Forum: World Health Organization (WHO)

Issue: The Question of Limiting Tobacco Production and Accessibility

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INTRODUCTION

Tobacco is the leading preventable cause of death in the world and has caused 5.4 million deaths in 2005. This means in average one death every 6 seconds and if current trends continue it is estimated to reach more than 8 million by 2030. 1 in 3 adults (more than 1,1 billion people) worldwide smokes and 50% of them will die because of tobacco consumption. Tobacco consumption affects every organ system in the body and is a risk factor for six of the eight leading causes of deaths in the world.

Second-hand tobacco smoke is dangerous to health as well and causes heart disease and many serious respiratory and cardiovascular diseases in adults, which can lead to death. An estimated 700 million children, or almost half of the world's children, breathe air polluted by tobacco smoke, particularly at home. There is no safe level of exposure to second-hand tobacco smoke; only 100% smoke-free environments provide effective protection.

DEFINITION OF KEY TERMS

Tobacco products: are products made entirely or partly of leaf tobacco as raw material, which are intended to be smoked, sucked, chewed or snuffed. All of them contain the highly addictive psychoactive ingredient, nicotine.

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. Despite this, it is common throughout the world. A number of countries have legislation restricting tobacco advertising, and regulating who can buy and use tobacco products, and where people can smoke.

The worldwide leading preventable cause of death kills up to half of all people who use it and without urgent action it will lead to 1 billion dead people in 21st century. Annual death toll will pass 8 million by 2030 and keep rising, with over 80% of deaths in developing countries, unless we act now.

RELEVANT UN TREATIES AND EVENTS

WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first international treaty negotiated under the auspices of WHO. It was adopted by the World Health Assembly on 21 May 2003 and entered force on 27 February 2005. It has since become one of the most rapidly and widely embraced treaties in United Nations history.

The WHO FCTC was developed in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation.

Different Member States have adopted their own national legislation and taken strong action against tobacco use by increasing tobacco taxation, banning tobacco advertising and promotion, prohibiting smoking in public places and worksites, implementing effective health warnings on tobacco packaging, improving access to tobacco cessation treatment services and medications, regulating the contents and emissions of tobacco products, and eliminating illegal trade in tobacco products.

Recommendations by WMA (World Medical Association)

The WMA urges the national medical associations and all physicians to take the following actions to help reduce the health hazards related to tobacco use:

Adopt a policy position opposing smoking and the use of tobacco products, and publicize the policy so adopted.

Prohibit smoking, including use of smokeless tobacco, at all business, social, scientific, and ceremonial meetings of the National Medical Association, in line with the decision of the World Medical Association to impose a similar ban at all its own such meetings.

Develop, support, and participate in programs to educate the profession and the public about the health hazards of tobacco use (including addiction) and exposure to second-hand smoke. Programs aimed at convincing and helping smokers and smokeless tobacco users to cease the use of tobacco products and programs for non-smokers and non-users of smokeless tobacco products aimed at avoidance are both important.

Encourage individual physicians to be role models (by not using tobacco products) and spokespersons for the campaign to educate the public about the deleterious health effects of tobacco use and the benefits of tobacco-use cessation. Ask all medical schools, biomedical research institutions, hospitals, and other health care facilities to prohibit smoking, use of smokeless tobacco on their premises.

Introduce or strengthen educational programs for medical students and physicians to prepare them to identify and treat tobacco dependence in their patients.

Support widespread access to evidence-based treatment for tobacco dependence - including counselling and pharmacotherapy - through individual patient encounters, cessation classes, telephone quit-lines, web-based cessation services, and other appropriate means.

Develop or endorse a clinical practice guideline on the treatment of tobacco use and dependence.

Join the WMA in urging the World Health Organization to add tobacco cessation medications with established efficacy to the WHO's Model List of Essential Medicines.

Refrain from accepting any funding or educational materials from the tobacco industry, and to urge medical schools, research institutions, and individual researchers to do the same, in order to avoid giving any credibility to that industry.

Urge national governments to ratify and fully implement the Framework Convention on Tobacco Control to protect public health.

Speak out against the shift in focus of tobacco marketing from developed to less developed nations and urge national governments to do the same.

Advocate the enactment and enforcement of laws that:

- provide for comprehensive regulation of the manufacture, sale, distribution, and promotion of tobacco and tobacco-derived products, including the specific provisions listed below.

- require written and pictorial warnings about health hazards to be printed on all packages in which tobacco products are sold and in all advertising and promotional materials for tobacco products. Such warnings should be prominent and should refer those interested in quitting to available telephone quit-lines, websites, or other sources of assistance.

- prohibit smoking in all enclosed public places (including health care facilities, schools, and education facilities), workplaces (including restaurants, bars and nightclubs) and public transport. Mental health and chemical dependence treatment centers should also be smoke-free. Smoking in prisons should not be permitted.

- ban all advertising and promotion of tobacco and tobacco-derived products.

- encourage the development of plain packaging legislation

- prohibit the sale, distribution, and accessibility of cigarettes, and other tobacco products to children and adolescents. Ban the production, distribution and sale of candy products that depict or resemble tobacco products.

- prohibit smoking on all commercial airline flights within national borders and on all international commercial airline flights, and prohibit the sale of tax-free tobacco products at airports and all other locations.

- prohibit all government subsidies for tobacco and tobacco-derived products.

- provide for research into the prevalence of tobacco use and the effects of tobacco products on the health status of the population.

- prohibit the promotion, distribution, and sale of any new forms of tobacco products that are not currently available.

- increase taxation of tobacco products, using the increased revenues for prevention programs, evidence-based cessation programs and services, and other health care measures.

- curtail or eliminate illegal trade in tobacco products and the sale of smuggled tobacco products.

- help tobacco farmers switch to alternative crops.

- urge governments to exclude tobacco products from international trade agreements.

BACKGROUND INFORMATION

The tobacco industry claims that it is committed to determining the scientific truth about the health effects of tobacco, both by conducting internal research and by funding external research through jointly funded industry programs. However, the industry has consistently denied and suppressed information concerning the deleterious effects of tobacco smoking. For many years, the industry claimed that there was no conclusive proof that smoking tobacco causes diseases such as cancer and heart disease. It has also claimed that nicotine is not addictive. These claims have been repeatedly refuted by the global medical profession, which because of this is also resolutely opposed to the massive advertising campaigns mounted by the industry and believes strongly that the medical associations themselves must provide a firm leadership role in the campaign against tobacco.

The tobacco industry and its subsidiaries have for many years supported research and the preparation of reports on various aspects of tobacco and health. By being involved in such activities, individual researchers and their organizations give the tobacco industry an appearance of credibility even in cases where the industry is not able to use the results directly in its marketing. Such involvement also raises major conflicts of interest with the goals of health promotion.

To tackle the problem of tobacco consumption and its harmful effect on public health many National and international medical associations such as World Medical Association (WMA) have contributed to the creation of national public health programs and the passing of legislation that regulates the use and production of tobacco.

Regardless of the effectiveness of existing public health programs in a jurisdiction, an important responsibility of professional medical associations is the awareness of community and national health needs that are not being met and public advocacy for activities, programs, and resources to meet those needs. These efforts might be in areas of public education for health promotion and disease prevention, monitoring and controlling environmental hazards, identifying and publicizing adverse health effects from social problems, such as interpersonal violence or social practices that affect the health of people, or identifying and advocating for services such as improvements in emergency treatment preparedness.

POSSIBLE SOLUTIONS

Efforts to prevent the onset or continuance of tobacco use face the pervasive, countervailing influence of tobacco promotion by the tobacco industry, a promotion that takes place despite overwhelming evidence of adverse health effects from tobacco use.

The available approaches to reducing tobacco use (educational, clinical, regulatory, economic, and comprehensive) differ substantially in their techniques and in the metric by which success can be measured.

Approaches with the largest span of impact (economic, regulatory, and comprehensive) are likely to have the greatest long-term, population impact. Those with a smaller span of impact (educational and clinical) are of greater importance in helping individuals resist or abandon the use of tobacco.

Educational strategies, conducted in conjunction with community and media based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents.

Pharmacologic treatment of nicotine addiction, combined with behavioural support, will enable 20 to 25 percent of users to remain abstinent at one year posttreatment. Even less intense measures, such as physicians advising their patients to quit smoking, can produce cessation proportions of 5 to 10 percent.

Regulation of advertising and promotion, particularly that directed at young people, is very likely to reduce both prevalence and uptake of smoking.

Clean air regulations and restriction of minors' access to tobacco products contribute to a changing social norm with regard to smoking and may influence prevalence directly.

An optimal level of excise taxation on tobacco products will reduce the prevalence of smoking, the consumption of tobacco, and the long-term health consequences of tobacco use.

The impact of these various efforts, as measured with a variety of techniques, is likely to be underestimated because of the synergistic effect of these modalities. The potential for combined effects underscores the need for comprehensive approaches.

State tobacco control programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use.

USEFUL LINKS

- http://www.who.int/fctc/en/
- http://www.wma.net/en/20activities/30publichealth/40tobaccocontrol/010304_Presentation_Tobacco_Seo.pdf
- http://www.who.int/topics/tobacco/en/
- http://www.wma.net/en/30publications/10policies/h4/index.html

- http://www.nature.com/onc/journal/v21/n48/full/1205810a.html
- https://en.wikipedia.org/wiki/Smoking_age
- https://www.cdc.gov/tobacco/data_statistics/by_topic/policy/legislation/