobacco

In the Western Pacific Region smoking is more common among poor men than rich men. Men's smoking behaviour explains nearly all of the difference in excess mortality between the rich and the poor (Bobak et al. 2000, Marsh and McKay 1994). The pattern for female smoking differs, with cultural attitudes appearing to influence rates in low- and middle-income countries. However, there are indications that this is changing (Samet 2000) as more young women take up smoking. These gradients in smoking between low- and high-income socioeconomic groups become even more marked in the lowest income countries. This in itself is a 'clear reason for smoking being a key link in economic development and places the issue of tobacco control on the agenda of economic, trade and strategic policy discussions for and between governments. Otherwise, the ability to enhance better health outcomes for populations will be compromised.

In the countries of Asia, Africa, the Pacific and Eastern Europe, tobacco is often seen as a palliative for poverty. The reasons why the poor smoke is unclear but lack of education, skills and resources compromise people's ability to make personal and societal decisions for better health. In the longer term, economic development and improved education are likely to contribute to reduced smoking and enhanced health outcomes.
Social consequences

Fundamental to the issue is that cigarettes are a very cheap, very accessible drug . . . this is the drug of dependence, that when you put it in your mouth, the effect hits your brain in seven seconds. It is incredibly cheap, you don't have to buy it illicitly on street corners, it serves a number of purposes – it's a sign of rebellion; it's a sign of belonging; it's a coping strategy; it's a relaxant; it's a way for girls to meet guys at a party; it is all of those things; it is a very, very nifty little product. This is what we are up against and that is what makes it so difficult (Goodin 2000).

Most smokers in Asia and the Pacific start early in life, usually as children. In Kiribati, Papua New Guinea, and Vietnam, for example, it is not uncommon to see children of eight or nine years of age smoking. The role of adult smoking appears to be a strong influence in children's experimentation and initiation to the habit. Experience in developed countries shows that the emphasis of many educational programmes has been to focus on youth smoking issues. In this connection, being counter-intuitive enhances effectiveness. Professor Stanton Glantz has probably been the target of more tobacco industry attacks than anyone else as he has stressed that "The message should not be, "we don't want kids to smoke"; it should be "we want a smoke-free society"" (Glantz 1996).

While tobacco use often begins from peer influence, it is continued through the development of a dependence on the psychophysical effects modulated by nicotine. Nicotine affects several key brain neurotransmitters. Indications are that nicotine restores neurotransmitter activity to more normal levels and that, without the effects of nicotine, many smokers experience significant depression. This has led to the introduction of anti-depressant medication in the cessation programmes of a number of countries.

Tobacco industry influence

Recent documentation has revealed the long-term, deliberate and strategic campaigns of the international tobacco companies. Their effects are now being felt in the Asia Pacific Region where they have influenced policy and policy makers, restricted the marketing of safer products, and used their extensive resources and influence against those who oppose them. Hils (1996:6-7) calls this a conspiracy 'to spend large amounts of money every year indefinitely to prevent ... scientists and public health officers, from warning people of potential hazard in the normal manner. There is no case like it in the annals of business or history'.

Activities have included the involvement of high-level government officials to promote market entry of tobacco products; the payment of movie stars to be seen smoking in feature films; and the strategic use of prominent consultants as critics of studies that validate links between smoking and disease (Glantz et al. 1996).

The US Court decisions and agreement with the states on compensation have enabled some redress for past actions within the USA, but this does little to benefit the wider global community, most particularly the smaller countries of the Pacific. Former US Surgeon General Koop indicated that the problem has simply been transferred to the low- and middle-income areas of the world.

For this reason, the recent suggestion by former Food and Drug Administration director David Kessler that the tobacco industry should be dismantled deserves serious consideration. All long-term efforts to control tobacco use will require vigilance on the part of governments, individuals and monitoring agencies in order to marginalise the social and economic influence that tobacco companies can bring to bear. Lobbying from the industry often reaches the highest levels of government and compromises the ability to make the best decisions in the interest of public health. The industry has also sought to influence policy decisions within WHO (2000b).

WHO has passed 18 resolutions on tobacco use since the first support for tobacco control in 1970. The level of compliance, however, has been disappointingly slow. The role of WHO and other public health organisations has on occasions been sabotaged by the influence of the tobacco companies.

Need for national and global controls

Efforts to reduce smoking require both national and global cooperation. WHO is seeking through the international Framework Convention on Tobacco Control (FCTC) to develop a strong and effective consensus in order to enhance health outcomes for all (Taylor and Bettcher 2000). While the trade and use of tobacco has an economic role within national economies, this role must always be subservient to public health. This issue will be critical in negotiating the FCTC (Physicians/WHO 2001).

As part of the FCTC development process, the Chair of intergovernmental negotiations was requested to draft elements of the proposed convention for further negotiation. This draft can be found on the WHO website.

Comprehensive control strategies to assist Asia Pacific

Foremost in the mind of many public health policy makers and health advocates is to ensure that, as tobacco becomes globalised, the measures taken to control its use have key provisions that ensure reduced prevalence and use, improved rates of quitting and prevention of uptake.

Trade and tax

As tobacco ownership and marketing are privatised and globalised, taxation becomes a critically important issue, one that is covered extensively in several recent publications (Abedian et al. 1999, Jha et al. 2000) and in other papers in this journal. The most effective policies appear to be large regular increases in tax on tobacco products, reducing their affordability, exclusion from the consumer index, and removal of tax-free and duty-free sales. The goals for taxation that most suit the manufacturers have been clearly documented.
The tobacco industry has often colluded in ensuring tax avoidance through smuggling. All possible measures to eliminate smuggling will be an important part of comprehensive policy. Such policy will also ensure that the industry does not receive subsidies for growing and production and that, as in other areas of consumer practice, it is liable for appropriate compensation for damage caused by use of the product.

Limiting promotional activities

To be effective, advertising and sponsorship restrictions need to prohibit all forms of imaging, thus removing tobacco's glamour image. In addition, regulation of packaging, labelling and design, including requiring full disclosure of product content, is necessary in order to effectively discourage consumption. This will also require truth in word usage, as recommended by the Oslo Declaration (2000).

Eliminating exposure to second-hand smoke

The majority of people are still non-smokers and governments have a responsibility to legislate in support of health-enhancing behaviours. This ensures that non-smokers, particularly those with limited access to information, are given protection from second-hand tobacco smoke in public places, transport, and workplaces, including restaurants and bars.

Providing treatment for tobacco dependence

A key feature of every national strategy must be to focus on reducing smoking among current smokers. Quitting strategies and resources have increased markedly in developed countries but receive little attention elsewhere (USDHHS 2000). Nicotine replacement therapies, and the newer non-nicotine therapies, give greater effectiveness to the social and behavioural strategies that enhance effective quitting. A number of developed countries are making these therapies available as part of their pharmaceutical benefits schemes.

Again, the gap between countries in available resources becomes apparent. Providing cessation therapies has been shown to be one of the most cost-effective measures that a health care system can implement. But, in most countries in Asia and the Pacific, where resources are already limited, these measures are little known or implemented, either in national policy or in the primary care system.

Conclusion

To a large extent, tobacco is a marker for development. The tobacco industry has a vested interest in keeping poor people addicted and in ensuring the continued uptake of smoking by the young. This entrenches them within the tobacco economy. This has particular relevance for countries in Asia and the Pacific at this point in time. The industry claims that freedoms are at stake, yet many of the leading governments in tobacco control are also considered exemplars in democracy, such as Norway, Canada, Australia, Thailand and South Africa.

Governments and agencies around the world must make crucial decisions on how to deal with tobacco in relation to trade, development and public health. These decisions will particularly affect the low- and middle-income countries of Asia and the Pacific. Will greater value be placed on public health?

Acknowledgement

While this text has been prepared outside the normal course of duty at WHO, it is very much related to the author's work there. The author is therefore grateful to the WHO Western Pacific Regional Office for the opportunity it has afforded to enhance the development of this article.

Notes

1. Tobacco industry documents, unknown author, Bates no. 20258804.
5. The Chair's text of a framework convention on tobacco control is on the WHO website at: <http://www.who.int/wha-1998/Tobacco/INB2/anglaisINB2.htm>. This site also has the document in the six official languages being used for the negotiations. Document no. A/FCTC/INB2/2.

References

Abedian, I., R. van der Merwe, R. Wilkins and P. Jha 1999, The economics of tobacco control: Towards an optimal policy mix, Applied Fiscal Research Centre, University of Cape Town.


WHO (World Health Organization) 2000b, Tobacco company strategies to undermine tobacco control activities at the World Health Organization, report of the committee of experts on tobacco industry documents, July (this document can be accessed via the WHO website).

World Bank 1999, Curbing the epidemic: Governments and the economics of tobacco control, Washington, DC.
Fighting tobacco in Asia

Mary Assunta, Consumers Association of Penang

Introduction

The decrease in tobacco use in the USA and Western Europe has resulted in the big tobacco transnational companies turning to developing countries to make up for the loss in their markets. Cigarette consumption in the USA shrank at the rate of about 4.5 per cent in the 1990s, while it rose 8 per cent in Asia (Headden 1998).

Philip Morris, the world's largest tobacco company, sells nearly three times as many cigarettes abroad as it does in the USA. Its overseas profits alone are US$24.1 billion (USA Today, 23 June 1997). Meanwhile, UK cigarette sales have dropped from 150 billion sticks a year to 80 billion over the last 25 years (World Development Movement 1998).

Asia is the fastest-growing market in the world. Tobacco transnationals find this market attractive because of its sheer size and the Asian love of tobacco (International Herald Tribune 1997). They are particularly looking towards newly opened economies such as Laos, Cambodia and Vietnam, not to mention the 320 million smokers in China alone.

The incidence of smoking among men is much higher in Asia than it is in the USA or Western Europe. Vietnam has one of the highest reported male smoking prevalence rates in the world, at 73 per cent. In rural Cambodia, 86 per cent of the men smoke, while 65 per cent of urban men smoke. In China, 66 per cent of men and 4 per cent of women smoke. Smoking rates among Asian women are still low and the international tobacco industry views this as a market to be fully exploited.

Most developing countries spend far more foreign exchange on tobacco imports than they gain from tobacco exports (International Union Against Cancer 1993). In 1997 the Philippines, for example, spent US$110 million on tobacco imports, while earning only US$29 million from tobacco exports (FAO 1999). Even for those countries that do export a significant amount of tobacco, most of the profits from the global trade go to the transnational companies rather than to developing countries.

Hooking Asia's children

Over the years Asia has evidence of tobacco transnational companies behaving in an increasingly scandalous manner to capture the young. In many Asian countries tobacco is the most advertised product and the marketing tactics used are those never imagined in their host countries. Young women clad in golden saris in Sri Lanka's discos, the Benson & Hedges Bistro in Malaysia and posters of the Virgin Mary in the Philippines are all used to sell cigarettes. Transnational companies exploit the lack of legislation or weak legislation, economic vulnerability, unemployment and poverty to market their product.

Twenty per cent of the Malaysian population, or 4 million, are between the ages of 10 and 20 providing a tempting market for the tobacco companies. There are about half a million children below 18 years in Malaysia already hooked on cigarettes. Of these one-third started smoking before 12 years of age and the rate is increasing rapidly. The 1986 morbidity survey showed that only 9 per cent of under-18s smoked. Ten years later that figure had almost doubled to 16.7 per cent. In this time the incidence of tobacco use among Malaysian girls has trebled.

Tobacco transnationals operating in Malaysia exploit loopholes in the country's tobacco control laws, nullifying its control initiatives. Cigarette advertisements are banned in the mass media under the Control of Tobacco Products Regulation 1993. However, the transnationals advertise indirectly through 'brand stretching', by associating their brands with non-tobacco products and services such as agencies, record shops, bistros, and shops selling apparel.

These front companies carry tobacco brands in their names, such as Benson & Hedges Bistro, Salem Cool Planet, Peter Stuyvesant Travel, and Dunhill store. These individual shops have multimillion-dollar advertising budgets to sponsor music events, sports and movies — activities that are popular with young people. To these add fun, glamour, an attitude, macho-toughness, success and gorgeous models and you have the right ingredients to attract young people.

Salem through the 'Cool Planet' has been organising regular concerts in Malaysia, flying in superstars such as Alanis Morissette, Savage Garden, Jewel and Brian McKnight. Peter Stuyvesant concerts feature Canto-pop stars such as Jordan Chan, Coco Lee and Aaron Kwok, and boy-bands such as Point Break and Westlife, who are all popular with teenagers.

Major sports events are sponsored by tobacco transnationals. Dunhill controls soccer, the number one sport in Malaysia. It organises all major soccer tournaments, such as the Malaysia Premier League, and the telecast of all major international tournaments such as the English League, World Cup, Copa America and the FA Cup. Advertisements for sponsorship activities are aggressive and extensive in all the national mass media.

Motor racing is a fast and trendy sport for the young. Marlboro has chosen to sponsor motor racing events because boys are twice as likely to become regular smokers if they are motor racing fans. A
1979 Philip Morris memo states that ‘Marlboro dominates in the 17 and younger age category, capturing over 50 per cent of the market’ (Action on Smoking & Health 1998). Malaysia has a long history of sponsorship of racing by Marlboro. Malaysia’s quest to host the Formula One has given Marlboro considerable support through its endorsement by the country’s leadership.

The Camel Trophy, Marlboro Adventure, Benson & Hedges Golden Dreams, and Mild Seven Outdoor Quest are all adventures organised to appeal to the thrill, macho and fun-seeking qualities in young people. Publicity around these events is extensive in the mass media and the events themselves are later telecast on television. The Benson & Hedges Golden Dreams contest offers winners the fulfilment of their extreme adventure dreams, such as chasing tornadoes in the USA or sky diving.

Tobacco companies also sponsor movies on Malaysian TV, such as the Dunhill Double and the Perileys 25 action films that appeal to young people.

Tobacco transnationals produce T-shirts, caps, mugs, stickers, umbrellas, clocks, bags and other non-tobacco paraphernalia that prominently display their brands and colours. Some of these are given away at their sponsored events, some can be redeemed with empty cigarette boxes and many are sold to the public. Children like these items because of the brand names. In Vietnam, for example, Dunhill T-shirts in child sizes are available (Lusher 1999). Countries may ban the sale of cigarettes to children, but children are not prohibited from buying and using these non-tobacco items.

Vietnam has banned all forms of direct advertising (except point-of-sale), but young women dressed in Marlboro outfits can be found distributing cigarettes, because product sampling is still permitted (INFACT 1998). Philip Morris distributes free samples of Marlboro in Cambodia. In Malaysia, Salem was handing out free cigarettes to young people attending its concerts until this practice was outlawed in 1994.

**Smoking exacerbates poverty**

In Asia, smoking rates are highest among the poor where average monthly expenditure on tobacco can be higher than per capita expenditure on essentials such as clothing, housing, health and education. For example, in Malaysia 30 per cent of income can be spent on smoking two packs of cigarettes a day. In China, a poor man can spend up to 30 per cent of his income on cigarettes (JAMA 1997).

The amount spent on tobacco in poor Asian countries exceeds that spent on health care and education. Vietnam has a GNP per capita of $US290 and most people earn less than $US1 a day while annual expenditure on cigarettes represents six times the amount spent on health care and twice the amount spent on education.

In Asia, the tobacco toll is more daunting than any other man-made epidemic. While most Asian developing countries do not have accurate data on tobacco related deaths, conservative estimates provided by health officials are very high and continue to rise. In Malaysia, with its relatively small population, about 10,000 people a year die prematurely because of tobacco. In Indonesia, annual deaths are estimated at over 60,000.

Children are the biggest victims of tobacco. Eighty per cent of those who start smoking do so before the age of 20. This problem is exacerbated by the fact that many of these children are poor and already malnourished, underweight or wasted. In India, 33 per cent of infants are low birth weight and 92 per cent of children are underweight or wasted, yet each day 55,000 children in India start using tobacco and about 4.65 million of under-15s are addicted (Times of India 1998). Tobacco use in India is growing by around 5 per cent a year.

**Who will produce tomorrow’s cigarettes?**

Like many other multinationals, the tobacco companies are good not only at securing markets in developing countries but also at shifting production to where labour, tax and plant costs are lowest (Tobacco Reporter 1998). Local directors welcome such investment as it provides employment opportunities for their poor. In Vietnam, for example, Philip Morris and BAT (British American Tobacco) have started production and in 1997 RJ Reynolds’s local venture sold $1 million worth of cigarettes to Canada and Germany (Jones 1998). Dimon Inc., one of the world’s largest tobacco-leaf dealers, was the first foreign tobacco company to open an office in Vietnam. It now develops new crop varieties for what it hopes will be a growing export market. The local manager is clear about why Vietnam was selected by this company: ‘Because of cheap labor, Vietnam can sell the majority of its tobacco for less than 43 per kilo . . . we will be extremely competitive. Tobacco is a fairly stable commodity. Come boom, come bust, there will always be smokers’.

**Trade liberalisation and tobacco profits**

Trade liberalisation is not good news for the smoking epidemic in developing countries in Asia. Once, foreign tobacco companies could only enter India through joint ventures and had to export at least half of their production (Daily News 1998). The Indian Government has relaxed this ruling and, since August 1998, multinational corporations have 100 per cent ownership of cigarette-manufacturing plants in the country. Market predictions are that the transnationals will initially operate through joint ventures and licensing arrangements with Indian companies but will eventually take over the market completely, much as they have done in other countries (Hindu 1998). Similarly, tobacco transnationals entered the Chinese market in 1998 by dangling membership to WTO as a carrot.

1999 saw the mergers of Rothmans International with BAT, and RJ Reynolds International with Japan Tobacco Inc (JTI). 'The outcome is that there are now fewer tobacco transnationals with a larger share of the global market. Despite the economic slowdown in Asia, these companies registered better profits in 2000. For example, BAT, which holds 70 per cent of the market in Malaysia.
and produces brands such as Dunhill and Benson & Hedges, saw a 16 per cent increase in pre-tax profits for the first quarter, compared with the same period in 1999 (Star 2000).

With the take-over of RJ Reynolds, JTI became one of the largest Asia-based tobacco companies. Malaysia is among its top 15 markets. JTI’s popular brands, Salem and Mild Seven, are aggressively advertised and promoted to the young. In 1999 it registered an 85 per cent increase in profit: RM136.6 million, up from RM73.7 million in 1998. Its Malaysian production plant has the capacity to produce 12 billion sticks a year and exports manufactured cigarettes to other Asian countries.

Tobacco export does not hold much promise for economic growth for many Asian countries as much of the tobacco grown locally or imported is smoked within a country’s own borders. The Philippines, for example, increased tobacco imports significantly from 476 million pieces in 1990 to about 14 billion in 1994. Exports during the same period dropped from 3.8 billion to 1.6 billion. The transnationals have captured about 70 per cent of its market.

In Indonesia, 90 per cent of all cigarettes smoked are kretek and the industry ranks as the second-largest employer after the government. In a population of about 200 million, where 60 per cent of men and 5 per cent of women smoke, many million kretek are smoked within the country.

Women in Asia currently provide some hope for tobacco control. In most parts of the region, it is still a taboo for women to smoke and the prevalence is below 8 per cent. However, if current trends continue, prevalence will increase to about 14 billion in 1994. Exports during the same period dropped from 3.8 billion to 1.6 billion. The transnationals have captured about 70 per cent of its market.

CAP’s fight against tobacco

The Consumers Association of Penang (CAP) has been campaigning nationally and internationally for several years against tobacco and the blatantly deceptive tactics of the tobacco industry. Anti-tobacco activities extend from monitoring the tobacco industry and the industry ranks as the second-largest employer after the government. In a population of about 200 million, where 60 per cent of men and 5 per cent of women smoke, many million kretek are smoked within the country.

Women in Asia currently provide some hope for tobacco control. In most parts of the region, it is still a taboo for women to smoke and the prevalence is below 8 per cent. However, if current trends continue, prevalence will increase to about 20 per cent. The challenge is therefore to keep the figures from increasing. This may truly be a huge task, as the tobacco industry is aggressively targeting women and girls with images of success, slimness, romance and fashion.

CAP provides this information. It also produces booklets are produced and distributed to health and social organisations, educational institutions and the public.

In 1995 the Religious Council of Malaysia passed a fatwa (an edict), declaring smoking to be haram or forbidden for Muslims. However, the fatwa, which has serious implications for Muslims involved in tobacco cultivation, production and trading, has not been seriously implemented. Since the 1990s CAP has carried out public education on the issue and also organised a national seminar for Muslim clergy, academics, youth and social organisations to bring about national debate. The tobacco industry fears the use of religion for tobacco control; for example, Philip Morris internal documents suggest identifying and supporting Muslim clergy who can take an alternative stand on the issue.

While tobacco is addressed locally, it is vital to extend the debate internationally. CAP calls upon the international community to look at the impact of the tobacco epidemic on developing and poor countries. The tobacco industry practises double standards, especially in poorer countries where control measures are lacking and the public is not organised. CAP has called upon the US Congress to stop its multinationals from spreading the epidemic to developing countries. CAP has also challenged Philip Morris at its stockholders meeting in Richmond, Virginia, to stop advertising to children in Malaysia and to stop the double standards.

WHO held a public hearing in Geneva in October 2000 to collect views from around the world in conjunction with the negotiations on the Framework Convention on Tobacco Control. CAP participated by calling for a strong and binding convention and for governments to have the courage to decide for public health over protecting an industry. CAP is also actively involved in international NGO coalitions on the convention.

References


FAO (Food and Agricultural Organisation) 1999, FAO database.


Hindu 1998, '100% equity to tobacco MNCs opposed', 8 September.
Jones, C. 1998, 'Brazilian leaf is smoked around the world – even in American made cigarettes', Richmond Times, 29 June.


Star 2000, 'BAT registers RM177mil profit for 1st quarter', 15 April.

Times of India 1998, 'Government plans legislation to reduce tobacco use', 13 June.

Tobacco Reporter 1998, 'Big tobacco's "growing the crop"', March.
Thai tobacco control: Development through strategic alliances

Prakit Vateesatokit, Action on Smoking or Health Foundation, Bangkok

Introduction

While some consider economic development the *sine qua non* of development, a wider view recognises social, political and ecological advances as the primary ends of economic progress. A central feature of these larger measures of human development is health. Health stands as both a development prerequisite and a goal in and of itself (Sen 1999). One of the goals sought in both the twentieth and twenty-first centuries is certainly an improved quality of life through the reduction of morbidity and mortality. This new century promises to bring even more attention to health as a positive state of 'complete physical, mental and social well-being' through health promotion mechanisms involving the greater 'civil society', not just the narrower health sector (Noak 1987). Tobacco control is central to future health promotive movements for social development.

Framing Thai tobacco control

In 1986, a group of prominent physicians with the support of ten health non governmental organisations (NGOs) formed the Thai Anti-Smoking Campaign Project (TASCP), currently the Action on Smoking or Health Foundation (ASH), to coordinate the country's smoking control activities. The TASCP's initial task was to lobby the Thai Government to introduce smoking control measures, specifically to ban the then-ongoing advertising war between domestic and foreign tobacco companies. Fortunately, the Government responded by banning all forms of cigarette advertising by law in February 1989 (Vateesatokit et al. 2000a).

Thailand's opposition to removing trade restrictions on foreign cigarettes resulted in a 1990 GATT decision which, although requiring Thailand to open its cigarette market, allowed tax, labelling, ingredient disclosure and advertising restrictions. Thailand passed two comprehensive laws in 1992 which provided many restrictions on public smoking (Non-smokers Health Protection Act) and on tobacco marketing (Tobacco Products Control Act). Tobacco control in Thailand now includes rotating cigarette pack warnings covering one-third of the upper portion of a pack.

Tobacco control is a national public health priority, incorporated in long-term government development plans and in tax policy. For example, the tobacco tax rate has been increased from 55 per cent to 71.5 per cent as one way of discouraging smoking. This has resulted in an additional US$1 billion for the government since 1993, while contributing to both reduced smoking prevalence and hence smoking-related health expenditures. Thailand has proved that 'it can be done' with very few resources.

Another early TASCP accomplishment was a revolutionary change in approach to tobacco control education and advocacy. By teaming physicians with people who had media experience, this new alliance produced an improved diffusion of information. For example, a review of tobacco and health stories in the media in 2000 showed that, of the 613 stories in the Thai press, 48 per cent were generated by ASH, another 12 per cent from government and other agencies, and the remaining 40 per cent from international news agencies.

Lessons learned from the Thai experience

Emphasising partnerships and the societal benefits of tobacco control was critical to dealing with many challenges in Thailand (Vateesatokit 1997a). Lessons learned included:

- It is essential to have an organisation(s) to push for tobacco control in both non governmental and governmental sectors.
- Health education is important but insufficient by itself for effective tobacco control.
- Ex-smokers are valuable partners in helping present smokers to quit.
- Policy-linked research is useful in mobilising public opinion and lobbying for government action.
- Networking and coalition building, both domestically and internationally, are crucial to increasing the lobbying power of tobacco control advocates.
- In lobbying for tax increases, it should be made clear to policy makers that the objective is to prevent children from smoking.
- Gaining Ministry of Finance cooperation in using taxation as a control measure is assisted by research showing the health care costs of smoking and evidence of increasing revenues, even with tax increases.
- In lobbying for legislation, it should be stressed that the objective is to prevent kids from becoming addicted to nicotine.
Development and obstacles to tobacco control

Increased disposable incomes

Tobacco is a luxury item. Its use fluctuates with available disposable income and social acceptability. Unfortunately, overall use has been increasing more rapidly in Asian countries because of the forced introduction of foreign brands through trade pressure from the USA (Chaloupka and Laixuthai 1996).

In Thailand, while income and amount of tobacco consumed have risen, total prevalence of use has declined (Table 1). The total number of smokers has remained stable since an estimated 2 million mostly male smokers have quit, female smoking has remained low and the base population has risen modestly. Adult male smoking prevalence between ages 20 and 59 declined by 20–30 per cent between 1986 and 1999 (Table 2).

In Thailand, tobacco use is already greater among the uneducated and poor. In 1993, 84 per cent of Thai smokers had no greater than a primary school education (Vateesatokit et al. 2000a). Further research is needed to determine why the poor smoke more. This is a paradoxical finding since, as incomes rise, cigarette use generally increases (Bobak et al. 2000). Efforts will be made to find possible reasons for this and to translate the research into programmes addressing smoking initiation and the most effective cessation support systems.

Research needs to be translational, that is, it must be rooted in immediate needs which are likely to inform and improve present national policy and practice. Research for development needs to be all things in all places.

### Table 1 Smoking prevalence (age 11+), Thailand, 1986–99 (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>4.1</td>
<td>3.8</td>
<td>3.8</td>
<td>2.5</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Males</td>
<td>48.8</td>
<td>48.9</td>
<td>46.6</td>
<td>43.2</td>
<td>44.5</td>
<td>38.9</td>
</tr>
</tbody>
</table>

### Table 2 Smoking prevalence among Thai males, 1986–99 (%)

<table>
<thead>
<tr>
<th>Age</th>
<th>1986</th>
<th>1996</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>11–14</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>15–19</td>
<td>24</td>
<td>18.3</td>
<td>12.4</td>
</tr>
<tr>
<td>20–24</td>
<td>54</td>
<td>48.7</td>
<td>35.4</td>
</tr>
<tr>
<td>25–29</td>
<td>65</td>
<td>54.4</td>
<td>47.6</td>
</tr>
<tr>
<td>30–34</td>
<td>67</td>
<td>55.9</td>
<td>48.3</td>
</tr>
<tr>
<td>35–39</td>
<td>70</td>
<td>58.3</td>
<td>51.5</td>
</tr>
<tr>
<td>40–49</td>
<td>72</td>
<td>56.4</td>
<td>51.4</td>
</tr>
<tr>
<td>50–59</td>
<td>76</td>
<td>57.9</td>
<td>50.0</td>
</tr>
<tr>
<td>&gt;60</td>
<td>67</td>
<td>48.7</td>
<td>45.1</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>44.5</td>
<td>38.9</td>
</tr>
</tbody>
</table>

Source: National Statistics Office

Limited resources for tobacco control

In Thailand, as in many countries, tobacco control activities show that a steady reduction of tobacco use is possible (USDHHS 2000, Vateesatokit et al. 2000b). These gains require constant vigilance since the tobacco industry, especially the transnational companies, use various means to constantly undermine control efforts (Saloojee and Dagli 2000). They are particularly clever in delaying, deleting or diminishing legislative efforts and devising methods of indirect promotion like point-of-sale advertising, price cutting, retailer incentive programmes and liberalisation of trade through regional and international ‘free trade’ agreements (Joossens and Vateesatokit 2000).

In these important areas, there is a need for both individual countries and the larger world community to combat tobacco industry methods. The corporate deceit of the industry is now revealed in millions of pages of documents disclosed through recent court cases in the USA. Despite a more thorough understanding of the industry’s use of very sophisticated marketing and political means to target marginalised populations, including women, ethnic groups, farmers, and even public systems like schools and government agencies, these abuses continue. There is a need to promote health as an essential asset of poor and vulnerable populations (Woodward et al. 2000, Yach and Bettridge 2000).

It is paradoxical that, even in the USA where tobacco industry documents are being researched most thoroughly, national and state governments still provide only limited support to programmes shown to be effective in tobacco control. Any adequate comprehensive challenge to the tobacco industry’s efforts to boost profits must include substantial resources (USCDC 2001).

ASH Thailand has sought to address this prerequisite by supporting action for a Thai Health Promotion Foundation, funded from an earmarked tax of about 2 per cent on cigarettes and alcohol worth an estimated $35 million/year (Jha et al. 2000, Vateesatokit 1997b). This new organisation has been established and the legislation authorising the budgetary allocation is moving through the parliament.

In the 15 years in which ASH has been working with the Thai Government and other health promotion agencies to further tobacco control, it has grown from a very small organisation to a well-recognised one, with a modest budget. It has never sought to do all things in all places. It has been strategically selective and has spent most of its energy and resources on bringing the importance of tobacco control to opinion leaders, policy makers and the public. A tax-supported effort in tobacco and alcohol control will fund systematic research and intervention programme development, with wider dissemination throughout Thailand (Buasai 1997, Moodie et al. 2000). While the government has funded an Office of Tobacco Consumption Control in the Public Health Ministry...
since 1991, it has had an inadequate budget and has been restricted by its organisational features and limited flexibility to carry out its initially broad responsibilities (Supawongse 1999).

Will the burden of death and disease continue?

The likening of tobacco-related disease to a contagious plague is misleading. Microbial diseases do not have corporate support, while tobacco use does. Given that tobacco is known to be the cause of illness and death, smarter, faster and stronger actions are necessary. If current smoking patterns persist, there will be about 1 billion deaths from tobacco during this century (Peto 2001). Paradoxically, tobacco-related disease is more complex and serious than any microbial disease, since governments and health agencies may not be prepared to deal with business and trade issues. Free trade of harmful commodities has important consequences, and tobacco is the most harmful global commodity (Lancet 2000). Despite the misrepresentations spun by tobacco interests, there is strong evidence that tobacco use can be reduced and that well-funded comprehensive programmes can have an impact on tobacco-related conditions like cardiovascular disease and cancer (Biener et al. 2000, Fichtenberg and Glantz 2000, USCDC 2000). The focus must be on taking action (Mackay 1999). A consensus of expert opinion is not enough. Consensus must be translated into preventive and control programmes with experts, government and the media working in concert (Wynder 1997).

The urgency of the need for tobacco control is not universally recognised (Gray 1999). Successful national and regional programmes that have served as examples and models must be utilised with appropriate pre-testing in long-term programmes for reversing trends in tobacco use. Internationally, the WHO Framework Convention on Tobacco Control should be strengthened to include vital tobacco trade issues as well as smuggling and advertising restrictions. ASH Thailand will continue to expand its strategic partnerships with those willing to face the challenge of human development through the control of tobacco.

References


Joossens, L. and P. Vatesatokit 2000, 'Role of multinationals and other private actors: Trade and investment', presentation at WHO International Conference on Global Tobacco Control Law, New Delhi, 7–9 January.


USDHS (US Department of Health and Human Services) 2000, Reducing tobacco use: A report of the surgeon general, Centers for Disease Control and Prevention, Atlanta.


April 2001
Vateesatokit, P. 1997b, 'Thailand health promotion fund: An ongoing pursuit', presentation at Regional Workshop on Organizational and Funding Infrastructure for Health Promotion, 17–19 November, Bangkok.


Vateesatokit, P., B. Hughes and B. Ritrphakdee 2000b, 'Thailand: Winning battles, but the war's far from over', Tobacco Control, 9, 122–7.


Smoking and development in the Pacific

Harley Stanton, Pacific Tobacco or Health Project

Tobacco was introduced to most countries in the Pacific region in the early nineteenth century. During the twentieth century it became so entrenched in culture that many Pacific customs have tobacco and smoking integrated into their rituals of welcome and decision-making and use tobacco extensively as an item of exchange in family life crises.

Smoking prevalence


In Tonga, 64 per cent of adult men smoke (Woodward et al. 1994); in Nauru, Tokelau, and Tuvalu, 50 per cent or more of both men and women smoke. In Kiribati, which has the highest rate of women smokers in the world, 89 per cent of men and 74 per cent of women regularly use tobacco. Smoking is even more prevalent among older women - over 80 per cent of women over the age of 45 are smokers. In Papua New Guinea, a youth survey has shown that only 10 per cent of young men and 37 per cent of young women were non-smokers in the national capital. The results for Manus Island showed a lower percentage of young men as non-smokers (5 per cent) and 40 per cent of the young women. A large number of children as young as 8 years of age were smokers. Marijuana was also being widely used (Hiawalyer 2001).

Legislation and control measures

Many of the smaller Pacific countries have no policy, legislation or plan of action to control tobacco use. Tobacco companies and importers capitalise on this by marketing products without adequate warnings, as single-stick sales and at very low prices (Thomson 1997). Their practices are often subversive of public health strategies to educate the community about health impacts and to introduce legislative change (CMCF 1995, WHO 1997).

However, some Pacific countries are making progress in tobacco control.

• In Fiji the Tobacco Control Bill came into law in 1999. This legislation will restrict the advertising and promotion of cigarettes; ban the sale of tobacco to young people; restrict smoking in public places and on public transport; and regulate the labelling on cigarette packets, with health warnings in three languages, and nicotine and tar contents restricted.

• The Cook Islands and Papua New Guinea have tobacco control legislation, but it is not adequately implemented. Papua New Guinea is currently reviewing its legislation and has indicated

<table>
<thead>
<tr>
<th>Table 1: Prevalence of tobacco use in selected Pacific Island countries, by age (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td><strong>Country</strong></td>
</tr>
<tr>
<td>Cook Islands</td>
</tr>
<tr>
<td>Kiribati</td>
</tr>
<tr>
<td>Nauru</td>
</tr>
<tr>
<td>New Zealand*</td>
</tr>
<tr>
<td>Niue</td>
</tr>
<tr>
<td>PNG+</td>
</tr>
<tr>
<td>Samoa</td>
</tr>
</tbody>
</table>

* In New Zealand smoking use prevalence is influenced by ethnicity. Tobacco use prevalence among the Maori population is 44%, Pacific Islanders 26%, and Europeans 21%. 30% of young people 15-19 years of age are smokers.
+ In PNG 14% of smokers are below 16 years of age,

April 2001
strong support for the WHO Framework Convention on Tobacco Control.
• Vanuatu has recently drafted its first Tobacco Control Bill. It will probably be introduced to parliament in the near future.
• Samoa has recently divested its 40 per cent share in the Western Samoa Tobacco Company. This opens the way for the government to implement legislation that has languished since it was drafted in 1993. Samoa implemented significant tax increases in 1996–97 that resulted in lowered smoking within the population.
• Tonga has recently introduced tobacco control legislation through the efforts of the new Minister for Health. This is strongly supported by the King, who has recently given royal assent for the prohibition of tobacco advertising and sponsorship and a ban on smoking in public places. This is an important step.
• The Solomon Islands drafted legislation some time ago but had difficulty getting it tabled. It appears that this will now be introduced by the Minister for Health at the earliest opportunity.
• In Kiribati, the Minister for Health is keen to develop policy and legislation.

Donor assistance
There is a pressing need for donor agencies to ensure that smoking is included within all Healthy Islands development programmes (Galea 1997, WHO 1995). The Australian Government recognises that tobacco use contributes to the increasing burden of non communicable diseases in the region. AusAID, the Australian aid programme, is using multilateral, regional and bilateral approaches to help Pacific Island countries improve their capacity to control tobacco use. In Kiribati, Tonga, and Vanuatu, support for the prevention of non-communicable diseases among young people, including diseases caused by tobacco use, is expected to help discourage young people from taking up smoking. In addition, the Australian Commonwealth Department of Health and Aged Care, along with AusAID, has provided support to WHO for its regional Tobacco Free Initiative.

The future scenario
It is unlikely that there will be significant improvements in life expectancy or a reduction of heart disease and cancer rates while the very high levels of smoking continue in the Pacific. Legislation and education need to be integrated in the development of national policies aimed at reducing adult smoking. The idea of taxation on commodities that are currently so destructive of life within the Pacific has been suggested, though not yet adopted (WHO 1995).

References
McGarvey, S.T. 'Cigarette smoking in American and Western Samoan adults – 1990–95', unpublished research, Brown University, Rhode Island. E-mail: SmcGarve@rihosp.edu
Thomson, G. 1997, The tobacco industry in Samoa and the establishment of Rothmans factory 1977–78, Pacific Tobacco or Health Project, 148 Fox Valley Road, Wahiwangga.
Toelupe, P.M. and D. Kiernan n.d., The smoking behaviour of Samoan youth, undated report, Department of Health, Apia.
Tuuau-Potoi, N., 1992, Western Samoa survey on prevalence rates of cigarette smoking habits in health professionals, MPH degree assignment, University of New South Wales, Sydney.
Tobacco control: The Fiji experience

Margaret Cornelius, National Centre for Health Promotion, Suva

Tobacco use in Fiji dates back a couple of centuries, when traders who came by sea exchanged cigarettes and other tobacco products for food, bêche-de-mer and sandalwood. The use of tobacco is now ingrained in culture, tradition and some healing activities. Visitors to the villages usually took cigarettes along with other manufactured goods as gifts, which were distributed free, to everyone including the children. Smoking and tobacco use is thus largely socially acceptable and more a normal behaviour than an exception.

Another contributing factor to the increasing use of cigarettes is the sale of single rolls. This increases accessibility for children and young adults not only to tobacco products but also to other drugs like marijuana.

The presence of a local tobacco manufacturing company, which claims to provide a livelihood for 20,000 people (growers and workers), to be paying ‘high taxes’ and to have a lot of influence in the right places, makes tobacco control that much more difficult.

Introduction

Tobacco control activity, until ten years ago, was very much focused on community awareness and education, mostly carried out by ill-equipped and under-resourced health workers. In some instances, the families of people dying of tobacco-related diseases like cancers took up the challenge. In one reported case, a whole village was influenced by visiting medical personnel, who provided free medical services, to give up smoking. However, the decision to become a smoke-free village was taken by the villagers themselves and they conducted a traditional ceremony to stop the use of tobacco products in their village. Even visitors are now encouraged to stop smoking, or to refrain from doing so while in the village.

There are an estimated 300 deaths a year in Fiji that are attributable to tobacco use. This burden on health services is estimated to cost more than $F5 million dollars annually. Loss of productivity due to tobacco-related illness and premature death adds to the overall losses. For a small island nation with limited human, monetary and other resources, these losses are too costly to absorb.

Tobacco control activities

Since the early 1990s a concerted effort has been made by the Ministry of Health and various organisations to consolidate tobacco control activities through coordinated intersectoral partnerships.

The establishment of NASSOF 1994

The National Anti-Smoking Society of Fiji, a non governmental organisation, was established in 1994 with membership from other anti-smoking lobby groups. It produced educational materials, conducted community education activities, organised oratory contests in schools on the hazards of smoking, and aired anti-smoking radio and TV messages. However, because of declining resources, NASSOF has been virtually inactive for the last four years or so.

The Tobacco Control Bill 1996

To strengthen community-based tobacco control activities, policy measures were needed to provide a supportive environment. The Ministry of Health declared the development and implementation of anti-smoking legislation a priority in 1989. Background work began through the Health Planner in collaboration with the Fiji School of Medicine and the Pacific Tobacco or Health Project. In 1996, a draft bill to ban advertising, restrict smoking in public places, prohibit sales of tobacco products to persons under the age of 18, and make strong health warnings mandatory on all product packaging, was introduced to parliament. There was overwhelming support for the bill from the general public, but it was not passed due to an unspecified ‘technicality’.

Public awareness campaign 1996–97

During consultations on the bill and its subsequent passage in parliament, the National Centre for Health Promotion launched a massive community education campaign. The goals were threefold: to advocate for the proposed legislation, to create widespread awareness, and to train health care workers in smoking cessation.

The major aim of the media campaign, entitled ‘Winners don’t smoke – Be smart, don’t start’, was to discourage young people from taking up smoking. The objectives were to decrease the attraction and social acceptance of smoking, and to increase public awareness of its dangers.

Television and radio spots, and messages for screening in the cinema, were prepared and used. Stickers, posters and phone cards were printed and distributed to appropriate outlets. In collaboration with the Pacific Tobacco or Health Project, health workers were educated on the effects of smoking and passive smoking and were trained to facilitate education and cessation programmes.
The Tobacco Control Action Group 1998

To strengthen tobacco control activities in the community, and to increase advocacy for the reintroduction of the control bill to parliament, an intersectoral Tobacco Control Action Group (TCAG) was established in 1998 under the National Health Promotion Council banner. Membership of the TCAG included NASSOE: Fiji Cancer Society, Counter-Stroke Association of Fiji, Fiji School Medicine, Adventist Development Relief Agency, National Diabetes Foundation, National Heart Foundation, Fiji Medical Association, National Substance Abuse Advisory Council, and Ministry of Youth and Sports, with UNICEF and WHO as advisers. Their responsibility through a five-year action plan is to continue community education and awareness activities, advocacy, smoking cessation programmes, and the monitoring of industry activities. During the passage of the bill, the TCAG engaged in public debate and other lobbying activities.

Tobacco Control Act 1998

A revised bill was passed as the Tobacco Control Act (TCA) in November 1998 after a long, tough and rough passage. The issue of sale of single rolls had still not been addressed. Sports sponsorship was prohibited but the ban did not come into force until 9 November 2000.

Surveys

The National Centre for Health Promotion conducted the National Adult Tobacco Use Survey in 1999 in partnership with Fiji School of Medicine and Red Cross Society of Fiji and in consultation with WHO. The survey covered adults 16–45 years of age. The results (still being analysed) will provide baseline information on tobacco use, as well as some attitude, behaviour and knowledge data.

Fiji also participated in the Global Youth Tobacco Survey in 1999. The results of this global survey of the 12–15 age group are still being analysed. These two surveys will provide a wealth of information for more appropriate intervention programmes. Both collected similar data and will complement each other, providing a comprehensive assessment of tobacco use as well as a basis for future evaluation of the impact of community education activities.

The TCA community awareness campaign 1999

This campaign was conducted at the request of the Minister for Health. It consisted of at least three television spots and radio spots in three languages. Printed educational materials consisted of two posters about the consequences of smoking, a pocket-sized booklet with a simplified version of the Tobacco Control Act 1998 with penalties, and stickers stating 'Thank you for not smoking' and 'Sale of cigarettes to under 18s is illegal'.

The appropriate printed materials were distributed to Ministry of Health outlets, schools, public transport owners, retail outlets and other organisations. Training of enforcement officers was considered but, since the minister had the authority to nominate additional enforcement officers in the forthcoming regulations, formal training was not conducted. Police officers were the only enforcement officers nominated under the TCA 1998 and they were very preoccupied and short-staffed at that time.

Camel Trophy Event 2000

Early in 2000, it was brought to the notice of some members of the TCAG that the Camel Trophy Event 2000 was to take place in Fiji and Tonga. This is a brand-stretching marketing strategy by the tobacco industry, although the organisers categorically denied that this was its purpose. A small TCAG subgroup met to discuss the strategies that could be used to minimise the publicity and its likely impact. The organisers had obtained permission from Fiji Visitors Bureau (FVB), Ministry of Fijian Affairs and other authorities for the staging of this event under the above banner.

The subgroup decided to assess the extent of association of the Camel Trophy logo with the Camel brand of tobacco, to design a position statement showing disapproval of such events, to obtain signatures from concerned organisations in support of the statement and to approach at least the FVB to express concern. The group also decided to monitor the progress of the event and to conduct a post-event survey to see if the association between logo and brand had increased.

The event organisers categorically denied having any association with Camel tobacco, despite the logo being essentially the same. However, Fiji’s political crisis on 19 May had them scurrying to a neighbouring island country and changing the name of the event to Salem Adventure (yet another brand of tobacco).

Participation in FCTC 2000

Fiji responded positively to the invitation to be part of the Intergovernmental Negotiating Body on WHO’s draft Framework Convention on Tobacco Control (FCTC), which it supports. One official delegate represented Fiji at the first session held in Geneva in October.

Tobacco Control Regulations 2000

The Tobacco Control Regulations took a long time to be drafted because of a number of difficulties. The process was initiated in 1999. The tobacco industry was consulted, as with the TCA 1998, and there were numerous delays. Finally, despite the political crisis, the draft regulations were presented to the Interim Government in July 2000. After discussion and debate the draft was referred to a select committee for ‘clarification’.

Cabinet finally endorsed the regulations in December. Most sections came into effect on gazetting (29 December 2000), the remainder on 1 January 2001.

‘Truth about tobacco’ campaign 2000–01

Starting in November 2000, this was a four-month campaign initiated and conducted by the National Centre for Health Promotion. It was designed to facilitate the passage of the Tobacco
Control Regulations and to advocate for support for the FCTC. Strip advertising on the consequences of smoking and tobacco use was placed in one of the daily newspapers for the first month. The sports page was chosen for this because of the tobacco industry’s sports sponsorship advertising prior to the ban coming into effect.

Television and radio spots then aired similar messages. The compulsory health warnings on cigarette packets were read by young children who then asked the listeners, 'If children can read these, why can’t you?'

The messages on television were aired at prime times, 15–20 times a month for three months. Radio messages were aired at least 10 times a day in three languages for three months. An assessment form is being finalised to assess the impact of this campaign on the community.

**Tobacco Control Enforcement Service 2001**

The Ministry of Health is taking the lead role in establishing this service. Two full-time tobacco control enforcement officers (TCEOs) from the Environmental Health Section will be appointed as project officers under the Ministry of Health and attached to the National Centre for Health Promotion. The two TCEOs, after training, will train all other authorised enforcement officers, including the police, occupational health and safety and fair trading officers, doctors, nurses, nurse practitioners, dentists, medical assistants, health inspectors and nominated officers from the Ministry of Fijian Affairs.

The Ministry of Health will provide incentives for the enforcement officers from other organisations, such as sharing of revenue generated by the prosecution of offenders. This proposal is yet to be presented to the Ministry of Finance.

**Future challenges for Fiji**

A tobacco smuggling operation has been uncovered in Fiji recently. The local tobacco industry is pressuring the police to accept their donation of some two acres of land and up to Fijian $25,000 to set up a police post in their plantation area. Some of the sugarcane farms where the tenants’ lease has expired are now being used for tobacco farming – these are new areas and not the traditional tobacco-planting areas.

Struggling non-governmental and civil organisations are being offered support by the industry, such as the donation of much-needed transport and, with it, pressure to display the company logo by way of acknowledgement. This constitutes advertising according to the Act.

**Commitment**

The National Centre for Health Promotion, Ministry of Health, and the National Health Promotion Council with its partners are very much committed to eliminating tobacco-related disease and ill health. This is a long process and the need to constantly lobby for support, to share knowledge and skills and to persist in the quest for health cannot be overemphasised. A multi-strategic approach needs to be pursued for the achievement of goals.
Tobacco smoking is common in Papua New Guinea. It continues to be a preventable cause of disease that needs to be addressed, but government and donor spending on prevention must compete with resources for more immediate infectious disease control. However, an examination of the contribution that tobacco-related diseases make to illness clearly shows that tobacco control should be a health priority.

**Effects of tobacco consumption**

The commonest causes of death in PNG health facilities in 1997-99 were, in order of frequency: pneumonia, malaria, perinatal disorders, tuberculosis, meningitis, heart disease, and cancer. Of all pneumonia deaths for 1995-97, 67.3 per cent occurred in children aged less than 1 year (Ministry of Health 2000:34, 55). Pneumonia was similarly a major cause of all admissions to health facilities and, together with simple cough and other respiratory conditions, made up 18 per cent of reported outpatient visits over the same period.

No studies have been done in Papua New Guinea to demonstrate the extent to which passive smoking contributes to pneumonia and respiratory disease in children, but several studies elsewhere have confirmed such a relationship (CEPA 1997, Strachan and Cook 1997, USDHHS 1986, Yue Chen et al. 1986). Of the 704 households I surveyed in Port Moresby in 1993, 70 per cent contained smokers, with 55.7 per cent of them having two or more smokers. This indicates that passive smoking in the home is a common occurrence.

Ten per cent of all children born in Papua New Guinea in 1997-99 weighed less than 2,500 grams (Ministry of Health 2000:110), which put them at increased risk of illness and perinatal death. Maternal smoking may be a neglected contributing factor in this situation (Abel 1980).

In those aged 45 years and over, national statistics for 1995-97 show that pneumonia, heart disease, cancer and other respiratory diseases are major causes of death, especially in males (Ministry of Health 2000:55). The data are insufficient to allow disaggregation, population standardisation, and further analysis to demonstrate whether in fact the incidence of specific tobacco-related diseases, such as chronic obstructive airways disease, ischaemic heart disease and lung cancer, are increasing or not. However, these statistics do generally indicate that tobacco-related diseases are likely to be common, given the high prevalence of smoking.

**Prevalence and type of tobacco use**

The most recent surveys of the prevalence of cigarette smoking in Papua New Guinea were carried out in 1991 (Table 1).

The urban Koki and rural Wanigela communities are almost exclusively followers of the Seventh Day Adventist church, which prohibits smoking, hence the low rates in these areas. Elsewhere, there are high rates in all age groups among men and Highlands women. (The surveys also showed that, in the Highlands, 73.7 per cent of men and 69.7 per cent of women smoked more than 20 cigarettes a day.)

<table>
<thead>
<tr>
<th>Age</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>25–34</td>
<td>5.9</td>
<td>0.6</td>
<td>3.1</td>
<td>0.0</td>
<td>91</td>
<td>60</td>
<td>1.9</td>
<td>5.9</td>
<td>0.0</td>
<td>3.9</td>
</tr>
<tr>
<td>No. studied</td>
<td>137</td>
<td>173</td>
<td>154</td>
<td>91</td>
<td>60</td>
<td>53</td>
<td>51</td>
<td>31</td>
<td>402</td>
<td>348</td>
</tr>
<tr>
<td>35–44</td>
<td>2.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>91</td>
<td>60</td>
<td>1.9</td>
<td>5.9</td>
<td>0.0</td>
<td>3.9</td>
</tr>
<tr>
<td>No. studied</td>
<td>35</td>
<td>138</td>
<td>27</td>
<td>77</td>
<td>31</td>
<td>61</td>
<td>71</td>
<td>101</td>
<td>164</td>
<td>377</td>
</tr>
<tr>
<td>45–54</td>
<td>47.6</td>
<td>10.0</td>
<td>86.2</td>
<td>17.2</td>
<td>56.0</td>
<td>25.0</td>
<td>50.0</td>
<td>25.0</td>
<td>58.2</td>
<td>17.0</td>
</tr>
<tr>
<td>No. studied</td>
<td>52</td>
<td>23.6</td>
<td>72.2</td>
<td>50.0</td>
<td>46.7</td>
<td>68.4</td>
<td>65.7</td>
<td>30.8</td>
<td>58.7</td>
<td>38.1</td>
</tr>
<tr>
<td>55+</td>
<td>52</td>
<td>23.6</td>
<td>72.2</td>
<td>50.0</td>
<td>46.7</td>
<td>68.4</td>
<td>65.7</td>
<td>30.8</td>
<td>58.7</td>
<td>38.1</td>
</tr>
<tr>
<td>No. studied</td>
<td>52</td>
<td>72</td>
<td>37</td>
<td>31</td>
<td>30</td>
<td>39</td>
<td>61</td>
<td>66</td>
<td>180</td>
<td>208</td>
</tr>
</tbody>
</table>

**Table 1** Age-specific prevalence of cigarette smoking in Papua New Guinea, 1991 (%)

Source: Collins and Dowse 1996
An unpublished survey in 1990 of a sample of 1,203 persons found overall that 46 per cent of males and 28 per cent of females smoked. It also found that 14 per cent of children aged 10–16 smoked (First Marketsearch 1990).

Three types of tobacco consumption predominate:

- packeted, commercially produced, filtered, flue-cured cigarettes;
- stick cigarettes, which are unfiltered, commercially produced, 12cm long cigarettes made from coarse air-cured tobacco rolled in newspaper; and
- brus, which is a traditional sun-cured wild variety of tobacco, homegrown in rural villages and smoked like cigars.

Flue-cured cigarettes dominate the market. Sticks, produced locally specifically for Papua New Guinea, make up the bulk of the rest of the market. Brus are confined largely to scattered rural areas but are intermittently available in town markets.

As of June 2000, all commercial tobacco distribution and the local production of flue-cured and stick cigarettes are controlled by British American Tobacco (BAT) (PNG), a subsidiary of the UK-based parent company. As has been the case for over 25 years, all tobacco used commercially is imported. The only economic benefit is through government excise tax and a limited amount of local employment. As long ago as 1974, in the only such analysis to date, von Fleckenstein estimated that the health costs to Papua New Guinea far outweighed any economic benefits.

**Tobacco promotion and availability**

Currently, the main activities that promote cigarette smoking in Papua New Guinea are the sponsorship of major public events and sport by BAT(PNG), and limited advertising in newspapers. An example of a major event sponsored by BAT(PNG) is the annual national Red Cross Miss PNG Quest, a beauty pageant that is a good vehicle for reaching women. Brand names are well highlighted through their association with such popular sporting events as rugby league. National papers such as the *Post Courier* carry whole-page, colourful advertisements which mention locally available brands of cigarettes and their recommended price under the banner ‘This is your price - Don’t Pay More’ (*Post Courier*, 14 April 2000:31). BAT(PNG) has also been active in lobbying the health, treasury, finance and justice ministers about their perspective on the WHO Framework Convention on Tobacco Control (*Post Courier*, 23 March 2000:25).

The ready availability of cigarettes in markets, roadside stalls, trade stalls and supermarkets — from the national capital, Port Moresby, to remote villages — is also very important in maintaining consumption. Flue-cured cigarettes are distributed in packs containing as few as ten cigarettes. Coarse tobacco sticks have always been sold individually, currently at 50 toea a stick. It is against the Tobacco Products Health Control Act of 1987 to sell flue-cured cigarettes individually. However, this is widely done, at an officially advertised price of 30 toea per stick (US$0.10), in produce markets, trade stores in remote areas, and the numerous roadside stalls (*Post Courier*, 23 March 2000:25). Although against the 1987 Act, it is commonplace to see cigarettes being sold to minors. Given the poor socioeconomic conditions in Papua New Guinea, where formal employment constitutes only 9.2 per cent of all economic activities, it is hard, and indeed likely to be impracticable, to prevent roadside sellers earning a few kina from selling cigarettes individually while cigarettes remain popular (UNICEF1996).

**Consumption trends**

The current tobacco trend in Papua New Guinea is likely to be one of decreasing use, due to the influence of tobacco excise and poor general economic conditions. Adult per capita consumption of tobacco increased by 29 per cent between 1966 and 1975 but under the influence of excise declined by 26 per cent in the period 1980–85 (Chapman and Leng 1988:176–80). From 1986 to 1990, average cigarette consumption per head of population decreased from 26 to 24 (Chapman 1992). Although reliable data are not available to indicate definitely if this trend is continuing, figures for the years 1996–98 and 1999–2000 show that the cost of alcoholic drinks, tobacco and betelnut has continued to increase out of proportion to other consumer price index expenditure groups (Department of Trade and Industry 1999:28, National Statistics Office 2000:7). This indicates that the price pressure that leads to decreasing consumption of these goods is still present.

**Tobacco control**

Since the 1987 Act was introduced the Ministry of Health has implemented a poorly funded tobacco control programme. Tobacco control activities are emphasised in the 2001–2010 National Health Plan (Ministry of Health 2000). The key components of this plan relevant to tobacco control are:

- along with a more scientifically rigorous approach to development of mass media, the Healthy Islands Settings Approach is to be adopted as a nationwide approach to health promotion; and
- tobacco-related diseases are seen as part of modern lifestyle diseases (including diabetes, heart disease, strokes and certain cancers) that should be addressed together.

Under the Healthy Islands Settings Approach, local communities are involved in developing their vision of a healthy community and identifying health problems (Ritchie et al. 1998). There are so many health problems in Papua New Guinea that it is difficult to sustain activity for any one programme. Properly facilitated, the Healthy Islands Approach has the potential to generate community awareness and ownership and to sustain health promotion concerning tobacco control by integrating it with that for other diseases.

In the current health plan, under the separate heading of 'Lifestyle Diseases and Malignant Cancers', several actions are proposed:

- The Tobacco Products (Health Control) Act 1987 will be strengthened, made more enforceable and reviewed in line with the WHO Framework Convention on Tobacco Control.
The multitudinous large billboards once advertising cigarettes can no longer be seen around Port Moresby. No longer are whole facades of supermarkets and trade stores painted in the colours of cigarette brands. However, newspaper advertisements still persist, allegedly only to inform the public of the price of products. Tobacco companies know well that the desire to smoke is dependent on such cues as brand names and the circumstances associated with previous smoking, even more so than on blood nicotine levels (Henningfield and Nemeth-Coslett 1988). Health promotion has also taken place in association with World No Tobacco Day. Currently, the National Capital District Commission has established a ban limiting the sale of betelnut, often chewed in association with cigarettes, and has replaced the old K500 fine on smoking in public motor vehicles with a more realistic fine of K40.

School children are being taught about tobacco-related illness, as part of the education curriculum. Health-promoting schools are being established which integrate a traditional curriculum with one promoting health. They strive to help students to gain the skills to develop and maintain healthy, environmentally sound lifestyles for themselves and their communities (WHO 1999).

Medical practitioners have an important leadership role in health care. The medical curriculum is currently being revised and converted into a problem-based format. Tobacco-related diseases are covered in this course. It is hoped that its implementation will help future PNG doctors to have a greater appreciation of their role as advocates for health promotion, education and prevention, rather than being just practitioners of curative medicine.

Conclusion

Given the limited resources available and the high rate of infectious diseases, a reasonable amount is being done in Papua New Guinea to control tobacco consumption. The major remaining challenges include:

- the provision of adequate funding and skilled personnel for the implementation of the tobacco control activities in the current health plan;
- finding funding sources for sport and major events so that tobacco brand-name sponsorship can be banned completely;
- the banning of all tobacco brand names from mass media;
- education of the community so that sharing a cigarette is no longer seen as a socially desirable activity;
- reaching and continuing to educate the high proportion of teenagers who are not getting more than 5th grade school education; and
- establishing a socially acceptable system to enforce laws against the sale of cigarettes to minors.

Throughout Papua New Guinea, individual behaviour is determined by one's obligations to others. For centuries, sharing tobacco has been a part of these relationships. If one has no money for cigarettes, one can reasonably expect one's kin to provide it. Such behaviour therefore limits the effect of increasing tobacco excise on consumption.

To decrease tobacco use further, health education needs to get across the message that the modern, flue-cured cigarette, widely available in Papua New Guinea since 1960, should not be socially acceptable, because of its effects on health. Given the cultural orientation to family and the group, emphasis on the acute detrimental effects of passive smoking on one's children and kin may be as useful a motivator to cease smoking as stressing the adverse health effects on smokers themselves.

References


CEPA (California Environmental Protection Agency) 1997, Health effects of exposure to environmental tobacco smoke, Office of Environmental Health Hazard Assessment, CEPA.


First Marketsearch 1990, 'Research report 1989–90 ... Boroko', unpublished survey for PNG Health Department, Port Moresby.


National Statistics Office 2000, March quarter 2000 consumer price index, Table 7: Change in all group index points from December quarter 1999 to March quarter 2000 by urban areas, National Statistics Office, Waigani.


WHO 1999, 'Health-promoting schools gain strong support in Papua New Guinea', *WHO in Action* (newsletter of WHO Western Pacific Regional Office), 1(2), December.

Tobacco use prevention and control activities have been taking place in Palau in earnest since 1995 when a conference was held in Saipan in the Commonwealth of the Northern Marian Islands (CNMI). At that time, representatives from the Micronesian nations of the Marshall Islands, Federated States of Micronesia, Palau and CNMI as well as Guam and Hawaii met to discuss issues of regional concern.

Upon their return, the Palau delegation formed the Coalition for a Tobacco Free Palau and participated in such activities as observance of World No Tobacco Day (WNTD). It has helped to organise and conduct tobacco vendor inspections to determine compliance with the youth access law forbidding the sale of tobacco to those under the age of 19. Membership commitment diminished over the years, until 2000 when Palau became the recipient of funding from the US Centers for Disease Control and Prevention. These funds, added to those already received for substance abuse prevention and treatment activities and some local support, enabled the Coalition to become re-invigorated.

With these funds Palau was able to recruit a full-time tobacco programme coordinator, to set up an office/resource centre and to reactivate the Coalition. The Coalition, now better organised, has divided into the several committees which make up the working body of the tobacco programme. Education, survey, legislation, Framework Convention on Tobacco Control (FCTC), WNTD and youth committees meet regularly to carry out programme objectives.

Tobacco use in Palau

Tobacco use in Palau is usually involves adding cigarette pieces or chewing tobacco to betel nut. The term 'betel-chewing' describes a complex practice of chewing a quid of ingredients, principally the nut of the Areca catechu palm (betel nut), the leaf of the creeping vine Piper betle, and lime, usually in the form of burnt shell or coral. Other ingredients that may be added include cigarettes/tobacco and/or cloves. Betel-chewing is a longstanding cultural practice, although the addition of tobacco is relatively new.

Data regarding tobacco prevalence in Palau are based principally on studies conducted in 1995 and 1997. The 1995 survey (Ysaol et al. 1996) of 1,110 individuals included at least 5 per cent of each age group in the population over 5 years of age. Results showed that the percentage of Palauans who chewed betel nut ranged from 55 per cent in the 5-14 age group to 86 per cent in the 35-44 age group. Cigarettes were added to the chew by 30 per cent of the chewers, and chewing tobacco added by 24 per cent. In the younger age group, 86 per cent added cigarettes to their chew. A substance abuse need assessment conducted in 1997 also revealed that over 70 per cent of adults chewed betel nut and that the majority of them added tobacco to their chew.

In January 2001, a comprehensive youth tobacco survey was administered to every student in grades 6-12 to determine prevalence, age of first use, details on tobacco use as well as betel-nut use, attitudes and knowledge. Analysis will be complete in April 2001. The administration of this survey was a huge logistical challenge, with many of the interviewers having to take boat trips to outlying states and islands and spend the night there (with some accommodations more acceptable than others). The administration of an adult tobacco survey is planned for 2002.

Palau's anti-tobacco programme

The tobacco programme has worked out an outreach schedule with the Ministry of Health's dental programme, which occurs on a regular basis. Tobacco prevention/education is now a part of the presentation to youth in the outlying states and islands. Other activities have included puppet shows to grade 1 students about the origin and effects of tobacco, presentations at regional conferences, observance of WNTD, FCTC education, and physician education. The tobacco office acts as a resource centre, open and available to anyone wanting information on tobacco and/or betel-nut issues.

The newly created youth arm of the Coalition has undertaken some specific activities, including a Hallowe'en event called 'Hall of Horrors, The Spooky Truth about Tobacco'. In the old hospital under demolition, the kids set up several areas to demonstrate how tobacco affects different parts of the body. After the final death scene, kids were given a bag of popcorn that included some literature about tobacco, and shoe 'bumper stickers' with anti-tobacco messages to stick on the back of shoes or on helmets or backpacks. They have also organised activities for Education Awareness Week, an annual event where all students in Palau gather for a week of educational activities in the central town of Koror. Palau's national track, a very popular gathering place for youth and adults, has two large billboards with anti-tobacco messages that are now familiar to all.

Tobacco vendor compliance checks are a big part of our anti-tobacco efforts and each year we survey every vendor in the main states of Koror and Airai (where over 90 per cent of the population
Compliance was 67 per cent in 2000, with just over 100 stores being surveyed. Contact with each vendor to either thank and congratulate or to warn, depending on the outcome of the surveys, will be one strategy that it is hoped will lead to improved compliance over the next two years. Our target rate is 80 per cent compliance.

The main challenge that we face is changing the social acceptability of chewing betel nut and adding tobacco to it. In order to strengthen our argument about tobacco use and its association with ill health and the cost of that ill health, we need data on the health risks of chewing betel nut with tobacco. However, there has been no research on attributable risk factors. Without this, we cannot go beyond how much the habit is costing in terms of the ingredients: we need to associate costs with health care, lost days of productivity, off-island referrals, morbidity and mortality. It appears that issues of economics must also be part of the educational process. Similarly, many resources worldwide have gone to the development of slick brochures, videos and promotional products emphasising the dangers of smoking, environmental tobacco smoke and spit tobacco (as used by sports players), but we have found little or no material dedicated to betel-chewing and the addition of tobacco. Thus, on a relatively limited resource budget (both human and fiscal), we are developing original material specific and appropriate to Palau.

**Regional partnerships**

The tobacco programme and the Coalition work closely with regional partners in the Pacific through e-mail and occasional meetings and training courses. Internet access is still very costly for us, but we would like to develop a website as soon as this becomes affordable. The Coalition has recently joined the Global Partnerships for Tobacco Control project to link with a US-based organisation for the purpose of sharing and learning from each other. This is a new endeavour for Palau and we are excited by the prospects of this new partnership. Regionally, we also work closely with the WHO Western Regional Office, the Pacific Islands Health Officers Association, and the Pacific Substance Abuse and Mental Health Collaborating Council.

**Conclusion**

In spite of the barriers, we are optimistic in Palau; we have the strong support of the newly elected president and vice-president of the republic (who is also the health minister), and some key legislators. Comprehensive legislation regarding tobacco use and control does not currently exist; one of our goals is to draft and introduce such legislation and ensure that enforcement activities are also supported. We have some very committed Coalition members who work tirelessly to inform and educate the public, youth and members of community agencies and organisations. There is certainly now a community awareness of the tobacco issue and the time is ripe for us to develop strong policies regarding tobacco industry sponsorship, advertising, trade and influence.

**References**


Youth tobacco survey in the Commonwealth of the Northern Mariana Islands

Isamu J. Abraham and Norma S. Ada, Department of Public Health, Commonwealth of the Northern Mariana Islands

A preliminary draft report of the Commonwealth of the Northern Mariana Islands (CNMI) Youth Tobacco Survey has been completed. Personnel in the Statistics Section and staff at the Mental Health Division are now developing graphs, figures and tables for the report. We want to file a Special Publication on Tobacco, Globalization and Development for the Commonwealth. The executive summary is as follows.

Recent findings

Recent findings from the 2000 Commonwealth Youth Tobacco Survey (CYTS), reported by the Department of Public Health revealed that nearly 55 per cent of middle schools students and 85 per cent of high school students have tried cigarettes in their lifetime. Even more disturbing is the fact that nearly 10 per cent of middle school students and 30 per cent of high school students are current smokers, defined as having smoked a cigarette on at least one occasion in the past 30 days. The majority of youth in grades 6 to 12 (60 per cent) do not use cigarettes. Among those who do, however, the most common methods of obtaining cigarettes involve:

• Giving money to another person so that (s)he can purchase them on the youth’s behalf (16 per cent);
• Borrowing (bum) cigarettes from friend and/or family members (11 per cent); and
• Purchasing cigarettes in a store (21 per cent).

Among youth reported buying cigarettes, nearly one student in four (23 per cent) list convenience stores as their primary point of purchase. The next most common source is the grocery store (12 per cent). Among youth that bought cigarettes in local store, a little less than one in three (30 per cent) were asked to show proof of age. A slightly higher number reported being refused a purchase because of their age (32 per cent). More than 65 students in grades 6 to 12 tried to quit smoking during the past twelve months (70 per cent). About 29 per cent of those who tried to stop smoking stayed away from cigarettes for more than a year.

Outcomes – the law and access to cigarettes

The CNMI has developed and implemented a local law restricting youth access to tobacco during the past two years. It is clear, however, that many youths are still able to obtain cigarettes in spite of the local law, raising concerns that the recently implemented youth access restrictions are not particularly effective or evenly enforced. This study will find out and document some of these major contributing factors to this dilemma. Our current data also found that important differences exist across age, gender, and racial/ethnic groups in terms of source of cigarettes, purchase locations, refusal rates and brand preferences. The fact that nearly ten per cent of middle school students and ten per cent of high school students report that they obtained cigarettes from “other” sources suggests that there are important access methods available for these youth that the government does not yet know about. Some of these issues and the CNMI trends in relationship to other countries will be investigated under this proposed study and write up.

Purpose of study

The purpose of our study is to examine the issue of youth access to cigarettes using data from the 2000 CYTS. The concept of youth access to cigarettes is described in terms of youth’s usual sources of cigarettes, the methods they use in obtaining cigarettes, the consequences they face, and the restrictions they encounter when they try to purchase cigarettes from local stores.

Contact Address: Isamu J. Abraham, samu_abraham@hotmail.com
Norma S. Ada, nada@saipan.com
The Development Studies Electronic Forum

This Forum was established by the Australian National University (ANU) to provide a world-wide communications vehicle and a central electronic archive for anyone working on or interested in the study of social and economic development, with a particular focus on Third World countries.

How to join

To join (subscribe to) the forum send e-mail

to: majordomo@cairo.anu.edu.au
message: subscribe Development-Studies-L your e-mail address
[eg: subscribe Development-Studies-L xyz@abacus.abc.edu.au]

To join (unsubscribe to) the forum send e-mail

to: majordomo@cairo.anu.edu.au
message: unsubscribe Development-Studies-L your e-mail address
[eg: unsubscribe Development-Studies-L xyz@abacus.abc.edu.au]

It will be helpful for all members of the Forum to provide a brief introductory note, as their first communication with the Forum: who you are, your institution or affiliation, your general and specific interest in development studies research. Most email systems permit the appending of a signature block to a message:

Participants are free to join and leave the Forum at any time. English is the preferred language of communication of this Forum.

Contributions

To contribute, you must have subscribed and been approved as a member of the list of contributors. Approval to join the Forum is a 'proforma' operation, but subscription does permit some basic control of the contents of submissions by the list owner. Any submission to the forum is immediately broadcast to all subscribed members, and a copy automatically archived.

Anyone, whether a registered member or not, can electronically view and retrieve the communications to the forum using a database 'ANU-Development-Studies-L' accessible through the standard WAIS software and through the ANU's COOMBSQUEST Social Sciences and Humanities Information Facility gopher running on the coombs.anu.edu.au as well as on the cheops.anu.edu.au machines.

To post your contribution to the forum send e-mail

to: Development-Studies-L@cairo.anu.edu.au
message: [the body of your contribution comes here]

If you are reporting findings or research results, treat the text as if it were a short note/abstract to a professional journal. Bibliographic information is always welcome and such contributions, if submitted, will be archived on in the Coombspapers Social Sciences Research Data Bank at ANU available by ftp/gopher/www access on the cairo.anu.edu.au system.

If in doubt how to interact with any of the coombs.anu.edu.au lists, end a message 'help' to: majordomo@cairo.anu.edu.au
At a mission conference in Aachen, Germany, about five years ago, I had what was to be a memorable conversation with a West African man. When I asked him how his country was doing, he replied, aggressively more than sadly, that it was not doing well at all. There was political instability, unrest about the poor economic showing of recent years, and many other problems facing his people. Before I could ask him about any of these problems, he started in on a long list of grievances: the depredations made by the early slave trade, the years of colonialism, and the exploitation of his and other African nations by lending institutions, leading to the enormous national debt that burdens them even today. From start to finish, he told me, his nation had been victimised by forces beyond their control. The slave trade and colonialism were evils perpetrated by Western nations. AIDS was unleashed by natural forces just as malevolent as the first. No matter what problem was mentioned, my African friend regarded it as another crippling blow from the hand of fate.

Racism, global forces, disease were all drawn up against this man and his nation. What could he and his fellow citizens do? I walked away from the conversation thinking that, whatever this man and his people suffered from, they were afflicted with an even more lethal malady, something that we might call 'victimisation'. What good would it do to work out strategies for restructuring the national debt? The nations of the world were aligned against his country. Political reform was not worth talking about, since the country had been hopelessly contaminated by its colonial masters. He was in the grip of a paralysis that had rendered him powerless over his life. He was a self-defined victim.

Becoming victims in the Marshall Islands

Whenever I recall this conversation, I think of the Marshall Islands, which have had their share of misfortunes. Like other parts of Micronesia, the Marshalls were battered during World War II. A few hundred Marshallese lost their lives during the hostilities, including about 140 on Jaluit during a single bombing raid. No sooner did peace come to the islands than the populations of two atolls were removed from their ancestral homes so that these islands could be used as nuclear test sites. About 12 years and some 70 explosions later, the people from the test sites were still homeless. Meanwhile, scores of Marshallese were affected by exposure to radiation during the tests, especially the famous Bravo test of 1954 whose fallout affected the populations of the neighbouring islands of Rongelap and Rongerik.

The misery that many Marshallese people suffered is undeniable. Perhaps no monetary compensation can redress these past wrongs. What worries me is that it might compound the damage done them. Whatever injuries and bodily problems they may have suffered, Marshallese at least retained their indomitable spirit. They once thought of themselves as survivors, as they were indeed. As pleas for compensation multiply and the road to the claims court becomes more clogged, I fear for this spirit. When people begin to regard themselves as no more than victims, their fate is fixed. They may be found sitting by the side of the road with their tin cup, waiting until others, the villains of the past, fill it with...
coins. The danger is not that they derive profit from what they
derived no profit or even the slightest hope they would have a chance
of recovering. The question is what should be done about
From this point onward, I will talk more about the question of
compensation. Take, for instance, the matter of compensation for the effects of
nuclear fallout on some island populations in 1954. Beyond any
question, damages were due those many people who, as a result of their
exposure to fallout from the Bravo explosion, suffered subsequent health problems. Accordingly, a settlement was made
between the USA and the Republic of the Marshall Islands as part of the Compact of Free Association. A few years later, as papers from US Department of Energy files came pouring into the Marshalls, thanks to the Freedom of Information Act, the Government of the Marshalls claimed 'changed circumstances'. Some of the new information that has come to light suggests that the USA may have known of the possibility of a last-minute wind shift that would carry fallout over other atolls but allowed the test to go ahead anyway. The supposition is that the US Department of Energy would have welcomed the chance to test the effects of radiation on human population, all the more so if this were to happen 'accidentally'.

If those Americans making the decisions on the nuclear testing ever did so with even the slightest hope they would have a chance to use human guinea pigs, their actions would be shameful and indefensible. The point is not whether such an action is good or bad; that is obvious. The question is what should be done about it. Naturally, the victims should be provided for and efforts intensified to provide adequate testing and health care for any Marshallese who may have been affected. The Marshallese Government, however, seems to be seeking punitive damages for what it regards as callous behaviour by the USA. The 'changed circumstances' are not something reprehensible but a lucky break for the government, for the Republic of the Marshalls may now be able to renegotiate the settlement for an even larger sum of money.

None of this will change the past, wipe away the shame of what was done or help the victims that suffered for it. What it will do, however, is allow the Marshalls to pick up a fatter cheque that can be used for defraying the cost of government services today. Is there really anything wrong with this? Perhaps not, unless it feeds the tendency of people in the Marshalls to find a seat in the shade, rattle the change in their tin cup, and ignore their responsibility for making the government work, comfortable that they are once again victims who can do no more than rue the past and make
claims on those responsible for their past misfortunes to create a future for them.

Marshall Island tobacco claims

A few years ago, the Government of the Marshall Islands entered a lawsuit against several US tobacco companies for about $12 billion in damages. Tobacco companies have notoriously deep pockets, as some of the out-of-court settlements in the USA have demonstrated. The argument that the Marshalls presented might be put something like this:

The tobacco companies seduced us, poor ignorant islanders that we are. They caused us to smoke, and in doing so they ruined our health. So, they should have to pay not just the medical bills that were the price of smoking, but also build for us in the future the health system that we have always dreamed of having. On top of this, of course, they will also have to pay big-time damages.

We do not have to be fans of the tobacco industry to pick up an off-key note in this querulous argument. The tune is one we have heard before: 'We bear none of the responsibility for what has happened to us. We are the victims of one disaster after another. If it isn't the Atomic Energy Commission or the Department of Defense that's to blame, then it's the American tobacco companies.' The chord is a familiar one: victimisation.

For these reasons I find myself on the unpopular side in the current tobacco case. It is not because I want to see the Marshallese cheated that I take this position but because I do not want them to cheat themselves for some alluring short-term gain. In my opinion, the paralysis brought on by the mind-set I am calling victimisation is a far bigger threat to the Marshallese people than the admittedly dangerous product that American tobacco companies make. To put the matter simply, I am doing everything I can to ensure that the Marshalls does not find a comfortable spot at the side of the road from which it can jingle the change in its cup while shrugging off responsibility for its future.

The use of tobacco is not a wise health choice, we can all agree. Yet to say that the tobacco companies are responsible for this unwise choice is like saying that the companies that market ramen and other high-sodium foods are responsible for the hypertension that is so common in the Marshalls. Lung cancer occurs in the Marshalls, but the most serious health problems are heart disease and diabetes. Health officials have urged again and again that the greatest health problem in the population is related to diet and lifestyle: too little exercise and too much salty and fatty food. According to a report on causes of death in the Marshalls between 1994 and 1997, drawn from health records, the leading cause of death was diabetes. Nearly one in five Marshall Island people died of diabetes-related conditions. Almost seven times as many people died of diabetes as of lung cancer during this four-year period. Indeed, twice as many people died of suicide (48) as of lung cancer (22). Heart disease, which claimed 106 lives during this period, was one of the major causes of death. Smoking may have contributed to the high rate of heart
disease but so did a lack of exercise and poor diet, the same factors that underlie the extraordinarily high rate of diabetes in the Marshallese population.

Even if tobacco use were responsible for destroying our population, whom should we blame for this problem? We cannot blame the American tobacco companies for introducing the weed to the Marshallese people, since that happened sometime in the mid-nineteenth century. Pohnpeians were already using tobacco as a medium of exchange in the 1840s, and tobacco plantations were being cultivated in Palau by 1870. Guamanians, the first in Micronesia to grow tobacco, already had plots in front of their houses in the early 1700s. When I first came to Micronesia in 1963, I found many people smoking, although there were no billboards, commercials or other advertisements urging them to do so. I would imagine that people smoked because they had seen others doing it, not because of any advertising campaign mounted by the tobacco companies.

**Taking responsibility**

The basic question, then, comes down to this: who is responsible for the toll taken by smoking? If we can point to someone else, then we can limp through life, drawing attention to our scars and blaming others for the damages we have suffered. We can continue to expect them, not ourselves, to see us through our future needs. The USA dispossessed us of our lands, ‘nuked’ us, and then poisoned us again through the tobacco they sold us. Because what they have done has destroyed our past, they owe us our future.

Is this the best that the Marshalls can do? Not from what I have seen. The Marshalls has a talented and resourceful people, a credible new government administration, and an upbeat attitude towards the future. I would like to see the Marshalls build on this and stay far removed from anything that would tempt them to take on the mind-set of my African acquaintance, the perpetual victim.
The challenge of capacity building is pronounced in the aftermath of complex political emergencies. The retaliatory violence that swept East Timor in late 1999 following the rejection of Indonesian rule in a UN-sponsored vote wreaked havoc on a people who already had a long history of suffering. Although the vote symbolised a major achievement in an independence struggle and the tenacity of the East Timorese people in resisting an unwanted occupying power, the challenges for recovery and rehabilitation were severe. These challenges extended well beyond the need for stabilisation of security conditions and for relief that were the initial focus of subsequent international military and humanitarian intervention. A significant gap was a lack of capacity at almost every level in society in terms of human, financial and technical resources.

In the post-conflict context, an obvious priority is the rebuilding or redesign of the collapsed state structure necessitated by the removal of Indonesian rule. Re-establishing vital central functions such as service provision and the rule of law is the main concern of the UN Transitional Authority for East Timor (UNTAET) in preparation for self-government. Similarly, such needs are the major focus of international assistance, including support by donors.

This article examines how the role of those elements of society lying beyond government, that is 'civil society', may be enhanced to contribute to both rehabilitation and longer-term development in East Timor. The specific focus is on capacity building with local non-government organisations (LNGOs) for this purpose. These organisations have an established but also burgeoning presence in East Timor, highlighting the potential and also the pitfalls associated with their contribution. The source of the capacity-building assistance for LNGOs is both donors and international non governmental organisations (INGOs).

LNGOs have a vital and significant role to play. In particular, they are well placed to contribute to peace building and community empowerment and participation in democratic processes. In order to augment this role, they require sustained support as part of a programme of international assistance.

Background

The destruction unleashed on East Timor had multiple impacts that extended beyond immediate death and injury. These included the destruction of infrastructure and housing, the collapse of services, and huge dislocations in the population as large numbers were either forced to relocate to West Timor or left alongside fleeing militia and Indonesian troops. Local capacity to cope was exacerbated by East Timor’s pre-existing status as one of the poorest areas in East Asia (World Bank 1999:2) and the long record of human rights abuses, where the local population had been disenfranchised under Indonesian military occupation (Cotton 2000, ETHRC 1997, Sherlock 1996). The lack of local experience in governance and decision making, and deficits in local technical and professional skills, made the transition to independence challenging (Joint Assessment Mission 1999). Similarly, there was a need for consensus building, reconciliation and peace building among a population torn by violence and a degree of factionalism along geographic, linguistic and clan lines (Salla 2000, UNDP 1999a).
The prevailing situation after the vote, with its mixture of terror and destruction, brought mounting pressure for international intervention. Beyond security measures, the task of initial assistance was to provide relief with airdrops of food, aid convoys, and the supply of shelter and basic services. By early 2000 the emergency phase was over, with assistance efforts shifting towards 'reconstruction and rehabilitation' (UN Security Council 2000a). The influx of international personnel and equipment at this time, including those from the newly established UNTAET, other UN agencies, international donors and INGOs, was dramatic. This prompted local disquiet about being swamped by external actors, who were seemingly privileged while local conditions remained challenging (PIA 2000).

Although an external evaluation indicates that the international assistance provided during the first ten months of relief and rehabilitation efforts was successful in re-establishing local services, there was one critical shortcoming in that local participation was largely overlooked (Bugnion et al. 2000). A range of local civil society actors, such as NGOs, church and political organisations, expressed increasing disquiet, insisting that they had a vital role to play in the reconstruction effort (NGOs 1999, WGSE 2000). There was a stark contrast between the overt aims of international assistance, which emphasised local involvement and capacity building, and the actual exclusion of local people and organisations (Ife 1999).

East Timorese NGOs

East Timorese NGOs had their genesis in the climate of civil society repression that characterised the military occupation. The Indonesian regime highly controlled and orchestrated the formation of local organisations and community involvement (Cotton 2000, Sherlock 1996). The Catholic Church was the most active organisation, as it was more politically acceptable to the state, and so the first East Timorese NGO was church based (Ng 2000).

Caritas East Timor commenced operations in 1976, and since then the numbers of NGOs, and also NGO-INGO-donor linkages, have slowly expanded (Caritas East Timor 2000). A turning-point was the opening of East Timor to increased foreign contact in 1989 following mounting international pressure about human rights abuses and lack of access and transparency (Ng 2000). From that time, an increasing number of INGOs, and also Indonesian NGOs, established offices in East Timor, although the formation and operation of NGOs remained highly restricted.

Around 10–15 NGOs of East Timorese origin operated prior to the vote.1 Numbers are difficult to estimate as some worked clandestinely. Most were involved in relatively benign sectors, such as education, agriculture, and water and sanitation. From 1997, however, there was a further loosening of control and several NGOs commenced operations in human rights and advocacy work, as well as assisting those displaced by violence or forced relocation (Ng 2000, OCHA 2000).

The post-vote violence was highly destructive for NGOs. The militia especially targeted the staff, along with other civil society leaders. NGO buildings, equipment and transportation were looted or destroyed (East Timor NGO Forum 1999). The destruction, however, also foreshadowed new possibilities. There was a huge groundswell of enthusiasm for rebuilding in the post-vote period, accompanied by visions of new forms of democratic and participatory governance (PIA 2000).

At the same time, NGOs were frustrated by feelings of exclusion and by difficulties in accessing resources to support their re-establishment. They were generally critical of a perceived arrogance displayed by INGOs, who appeared preoccupied by the implementation of prepackaged, externally managed projects (WGSE 2000). Views expressed at a 1999 NGO workshop were similar:

National NGOs have been overtaken by the international NGOs who have resources, say they know everything and communicate in English. Local NGOs feel they have been reduced to being observers and critics who have to ask for what they want. (East Timor NGO Forum 1999:3)

Despite these constraints, the numbers of NGOs multiplied rapidly in the post-vote period. The 34 recorded in January 2000 (OCHA 2000) had increased to 124 by September (East Timor NGO Forum 2000), because of the new climate of freedoms for civil society, the response to need, the availability (real or expected) of funding sources, and high unemployment (OXFAM 2000, Walsh 2000a).

This sort of rapid multiplication is commonplace in post-conflict contexts, particularly where considerable aid funding is present (Goold 2000, Harvey 1998, Mateeva 2000). A corollary of this trend, as demonstrated in the context of East Timor, is that a majority of them lacked organisational experience. Moreover, many had tenuous connections with the communities that they claimed to represent. Similarly, there were questions about the accountability and expedient motivations of some of them (Walsh 2000a). In such a climate, there was an urgent need for standard setting and regulation, prompting UNTAET to start developing regulations for this purpose (UNTAET 2000).

The profile of NGOs in the post-vote period was of a core of older, more experienced organisations, and a much larger group of newer players. Despite constraints, the older operators found it easier to attract funding through new or re-established partnerships. With this support, most recommended activities at the community level.2 In contrast, the inexperience of the newer groups contributed to their relative exclusion from recovery efforts.3

While the NGO sector reflected inherent weaknesses, there were also positive trends. Activities expanded across a range of sectors. There was intensified activity in response to rehabilitation needs in health, agriculture and education. Vulnerable groups, including those experiencing psycho-social trauma, were an additional focus. Similarly, human rights NGOs commenced investigation of abuses perpetrated during the occupation and lobbied for international investigation. Advocacy activities also focused on emerging issues, such as the role of INGOs and donors, the transparency of UNTAET operations, and identifying priorities in rehabilitation (PIA 2000, WGSE 2000). Such trends

April 2001

83
reveal flexibility and responsiveness in the LNGO sector. They also demonstrate an ability to represent popular concerns and to work towards the empowerment of civil society.

The potential of the sector is reflected in its tenacity and survival before the vote and its rekindled activity afterwards. This potential underlines the value and need for capacity building with LNGOs, and the related need for expanded and equitable partnerships between them and INGOs and donors to facilitate this activity.

**Developing LNGO capacity**

The development of appropriate and effective capacity-building endeavours with LNGOs relies on an assessment of their role both present and projected, and the subsequent identification of gaps and resources that may be applied. Similarly, capacity-building activities already mounted need thorough evaluation to assess their effectiveness and to support the refinement of further initiatives.

The aspirations of East Timorese NGOs provide some direction to the design of activities that are appropriate and not imposed. Such aspirations are articulated by the East Timor NGO Forum, a nascent coordinating organisation formed in 1998:

To contribute to the building of a pluralist, democratic, just and sustainable East Timor through the development of a strong, independent and responsible civil society committed to upholding and making real in the daily life of the community both village and urban, the full range of human rights so that all East Timorese, particularly the poor and disadvantaged, can enjoy the fruits of liberation and development in East Timor forever free. (Walsh 2000b:27)

Weak capacity in LNGOs, most particularly among the host of newer arrivals, and also shortfalls in their coordination are constraints on the achievement of this vision. Both areas have been the subject of capacity-building initiatives supported by INGOs and donors. Although activities of this kind were slow to commence in the initial emergency phase, they escalated from mid-2000 as donor and NGO programmes shifted to a more developmental orientation.

An early initiative was the Capacity Building with National NGOs Project, supported by the UN Development Programme (UNDP), which incorporated organisational development for the forum as well as training for LNGOs (UNDP 1999b). The pilot phase recognised the need for enhancing both awareness and skills. The top-down model of development inherited from Indonesian occupation was a legacy for many LNGO workers and provided little basis for an alternative vision of development practice (Walsh 2000a). A mix of international and local staff provided training on the role of NGOs, development issues, organisational management, and community development methods to promote empowerment.

Evaluation of the training was positive and considered by participants as a basis for more expanded initiatives. Other positive outcomes were the building of networks among new NGOs, and increasing awareness of the forum. Some newer groups reported that they were considering mergers to reduce overlap and to increase chances of organisational survival. Potential candidates were identified for a projected train-the-trainer programme, aimed at increasing the local contribution to future LNGO training (Walsh 2000a).

The scope of the training supported by the UNDP reflected the two-pronged needs of many newer LNGOs for organisational development, and enhancing linkages with communities through applied community development work. The former area was a particular focus of initial capacity-building activities implemented by INGOs, including office rehabilitation and enhancing financial management, proposal preparation and reporting functions (Patrick 2000, Walsh 2000a). LNGOs were keen to participate to address real organisational needs and to cement their relationships with INGOs together with sources of funding. There is a risk, however, of such an orientation consolidating a dependent and weak position of LNGOs as service delivery agents relative to the more powerful and better-resourced international actors. A strong need remained to extend capacity-building activities to promote a more dynamic, interactive and autonomous role for LNGOs in civil society. This included a greater focus on areas such as community development, advocacy and gender analysis.

A more comprehensive framework for capacity building additionally recognises the need for coordination in the sector to promote minimum standards and also cooperation between the various actors. Without coordination, in the frenetic aid community that characterises post-vote East Timor there is a risk of unsustainable activities, and attendant overlaps and gaps in activities. Much of the responsibility for this coordination rests with the forum and represents a major part of its projected work programme for:

- provision of information (including NGO and donor databases and resource centre);
- training (particularly in community development, financial management and management of a cadre of local trainers);
- provision of collective facilities (such as meeting space, computers);
- standard setting (including code of conduct/monitoring, registration); and
- coordination (within and across sectors, and advocacy for membership) (Walsh 2000b:3).

The fulfilment of this programme requires that the East Timor NGO Forum, together with individual LNGOs, receive considerable support. Capacity-building programmes being developed by donors such as the UNDP, AusAID and the Japanese Government, as well as INGOs, offer considerable potential. Thorough programme design, monitoring and evaluation are essential to ensure that they maximise a constructive and dynamic role for LNGOs within civil society.

**Conclusion**

East Timorese NGOs are expanding their role within a society where there are new possibilities for participation and democratic
expression. They have strong aspirations to contribute to a vibrant civil society and to support communities to enjoy new rights as well as the benefits of development. In turn, LNGOs seek partnerships with donors and NGOs that will provide support for their activities and also build their capacity.

The dynamics of the international assistance programme mounted for East Timor has frustrated the aspirations of many LNGOs. The skewed power relationships that characterise this context have tended to exclude them. Such exclusion has a retrograde effect on LNGOs and, more broadly, on the vitality of civil society.

Capacity-building support from the international community is a pressing area of need for post-conflict East Timor and applies across all sectors. Within a context of competing priorities, the LNGO sector has been overlooked. As assistance efforts move away from emergency towards a more developmental focus, there is greater opportunity to redress previous oversights and to mount initiatives with LNGOs in a more collaborative and participatory manner. This type of approach is vital to engendering local ownership and self-sufficiency.

For LNGOs, capacity-building support is particularly critical given the number of new players. The sector is characterised by wide contrasts in experience. It is important, therefore, that capacity-building efforts be accompanied by broader programmes of standard setting, coordination and regulation.

Systematic evaluation of future capacity-building activities will enhance practice and allow the identification of approaches particularly suitable for East Timor. An effective approach for direct training with LNGOs encompasses organisational management as well as building awareness of development issues and applied community work approaches. In the energetic and idealistic context of the post-vote period, there is considerable interest in discussing and debating development issues. Given the previous denial to this population of open participation and democratic expression, there is an on-going need to deepen awareness of these issues, and to identify and promote approaches that will further reinforce the role of civil society. This is the domain and challenge of future capacity-building initiatives.

Notes
This article is based on a paper presented at the Capacity Building for Community Development Conference, 2nd International Outlook Conference on Community Development in the Asia-Pacific, 20–23 December 2000, Ho Chi Minh City.

1. Interview with Alexio da Cruz, Chairman, East Timor NGO Forum, Dili, 19 January 2000.
2. Interview with Sally Gregory, Coordinator, NGO Information Centre, OCHA, Dili, 20 January 2000.
3. Interview with Deborah Cooke, Second Secretary, AusAID, Dili, 20 January 2000.

References


NGOs 1999, 'Joint statement from national and international NGOs for the Tokyo meeting on East Timor', 17 December.


OCHA (UN Office for the Coordination of Humanitarian Affairs) 1999, United Nations inter-agency and non-government organisation preliminary assessment of needs for humanitarian assistance for East Timor, OCHA, Dili, October.

OCHA 2000, East Timorese NGOs: Interim directory, OCHA, Dili.


PIA (Plan International Australia) 2000, Plan's development bulletin: East Timor – supplement to PLAN news, PLAN International Australia, Melbourne, Summer.


UNDP (UN Development Programme) 1999a, Conceptual framework for reconstruction, recovery and development of East Timor, UNDE, Geneva.


April 2001

UNTAET (UN Transitional Administration in East Timor) 2000, 'Regulation no. 2000/- on the registration and operation of associations and foundations in East Timor', draft, UNTAET, Dili, 12 March.

Walsh, P. 2000a, All the king’s horses and all the king’s men: Report on UNDP East Timor NGO capacity building project, UNDP, Dili, June.

Walsh, P. 2000b, New NGOs for a new East Timor: Discussion paper on the role of the East Timor NGO forum (Fongil), UNDP, Dili.

WGSE (Working Group for Study and Examination) 2000, 'From “scorched earth operation” to “humanitarian operation”', Yayasan HAK, Dili.

World Bank 1999, Background paper prepared for the information meeting on East Timor, East Asia and Pacific Region, World Bank, Washington DC.
Tobacco control in developing countries


Tobacco was responsible for about 100 million deaths in the twentieth century. On current smoking patterns, it is expected to account for 1 billion deaths, a tenfold increase, in the twenty-first century. While the health impact of tobacco is little disputed, there is widespread debate on the economic arguments for and against tobacco control. This book brings together a set of critical reviews of the current status of knowledge on the economics of tobacco control. It is intended to provide a sound and comprehensive evidence base for the design of effective tobacco control policies in any country, with an emphasis on the needs of the low-income and middle-income countries where most smokers live. Each of the book’s 19 chapters has been through a thorough peer review process. The book is written for academic economists, epidemiologists, those working in tobacco control programmes, health planners, officials in ministries of finance, commerce, trade and health in low- and middle-income countries and and those working in development agencies.

Tobacco War: Inside the California battles


Tobacco War, a detailed chronology of 20 years of tobacco control in California, illustrates several key lessons for public health advocates. The early chapters present more detail about the origins of the California tobacco control movement than many readers may want, although the information is accessible and interesting. The later chapters provide gripping drama that has broad relevance for public health advocates, health care providers, educators, and the general public.

Tobacco and Women’s Health


Tobacco and Women’s Health is a comprehensive book. The author, an obstetrician-gynecologist, provides a detailed description of the adverse effects of smoking on women’s health, including effects on the fetuses, infants, and children of women who smoke, and describes women’s particular vulnerabilities to the effects of smoking (eg, women have smaller lungs than men). Primary care professionals and public health workers will find Tobacco and Women’s Health a useful book, providing up-to-date material on the wide range of effects of smoking on women’s health and basic information on methods of smoking cessation. It may also be useful to researchers and specialists, but its utility is somewhat limited by the spotty referencing and difficult to follow organizational framework.

Nicotine in Psychiatry: Psychopathology and emerging therapeutics


This book meets the goal of providing ‘enrichment reading in a compact format’ to
Tobacco in Australia: Facts and Issues

Second edition, 1995, published by the Victorian Smoking and Health Program, Australia (Quit Victoria), ISBN 0 646 14103 1, c.386pp, available in hardcopy for $AU60 (plus postage and handling for orders outside Australia) from Quit Victoria, PO Box 888 Carlton South, Victoria 3053, Australia. Phone: +61 (0) 3 9663 7777, Fax: +61 (0) 3 9663 7761. Email: vichealth@vichealth.vic.gov.au. URL: http://www.quit.org.au/Fandii

This book is a result of a joint initiative of the Commonwealth Department of Human Services and Health, ASFI Australia, Victorian Smoking and Health Program, New South Wales Drug and Alcohol Directorate and the Health Department of Western Australia. Tobacco in Australia: Facts and Issues has been produced with the objective of bringing about a reduction in death and disease levels due to smoking and is available in hard copy and online. As new research, information and statistics become available the online version of Facts and Issues is updated and printed; chapter updates are also available from Quit Victoria on request.

Mortality from smoking in developed countries 1950-2000: Indirect estimates from national vital statistics


The following publications are available from:

World Health Organization, Distribution and Sales, CH-1211 Geneva 27, Switzerland Phone: +41 22 791 24 76 Fax: +41 22 791 4857 E-mail: To place orders: bookorders@who.ch For questions about publications: publications@who.ch URL: http://www.who.int/tobacco/TFI/whopubs.htm All prices are based on the Swiss franc (SwF). A 30% discount is offered to all clients in developing countries. Additional discounts are granted to NGOs in official relations with WHO, WHO collaborating centres, and for bulk orders. Orders directed to WHO, Geneva must be accompanied by payment in Swiss francs or US dollars. Prices include postage by surface mail and handling charges.

Evaluating Tobacco Control activities: Experiences and guiding principles

C. Chollat-Traquet, 1996, xii + 220 pages, ISBN 92 4 154490 2, SwF60, US$54; in developing countries: SwF42

This book provides the first practical guidelines and advice on how to evaluate the effectiveness of public health measures to reduce tobacco use. Noting that funds for health promotion are increasingly scarce and closely watched, the book aims to show how evaluation can be used as a tool for proving the effectiveness of specific measures, calculating costs and benefits, and thus guiding the selection of control options that will have the greatest impact. Recommended methods of evaluation, which cover virtually all measures used in tobacco control, are firmly rooted in experience in a range of different countries. The book has 18 chapters presented in four parts. Chapters in the first part introduce and explain the main principles, concepts and methods of evaluation as these pertain to the problems facing tobacco control programmes. While warning readers that evaluation is a difficult and exacting science, the author explains how the simplified methods described in the book, which have been tried and tested in many different settings, can bring the tools of evaluation within the reach of programme staff at all levels. Against this background, chapters in the second part offer detailed advice on nine economic measures and restrictions, focused on health protection, that have been used to decrease tobacco consumption. Measures covered include calculations of the impact of tobacco production and use on national economies; subsidies, taxes and individual economic incentives; restrictions on tar and nicotine content; age restrictions; bans on advertising and sponsorship; health warnings; and smoking prohibitions in public places, work environments, and health services. Information ranges from examples of successful crop substitution, through ways of determining whether low tar and nicotine cigarettes encourage women to smoke, to advice on inexpensive methods for measuring the impact of bans on the sale of tobacco products to minors. Chapters in the third part provide similarly detailed information for five health promotion measures involving advocacy, information and education. These include use of the mass media, education in schools, community interventions, smoking cessation programmes, and the use of health personnel as educators. The final part offers advice on how to use legislation, including litigation, and evaluate its effectiveness.
Guidelines for controlling and monitoring the tobacco epidemic
1998, x + 190 pages, ISBN 92 4 154508 9, SwF 65/US $58.50; in developing countries: SwF 45.50

This book uses extensive country experiences and abundant practical examples to explain how to establish comprehensive national tobacco control policies that have the greatest chance of combating the tobacco epidemic. It is addressed to policy makers who have no specialised training in epidemiology. The book aims to demystify the procedures of data collection and analysis that are an essential component of any long-term comprehensive programme for tobacco control. To this end, emphasis is placed on the collection and use of information that is easy to obtain and directly relevant to the establishment and monitoring of national policies. The basic principles that should guide a national programme are also described in detail. The book has nine chapters presented in two parts. Chapters in the first part explain the need for national action to control tobacco use, discuss seven basic principles and seven corresponding strategies for tobacco control, and describe in detail the steps to follow in order to implement effective tobacco control programmes. Part two offers a practical guide to the collection and use of data for monitoring the tobacco epidemic and assessing the health effects of tobacco use. Details range from a simple set of seven core questions recommended for assessing smoking status, through a table listing the strengths and weaknesses of four main approaches to data collection, to a step-by-step example of how to calculate the age-standardised death rate from lung cancer and the numbers of deaths caused by tobacco.

Further practical guidance is provided in a series of annexes, which include a model law on tobacco control, advice on sampling for a national prevalence survey, and several model questionnaires.

Islamic ruling on smoking

The Right Path to Health: Health Education through Religion, No. 1, Nonserial publication of the WHO Regional Office for the Eastern Mediterranean, 1996; 95 pages, ISBN 92 9021 167 9, SwF10/US $9.00; in developing countries: SwF 7

A collection of the opinions of ten eminent Muslim scholars concerning the Islamic ruling on smoking, including the issue of passive smoking. The collection is part of a series of publications, issued by the WHO Regional Office for the Eastern Mediterranean, that acknowledge the strong influence of religion in this part of the world and the power of religious teachings to encourage healthy behaviour. Succinct summaries of the conclusions reached by these scholars are followed by reproduction of the full texts of their formal religious legal opinions. These texts enable readers to follow the reasoning used in reaching conclusions. The general consensus concerning the Islamic ruling is that smoking is either completely prohibited or abhorrent to such a degree as to be prohibited. The book concludes with a series of 17 questions and answers, suitable for use in health education campaigns, about smoking and the harm it causes.

Tobacco or Health: A global status report

This publication documents, with comprehensive up-to-date statistics, the current situation of the tobacco epidemic in virtually every country in the world. Trends over the past two decades are also presented and discussed. Intended to serve as a resource and reference work for those concerned with epidemiological surveillance, the report draws on a vast body of data that have been systematically collected and carefully validated by WHO. The result is an authoritative account of both the current global situation and the many factors, from industry practice to national control policies, that are likely to influence future trends. By comparing and ranking countries according to key indicators of the tobacco situation, the report also allows policy makers to see where their own countries stand in terms of global patterns of tobacco production and use, related mortality, national policies for control, and the specific measures used. The report has two parts. Chapters in the first part provide a global overview of the current tobacco or health situation. A chapter on smoking prevalence ranks 87 countries according to estimated smoking prevalence in men and in women. Tobacco consumption is profiled in the next chapter, which ranks 111 countries according to estimated annual per capita consumption of cigarettes and assesses global trends, by region, over the past two decades.

Tobacco or Health: Status in the Americas: A report of the Pan American Health Organization
PAHO Scientific Publication, No. 536, 1992, xiv + 387 pages, ISBN 92 75 11536 2, SwF 40/US $36.00; in developing countries: SwF 28

A detailed, country-by-country report on the status of tobacco use, tobacco-related diseases, and efforts to control tobacco use in Canada, Latin America, and the Caribbean. For each of 37 countries, the report provides information on the general socioeconomic context, the tobacco industry and its marketing strategies, tobacco use, rates of mortality and morbidity attributed to smoking, and smoking prevention and control activities. The report responds to a rapidly emerging epidemic of smoking-related diseases, fuelled by the marketing tactics of the transnational tobacco companies and aided by changing lifestyles in many of the developing countries in this region. Because of the importance and innovation of the Canadian tobacco control programme, the report devotes considerable space to descriptive and analytical information on Canada.

The global burden of disease

April 2001
Women and Tobacco


This publication explores the many special issues that surround the impact of tobacco use on the health and well-being of women. Noting that most tobacco control programmes fail to address the distinct needs of women, the book concentrates on the identification of gender-specific factors that help explain why girls and women smoke and how tobacco damages their health. Data are used from a wide range of sources and the book makes a special effort to cover all dimensions of the problem, ranging from conditions in developing countries that deter female smoking to the reasons why women may find it more difficult to quit than men.

The impact of the tobacco industry's efforts to recruit female smokers is also considered. Detailed country-specific statistics revealing changing trends in female tobacco use and related morbidity and mortality are given in the report. Data linking female smoking to a greatly increased risk of eight forms of cancer and six other major diseases soundly refute the myth that women are somehow immune to the adverse effects of tobacco. Additional effects on reproductive health, on physical appearance, and on the health of children are also clearly demonstrated in this comprehensive report.

Young people and tobacco: European alcohol action plan


A review of recent studies that shed light on the extent to which substance use by school-age young people in Europe is a problem, the reasons why young people drink, take drugs, or smoke, and the best opportunities for prevention. Emphasis is placed on the capacity of well-designed educational programmes in schools to influence substance-related attitudes and behaviour. Throughout, findings from recent research are supported by abundant practical examples of successful interventions, including several innovative projects.

The first three chapters look at drinking, drug use and tobacco use by young people. Each chapter follows a similar format, beginning with an assessment of the extent to which the substance is misused, followed by a review of the reasons why youth use the substance, and concluding with a discussion of the harm caused to youth. A second group of chapters outlines opportunities for prevention within the school setting. Individual chapters introduce the concept of health-promoting schools, discuss the strengths and weaknesses of different school-based preventive measures, and offer advice on the aims, content, and steps involved in the development of a school policy. Affective and skills-based approaches, preferably led by peers, were judged the most effective, with facts-only programmes receiving the most negative evaluations.

Young people and substance use: A manual to create, use and evaluate educational materials and activities

Edited by M. Monteiro, 1999, 161 pages, WHO/HSC/SAB/99.3, SwF 30/US $27.00; in developing countries: SwF 21

A sourcebook of ideas, materials, and wide-ranging activities that can be used to involve young people in the development of educational programmes aimed at preventing or reducing substance use. Richly and imaginatively illustrated, the manual responds to the urgent need for a simple, straightforward and easy-to-use guidebook to help health workers without extensive training or sophisticated resources to produce educational resources. Although examples and advice are appropriate for a broad range of audiences, and relevant to alcohol and tobacco as well as psychoactive drugs, particular attention is given to the complex needs of street children and the widespread problem of solvent abuse.

Finalised following field testing in seven countries, the manual shows how much can be accomplished with surprisingly little in the way of equipment and funds. Central to the approach is abundant evidence that health messages alone are not sufficient to persuade changes in attitudes and behaviour, and that the best success occurs when young people themselves participate in the design, utilisation, dissemination, and evaluation of educational materials. Material in the manual can also be used to foster the motivation, skills and confidence necessary to take action to improve health.

It can be done: A smoke-free Europe


This report summarises the tough lines of action mapped out during Europe's first conference on tobacco policy, a watershed event in the history of action against tobacco. The conference united some of the most experienced scientists, social scientists, and experts on health education and public health policy in Europe. The book opens with a six-point charter asserting the moral right of Europe's citizens to be protected not only from the diseases tobacco causes but also from the severe hazards of breathing air polluted by tobacco smoke. To make it possible for every person in Europe to enjoy the rights stipulated in the charter, the book sets out ten precise strategies for a smoke-free Europe, further concluding that a tobacco control policy that encompassed these ten strategies could bring about a significant reduction of tobacco consumption in Europe and eventually eliminate the diseases caused by tobacco. Measures proposed in this model tobacco policy, which stresses the importance of strong legislation, include a total ban on all forms of direct and indirect promotion of tobacco products, a 1 per cent levy on all tobacco sales in every country of Europe, the use of funds from the levy for health promotion and to buy out tobacco industry sponsorship of sports and cultural events, regular increases in tobacco taxation.
Legislative action to combat the world tobacco epidemic


This book examines the ways in which legislation, whether involving comprehensive national laws or personal litigation against the tobacco industry, is being used to reduce tobacco use and promote the goal of a tobacco-free society. Drawing upon over 250 studies conducted throughout the world, the book concentrates on the many promising new legislative strategies that have developed within a climate of opinion that regards tobacco and sidestream smoke as toxic substances, gives priority to the non-smoker's rights, and rejects the industry's freedom to promote an addictive, lethal product. By describing and analysing recent legislation, the book also provides a heartening account of both the spread of legislation and the reasons for its increased strength and effectiveness. The ten chapters which constitute the core of the book are organised to reflect two main categories of smoking control measures: those leading to changes in the production, manufacture, promotion, and sale of tobacco; and those designed to achieve changes in practice among smokers. On the production or 'supply' side, five chapters describe measures involving the control of advertising and sales promotion, the use of health warnings and statements of tar and nicotine content, control of harmful substances in tobacco, restrictions on sales to adults, and economic strategies for decreasing tobacco production. Chapters concerned with controlling demand cover tax and price policies, legislation on smoke-free public places and workplaces, strategies for preventing young people from smoking, and the use of legislation to mandate health education.

Lexicon of Alcohol and Drug Terms


This lexicon provides concise definitions for some 230 terms frequently used by clinicians, researchers, teachers, and others working in the field of substance abuse. Explanatory definitions, often including psychoactive effects, symptomatology, sequelae, and therapeutic indications, are given for each general class of psychoactive drugs, including alcohol and tobacco, and for some related classes. In producing the lexicon, WHO aims to encourage consistency in the use of terms and in the understanding of their meaning. The lexicon also provides a convenient reference to concepts and terminology recommended by WHO.

Guidelines for the Control of Narcotic and Psychotropic Substances in the Context of the International Treaties


This book presents and explains the international legal framework established to facilitate the control of narcotic and psychotropic substances. It explains the obligations of parties to the conventions and shows how parties should formulate their national drug policies and legislation to conform with the aims and purposes of the international drug conventions. Readers are also guided in the formulation of alternative policies allowing adaptation of the provisions of the conventions to national situations.
Reports and monographs

Case Study Report: Global analysis project on the political economy of tobacco control in low-and-middle-income countries

Edited by J Patrick Vaughan, Jeff Collin and Kelley Lee, July 2000, London School of Hygiene and Tropical Medicine, ISBN 0 902657 67 4, cost £5 (+ £2.50 postage), available from Dr Jeff Collin, Health Policy Unit, London School of Hygiene and Tropical Medicine (LSHTM), Keppel Street, London WC1E 7HT, UK, Phone: +44 20 7612 7884, Fax: +44 20 7637 539, Email: jeff.collin@lshtm.ac.uk

This report covers case studies on tobacco control in Thailand and Zimbabwe and looks at developing guidelines for policy analysis, identifying two urgent priorities for the future momentum for tobacco policy research: that it is necessary to further develop and finalise a set of guidelines for tobacco policy research and that there is also a need for a new and broad international strategy for tobacco policy research that promotes new country, regional and global studies while coordinating and supporting worldwide efforts of researchers.


Available online: http://www.who.int/bulletin/tableofcontents/2000/vol78no.7.html

Contents include papers on:
- Tobacco control challenges and prospects
- Tobacco use by youth: a surveillance report from the Global Youth Tobacco Survey
- Cohort study of all-cause mortality among tobacco users in Mumbai, India
- Building the evidence base for global tobacco
- Women and tobacco: moving from policy to action
- Tobacco industry tactics for resisting public policy on health
- Lessons from private statements of the tobacco industry
- Political economy of tobacco control in low -income and middle-income countries: Lessons from Thailand and Zimbabwe
- Framework Convention on Tobacco Control: a global 'good' for public health
- From public health to international law: Possible protocols for inclusion in the Framework Convention on Tobacco Control

British Medical Journal (BMJ): Special theme on tobacco, 5 August 2000

Available online at: http://www.bmj.com/contentvob/issue72571

This special issue with the theme of tobacco has articles on health policy, lung cancer, passive smoking, tobacco dependence, tobacco litigation.

Tobacco Control Country Profiles

American Cancer Society publication (website hosted by the World Health Organization), available online at: http://tobacco.who.int/en/statistics/ To contribute data contact: The Tobacco Free Initiative on email: tfi@who.int To seek further information contact: International Tobacco Surveillance American Cancer Society, 1599 Clifton Rd., NE, 4th Floor Atlanta, GA 30329-4251 USA, Phone: +1 404-327-6554, Fax: +1 404-327-6450 Email: Omar Shafee@cancer.org

The Tobacco Control Country Profiles details national tobacco production and consumption, smoking prevalence, cancer and other tobacco-related disease mortality, tobacco control legislation and national organizations engaged in tobacco control in 197 countries. While new data become available everyday, the monograph provides the most current information available as of May 2000.

Curbing the epidemic: Governments and the economics of tobacco control

The full report is available on two websites by approval at:
http://www.adventist.org.au/SPD/AHD/ then choose the Economic Impact of Smoking in Pacific Islands; or available online at: http://www.globalink.org/tobacco/9910eco/

2020 Vision: A nicorette study, an independent forecast of Australia’s smoking habits in 2020


This report brings together the views of a large number of experts in the field of tobacco and health, with the aim of predicting the future for smoking in Australia in the year 2020. Both published materials and personal interviews were used in the preparation of the report. Although Australia’s new National Tobacco Strategy is ostensibly a plan for the next three years, it sets a pattern for developments in tobacco control well beyond its time.

The Health of Young Australians: A national health policy for children and young people


The National Tobacco Strategy 1999 to 2002-03: a framework for action builds on the National Health Policy on Tobacco 1991 and is the Australian government’s platform for tobacco control. It emphasises a national collaborative approach to tobacco control issues, nominating a range of government, non government and community partnerships and links, under six key strategy areas: strengthening community action; promoting cessation of tobacco use; reducing availability and supply of tobacco; reducing tobacco promotion; regulating tobacco; and reducing exposure to environmental tobacco smoke. The National Tobacco Strategy provides a comprehensive framework for action that will assist all jurisdictions, including the Commonwealth, to develop their own action plans on tobacco.


Hassard K (Editor), Commonwealth Department of Health and Aged Care, Canberra. Requests for these evaluation reports and requests or enquiries concerning reproduction of Australia’s national tobacco campaign material should be directed to The Manager, National Tobacco Campaign, MDP 15, Commonwealth Department of Health and Aged Care, GPO Box 9848, Canberra, ACT, 2601.


Copies of the ‘Federal Trade Commission Cigarette Report for 1999’ are available from the FTC’s web site at http://www.ftc.gov and also from the FTC’s Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580; 1-877-FTC-
HELP (1-877-382-4357); TDD for the hearing impaired 202-326-2502. To find out the latest news as it is announced, call the FTC News Phone recording at 202-326-2710. FTC news releases and other materials are also available on the Internet at the FTC’s World Wide Web site. The report is available online: http://www.ftc.gov/reports/cigarettes/1999cigarettereport.pdf

The Federal Trade Commission’s annual report on cigarette sales and advertising for 1999 shows that cigarette sales fell from 1998 to 1999, but advertising and promotional expenditures increased significantly. According to the report, which details the first year of spending affected by the tobacco industry’s Master Settlement Agreement (MSA) with the Attorneys General of 46 states, the five largest cigarette manufacturers spent $8.24 billion on advertising and promotional expenditure in 1999, a 22.3 per cent increase from the $6.73 billion spent in 1998. The MSA imposed phased-in restrictions on the companies’ use of outdoor advertising and brand-name sponsorships, their distribution of free samples, and their distribution and sale of apparel and merchandise with brand-name logos. The industry’s total expenditures were the most ever reported to the commission.

Investment in Tobacco Control: State highlights 2001

Available online at: http://www.who.int/toh/Otherlinks/tabacweb.htm Mailing address: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Publications Catalog, Mail Stop K-50, 4770 Buford Highway, NE, Atlanta, GA 30341-3717, Toll-free telephone number: 1-800-CDC-131, Fax Information Service: (770) 332-2552, Email: tobaccoinfo@cdc.gov

Published by CDC’s Office on Smoking and Health (OSH), this report analyses current investments in tobacco control and places these investments in the context of health and economic consequences of tobacco use specific to the state, comparing current investments with the specific funding ranges contained in CDC’s Best Practices for Comprehensive Tobacco Control Programs. Other OSH, NCCDPHP; CDC publications titles include: Targeting Tobacco Use: The Nation’s Leading Cause of Death; At-A-Glance 1999, a brochure documents the efforts of the Centers for Disease Control and Prevention’s Office on Smoking and Health to reduce tobacco use in the United States (6 pages); and Tobacco Control Information Sources 1996, a listing of government agencies and nonprofit organisations that provide information about smoking and health (4 pages).

Tobacco Industry Strategies to undermine Tobacco Control Activities at the World Health Organization, World Health Organization, July 2000

Tobacco Free Initiative, World Health Organization, Avenue Appia 20 1211, Geneva 27, Switzerland, Fax: 41 22 791 4832, Phone: 41 22 791 2108, Email: tfi@who.int Available online in PDF format: http://www.who.int/genevahearings/inquiry.html

This report was produced by a Committee of Experts appointed by Dr Gro Harlem Brundtland, Director General of WHO, who recommended that WHO should conduct further investigations into how governments and organisations had been influenced by the tobacco industry. This report is a result of that recommendation.


World Health Organization, ISBN: 9241561947, ISSN: 1020-3311, 121p, World Health Organization, Distribution and Sales, CH-1211 Geneva 27, Switzerland, Fax: +41 22 791 4857, Phone: +41 22 791 2476, E-mail: publications@who.ch, URL: http://www.who.int/whr/1999/en/pdf/Chapter5.pdf

The health effects of passive smoking: a scientific information paper


Foreword (discussing litigation by the Tobacco Institute of Australia Limited, Philip Morris (Australia) Ltd and Rothmans of Pall Mall (Australia) Ltd in the Federal Court of Australia against the NHMRC, resulting in the NHMRC being restrained from acting on the draft regulatory recommendations proposed guidelines contained in the draft report) available online at: http://www.health.gov.au/nhmrc/advice/nhmrcforeword.htm


This scientific information paper is an extensive review of evidence published in peer-reviewed scientific journals linking passive smoking (the intake of second hand smoke or environmental tobacco smoke) to disease. This review has found important associations between passive smoking and a number of serious illnesses including asthma in children, lower respiratory illness, lung cancer, major coronary conditions and other illnesses. As there are very few Australian data on the exposure to environmental tobacco smoke outside the home, this information paper estimates the risk of illness from exposure to tobacco smoke at home for people who have never smoked.

Proceedings of ‘Poverty Prosperity & Progress’ Conference 2000

ISBN 0-473-07277-7, NZ $25 within New Zealand, NZ $30 in Australia and the South Pacific, and NZ $35 for the rest of the world (includes postage and packaging), available from: Gitanjali Bedi, Devnet Conference Coordinator, PO Box 12440, Wellington, New Zealand, Phone: +64 4 496 9597, Fax: +64 4 496 9599, Email: gbedi@dr.org.nz URL: www.devnet.org.nz Conference index.html
Major reductions in poverty are possible but achieving these will require a more comprehensive approach that directly addresses the needs of poor people in three important areas: opportunity, empowerment, and security, according to the World Bank's latest World Development Report 2000/2001: Attacking Poverty. The new study, the World Bank's most detailed-ever investigation of global poverty, adds that economic growth is crucial but often not sufficient to create conditions in which the world's poorest people can improve their lives.

The following publications are available free of charge online, or from the State Society and Governance in Melanesia (SSGM) Project:

**Issues and Mechanisms of Accountability: Examples from Solomon Islands**

Discussion paper 00/1 Peter Larmour
http://rspas.anu.edu.au/melanesia/PDF/larmour00_1.pdf

**Women and governance from the grassroots in Melanesia**

Discussion paper 00/2 Bronwen Douglas (editor)

**Weak states and other nationalisms: Emerging Melanesian paradigms?**

Discussion paper 00/3 Bronwen Douglas

**Issues of governance in Papua New Guinea: Building roads and bridges**

Discussion paper 00/4 Philip Hughes

**The Ombudsman role: Vanuatu's experiment**

Discussion paper 00/5 K J Crossland

**Understanding conflict in Solomon Islands: A practical means to peacemaking**

Discussion paper 00/7 Ruth Liloucla and Alice Pollard,
Newsletters and journals

(See Electronic Fora section of this issue for more journals available online)

Addiction publishes peer-reviewed research reports on alcohol, tobacco and other drugs and brings together research conducted within many different disciplines.

Email: enquiry@tandf.co.uk

Addictive Behaviors is a professional journal designed to publish original research and theoretical papers in the area of substance abuse. The journal focuses on alcohol and drug abuse, smoking, and problems associated with eating.

British Medical Journal (BMJ)
The online site contains the full text of all articles published in the weekly BMJ from January 1994. In addition it contains material which is unique to the website. Access to the entire site is free.

URL: http://www.bmj.com/

The Journal of the American Medical Association (JAMA)
JAMA, which began publication in 1883, is an international peer-reviewed general medical journal. “JAMA” is a registered trademark of the American Medical Association. The key objective of JAMA is to promote the science and art of medicine and betterment of public health.

URL: http://jama.ama-assn.org/

Tobacco Control Journal (also available online)
Tobacco Control is a quarterly scientific journal launched in 1992 to consider all aspects of tobacco prevention and control. Essentially, this journal offers a one-stop shopping guide for anti-smoking literature and other resources. Philip Morris 1992. The journal aims to study: the nature and extent of tobacco use worldwide; the effect of tobacco use on health, the economy, the environment and society; the efforts of the health community and health advocates to prevent and control tobacco use; and the activities of the tobacco industry and its allies to promote tobacco use. Research areas include: evaluation of smoking prevention and cessation programmes; tracking and evaluation of tobacco control policies and legislation; epidemiological and behavioural research on tobacco use; health effects of smoking, smoking cessation, passive smoking and smokeless tobacco use. Publication is quarterly. ISSN: 0964-4563 (print version) ISSN: 1468-3318 (electronic version)

For more information contact:
Subscriptions Department BMJ
Publishing Group BMA House, Tavistock Square, London WC1H 9JR
Phone: +44 (0)20 7383 6270
Fax: +44 (0)20 7383 6402
Email: subscriptions@bmjgroup.com
URL: http://tc.bmjournals.com/
http://www.tobaccocontrol.org/
URL: http://tc.bmjcontrol.org/subscriptions/online.shtml

Insights Health, development research (also available online)
Insights Health is published by the Institute of Development Studies and is supported by the UK Government Department for International Development (DFID), as part of the ID21 programme. ID2 is enabled by the UK Government Department for International Development (www.dfid.gov.uk) and hosted by the Institute of Development Studies (www.ids.ac.uk/ids), at the University of Sussex, UK. Charitable Company No. 877338. ID21 is a oneworld.net (www.oneworld.org) partner and a media channel affiliate (www.mediachannel.org).

To subscribe to a free email newsletter, send a message to lyris@lyris.ids.ac.uk with the words 'subscribe id21 Health News'. To subscribe free of charge to the hard-copy edition of Insights Health, send an email with your name and full postal address to id21’s health editor, Heidi Brown at Email: heidib@ids.ac.uk

URL: http://www.id21.org/health/

For more information contact:
ID21 at the Institute of Development Studies
University of Sussex, Brighton BN1 9RE, UK
Phone: +44 (0) 1273 678787
Fax: +44 (0) 1273 877335
Email: id21@ids.ac.uk
URL: www.id21.org
The Eleventh World Conference on Tobacco or Health
August 6-11, 2000, Chicago, Illinois, USA

The American Cancer Society hosted this event, with the American Medical Association and the Robert Wood Johnson Foundation. (The 10th world conference was held in Beijing, China, in 1997.)

Purpose:
The 11th World Conference on Tobacco or Health attracted over 5,000 people from 173 countries. The major theme was 'Promoting a Future Without Tobacco'. The symposium encouraged sharing information and ideas, developed a consensus on global approaches to tobacco control, provided networking opportunities among national and community health leaders from every health discipline, and identified new ways to use technology in the fight against tobacco.

Themes:
The themes of the 11th World Conference on Tobacco or Health were:
1. Are We Winning? Appraising Progress and Celebrating Success
This theme had two components. The first was a report-card segment critiquing our effectiveness as we enter the new millennium, providing an opportunity to learn from evaluations of major programs in the US, Canada, and other nations and to review country tobacco profiles. The second was a celebrating successes segment with state-of-the-art sessions on neuroscience breakthroughs, prevention, cessation and policy approaches, with the purpose of transferring what we know from science to field applications.
2. Nicotine: the Present and the Future
This theme had three components. The first involved the product: what is known about nicotine and its effects, including fascinating variations of tobacco products and their uses around the globe, and what changes are likely for the future, including product composition, addictive properties, tobacco/nicotine formats and government regulation. The second was about the tobacco industry: its composition, current and emerging strategies, changes in the worldwide production of tobacco, local and global marketing strategies and trade issues. The third was about exposure reduction: alternative nicotine products, nicotine analogue products, 'safer cigarettes' and methods to decrease exposure to environmental tobacco smoke.
3. Advocacy in Action
This theme was about mobilizing tobacco control activities within countries and creating a global advocacy movement. Innovative formats such as multi-day skill-building workshops, interactive learning and mentoring were used to improve the advocacy skills of attendees at both introductory and advanced levels. Topics included capacity building, advocacy techniques, youth advocacy, systems for communication, reaching non-conventional allies, public policy, government relations and fundraising.

For further information:
11th World Conference on Tobacco or Health
c/o American Medical Association
Attn: Anne Jenkins, Conference Manager
515 North State Street, Chicago, IL 60610 USA
Phone: +312 464 9059, Fax: +312 464 4111
Email: 11thwctoh@ama-assn.org
URL: http://www.wctoh.org/about.html

Poverty, Prosperity, Progress, Biennial New Zealand International Development Studies Network (DEVNET)
Conference, 17-19 November 2000, Victoria University, Wellington

The Second Biennial New Zealand Development Studies Network (DEVNET) Conference provided an
opportunity for participants to analyse and reflect upon the relationships between poverty and development in New Zealand and overseas and to share experiences and lessons from addressing poverty, prosperity and progress in different places. The conference also sought to link local and global wisdom and practice to foster new visions and approaches towards poverty alleviation and self-determination. Three broad themes were developed to stimulate thought and encourage connections across the conference: Poverty to explore the parameters of poverty from varying perspectives and to identify common issues and lessons; Prosperity to recognise and measure the wealth, health and wellbeing of societies; and Progress to envision socially and environmentally responsible and diverse futures.

Keynote speakers included Michael Edwards, Director of the Governance and Civil Society Programme, Ford Foundation, New York; Motarilavoa Hilda Lini, Director of the Pacific Concerns Resource Centre, Suva; Charles Waldegrave, Senior Researcher, Social Policy Research Unit, The Family Centre, Lower Hutt; and Manuka Henare, Senior Lecturer and specialist in Maori and economic development, Auckland University, Auckland.

Issues explored over the three days were the nature, causes and effects of poverty; ways of recognising and measuring the wellbeing of societies; and envisioning diverse futures that are both socially and environmentally responsible. The sessions enabled participants to analyse and reflect upon the relationships between poverty and development here and overseas and to re-evaluate conventional definitions of prosperity and progress. Definitions of poverty went well beyond the World Bank's definition (in terms of consumption and income levels) to include inequalities in income distribution, powerlessness, rights, gender relations, participation, relationships, social, cultural and ethnic marginalisation, absence of distributive justice and so forth.

Concern was expressed that strategies for poverty alleviation need to go beyond the economic causes of poverty. Impact of globalisation, poor governance, feminisation of poverty, declining employment opportunities, land tenure related conflict and environmental degradation were all contributing to diverse forms of poverty. Developing country presenters from the Asian and Pacific regions in particular, identified World Bank, Asian Development Bank and International Monetary Fund led structural adjustment programmes and associated economic reforms as contributing to increases in poverty.


Individual papers can be viewed and downloaded from: http://www.devnet.org.nz/conf/proceedings.html

For further information:
Gitanjali Befi, DEVNET Coordinator Development Resource Centre International Development Studies Network (DEVNET) PO Box 12440, Wellington, New Zealand.
Phone: +64 4 496 9597, Fax: +64 4 496 9999 Email: gbe@drf.org.nz URL: www.dr.org.nz

Religion and Culture in Asia Pacific: Violence or Healing?
22-25 October 2000, RMIT University, Melbourne, Australia

The Religion and Culture in Asia Pacific conference attracted approximately 300 participants from Pakistan, India, Sri Lanka, Bangladesh, Cambodia, Thailand, Philippines, Malaysia, Indonesia, East Timor, Papua New Guinea, Fiji, Japan, the USA, New Zealand and diverse cultural and religious traditions from within Australia. The principal aim of the conference was to create a positive environment for conflict resolution in the region by drawing on the contributions, resources and insights which cultural and religious communities can provide.

Objectives of the conference:
The conference combined the analysis and insights of academics and experts with the practical experience of those involved in real-life situations of conflict; examined the factors making for conflict, violence, peace and justice; explored the role of culture and religion in both contributing to and resolving conflict; and reflected on the potential for resolving conflict through the application of the core spiritual values at the heart of the religious, ethical and cultural traditions of the region. The conference mirrored something of the diversity of peoples of the Asia-Pacific region.

Summary of proceedings:
The main points were summarised by Dr. Chandra Muzaffar and Prof. Joe Camilleri. These included:
- Whilst recognising that religion has served as a conduit of abuse, the conference made an attempt to look for ways in which the resources and insights of religions could be placed at the service of the greater common good, along with the need to articulate more clearly a spirituality that is equal to the challenges of a globalising yet fragmenting world.
- This contribution to the common good can be maintained only through a constant recapturing of the core values, the essence of the cultural and religious traditions – justice, love, compassion, hospitality, dignity, unity in a common humanity, recognition of the interconnectedness of all living realities and an intuitive grasp of the sacred.
- The diversity of cultures and religions is as important as those core parallel values which unite cultures and religions. This diversity can be a source of great enrichment.
- To understand the core values of the traditions more deeply will enhance inter-faith, inter-civilisational dialogue in the Asia-Pacific region, which is home to all of the major religions and moral systems of the world.
Avoiding the Tobacco Epidemic in Women

Making a Difference to Tobacco and Health: dialogues between multiple stakeholders.

Participants discussed research priorities, tobacco control and the importance of sciences, anthropology, gender studies, and social and economic factors that make it difficult for women to quit.

The objectives of the meeting were to:

1. Define the current impact of tobacco use on women and youth, particularly in the Asia-Pacific region;
2. Identify practical policies that would prevent women throughout the world from starting to smoke and assist them with cessation; and
3. Identify priority research gaps requiring urgent attention.

There were three themes: Prevalence and impact of tobacco on women throughout the life cycle; determinants of tobacco use among women and girls; and taking action through policy-making, mobilisation and tools.

Specific outcomes of the meeting included a meeting report and the Kobe Declaration.

Some major conference recommendations:

On women
1. Women leaders should be actively involved in the development of the Framework Convention on Tobacco Control (FCTC) and subsequent protocol negotiations by each state. There should also be equal representation of women on international and regional tobacco policy committees.
2. The FCTC should integrate gender perspectives and include a protocol on women and agreements by nations to ban advertising and promotion of tobacco and sponsorship of events that target women; require reporting by tobacco companies of any revenues spent on advertising, promotion, sponsorship, or product placement; and require plain packaging of tobacco products, with all ingredients listed on the package.
3. WHO's joint action programme with the European Union known as the 'European Action on Tobacco for a Smoke-Free Europe' should be replicated in other regions such as Asia and the Pacific. Collaboration with regional organisations should be promoted.

On governments and national bodies:
1. National machineries for the advancement of women and nongovernment organisations (NGOs) engaged in the field of women's empowerment must be involved at all stages of the tobacco control policy formulation and drafting of the FCTC.
2. National tobacco control committees should be established in each country and designate a focal point on women and tobacco. They should also help establish national tobacco control centres that promote gender equality and address the needs of women and youth.
3. Legislation must be passed to discourage women and youth from using tobacco, including a complete ban on tobacco advertising across all media.
4. Stronger measures are needed in legislation and enforcement for the provision of smoke-free places. Monitoring mechanisms are needed to reduce women and children's exposure to environmental tobacco smoke (ETS).
5. Tobacco control programmes should be gender-sensitive, and should also address the social and economic factors that make it difficult for women to quit.
6. Finance ministries should increase taxes per cent of the total price of the product, provide greater financial assistance to improve school and health information programmes and use other economic policies that decrease demand.

Local authorities, the media, women's organisations and NGOs
1. Men should take greater responsibility to protect women and children's exposure to environmental tobacco smoke. They should promote national and community projects such as more cessation programmes for boys and men, Tobacco-Free family campaigns, Tobacco-Free school and Tobacco-Free hospital projects and family planning projects.
2. Women and health, women and environment, consumer and human rights groups should be involved as equal partners in the development of local materials on women and tobacco.
3. A Women's Watch Group should be established to monitor the marketing practices of tobacco companies and regional and international networks of information.
4. NGOs must be encouraged to send inputs on state parties' implementation of the convention to the expert body. Resources
should be provided to produce 'shadow reports' that help monitor progress on gender and tobacco issues.

5. Media literacy skills that teach the media and women leaders to understand the marketing strategies used by the tobacco industry should be part of a comprehensive health education programme.

6. Special efforts should be made to reach rural and indigenous women with little or no access to health care services with health information on the harmful effects of tobacco on family health.

Research and data:

1. Governments and the UN should increase funding for research on women and tobacco. They should also help improve the collection of gender-specific, population-level data on smoking prevalence especially in the developing world. Data collection should include information on the wide variety of tobacco products such as smokeless tobacco, cultural beliefs and practices, and standardised measures used to define various aspects of active and passive smoking.

2. Studies should be designed not only to test extensions of older hypotheses and findings, but also to examine the accuracy of extending prior findings from males to females.

3. Research should be conducted on the occupational health risks to women and children who work in tobacco production, processing and sales to determine if they are at increased risk of disease, including any health risks to the babies of pregnant workers.

4. Each country, particularly in the Asia-Pacific region, needs to conduct a survey to document existing levels of active and passive exposure among women of childbearing age, especially pregnant women, new mothers and fathers. These should be culture-specific, disaggregated by ethnic, religious and geographic areas.

5. More research is needed on initiation, prevention and treatment of tobacco addiction that is gender- and age-specific. This research should consider women's diversity by culture, religion, ethnicity and socio-economic status so as to include rural and indigenous women.

The Kobe Declaration is available on the Tobacco Free Initiative website: http://tobacco.who.int/en/tfi/tabacweb.htm


WHO website: http://tobacco.who.int/

Future conference on tobacco control

First National Tobacco Control Conference, 12-14 June 2001

Hilton International Hotel, Adelaide, Australia

The First National Tobacco Control Conference will provide a forum for all tobacco control workers and advocates to learn, debate and network. Eminent speakers and a series of scientific evidence updates will inform the direction of a shared vision and the content of tobacco control activities in Australia for the next decade.

The conference is sponsored by the South Australian Department of Human Services in conjunction with the Commonwealth Department of Health and Aged Care.

If you are interested in tobacco control you should not miss this exciting conference.

Contact details:

The Anti-Cancer Foundation (South Australia)
202 Greenhill Road
Eastwood, South Australia, 5063.
Phone: +61 (0)8 8363 1307,
Fax: +61 (0)8 8291 4122
Email: acf@cancersa.org.au
URL: http://www.conference.cancersa.org.au

The Kobe Declaration is available on the Tobacco Free Initiative website: http://tobacco.who.int/en/tfi/tabacweb.htm


WHO website: http://tobacco.who.int/
Short Course in Tobacco Control and Gender

26 November – 5 December 2001, Key Centre for Women’s Health in Society, WHO Collaborating Centre, The University of Melbourne, Australia

For policy makers, health promotion planners and researchers in governmental, nongovernmental and multilateral organisations

By the year 2025, the number of women smokers is expected to almost triple. The Short Course in Tobacco Control and Gender provides an opportunity to consider new approaches to tobacco control that incorporate a gender perspective. Issues for both men and women will be discussed. This is the second year in which the course is being held. The Key Centre for Women’s Health in Society, a WHO Collaborating Centre, is active in collaborative research and short course training in Australia and internationally. Course facilitators will be drawn from the centre and other organisations involved in tobacco control. The organisers are currently seeking accreditation of the course (with an assessment component) for academic credit within the Master of Public Health Course at the University of Melbourne.

Course objectives:

Raise awareness of the links between tobacco use and gender internationally
Discuss research techniques to investigate social influences on tobacco use
Stimulate development of innovative strategies for tobacco control
Strengthen linkages for advocacy and policy change

Course content and structure:

Epidemiology on smoking trends and health effects for men and women; overview of research techniques for program/policy formulation; strategic planning for post-course action; interactive presentations and small group work; visits to local tobacco control organisations

Fee:
The standard fee is AU$1,800 (GST included). This includes bound course readings, all tuition and field visits, morning and afternoon tea and a farewell lunch. A residential option may be available (contact organisers for details).

Enquiries:

Dr Martha Morrow
Key Centre for Women’s Health in Society
The University of Melbourne, Victoria 3010, AUSTRALIA
Phone: +61 (0)3 8344 4417,
Fax: +61 (0)3 9347 9824
Email: martham@unimelb.edu.au
URL: www.kcwh.unimelb.edu.au

Short Course on Tobacco Control in the 21st Century

31 August – 3 September 2001
Australian Centre for Health Promotion
Department of Public Health and Community Medicine, The University of Sydney, NSW 2006 Australia

This course is designed for those wanting to work in tobacco control advocacy or research. The course has a population rather than clinical or individual orientation and will include several of Australia’s leading tobacco control researchers and policy advocates. Course topics include advocacy strategies, ethical issues, reducing access, international trends in consumption and projected patterns, economic issues, the international tobacco industry and nicotine pharmacology.

A detailed website has been developed to provide extensive background material to support the course and to allow participants to continue learning at a pace most suited to their own needs.

Australian Centre for Health Promotion
Building A27
University of Sydney, NSW 2006 Australia
Phone: +61 (0)2 9351 5129,
Fax: +61 (0)2 9351 5205
Email:healthpromotion@health.usyd.edu.au
URL: www.achp.health.usyd.edu.au
Sixth Summer Institute on Sexuality, Culture, and Society

organised by the Universiteit van Amsterdam, 2001 program: July 1-July 26, 2001

Suitable for PhD and MA students in the socio-cultural sciences and professionals working for NGO's. The Summer Institute is an intensive four-week summer program which focuses on the study of sexuality across cultures and is taught by an international faculty team. The scientific directors are Dr Carole Vance (Columbia University) and Dr. Han ten Brummelhuis (Universiteit van Amsterdam).

The institute was founded in 1995, and has enjoyed five years of unparalleled success. Over 100 students from twenty-seven different countries have participated in courses. Nearly a quarter of the participants have been professionals working for NGO's. The other participants came from such diverse educational backgrounds as the social sciences (anthropology, sociology), psychology, women's studies, history, public health and human sexuality studies.

The 2001 class will be approximately 30-35 students. The institute's classes are intensive small group seminars, with discussions, lectures and guest lectures by prominent people in the field. The details, latest information and application forms are available on the website. Applications must be addressed to the Universiteit van Amsterdam at:

Summer Institute
International School for the Humanities and Social Sciences
Universiteit van Amsterdam
Herengracht 514
1017 CC Amsterdam
The Netherlands
Phone: +31 20 525.3776
Fax: +31 20 525.3778
Email: SummerInstitute@ishss.uva.nl
http://www.pscw.uva.nl/InternationalSchool/SummerInstitute/
Organisations

Australian Commonwealth Department of Health and Aged Care

The Population Health Division of the Commonwealth Department of Health and Aged Care has a tobacco website at www.health.gov.au/tobacco which outlines the tobacco control activities done within the Commonwealth. The Commonwealth Department of Health and Aged Care also has a specific FCTC website outlining Australian processes for participating in the negotiations and the consultation strategy within Australia:

URL: www.health.gov.au/fctc

Action on Smoking and Health (ASH)

Action on Smoking and Health (ASH) is an international charitable anti-smoking organisation entirely supported by tax-deductible contributions.

Email: action.smoking.health@dial.pipex.com

Action on Smoking and Health (Australia) Limited is a registered not for profit organisation which aims to reduce the harmful effect of tobacco use by advocating a comprehensive tobacco control strategy at national, state and local levels. Funding bodies are the National Heart Foundation and the NSW Cancer Council. As both funding organisations are charities, ASH depends upon people's generosity to help improve tobacco controls. ASH seeks to improve policies, legislation and community awareness to achieve the following aims:

• to prevent as many young people as possible from taking up smoking;
• to reduce the number of public places where people are exposed to tobacco smoke;
• to increase consumer protection for smokers and young people exposed to smoking;

The Executive Director of ASH (Australia), Anne Jones, reports to the ASH Board which includes representatives from the National Heart Foundation, NSW Cancer Council, the Australian Lung Foundation and the Royal Australasian College of Physicians. Associate Professor Simon Chapman is the ASH Chairman.

ASH contact details:
153 Dowling Street
Woolloomooloo 2011
PO Box 572
Kings Cross 1340
Australia
Phone: +61 (0)2 93341876
Fax: +61 (0)2 93341742
Email: annej@ashaust.org.au

American Cancer Society

The American Cancer Society is the nationwide community-based voluntary health organisation dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. The society's headquarters are in Atlanta, Georgia, with state divisions and more than 3,400 local units. The society is the largest source of private, nonprofit cancer research funds in the United States. The society's prevention programmes focus on tobacco control, sun protection, diet and nutrition, comprehensive school health education, early detection, and treatment. A variety of service and rehabilitation programmes are available to patients and their families. Through its advocacy programme, the society educates policy makers about cancer and how it affects the individuals and families they represent.

Contact details:
the American Cancer Society
Phone: 1 800 ACS 2345 (in the USA) or
URL: http://www.cancer.org
**Adventist Development Relief Organisation (ADRA)**

ADRA is an NGO which focuses on family health. It currently has projects on tobacco control and smoking awareness in Lao PDR and Cambodia. In the past it has been active in tobacco control in Pacific Island countries.

For further information:
- Michael Peach
- ADRA
- 146 Fox Valley Road,
- Wahroonga, NSW 2076
- Phone: +61 (0)2 94895488
- Email: mpeach@adra.org.au

---

**Infact**

Infact is a grassroots corporate watchdog organization. Since 1977, Infact has been exposing life-threatening abuses by transnational corporations and organizing successful grassroots campaigns to hold corporations accountable to consumers and society at large.

From the Nestlé boycott of the 1970s and 80s over infant formula marketing; to the GE boycott of the 1980s and 90s to curb nuclear weapons production and promotion; to today's boycott of Kraft macaroni and cheese, both products of tobacco giant Philip Morris, Infact organizes to win. Through broad-based consumer campaigns and their Corporate Hall of Shame, Infact is building an active, aware public and a core of well-trained organizers to lead the grassroots challenge to unwarranted corporate influence in the future.

Contact details:
- Infact Campaign Headquarters
- 46 Plympton Street
- Boston, MA 02118
- Phone: 617-695-2525,
- Fax: 617-695-2626
- URL: infact@igc.org

---

**International Non Government Coalition Against Tobacco (INGCAT)**

The International Non Government Coalition Against Tobacco is a coalition of non government organisations (NGOs) from all over the world comprising groups interested in tobacco prevention and control, pneumonia, cancer, cardiology and health education. The need for an international coalition of NGOs was identified by delegates after the 9th World Conference on Tobacco or Health in Paris in 1994. The coalition was founded by the International Union against Tuberculosis and Lung Disease (IUATLD), the International Union against Cancer (UICC) and the World Heart Federation (WHF). The Danish Lung Association, the American Lung Association, the American College of Chest Physicians and the European Respiratory Society are full members. There are 57 associate member organisations and INGCAT is also in regular contact with more than 1400 NGOs and individuals.

The INGCAT Update is published four times per year in English and French and sent to all contacts. It has news features, literature reviews, reports on recent meetings and announcements of upcoming events. It is the vehicle for INGCAT’s advocacy activities, along with the website. An international network of journalists is being built up through members and others who are in regular contact with the media about topical issues and for World No Tobacco Day.

Contact details:
- INGCAT
- 68 Boulevard Saint-Michel, 75006
- Paris, France
- Phone: +33 1 44 32 04 41,
- Fax: +33 1 43 29 90 87
- Email: info@ingcat.org
- URL: http://www.ingcat.org/

---

**Australian Council on Smoking and Health (ACOSH)**

ACOSH is a coalition of 34 medical, educational and community organisations concerned with reducing the health consequences of smoking at a statewide, national and international level.

Address: PO Box 327, Subiaco WA 6008
- Australia
- Phone: +61 8 9388 3342
- Fax: +61 8 9382 4611
- Email: acosh@acosh.org
- URL: http://www.acosh.org/

---

**The International Network of Women Against Tobacco (INWAT)**

The International Network of Women Against Tobacco was founded in 1990 by women tobacco control leaders to address the complex issues of tobacco use among women and young girls.

Contact: PO Box 224, Metuchen, NJ 08840 USA
- Phone: +1 732 549 9054
- Fax: +1 732 549 9056
- Email: info@inwat.org
- URL: http://www.inwat.org/
- Jane Martin, INWAT Regional Representative (Asia Pacific)
- Contact: Quit Victoria, 100 Drummond Street, Carlton South VIC 3053
- Phone: +61 3 9635 5518
- Fax: +61 3 9635 5510
- Email: Jane.Martin@accv.org.au

---

**International Union Against Cancer (UICC)**

UICC’s purpose is to promote awareness and responsibility for the growing global cancer burden; to take effective action to prevent and reduce cancer incidence and mortality; to improve the quality of life of cancer patients and their families; and to build the capacity of our members and partners to meet local cancer control needs. UICC works in collaboration with the World Health Organization (WHO), the International Agency for Research on Cancer (IARC) and other concerned groups, decision-makers and national governmental and nongovernmental organisations, encouraging collaboration among them. UICC’s Tobacco and Cancer Programme aims to change attitudes to tobacco use in society and to promote a comprehensive strategy to eradicate tobacco production, sales, promotion and use. To help achieve these objectives, collaboration with UICC member organisations and other UICC programmes is close and ongoing.

Contact details:
- UICC
- 104 Development Bulletin 54
tobacco control; building capacity to conduct tobacco control programmes; communicating information to constituents and the public and facilitating concerted action with and among partners.

Contact details:

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health Publications Catalog, Mail Stop K-50
4770 Buford Highway, N.E.
Atlanta, GA 30341-3724
Phone: +1 770 488 5705
Fax: 1-800-CDC-1311 (in the USA)
Toll-Free Number: 1-800-CDC-1311 (in the USA)
URL: http://www.who.int/toh/Otherlinks/tabacweb.htm

Society for Research on Nicotine and Tobacco (SRNT)

This society seeks to stimulate the generation of new knowledge concerning nicotine in all its manifestations, from molecular to societal. The society has the following goals:

• to sponsor scientific meetings and publications fostering the exchange of information on the biological, behavioural, social, and economic effects of nicotine;
• to encourage scientific research on public health efforts for the prevention and treatment of cigarette and tobacco use and;
• to provide the means by which various legislative, governmental, regulatory and other public agencies and the ethical drug industry can obtain expert advice and consultation on critical issues concerning tobacco use, nicotine dependence, and the therapeutic uses of nicotine.

Contact details:

SRNT Central Office, SRNT,
7600 Terrace Avenue, Suite 203,
Middleton, WI 53562, USA,
Phone: +1 608-836-3787, Fax: +1 608-831-5485, Email: SRNT@tmahq.com

QUIT – Victorian Smoking and Health Programme

This is a joint initiative of the Anti-Cancer Council of Victoria, the Department of Human Services, the National Heart Foundation and the Victorian Health Promotion Foundation. It develops and implements tobacco control and tobacco awareness programmes and provides assistance to developing countries in these areas.

Contact details:

100 Drummond Street, Carlton South
Victoria, 3053, Australia.
Phone: +61 3 9663 7777
Fax: +61 3 9663 7761
URL: http://www.quit.org.au/

Thailand Action on Smoking and Health

is working to try to reduce smoking rates amongst Thai people through grassroots projects and advocacy work.

URL: http://www.ash.or.th/

Tobacco Free Initiative/World Health Organization

The WHO Tobacco Free Initiative provides links to other tobacco-related websites in the belief that the informed individual is better able to make health and lifestyle decisions. For links to books, conferences, discussion groups, bulletin boards, journals and more go to: http://www.who.int/toh/Otherlinks/tabacweb.htm

Contact details:

Tobacco-Free Initiative
World Health Organization
Avenue Appia 20 1211, Geneva 27,
Switzerland
Fax: +41 22 791 4832
Phone: +41 22 791 2108
Email: tfi@who.int

Victorian Health Promotion Foundation

The Australian health promotion foundation is funded from tobacco taxes. VicHealth (the Victorian Health Promotion Foundation

Office on Smoking and Health

The Office on Smoking and Health (OSH) is a division of the US National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), which is one of the centres of the Centers for Disease Control and Prevention (CDC). OSH is responsible for leading and coordinating strategic efforts aimed at preventing tobacco use among youth, promoting smoking cessation, and protecting nonsmokers from environmental tobacco smoke. OSH accomplishes these goals by expanding the science base of
with our current health knowledge and of activity: research of an international and started in 1999. it will seek to identify the best new approaches can be effectively merged and interdisciplinary nature; the collection, analysis and dissemination of information; and the organisation of significant symposia and conferences which will serve as international fora in which the successes and failures of national and international experiences can be shared.

Contact details:

WHO Centre for Health Development, PO Box 154, Carlton South Victoria 3053, Australia
Phone: +61 3 9345 3200
Fax: +61 3 9345 3222
Email: vicehealth@vichealth.vic.gov.au

World Health Organization (WHO) Kobe Centre

The WHO Centre for Health Development, known as the WHO Kobe Centre, is a global and interdisciplinary research organisation started in 1999. It will coordinate and foster research for health development through an innovative, interdisciplinary and evidence-based approach. The centre will initiate research designed to support the efforts of people to attain and maintain as independent and self-reliant a health status as possible. It will seek to identify the best ideas and practices from east and west and from north and south, and will explore how new approaches can be effectively merged with our current health knowledge and practice.

Consistent with its mission, the WHO Kobe Centre will pursue three major programmes of activity: research of an international and basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to promote health and prevent disease by reducing the harm caused by substance abuse — tobacco, alcohol, and illicit drugs.

Robert Wood Johnson Foundation
PO Box 2316
College Road East and Route 1
Princeton, NJ 08543 2316, USA
URL: http://www.rwjf.org/index.jsp

Tobacco Control Resource Center

The Tobacco Control Resource Center (TCRC) or Boston, is a non-profit organisation founded in 1984 and based at Northeastern University. It provides legal, technical, research and training support for legislative, regulatory, and litigation-based initiatives to control the sale and use of tobacco as a public health strategy. TCRC is a national research clearinghouse, providing information and assistance to attorneys, advocates and federal, state and local officials through individual consultation, training workshops, a website and periodicals. TCRC also seeks to inform the public about tobacco-related issues through ongoing work with the media. Most of TCRC's law-related tobacco control work is performed by the Tobacco Law and Policy Project (TLPP). The Tobacco Products Liability Project (TPLP), TCRC's other legal division, works to establish the legal responsibility of the tobacco industry for tobacco-induced disease, death and disability. TCRC's annual operating budget is approximately $1,000,000. It has a 16-person staff and a 10-person board of directors.

Contact details:

Northeastern University School of Law, 400 Huntington Avenue Boston, MA 02115, USA
Phone: +1 617 373-2026,
Fax: +1 617 373-3672.
Email: tobacco@bigfoot.com
URL: http://www.tobacco.neu.edu/
Materials

National Clearing house on Tobacco and Health

Information and networking services relevant to tobacco use prevention and reduction projects, programs, projects, resources, and advocacy initiatives with the objective of contributing to the goal of a tobacco-free Canada.

Mailing address:

170 Laurier Avenue West, Suite 1000
Ottawa, Ontario, K1P 5V5 Canada
Phone: +1 613 567 3050
Email: info-services@ccctc.ca
URL: http://www.ccc.ca/

Tobaccopedia

Tobaccopedia is an online tobacco encyclopaedia, organised by subject. Most sites in it are suggested by users. Sites are placed in categories by moderators, who visit and evaluate suggestions and decide where they best belong.

URL: http://www.tobaccopedia.org/

Tobacco and Health Abstracts (early twentieth century to present)

This CD-ROM contains over 66,000 succinct abstracts assembled from the most significant journals on tobacco and health research, policy and legislation. 200 records are added each month and over 1,500 publications are scanned for relevant articles. Articles are selected from legal, behavioural, biomedical and chemical journals, technical reports, books, conference proceedings and theses. Topics include smoking behaviour and psychology, environmental tobacco smoke, cessation methods, respiratory diseases, pregnancy, pharmacology and toxicology, and cardiovascular disease. There is a section that lists details of relevant future conferences and meetings.

Available from:

Margaret Crampton
National Inquiry Services Centre
22 Somerset St

PO Box 377
Grahamstown 6140, South Africa
Phone: +27 46 622 9698
Fax: +27 46 622 9550
Email: NISC@ru.ac.za
URL: http://www.nisc.com

Smoking and Health Database

The database contains abstracts of journal articles, books and book chapters, dissertations, reports, conference proceedings and conference papers, government documents, policy or legal documents, editorials, letters, and comments on articles. The database is used by researchers, librarians, medical and other health professionals, educators, and students. Many items are abstracts of articles that have been published in peer-reviewed scientific or technical journals, such as the Journal of the American Medical Association and The American Journal of Public Health. The database also includes abstracts of many hard-to-find documents including government documents and conference proceedings, many with historical significance. The database focuses on information published in the past 35 years, although several records date back to the 1800s. Approximately 1,800 new items are added each year. With the most recent update, the database contains abstracts of more than 62,000 items. Items in the database focus on the scientific, medical, technical, policy, behavioural, legal and historical literature related to smoking and tobacco use and their effect on health.

The Smoking and Health Database is available for use from the Office on Smoking and Health website: http://www.cdc.gov/tobacco/search/index.htm and on a CD-ROM called the CDP File. The CDRom version also contains additional databases on chronic diseases and is available for use at Federal Depository libraries. You may purchase the CDP File from the Government Printing Office at an annual subscription fee of $US104. The GPO stock number is 717-145-00000-3. Phone: GPO 202 512 1800 to order and verify cost and availability.

Making a Killing: Philip Morris, Kraft and Global Tobacco Addiction

A new documentary from award-winning filmmakers Kelly Anderson and Tami Gold, and Infact, the executive producer of Academy Award winner Deadly Deception, this video reveals the truth in once-secret corporate documents: how Philip Morris has conspired to hook children on tobacco and keep governments from protecting public health. It shows shocking international promotion of brands like Marlboro, including free cigarette giveaways; documents how Philip Morris hides behind Kraft Foods, contributing to political campaigns, lobbying against regulations, and influencing media coverage; exposes those who profit from this corporation's worldwide expansion at the expense of people and communities around the globe; tells the inspiring stories of people who have suffered grave losses to tobacco giants and are fighting back. Cost: $US25 individual, $US50 nonprofit, $US75 institution.

Available from:

Infact
46 Plympton Street
Boston, MA 02118
Phone: +1 617 695 2525
Fax: +1 617 695 2626
For online ordering, see Infact's website:
http://www.infact.org/

High Wire Press, Internet imprint of the Stanford University libraries

High Wire Press is one of the largest archives of free full-text science with online publications of 240,022 free full-text articles and 939,754 total articles. Free text of many journals online with 247 sites.

April 2001
Conflict and Resolution teaching resource

A social studies teaching resource for year eight and nine students on conflict and conflict resolution using Bougainville as a case study is now available. This resource has been written on the premise that at any time, somewhere in the world, a conflict will be going on. This kit looks at conflict in general and at the Bougainville conflict in particular. Using a range of different activities and information, students are introduced to the groups involved in the war, and take part in the road to resolution and peace. The resource kit has been developed by the Development Resource Centre, Wellington, a non government, not for profit, organisation providing information and training on development issues and practice. The education program works within the formal education sector running workshops for teachers and teacher educators about teaching with a global perspective. The Development Resource Centre also produces global education teaching resources. For further information contact:

Penny Diederichsen
Education Manager,
Development Resource Centre,
PO Box 12440
Level 5, PSA House, 11 Aurora Terrace
Wellington, New Zealand
Email: penny@drc.org.nz
Phone: +64 (0)4 496 9591
Electronic fora

**Tobacco Control Supersite**
This revealing site is maintained by Simon Chapman, Professor of Public Health in the Department of Public Health and Community Medicine, University of Sydney; editor of the British Medical Journal's specialist journal Tobacco Control, chairman of Action on Smoking and Health (ASH) and member of the World Health Organization (WHO) Expert Advisory Panel on Tobacco and Health. This site carries information of direct relevance to tobacco control in Australia.

Sites concerning Australian tobacco policy are available online. ‘Tobacco in Australia: Facts and Issues’ is at http://www.quit.org.au/Fand!welcome.htm
Links to other sites are at: http://www.quit.org.au/

**Tobacco Control Policy Research Network (TCPRN) Bulletin**
The TCPRN Bulletin is published three times per year in February, June and October. It presents short informative news on tobacco control, policy-relevant research and changes worldwide, with some commentary on the meaning of the news for Asia. The TCPRN is a small operation trying to keep relevant tobacco control research and policy-research opportunities before its readers in Asia. It has been published for five years and is available by email. Contact: Stephen Hamann, founder and bulletin editor at: slhamann@usa.net

**QuitNet** brings proven scientific methods to the Web to deliver support to smokers whenever they need it. URL: http://www.quitnet.org/qn_main.jml

**Tobacco** provides anti-smoking news, information and links. Collection and delivery of Tobacco News Daily is provided by Tobacco BBS, and funded by the American Legacy Foundation.
 URL: http://www.tobacco.org/

**Tobacco Free Kids** is fighting to free America's youth from tobacco and to create a healthier environment.
 URL: http://tobaccofreekids.org/

**Tobaccorepia** is an online tobacco encyclopedia.
 URL: http://www.tobaccorepia.org/

**NZ Smokefree e-News** is a weekly service of Health New Zealand, PO Box 25-920, St. Helliers, Auckland, New Zealand, Phone: +64 9 5851228, Fax: +64 95851229, edited by Murray Laugesen, QSO, public health physician. Email: hnz@healthnz.co.nz
For subscriptions and back copies, see website: www.healthnz.co.nz

**GLOBALink** is the International Tobacco Control Network, managed by the International Union against Cancer. Its aim is to serve all those active in tobacco-control, cancer control and public health, using instant modern technology.
 URL: http://www.globalink.org/

**Society for Research on Nicotine and Tobacco** aims to stimulate the generation of new knowledge concerning nicotine in all its manifestations, from molecular to societal.
 URL: http://www.srnt.org

**The CDC's Office on Smoking and Health**
www.cdc.gov/tobacco

**The National Cancer Institute's Tobacco Control Research Branch**
http://dcep.nic.nih.gov/creb/

**The World Health Organization Site on Tobacco**
www.who.int/tobh/

**Smokeless States Program**
www.ama-assn.org/special/ao/tobacco/main.htm

**Substance Abuse Policy Research Program**
URL: www.phs.wfubmc.edu/sshprw/jrw.htm

**TobaccoVictims.org**

*TobaccoVictims.org* is a voluntary project dedicated to the memory of tobacco victims. It is the fruit of the work done by several volunteers and is not funded by any source. A US Tobacco Victim's Memorial can be found on GetOutraged.com.
Contact: TobaccoVictims.org UICC GLOBALink 3, rue du Conseil General, 1205 Geneva, Switzerland
Phone: +41 22 809 18 50
Fax: +41 22 809 18 10 Email: victims@globalink.org
URL: http://www.tobaccovictims.org/

**Tobacco Leaf, The International Tobacco Growers' Association**
The International Tobacco Growers' Association offers facts and figures about the production of tobacco, claiming that tobacco has great economic and social importance in many developing and developed countries.
 URL: http://www.tobaccoleaf.org/

**Global Development Network (GDN)**
The goal of the Global Development Network (GDN) is to support and link research and policy institutes involved in the field of development. GDN is a collaborative initiative of development institutions globally. Contact: The World Bank, Lyn Squire, Director, Global Development Network.
Presentation and analysis of confidential industry memos and papers includes youth programs; PR analysis and campaigns; attempts to influence science, media and government; studies of its customers; the 'youth market;' and more.

**BBC News | Smoking**

URL: http://38.160.150.33/low/english/health/background_briefings-smoking/Collection of stories from the BBC.

**Bearing Witness for Tobacco**

URL: http://www.prospect.org/archives/V11-10/maggi-l.html

Article on expert witnesses for the tobacco industry; concludes 'plenty of independent scholars, when paid enough money, are evidently willing to lend their names to...what would be dubious scholarship in any other context.'

**The British-American Tobacco document collection**

URL: http://www.library.ucs£edu/tobacco/barco/ Archive provides search and browse access to over 2000 BATCO documents. The documents range in date from the 1950's to the 1990's, and in subject matter from marketing, research and development, cigarette analysis and design, and establishing business in developing countries. BATCo's efforts toward developing new, 'safer' cigarettes gradually change into efforts to make consumers believe that certain cigarettes (low-tar, and the like) are safer.

**Cochrane Tobacco Addiction Group Abstracts**

URL: http://www.cochrane.org/cochrane/revabsrr/g160/index.htm

Abstracts of Cochrane Reviews of the scientific literature on: different methods of quitting smoking, prevention, and protection from secondhand smoke.

**eBMJ — Collected Resources: Smoking**

URL: http://www.bmj.com/cgi/collection/smoking

Recent articles on smoking from the British Medical Journal.

**National Cancer Institute Publication Index**

URL: http://rex.nci.nih.gov/NCI_PUB_INDEX/PUBS_SMOKE.html

Reports on lung cancer, spit tobacco, quitting, and issues for physicians, dentists, health professionals, smokers, and the public.

**Smoke and mirrors**

URL: http://www.storytellerdesign.com/smokeandmirrors.html

Large collection of links on smoking and health, marketing of tobacco products, laws and litigation, advocacy and organizations concerned with smoking.

**Smokefree Lifestyle**

URL: http://www.wce.ac.nz/cancer/lifestyles_smokefree/smokefreecont.html

Factsheets from the Cancer Society of New Zealand on passive smoking, quitting, smoking and pregnancy, remaining a non-smoker after pregnancy, protecting children from secondhand smoke, smoking facts for Maori, and more.

**Tobacco Wars**


Quotations from 'Tobacco Wars' a BBC documentary on the history and politics of tobacco.
EU plans regional cigarette tax to fight fraud and smuggling

*The Wall Street Journal Online - 5:20 pm, Saturday 17 March 2001*

The European Union’s head office announced plans to slap an EU-wide tax on all packs of cigarettes in the hope that it will cut down rampant fraud and smuggling of tobacco products across the 15-nation bloc. The European Commission said the need for an EU-wide minimum tax on cigarettes was necessary to end the current differences in excise rates for tobacco products among member nations, which has cost EU governments billions of euros in lost revenue. ‘The proposal would ensure a fair and reasonable level of taxation of all tobacco products’, said Frits Bolkestein, the EU’s taxation commissioner, adding that the proposal would ‘help to tackle fraud and smuggling.’ The plan calls for a minimum duty of 1.40 euros ($1.28) to be charged on one packet of 20 cigarettes, on top of all other national duties charged. Other tobacco products will also come under a minimum rate, including cigars, cigarillos and rolling tobacco. Tobacco manufacturers reacted negatively to the proposal, arguing the plans would force countries to raise the prices of tobacco products, increasing the potential for cross-border smuggling from Eastern European countries that are not in the EU, where tobacco products are sold much less expensively.

Bar worker sues RSL in landmark passive smoking case

*Sydney Morning Herald, Friday, 16 March 2001*


A former bar worker who developed throat cancer after working at an (RSL) club for 11 years is suing her employer in the first passive smoking case in New South Wales involving a worker in the hospitality industry. Mrs Marlene Sharp, 62, a non-smoker, told the jury of four men yesterday that about 80 per cent of the patrons at the Port Kembla RSL Club, in Wollongong, were smokers. She worked at the club from 1984 to 1995. ‘The smoke seemed to rise and come straight at me. There were people sitting, smoking, drinking, exhaling. Cigarettes in the ashtrays burning away. It wasn’t very nice,’ Mrs Sharp said. Her counsel, Mr Peter Semmler, QC, said Mrs Sharp was suing for negligence and a breach of statute, alleging that the club exposed her to an ‘unnecessary risk’ and failed to provide a safe workplace.

New book warns employers of legal risks of passive smoking

*ABC The World Today Tuesday 20 March 2001*

The Cancer Council of New South Wales has launched a book to make employers and proprietors more aware of the legal dangers of exposing people to passive smoking. The Liquor, Hospitality and Miscellaneous Workers’ Union says it’s the industrial issue of the new millennium.

http://www.abc.net.au/worldtoday/s263042.htm

US FDA asked to regulate reduced risk cigarettes

*Reuters, Washington, Friday 16 March, 4:51 pm Eastern Time*

Public health groups asked the Bush administration on Friday to curb the marketing of so-called ‘reduced risk’ cigarettes by R.J. Reynolds Tobacco Co., accusing the company of making unsubstantiated health claims. In a letter to Health and Human Services Secretary Tommy Thompson, 22 groups, including the American Cancer Society and the American Lung Association, disputed claims by R.J. Reynolds that its Eclipse cigarettes may present
smokers with less risk of cancer and other diseases, and urged the Food and Drug Administration to take action. The groups cited a February report by the Institute of Medicine (IoM) that found that cigarettes made with modified tobacco or designed to burn at low temperatures do not necessarily deliver on promises to make smoking safer and may even be dangerous.

Smoking case

*Lateline, ABC TV, Wednesday 14 March 2001*

This week will see the start of a damages case which puts the New South Wales 'Clean Air Act' on trial. Marlene Sharp blames the RSL Club, where she worked as a barmaid for her cancer and she is seeking damages. While smoking is banned in most workplaces, under laws introduced just last year, clubs and pubs enjoy an exemption.

Passive smoking

*Canberra Times 8 March 2001*

Washington: Scientists today said they had found the first evidence that the wives of smokers absorbed cancer-causing chemicals from tobacco smoke in their homes. Researchers at the University of Minnesota said levels of the chemicals, which originated only in tobacco, were five to six times higher in wives of smokers than in wives of non-smokers. The findings were published in the latest edition of the *Journal of the National Cancer Institute.*

I'm your cigarette packet, can we have a little chat?

*Special report: Smoking, Guardian, Thursday 8 March 2001*

URL: http://www.guardian.co.uk/Archive/

For smokers still in doubt about the health risks involved in each puff, a loud reminder is on the way. Molins, one of Britain's leading suppliers to the tobacco industry, has secretly developed a cigarette packet that talks. The firm has applied for a patent for the idea, which was developed by engineers at its Coventry research centre. A tiny speaker concealed within the packet is activated each time it is opened. *New Scientist* reports that a patent for the new idea has been filed, ironically by a firm that supplies machinery to make cigarettes. A spokesperson for Philip Morris told ABC Science Online that this was the first they had heard of the idea. 'We agree with health warnings as long as our trademarks are protected and our consumers aren't ridiculed,' he said. 'We would be concerned about any increase in the cost to consumers, given that 73% of the retail price goes in taxes and this is continually increasing.' Professor Chapman said there had been three generations of warnings in Australia, with pictorial warnings being the next to be considered. These had already been adopted in Canada. The spokesperson for cigarette manufacturer Philip Morris said he 'wouldn't like to comment' on pictorial warnings given that the Federal Health Minister was currently looking at the issue.

'These had already been adopted in Canada. The spokesperson for cigarette manufacturer Philip Morris said he 'wouldn't like to comment' on pictorial warnings given that the Federal Health Minister was currently looking at the issue.

Tobacco giant linked to deadly smuggling ring

*Sydney Morning Herald, Monday 5 March 2001, Bill Birrnbauer, William Marsden and Maud S. Beelman on a trail of cigarettes, triad and murder.*


Full report: www.publici.org

When Tommy Chui failed to show up at the grand opening of his wife's new boutique in downtown Singapore, alarm bells rang. A former director of British American Tobacco's biggest distributor of contraband cigarettes to China and Taiwan, Chui, 38, had been abducted, tortured, gagged, suffocated and thrown into the harbour just weeks before he was to testify against his ex-associates. Chui was the star witness in an international tobacco smuggling investigation launched in 1993 by the Hong Kong ICAC. He was about to blow the lid off a $2.3 billion smuggling operation to China and Taiwan and implicate three former BAT executives in a $24.5 million bribery scandal. In addition, his testimony was vital to the prosecution of his two former business associates, several corrupt customs officers and various members of Asia's most notorious criminal gang, the Triad.
The case of Chui and BAT reveals the underbelly of a billion-dollar business fed by international corporations and operated by organised crime. The International Consortium of Investigative Journalists has released a 15,000-word report that examines links between tobacco manufacturers and companies and people directly connected with organised crime in Hong Kong, Canada, Colombia, Italy and the United States.

**BAT boosts profit despite loss of volume**

*Financial Review online, 28 February AAP 15:56*  
Full report: [http://www.who.int/tob/Otherlinks/tabacweb.htm](http://www.who.int/tob/Otherlinks/tabacweb.htm)

Australia's largest tobacco company, British American Tobacco Australasia Ltd (BAT), managed a substantial increase in profit last year despite a 10 per cent drop in volumes in the local market. BAT managing director Mr Gary Kelle said the Australian tobacco market remained soft although the company expected a slowdown in the rate of volume decline this year. On Wednesday BAT reported an operating profit before tax and abnormal items of $246.4 million for the year 2000, achieving synergy benefits from the 1999 merger of WD & HO Wills and Rothmans Holdings Ltd much earlier than expected. That compared to $153.7 million for the nine months to December 1999 and $186.9 million for the year to March 1999, before BAT changed its reporting period. After $50.4 million in post-tax abnormal costs relating to the merger, BAT's net profit for the year to December 2000 was $92.97 million.

**Indonesian Observer**

*24 February, p.14*

Indonesia now has the dubious honour of being the fourth largest tobacco consumer, following a massive 44% rise in cigarette consumption in the last 7 years. Health groups are concerned Indonesia will become a target for tobacco companies who are being squeezed out of developed countries by restrictive tobacco control.

**New anti-smoking drug kills 18 in UK**

*ABC Online, PM - Monday, 19 February 2001 6:35*

Smokers beware - is it a case of doomed if you do, doomed if you don't? British health officials have confirmed that 18 people have died after taking a new anti-smoking drug. Millions of people are currently using Zyban to help quash the craving for nicotine. Health officials say that there is no evidence of a direct link between the deaths and the drug, but its use is being clearly and closely monitored.

URL: [http://www.abc.net.au/news/](http://www.abc.net.au/news/)

**Jordan health officials expand ban on public smoking, Amman**

*Jordan, 12 February 2001 5:00 p.m. EST*

[http://www.nandotimes.com](http://www.nandotimes.com)

Jordan's Health Ministry has expanded its list of public places where smoking should be banned, an official said on Monday. The new regulation must be endorsed by the Cabinet of Prime Minister Ali Abu-Ragheb, said Zeid Kayyed, the Health Ministry's secretary-general. 'Smoking will be banned in airports, banks, conference halls, taxis, buses and other means of public transportation', Kayyed said. He said that smoking will be allowed only in designated areas at restaurants, coffee shops, movie theaters, Internet cafes and universities. Violators will face punishment of up to one year in jail and a fine of $280. In the last four years, the government has banned smoking in public offices and aboard flights of its national carrier, Royal Jordanian, to short destinations and to the United States.

Official statistics show that more than 45 per cent of Jordan's 4.6 million population have smoked at least once in a lifetime. At least 30 per cent of the total - mostly teenagers - smoke regularly. Queen Rania, the wife of Jordan's King Abdullah II, is an ardent opponent of smoking. She has sponsored several anti-smoking rallies and seminars in the last two years.

**Researchers complete extensive youth smoking prevention study**

*National Institutes of Health Press Release, Tuesday 19 December 2000*

NCI Press Office (301) 496-6641

Researchers at the Fred Hutchinson Cancer Research Center in Seattle have found that a curriculum-based approach to preventing youth smoking was ineffective when used alone in a school setting. The study was conducted over a 15-year period, from 1984 through 1999, in 40 Washington state school districts. Arthur V. Peterson Jr, Ph.D., and colleagues from the Hutchinson Center, published their results in the 20 December 2000 issue of the *Journal of the National Cancer Institute* (Volume 92, Number 24). The researchers tested a social-influences approach in a school-based setting, which aimed to make youth more aware of and better able to resist the social factors that might lead them to smoke. 'Although the study demonstrated that this approach alone had no effect, it provides a valuable contribution to our knowledge about youth smoking behavior,' said Richard Klauser, M.D., director of the National Cancer Institute (NCI). 'Carefully conducted studies such as this one help us to understand what works and what does not in preventing youth smoking.'

To learn more about tobacco control programs at the NCI, please visit NCI's Tobacco Control Research Branch at [http://cancercontrol.cancer.gov/tcrb](http://cancercontrol.cancer.gov/tcrb)

For questions and answers about this study or for additional information about cancer, please visit NCI's website at [http://www.cancer.gov](http://www.cancer.gov)

**BAT chief mounts attack on regulators**

*Guardian, Wednesday 1 November 2000*

[http://www.guardianunlimited.co.uk/bat/article/0,2763,390750,00.html](http://www.guardianunlimited.co.uk/bat/article/0,2763,390750,00.html)

Guardian homepage: [http://www.guardianunlimited.co.uk/](http://www.guardianunlimited.co.uk/)
British American Tobacco yesterday attacked regulators for suffocating the industry and admitted it was disappointed to be under investigation by the government over alleged smuggling links. Martin Broughton, the chairman, said calls for global legislation and universal tax rules championed by the World Health Authority and European Union were 'invariably unworkable'.

Speaking after the decision by trade secretary Stephen Byers to send in a team of Department of Trade and Industry investigators, he said: 'The stark choice facing regulators is whether to continue with their battle against the industry leaders, cheered on by a chorus of single issue pressure groups, or to engage in more constructive debate.'
Building a secure region

The Australian Council for Overseas Aid (ACFOA) has recently completed a round of parliamentary lobbying based on the arguments outlined in the summary of our budget submission brought to you in this edition of the Development Bulletin. The reaction from Liberal and Labor MPs alike has been favourable, and most acknowledge the important relationship between regional security and development cooperation. However, with the recent announcement to reduce the government's share of petrol excise, it remains debatable as to whether we will see any increase in this year's aid budget.

ACFOA 2001–2002 budget submission summary

It is clear from Australia's recent involvement in conflict situations that, while we can contribute effectively to the prevention of conflict and to peacekeeping, to be sustainable our efforts must be underpinned by strategies to fight poverty. Put simply, a significant part of any regional security strategy therefore lies in support for poverty reduction and more equitable sustainable development – the key aim of Australia's development cooperation programme.

Conflict and tensions in Fiji, the Solomon Islands, East Timor, Bougainville and Indonesia show just how unstable our region has become. But, while the situation continues to fire domestic debate on Australia's defence policy, ACFOA believes much of this continues to take place without a clear vision of the real threats to Australian and regional security. These include not only regional conflicts but also 'threats without enemies', for example people-smuggling, drug trafficking and the spread of HIV/AIDS, as well as continued population growth and the pressures this is placing on natural resources and the environment. Additional resources are needed to tackle such issues.

The level of Australian aid is currently 0.25 per cent of GNP, its lowest level ever. In the lead-up to the 2001–2002 federal budget, ACFOA is campaigning for the government to increase overseas development assistance (ODA) to 0.28 per cent of GNP, or $324 million, taking into account inflation and growth in the economy.

From regional to global security

Conflict in our region reflects the broader problems facing developing countries in the face of rapid globalisation. The sheer number of people living in absolute poverty has risen by 200 million since 1997 to a total of approximately 1.5 billion. The majority of these people are women; they live in rural areas and they have little or no access to technology.
The wealthiest countries and powerful transnational corporations have disproportionately captured the benefits of globalisation. Without fundamental changes, severe poverty and public protests will continue to intensify, encouraging the further breakdown of states, a return to unhelpful forms of trade protectionism and ultimately the possibility of increased ethnic and religious conflict as scarce resources dwindle and old rivalries surface.

If the widening gap between rich and poor is to be arrested, it will require the political will of nation-states, including Australia, with the active support of civil society to intervene and regulate those underlying international financial and economic fundamentals which are currently shaping the widening inequality gap.

It is now well accepted that human development is too important to be left to markets alone. Global economic integration poses a huge challenge if the poor of the world are to benefit. Multilateral organisations, along with governments, will need to establish far greater credibility than at present if people are to believe that the broader interests of the global community are at heart.

Thus, in addition to an increase in Australia's aid programme, ACFOA is also supporting a number of other initiatives aimed at ensuring a fairer share of resources flow to poorer nations:

- faster, deeper debt reduction for developing countries;
- trade policy which supports better access for poorer countries to developed country markets;
- an enforceable code of conduct for Australian transnational corporations operating in the region;
- an effective set of global mechanisms to stabilise capital and investment markets;
- an effective redistribution of global revenue and tax regimes, including the introduction of a currency or 'Tobin' tax;
- fundamental reforms to global institutions, such as the International Monetary Fund, World Bank, Asian Development Bank and World Trade Organization, to ensure their policies are consistent with poverty reduction, sustainable development and with international human rights law; and
- support for the drive for a comprehensive technology transfer to developing countries through investment in primary and secondary education, particularly for young people and women;

**Further improving our aid: Nine steps in the right direction**

In addition to these broad policy directions, ACFOA advocates the following nine key areas in which Australia can improve the quality of its aid programme.

1. **East Timor**

East Timor is expected to be a sovereign state by the end of 2001. However, there is much to be done before then. East Timor is currently one of the poorest countries in the world and it lacks the human and material resources to help its rehabilitation and development.

ACFOA congratulates the government on its generous level of aid to East Timor and urges that this be continued in the 2001–02 period. The priority should continue to be on capacity and institution building. Emphasis should also be given to the repatriation and reintegration of refugees from West Timor, as well as reconciliation and peace-building activities.

2. **The Pacific**

Tensions and political instability have escalated in the Pacific, particularly in the Solomons and Fiji, linked to such issues as land management and ownership, increasing urbanisation, youth unemployment, and the uneven impacts of globalisation and development.

Ensuring trade access to developed country markets, regulation and protection from the exploitative practices of some foreign corporations and the enshrining of local community enterprise development, especially through the involvement of women, will go some way to ensuring a more equitable form of growth. The Pacific region has an extremely rich biodiversity, essential for the survival of local communities. As such, community development needs to be integrated with conservation of the region's biota.

Australia should budget for an overall increase in aid for the Pacific, as it underpins the goal of regional security. ACFOA recommends an increase in aid of $15 million over 2001–02, with a focus on local community development programmes concentrating on women, agriculture, employment generation, young people and vocational training. These should be underpinned by support for trade-related capacity-building measures and human rights.

3. **Africa**

The limited gains made by Africa over the last decade are being increasingly undermined by civil and ethnic strife, coupled with problems of high debt burden, low-income growth, weak and fragmented economies, and major epidemics like AIDS and malaria.

At the same time, official Australian ODA to Africa has fallen approximately 39 per cent since the 1995–96 budget, part of a global trend that has seen ODA to Africa decline significantly since 1990. ACFOA believes that Australia's hosting of the Commonwealth Heads of Government Meeting in Brisbane in October 2001 presents an excellent chance to revitalise Australia's aid programme for the Africa continent.

On the evidence of substantial and on-going Australian community support for assistance to Africa and the immense needs of the continent, ACFOA urges an increase in aid of $25 million over 2001–02. The focus should be on HIV/AIDS, food security, water and sanitation, and responding to women's poverty.

4. **Indonesia**

Indonesia is continuing to go through an extensive political and economic transformation following the fall of the Suharto regime.
and the impact of the Asian financial crisis. The transition has resulted in an increasingly volatile political environment.

For the financial year 2001–02, ACFOA urges the maintenance of real funding to Indonesia, with the establishment of a funding window for Australian NGOs working with Indonesian counterparts so as to better utilise existing links and partnerships to achieve the objectives of AusAID’s country strategy.

5. Mekong

While 2000 brought signs of a slight economic recovery in Thailand, the remainder of the Mekong region — Cambodia, Laos and Vietnam — remain mired in poverty. Adding to these economic problems have been the severe storms and widespread flooding that occurred along the Mekong River in 2000. These have left hundreds of thousands of people homeless in these countries.

ACFOA believes that the enormous development challenges facing much of the Mekong region provide a strong rationale for directing a greater share of aid budget to this area. This includes a larger role for Australian NGOs, given their proven track record in areas such as HIV/AIDS and rural development in the Mekong region.

ACFOA recommends an increase in funding to the Mekong region of $10 million, with a focus on Australian NGOs working at local levels on education and training, primary health care, and rural development. Increased assistance is also needed to programmes which promote gender equity, particularly women’s education.

6. Basic social services

For several years ACFOA has been calling for the government to increase aid funding to the basic social services (BSS) — basic education, basic health care, reproductive health and family planning, and low-cost water and sanitation programmes.

We have called for a total of at least $400 million (or $320 million in bilateral funds) to be spent in these areas through redistribution of current aid funding and/or additional funding. This figure is based on Australia’s proportion of OECD wealth and represents the UN’s calculation of Australia’s ‘fair share’ of the costs of ensuring universal access to critical basic social services.

ACFOA supports AusAID’s increased emphasis on BSS and congratulates the government and AusAID for the real increases in funds to basic education and basic health. However, we are concerned that growth in BSS spending may have stalled.

ACFOA recommends an increase in funding to basic education and training, primary health care, and low-cost water and sanitation programmes. Increased assistance is also needed to programmes which promote gender equity, particularly women’s education.

7. HIV/AIDS

According to the UNDP Human Development Report 2000, the HIV/AIDS epidemic is the biggest obstacle to world human development. By the end of 1999, nearly 34 million people were infected – half of them, women and children.

ACFOA commends the government for its continued emphasis on HIV/AIDS. While we recognise that much of the government’s effort will focus on the Asia-Pacific region, ACFOA urges more attention to the situation in Africa, which has more than half of the world’s HIV-positive people and which accounts for 60 per cent of the 16.3 million lives lost to AIDS since the epidemic began.

ACFOA urges the Australian Government to increase funding for HIV/AIDS community-based activities targeted at Asia, Pacific and Africa by $10 million in the coming year.

8. Gender

Australia’s development assistance programme has played a vital role in addressing the concerns outlined during the World Women’s Conference held in Beijing in 1995, but there is still much to be done. Governments in two-thirds of the countries of the Asia-Pacific region have adopted national plans of action incorporating some or all of the twelve critical areas of concern identified in Beijing, but they have not been incorporated in national development plans or translated into real change on the ground.

ACFOA recommends an increase in funding to direct gender activities of $5 million, with a focus on the promotion of human rights instruments and principles with special relevance to the rights of women, education, and the promotion of programmes to combat violence against women.

9. The Middle East

ACFOA commends the Australian Government for its support of the Middle East peace process. The on-going assistance is both timely and necessary, but it falls short of the present development needs in the Middle East, especially in the Palestinian Territories.

Based on the specific and significant role Australian NGOs can make at this important time, ACFOA recommends that the government increase its current annual commitment of $6.23 million to a total of $11 million in the 2001–02 financial year, and maintain this real level of aid over the next three years.

ACFOA also acknowledges the terrible humanitarian impact the current international sanctions are having on the people of Iraq. These sanctions have had a devastating impact on the lives of ordinary people and have destroyed Iraq’s major infrastructure while having shown to be ineffective in bringing about any change to the domestic political situation. Further, ACFOA notes the significant difficulties being experienced by refugees who flee this regime.

ACFOA recommends that the Australian Government immediately review its policy of supporting sanctions on Iraq. ACFOA also urges the government to provide a funding commitment of $5 million through the relief and rehabilitation window to Iraq, to be administered through NGOs to facilitate integrated interventions in paediatric nutrition, health, water and sanitation, and education.
Summary of major funding recommendations

<table>
<thead>
<tr>
<th>Main recommendations</th>
<th>Funding implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>An aid programme which provides an integrated and consistent approach to poverty reduction, with increased funding mainly for the Pacific and Africa.</td>
<td>Increase ODA to 0.28 per cent of GNP—an increase of $324 million.</td>
</tr>
<tr>
<td>Increase ODA to the Pacific, along with broader support for trade-related capacity-building measures, support for human rights and peace-building measures.</td>
<td>An extra $15 million in real terms over the next year.</td>
</tr>
<tr>
<td>In recognition of the enormous development challenges facing Africa, increase funding focusing on HIV/AIDS, education, human rights and governance.</td>
<td>A $25 million increase.</td>
</tr>
<tr>
<td>Continue funding to Indonesia at 2000–01 levels. A focus on poverty reduction, human rights and civil society should be enhanced through the addition of a funding window for Australian NGOs.</td>
<td>Maintain real expenditure. For Australian NGOs working with Indonesian counterparts—$4 million extra.</td>
</tr>
<tr>
<td>Increase funding to the Mekong because of impacts of economic crisis and recent floods.</td>
<td>A $10 million increase.</td>
</tr>
<tr>
<td>Establish a new three-year aid programme to the Middle East, with increased funding for Palestinian Territories and fund a relief and rehabilitation window for Iraq.</td>
<td>A $9.77 million increase. Relief and rehabilitation funding—$5 million.</td>
</tr>
<tr>
<td>Increase funding for South Asia, with emphasis on peace, women and marginalised groups.</td>
<td>A $10 million increase.</td>
</tr>
<tr>
<td>In line with poverty focus, increase BSS funding by 20 per cent overall each year for the next four years. Also provide an additional $10 million for HIV/AIDS initiatives.</td>
<td>HIV/AIDS initiatives in Asia, Pacific and Africa—$10 million increase. 20 per cent overall increase in BSS.</td>
</tr>
<tr>
<td>Increase direct funding of gender activities.</td>
<td>A $5 million increase.</td>
</tr>
<tr>
<td>Increase technical assistance for developing countries in Asia and Africa related to trade and participation in the WTO.</td>
<td>$10 million.</td>
</tr>
<tr>
<td>Non-AusAID ODA: Allocate debt repayments on the $72.5 million owing to Australia from Vietnam and Ethiopia into a trust fund for poverty reduction until they become eligible for debt relief under the HIPC Initiative.</td>
<td>$72.5 million.</td>
</tr>
<tr>
<td><strong>Total funds recommended</strong></td>
<td><strong>$324 million in 2001–02 (0.28 per cent of GNP. Of this, $52 million is needed to maintain real funding to existing programmes; and ACFOA’s specific recommendations require a minimum of $110.77 million plus reallocation of existing funding to priority areas.</strong></td>
</tr>
</tbody>
</table>

**Note**

The ACFOA budget submission 2001 is based on contributions from ACFOA’s 97 member agencies and is written and edited by ACFOA Policy Officer Andrew Nette and Policy Director Jim Redden. The full ACFOA submission is available on the Internet at <www.acfoa.asn.au> or by telephoning (02) 6285 1816.
Copyright
Articles and reports published by the Network may be republished, but we would appreciate your acknowledgement of the source. No acknowledgement is needed for conference announcements, other notices or publication lists.

Manuscripts
Manuscripts are normally accepted on the understanding that they are unpublished and not on offer to another publication. However, they may subsequently be republished with acknowledgement of the source (see 'Copyright' above). Manuscripts should be double-spaced with ample margins. They should be submitted both in hard copy (2 copies) and if possible on disk or by e-mail, specifying the programme used to enter the text. No responsibility can be taken for any damage or loss of manuscripts, and contributors should retain a complete copy of their work.

Style
Quotation marks should be single; double within single.
Spelling: English (OED with '-ise' endings).

Notes
(a) Simple references without accompanying comments to be inserted in brackets at appropriate place in text, e.g. (Yung 1989).
(b) References with comments should be kept to a minimum and appear as endnotes, indicated consecutively through the article by numerals in superscript.

Reference list
If references are used, a reference list should appear at the end of the text. It should contain all the works referred to, listed alphabetically by author’s surname (or name of sponsoring body where there is no identifiable author). Authors should make sure that there is a strict correspondence between the names and years in the text and those on the reference list. Book titles and names of journals should be italicised or underlined; titles of articles should be in single inverted commas. Style should follow: author's surname, forename and/or initials, date, title of publication, publisher and place of publication. Journal references should include volume, number (in brackets), date and page numbers. Examples:

Strachan, P. 1996, 'Handing over an operational project to community management in North Darfur, Sudan', *Development in Practice*, 6(3), 208-16.

Publication/resource listings
An important function of the Network is to keep members up-to-date with the latest literature and other resources dealing with development-related topics. To make it as easy as possible for readers to obtain the publications listed, please include price information (including postage) and the source from which materials can be obtained.