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Global Tobacco Control Law: Towards a WHO Framework Convention on Tobacco Control

Report of an International Conference
7-9 January 2000, New Delhi

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Contents

THE NEW DELHI DECLARATION

Recognizing the indisputable scientific evidence establishing that tobacco consumption in any form and exposure to environmental tobacco smoke are causally linked to numerous causes of death, disease and disability;

Recognizing also that cigarettes are among the most highly engineered consumer products, designed to create and maintain addiction and containing over 4 000 compounds, many of which are pharmacologically active, toxic, mutagenic and carcinogenic;

Recognizing further that 4 million people die each year from tobacco related diseases and that this number is expected to rise to 10 million deaths per year within the next 25 years, with 70% of these deaths occurring in developing countries;

Deeply concerned about the global spread of the tobacco epidemic and the dramatic increase in the worldwide consumption and production of cigarettes and other tobacco products in the last several decades, particularly in developing countries;

Deeply concerned also about the escalation in smoking and other forms of tobacco consumption especially by women, children and indigenous peoples worldwide;

Deploring all direct and indirect advertising, marketing, promotion, sponsorship and other practices by the tobacco industry aimed at encouraging the use of tobacco by children and young adults;

Recognizing that the tobacco epidemic is a problem of global dimension that calls for immediate national action and the widest possible cooperation by all countries in an effective and coordinated international response;

Recognizing also that the World Bank report has clearly shown that tobacco price increases, tobacco advertising bans and controls on smoking in public places are effective strategies for reducing tobacco consumption;

Mindful of the difficulties in adopting and implementing effective national tobacco control programmes, including comprehensive tobacco control legislation in countries in which public health resources are limited and tobacco industry pressure is overwhelming;

Recalling the preamble of the Constitution of the World Health Organization which provides that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition";

Recognizing the need for international consensus on the right to be fully informed about the addictive and damaging nature of nicotine and the right to a smoke-free environment;

Emphasizing the contribution that nongovernmental organizations, including health professional bodies, women, youth, consumer, and environmental groups, academic institutions, media, private industry, hospitals and other members of civil society make to tobacco control efforts;

We the participants at the WHO International Conference on Global Tobacco Control Law: Towards a WHO Framework Convention on Tobacco Control, strongly recommend that:

(1) Governments urgently develop and implement multisectoral national tobacco control strategies, including comprehensive tobacco control legislation. To this end, governments should establish mechanisms to monitor and enforce implementation of all tobacco control laws and regulations.

(2) Governments support the development, ratification and implementation of the WHO Framework Convention on Tobacco Control (FCTC) to encourage comprehensive national tobacco control action and global coordination on aspects of tobacco control that transcend national boundaries. The WHO FCTC and key related protocols should be adopted by 2003 or earlier.

(3) The complex circumstances faced by developing countries in implementing effective national tobacco control strategies should be addressed in the FCTC. The FCTC should include a mechanism to assist countries in which public health resources are limited and tobacco industry pressure is overwhelming, in developing and implementing comprehensive national tobacco control programmes. Industralized countries should support the establishment and strengthening of effective national tobacco control programmes in developing countries. Such programmes should include, but not be limited to, building sustainable capacity in national and international tobacco control strategies, including legislation; assisting with the treatment of tobacco dependence; and assisting research into alternative livelihoods for tobacco workers and alternative uses of tobacco.

(4) The tobacco industry be held publicly accountable at the national and international level through legislation, litigation and other means.

(5) Given the impact of tobacco products on public health, WHO should coordinate closely with regional and international trade organizations to ensure that tobacco control measures and trade liberalization measures are complementary.

(6) Nongovernmental organizations, including health professional bodies, women, youth, consumer and environmental groups; academic institutions; private industry; media; hospitals; and other members of civil society should take an active role in tobacco control initiatives at the subnational, national, regional and global levels.

1. INTRODUCTION

Tobacco causes 4 million deaths annually. This figure is expected to rise to 10 million by the year 2030, 70% of which will occur in the developing world. Increase in the population of the south, inadequate knowledge of the health risks associated with tobacco, increased smoking prevalence, intensive and ruthless advertisement, and poor funding for tobacco control are likely to increase the number of tobacco deaths.

WHO convened a consultative technical conference in New Delhi from 7-9 January 2000, aimed at obtaining a developing country perspective towards the negotiation of the WHO Framework Convention on Tobacco Control. The conference was hosted by the Government of India and inaugurated by H.E. Mr Atal Behari Vajpayee, Prime Minister of India. The conference was also addressed by Dr Gro Harlem Brundtland, Director-General, World Health Organization, Dr Uton Muchtar Rafei, Regional Director, World Health Organization/South-East Asia Regional Office and H.E. N T Shanmugam, Union Minister of State for Health and Family Welfare, Government of India. For full text of the speeches, see annexes 1, 2, 3 and 4. The programme of the conference is at annex 5 and list of participants is at annex 6. Participants came from over 50 developing and least developed countries from Asia, Africa, the Middle East and the Pacific.

2. OBJECTIVES

The objectives of the conference were:

(1) To formulate a developing country perspective on the WHO Framework Convention on Tobacco Control;

(2) To identify difficulties developing countries may encounter in enacting tobacco control measures;

(3) To propose capacity-building measures for tobacco control;

(4) To mobilize technical and political support for tobacco control in the developing world; and

(5) To identify mechanisms for stimulating intersectoral collaboration for the development and future implementation of the Convention.

The conference was organized around three themes:

(1) Global Tobacco Control: The Economic and Agricultural Context,

(2) Industry Challenges and Public Health Responses,

(3) Global Tobacco Control Law: Towards a Framework Convention on Tobacco Control

All papers presented on the three themes may be accessed from the WHO Tobacco Free Initiative web site on the following address:

http://tobacco.who.int/en/fctc/index.html

3. GLOBAL TOBACCO CONTROL: THE ECONOMIC AND AGRICULTURAL CONTEXT

The following papers concerning the economic and agricultural context on tobacco control were presented:

(1) "An Overview of the Role of the World Bank and WHO in Global Tobacco Control" by Dr Iraj Abedian;

(2) "The Role of Multinationals and Other Private Actors: Trade and Investment Practices" by Dr Luk Joossens, Professor Prakit Vateesatokit and Ms Bungon Rithiphakdee;

(3) "Ownership of Tobacco Companies and Implications on Health" by Dr Hatai Chitanondh;

(4) "The Cost of Tobacco Related Diseases in India-Report of an ICMR Task Force" by Dr G.K Rath; and

(5) "Agricultural Diversification as a tool of Tobacco Control" by Dr P. Panchimukhi.

The highlights of the discussions were as follows :

Tobacco production and consumption, is as much an economic issue as it is a health issue. Effective global tobacco control needs to include an analytic economic approach.

- Global tobacco control is intricately linked to economics.
- A coherent global tobacco control strategy involving both demand and supply reduction is needed which takes into account the different economic, financial and legal situations in different regions of the developing world.
- Interventions affecting the price of cigarettes are the most feasible and effective. Excise taxes are the obvious way for Governments to raise the price of cigarettes.
- Increases in tobacco taxes lead to a rise in fiscal revenues, which in turn, provide extra resources for, *inter alia*, public health expenses.
- To avoid increased smuggling and to enhance substantial tax revenue gains, coordinated and ideally proportionate tax increases across an entire region are needed.
- Tobacco price elasticity is greater among the poor than the rich and can accelerate tobacco control in developing countries.
- When smokers reduce their consumption of tobacco, they spend their money on other labour intensive products and services resulting in no job losses.
- The tobacco industry should be made to pay for expenditures on healthcare and income loss due to absenteeism.

The purpose of transnational tobacco companies(TTCs) in taking over factories in developing markets is not to provide help, but rather to penetrate a new market and to sell more of their products.

- Stronger laws, regulations and declining consumption in developed countries forced transnational tobacco companies (TTCs) to expand into developing markets. Phillip Morris, British American Tobacco (BAT) and RJ Reynolds each own or lease cigarette plants in at least fifty different countries, a large number of which are in the developing world.
- Acquisitions and joint ventures worldwide, especially in Eastern Europe and Asia, led to the loss of market share by local companies.
- Regional and international trade agreements have had negative effects on tobacco control. Following the signing of the North American Free Trade Agreement (NAFTA) Philip Morris and BAT paid a combined US$ 2.1 billion to buy two Mexican cigarette companies.
- Tobacco should be exempt from recommended tax reductions under NAFTA and the Asian Free Trade Agreement.
- The governments of WHO Member Countries should not be involved in the production or marketing of tobacco products.
- Governments should increase excise taxes and restrict marketing before privatizing state tobacco companies.

It should be recognized that tobacco is a killer and also very costly to cultivate.

- In 1999, tobacco only contributed 2 -3 % of the total foreign exchange earnings of the top 5 tobacco-growing countries in the world.

- Tobacco cultivation has been increasing in developing countries such as Brazil, China, India, Indonesia, Malawi and Zimbabwe which continue to be in the grip of poverty and inequality.
- Rise in the export price of tobacco leaves, high import value for tobacco leaves, high demand for tobacco products, subsidies for tobacco farming, and exaggerated estimates of employment revenue and foreign exchange gains from tobacco production lead to increase in areas brought under tobacco cultivation.
- Provision of guidance, support and high rates of return for alternative crops, mixed cropping, and crop insurance for alternative crops discourage tobacco cultivation.
- Given technical and financial assistance for the cultivation of equally remunerative alternative crops, Indian farmers were found to be willing to shift away from the cultivation of tobacco. The Indian study holds true for many other developing countries.
- Governments need to apply the results of surveys and data, withdraw direct and indirect subsidies for tobacco, give insurance for alternative crops, and provide income support for tobacco farmers until the process of diversification is complete and sustainable.
- The disappearance of rural farming communities around the world means diversification should include alternative livelihoods.
- WHO, other international organizations and governments need to study the implications of global, regional and national investment policies, such as World Trade Organization regimes, to ensure that they are compatible with the objectives of global tobacco control.

4. INDUSTRY CHALLENGES AND PUBLIC HEALTH RESPONSES

The following papers on industry challenges and public health responses were presented :

(1) "Industry Lobbying of the Public Sector and other Tactics" by Dr Yussuf Saloojee and Dr Elif Dagli;

(2) "Case Study in Consumer Protection from Tobacco in South East Asia" by Dr Sri Ram Khanna and Ms Mary Assunta;

(3) "Multisectoral and Intersectoral Approach to National Tobacco Control" by Dr Kishore Chaudhry;

(4) "Media and Global Responsibility" by Ms Ambika Srivastava; and

(5) "Women, Children and Tobacco" by Dr Mira Aghi.

The following were the highlights of the discussions :

- Three companies, Philip Morris, BAT and Japan Tobacco dominate the global tobacco market. The tobacco companies' exclusive commitment to shareholders at the cost of accountability to all stakeholders, has led to the disregard of common and public good.
- Increasing media and scientific focus on the role of cigarettes in causing disease led the industry to react.
- The industry's reactions included friendly research, old-fashioned political lobbying and legal action. Vast sums of money were spent to fund research by scientists who would dispute the health risks of passive smoking.
- Tobacco companies have developed global networks to scan, monitor and track external forces through its own employees, distributors, and allies in the advertising industry and public relations companies.
- The industry has attempted to shift the debate to other issues, such as employment.
- The industry's first line of defence is to assert self-regulation instead of government regulation.
- The tobacco industry has been backing smoker's rights bills in order to reduce the ability of smokers to mount class action suits.

Through both direct and indirect advertising, the tobacco industry associates cigarette smoking with athletic prowess, sexual attractiveness, professional success, adult sophistication, independence, adventure and self-fulfilment.

- The industry has used the media to promote individual choice and economic arguments against taxes or advertising bans, while targeting youth and women.
- Advertising strategies that have increased sales in mature western markets are now being used in the developing countries of Asia, Africa, Central and Latin America, as well as the transitional economies of Eastern Europe.
- Every aspect of media has been used, including radio, television, magazines, newspapers, billboards and the internet.
- The increasing use of total or partial bans on tobacco advertising have caused tobacco companies to become more creative in developing new ways to advertise their brands:
  - **Internet:** BAT, Brown & Williamson and R.J. Reynolds have launched websites to advertise products.
  - **Indirect Advertising:** A BAT subsidiary company, World Investment Company, has planned to legally promote cigarette brand names in a new range of coffee products.
  - **Social Development Support Programmes:** Companies have been launching anti-smoking campaigns in collaboration with governmental ministries or other organizations. In 1997, tobacco companies, through the Malaysian Ministry of Education, funded a US$ 280 000 anti-smoking campaign in various secondary schools.
  - **Point of Sales Advertising:** Absence of compliance or enforcement of restrictions on point-of-sale advertising by shop owners has led to the unabated increase of cigarette sales in most developing countries.

  - **Corporate Affairs Sponsorship:** For example, sponsoring by Philip Morris of the ASEAN Arts Awards.
  - **Music and Pop Concerts:** R.J. Reynolds Berhad operates a record shop called the Salem Power Station in Malaysia. It has prominently sponsored pop or music concerts by music celebrities.
  - **Sports:** R.J. Reynolds has been very involved in sponsoring sporting events, including tennis and wrestling in Malaysia.
  - **Youth Access Campaigns:** Youth prevention campaigns sponsored by Philip Morris are now a well-known activity in various countries.

- Studies in different countries have shown that banning advertising resulted in 4 –9% reductions in consumption. Parallel to these bans, the media needs to be mobilized to disseminate the public health and economic arguments against tobacco use.
- It is imperative to build partnerships with the media in the developing world, so that it can champion tobacco control programmes. Specific activities could include: action on a global basis with key media companies that provide access to audiences across borders through satellite transmission; running a multimedia campaign against passive and active smoking; countering the lobbying efforts of the industry through effective media advocacy and monitoring to ensure industry compliance with existing and new laws.
- Governments need to ensure that the media is not used to promote tobacco. In many developing countries, tobacco companies use government media to advertise their products.
- Tax exemptions for responsible media could be effective, for example, tax exemptions for films that do not promote tobacco.

Tobacco is the only consumer product that kills when used exactly as the manufacturer intended.

- Consumers have fundamental rights including: the right and need to consume safe products; the right to information; the right to redress; and the right to a healthy environment.

- These rights are violated by the tobacco industry. Tobacco is not safe. The industry should provide a full disclosure on the health effects of their products. Consumers can demand redress from producers for the death, injury and harm caused by tobacco to themselves or their next of kin. Healthy environments necessitate comprehensive smoking bans in public places.

Lung cancer is overtaking breast cancer as the most common malignancy in women in parts of the world where smoking by women is on the increase.

- Women suffer from innumerable tobacco-related diseases which affect them throughout their lifecycle.
- Women, like men, suffer from bronchitis, emphysema and ischaemic heart disease and other diseases of the vascular system.
- A strong association has been established between tobacco use and lower birth-weight babies, high incidence of still births, and prenatal mortality among female tobacco chewers in India, who contribute 60% of the female population.
- Viewing the tobacco scourge as a violation of women's and children's rights could help widen the realm for tobacco control.
- A global tobacco control law relates to other United Nations conventions that cover women and children, including the International Convention on Economic, Social and Cultural rights (article 12:2a), the Beijing Platform for Action (articles 89,106) and the United Nations Declaration on Violence Against Women.
- The tobacco industry is deliberately targeting women in developing countries. Surveys in India have shown that up to 60% of women chew tobacco.
- An alliance between WHO, nongovernmnetal organizations and consumer groups is crucial to reduce tobacco consumption in developing countries.

- Nongovernmental organizations play an important role in working with national and intergovernmental bodies to monitor, expose and confront the tobacco industry's tactics. They can warn consumers about the harmful effects of smoking tobacco and make them aware of the deceptive practices of the tobacco industry. Nongovernmnetal organizations can also pressure governments to shift policy in favour of tobacco control.

The need for social change and action for tobacco control as a social cause must be realized by growers, producers, transporters, traders, advertisers, users, public authorities and health experts.

- Intersectoral cooperation will help in the formulation of clear government policies on tobacco. Although the important role of non-health sectors has been known for a long time, tobacco control has remained largely a public health initiative.
- Policies requiring intersectoral cooperation include: taxation on tobacco products; prevention of smuggling of tobacco products; health warnings on tobacco products; reduction of toxic elements in tobacco products; bans on tobacco advertisements; bans on smoking in public places; community education; bans on tobacco products; and agricultural substitution of tobacco.

5. GLOBAL TOBACCO CONTROL LAW: TOWARDS A FRAMEWORK CONVENTION ON TOBACCO CONTROL

The following papers on law and policy were presented :

(1) "International Legal and Policy Framework for the WHO Framework Convention on Tobacco Control" by William Onzivu;

(2) "Regulation of Tobacco Products" by Mitchell Zeller;

(3) "The Prospects for Globalizing Tobacco Litigation" by Roberta Walburn; and

(4) "The Application of International Law into National Law, Policy and Practice, Lessons for the Framework Convention on Tobacco Control" by Judy Obitre Gama.

The following were the highlights of the discussions :

- The World Health Organization's power to develop treaties in order to protect global public health is granted in Article 19 of the WHO Constitution.
- Resolution WHA52.18 of the 52nd World Health Assembly in May 1999 urged Member States of WHO to work and act for tobacco control. It established a working group and an intergovernmental negotiating body charged with forwarding the convention-making process. An important affirmation was made concerning the need for technical and financial support for developing countries in order to involve them fully in the process.

Treaties have become important instruments to regulate changing global issues of common concern such as the environment and public health.

- The WHO Framework Convention on Tobacco Control(FCTC) will be ratified by Member States of the World Health Organization. In many countries, the Convention will be immediately applied into domestic law. Following adoption, some countries will have to pass a specific tobacco control bill, incorporating and making effective all the obligations imposed on the countries through the Convention.
- Once a country has signed and become a party to an international treaty, it is obliged to implement it in its domestic law. It must comply fully with the obligations under the international convention. A country cannot use the excuse of conflict with domestic law for not implementing international law.
- A global tobacco control convention is compatible with the World Trade Organization's rules and policies. The World Trade Organization regime recognizes the protection of human health and the authority of ratified treaties created by other international organizations such as WHO.

- WHO and WTO have started discussions on tobacco trade and how it impacts health, and WHO has appointed an in house trade and health group.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

- The WHO Constitution states that health is a fundamental human right. United Nations and regional conventions, including the Universal Declaration of Human Rights; Convention on Economic, Social and Cultural Rights; African Convention on Human and Peoples Rights; and American Convention on Human Rights provide for the right to health. Conventions providing the right to health, and which cite tobacco as a serious health problem, include the Convention on the Elimination of Discrimination against Women (CEDAW) and the UN Convention on the Rights of the Child.

Tobacco products are deliberately designed by their manufacturers to deliver nicotine, an addictive drug.

- Tobacco contains multiple harmful constituents. Food and drug regulations need to include lethal tobacco products. Many developed countries have various legal and policy structures for drug control, which offer instruments for tobacco control.
- The manipulation of nicotine offers a strong justification for regulation. Tobacco companies manipulate and control nicotine levels in finished tobacco products. Evidence supporting this can be found in the millions of pages of previously secret industry documents, which prove that the tobacco industry knew that their products were addictive and had been working to conceal and control nicotine levels to enhance addiction.
- The regulation of components of tobacco products should be given a high priority in the FCTC.

Physicians and the public should support legal action against the tobacco industry to recover billions of dollars in excess medical costs from tobacco-related diseases... all avenues of individual and collective redress should be pursued through the judicial system

- Multinational tobacco companies are under increasing attack in developed countries from litigation and regulation.
- Document disclosures have led to calls from the public health community for litigation against the tobacco industry. In March 1999, an International Policy Conference on Children and Tobacco made up of 60 health ministers, legislators and senior policy makers from 30 countries and six international organizations adopted a policy recommendation to "hold tobacco companies accountable for past wrongdoing through litigation or other action."
- Tobacco litigation began in the United States in 1954. For more than 40 years, the industry never lost a single case. The decades of United States litigation provide a number of lessons which should be considered by the developing world in their own litigation efforts.
- In-depth inquiries into the facts and laws within a particular jurisdiction are necessary before undertaking litigation. It is important to know the rules of residency existing in each jurisdiction and to consider how a judgement against a non-resident defendant can be enforced.
- Legal options for litigation against the tobacco industry vary. In the USA, litigation has been based on civil liability, but criminal liability is also possible.

6. CONCLUSIONS/WORKING GROUP RECOMMENDATIONS

6.1 Establishment of National Institutions

The objective of the working group was to review the legal, policy and practical options available to facilitate the establishment of national tobacco control institutions in developing countries. The major outputs of the group were as follows:

(1) Several governments have sector specific responsibilities for tobacco. While some sectors have tried to reduce demand for tobacco to promote public health, others have supported tobacco production, manufacturing and exports.

(2) Although armed with strong evidence about the severe health consequences of tobacco use and exposure, health departments find themselves in a weak position to promote tobacco control.

(3) In the short-term, tobacco control should concentrate on demand reduction. In the long term, the social, economic and agricultural implications of tobacco control need to be addressed.

(4) By building a global argument to stop, delay or subvert tobacco control policies, the tobacco industry has been able to stop the development and implementation of coherent intersectoral cooperation. Court cases in the USA have shown that these plans have existed for decades.

(5) There is an urgent need to establish national institutions to further the FCTC process and implementation. The establishment of these institutions should correspond with the gradual dismantling of other public and private institutional structures that directly or indirectly promote the tobacco industry in the developing world, for example, tobacco institutes in India and Malawi.

(6) National institutions should be composed of the governmental sectors, such as finance, agriculture, labour/employment, commerce/industry, foreign affairs, trade, information/ communications, sports, arts or culture, women's affairs and youth, justice, environment and science.

(7) The establishment of national institutions could be based on either a policy instrument such as a white paper (non-statutory institutions) or using statutes (legislation).

Specific recommendations for countries to establish national institutions were:

(1) National institutions must be interdisciplinary. The ministries of health should initiate consultation with other ministries, nongovernmental organizations, professional bodies and other institutions interested in tobacco control.

(2) If no law exists to establish such an institution, the ministry of health, either independently or in concert with other ministries and nongovernmental organizations, should initiate the production of a policy paper or law to establish these institutions.

(3) If establishing a separate, new institution is not possible, countries could expand the mandate of existing institutions that address health and health research issues.

(4) Funding for institutions should be provided within existing health budgets and possibly from a proportion of tobacco excise tax revenues.

(5) As these institutions are being established, it is important to conduct awareness campaigns on the tobacco problem and the FCTC.

(6) WHO should facilitate the sharing and exchange of information between countries with strong national institutions and with those which are establishing them.

(7) Countries should see nongovernmental organizations and other professional bodies as partners and promote their participation. They are crucial organs for raising awareness and building the public support necessary for the establishment of national institutions for tobacco control.

6.2 Economic Implications of Tobacco Production and Marketing

The objective of the working group was to produce specific guidelines for developing countries to facilitate action on the economic aspects of tobacco control. The main outputs of the group were as follows:

(1) While accepting the findings of the World Bank study that for the overwhelming majority of countries, the economic costs of tobacco production and consumption far exceed the revenue gains. The specific needs of individual countries need to be taken into account in the implementation of its recommendations.

(2) Tobacco production and consumption are economically unviable and extremely harmful to health. Even at the individual consumer level, tobacco has a high opportunity cost, whereby the benefits are overridden by the cost. Tobacco should be declared demerit product.

(3) Meetings with government cabinets should be held to inform them about the World Bank study. In addition to the ministries of finance and health, the ministries of sports, culture and tourism should work to find alternative sources of sponsorship. Findings from the study will need to be presented in the appropriate format and languages for these policy-makers.

(4) Excise tax earnings from tobacco products should be earmarked for health promotion activities, including the funding of sporting activities, to offset the loss of sponsorship for sporting events from tobacco companies.

(5) Meetings with hospitality and advertising industries should be held to assure them that the introduction of smoke-free areas would not significantly affect their business. At the same time, nongovernmental organizations and consumer groups should be encouraged to demand smoke-free environments.

(6) The "polluter pays" principle should be applied to the tobacco industry. The company that owns or markets the most popular brand of tobacco products used by youth should face punitive fines for selling tobacco products to youth.

(7) WHO should lobby the Fédération Internationale du Football Associations (FIFA) and other international sports organizations to avoid sponsorship from tobacco companies.

(8) National capacity should be built in health economics and legislation. This will facilitate research in support of policy and advocacy decisions. Areas for research include: the dynamics of demand for tobacco products among different groups; the economic impact of diversifying tobacco production, and the development of a database on the economic costs of tobacco.

(9) Studies should be carried out on smokeless tobacco products in the Indian sub-continent which should be coordinated by the South East Asian Regional Office of WHO.

6.3 Addressing Industry Tactics

The objective of the working group was to offer specific practical actions which tobacco control advocates and governments could undertake in order to identify and counter the effectiveness of industry tactics. Following are their recommendations:

(1) Tobacco control opponents at the national level should be identified; capacity for collecting information to be used in countering the tobacco lobby should be built; and national tobacco control institutions should be established.

(2) Tobacco industry funding of individuals and parties should be publicized.

(3) Disclosure should be sought on the amount of money spent by the tobacco industry on lobbying and government officials should be made aware of the existence of a tobacco lobby. Tobacco control activists should be educated on the decision-making process and the influence of lobbying.

(4) Tobacco funding of political groups should be exposed and their real intentions identified.

(5) Public relations and advertising agencies working for tobacco industry should be identified.

(6) Relations with journalists working on tobacco issues and media advocacy skills among activists should be built.

(7) Alliances with celebrities, persons and interests should be created and celebrities and stars sought to sponsor tobacco-free campaigns.

(8) Professional groups for passive smokers 'rights should be created.

(9) Be prepared for intimidation.

(10) Bribery by the tobacco industry should be exposed.

(11) The attention of the media should be drawn to the alleged involvement of the tobacco industry in smuggling.

6.4 Prospects for Globalizing Tobacco Litigation

The working group was mandated to formulate a set of guidelines for application in transnational litigation against the tobacco industry. However, due to time constraints and the differences in the legal systems of the participants, the group instead focused its attention on recommendations for the FCTC to facilitate international litigation. The major outputs of the group were as follows:

(1) A suit may be filed against a tobacco company in the country of harm or it may be filed in the country where a tobacco company has 'the most intimate connection." The FCTC should include a provision allowing multinational companies to be sued in their respective home countries.

(2) There are various types of actions that may be pursued. A suit could be a tort action, essentially seeking compensation from the tobacco companies on behalf of victims and the government. It could also be classified as a human rights violation case. This has been especially successful in the *Kerala cigarette case* in India and the *Union Carbide case* in Bhopal.

(3) The FCTC should include a provision allowing the use of the substantive laws of the home country of the transnational tobacco companies' home country if they are stricter than those in the country of harm. This is to prevent double standards where multinational companies exercise a higher degree of care in their home countries than when they operate abroad.

(4) The FCTC should obligate states parties to apply the same regulations to exported tobacco and tobacco products as for home consumption.

(5) The doctrine of enterprise liability should be adopted in the FCTC to make transnational tobacco companies liable for harm committed by their subsidiaries.

(6) The FCTC should obligate states parties to introduce changes in their procedural laws to address problems relating to, among others, *locus standi* and statute of limitations.

(7) The FCTC needs to facilitate the sharing of information among tobacco control campaigners in various countries. A website should be created with a database containing, among others, information on ongoing tobacco control litigation, violations of advertising laws, and various theories on the liability of the tobacco industry. Research results should be shared with tobacco control campaigners in developing countries, given their limited resources.

(8) A pool of international experts should be made available to serve as witnesses in tobacco litigation.

(9) The FCTC should include reporting mechanisms. Experience, particularly with the United Nations Convention on the Right of the Child, has shown how effective the reporting requirement can be in pressuring governments to take a more active role in the implementation of a treaty, especially if the reporting mechanism allows the submission of parallel reports by nongovernmnetal organizations.

(10) The FCTC should obligate governments to promulgate and enforce anti-tobacco laws in their respective jurisdictions.

(11) Participation of civil society is important in the areas of advocacy, monitoring and evaluating tobacco control activities.

7. CONCLUSIONS OF THE CONFERENCE

The tobacco industry has for too long eluded acceptable behaviour based on law, policy or ethics. The globalization of tobacco trade makes it imperative that matching global legal instruments effectively set standards for tobacco control. The WHO conference on tobacco control law was able to mobilize the support of developing countries towards global tobacco control.

The meeting identified some of the main challenges developing countries face throughout the global tobacco control process, including lack of resources; weak political support; lack of knowledge on issues such as prevalence, epidemiology, legislation and tobacco control policy, and the failure to prioritize the health sector. Tough issues were critically discussed in a developing country context and solutions were explored. These included:

addressing the demand and supply sides of tobacco control; countering industry pressure and increasing political support for tobacco control; addressing the trade aspect of tobacco control and the privatization of state monopolies.

The conference affirmed the need for developing countries to increase their knowledge and develop better strategic plans for countering tobacco. Knowledge must be increased concerning the use of subsidies, industry plans and methods, and product design. Countries must also build better alliances between lawyers and public health people, consumers, nongovernmental organizations and farmers. Developing countries cannot fight tobacco alone. There is need for effective action at the national, regional and global levels to enhance tobacco control. The Framework Convention on Tobacco Control offers the best forum for global solidarity in tobacco control.

The conference resolved to integrate global tobacco control in development programme. The WHO Framework Convention on Tobacco Control can be a tool of sustainable development. Strong support was given towards the development of alternative livelihoods for developing countries. In their recommendations, the conference participants laid a framework for the establishment of national multisectoral institutions or bodies for tobacco control. Developing and least developed countries were urged to established either adhoc bodies or those based on policy or law to further the development of the Convention and to help other tobacco control efforts within the countries.

The New Delhi Declaration affirmed the support of developing countries towards comprehensive tobacco control. The Declaration stressed that tobacco is a global epidemic that calls for comprehensive multilateral and national action. It called on Governments to develop laws and policies for multisectoral tobacco control. The New Delhi Declaration urged governmental support for the development of tobacco control policies and serves as a major impetus to develop and negotiate the WHO Framework Convention on Tobacco Control.

Annex 1

TEXT OF INAUGURAL ADDRESS
BY
SHRI ATAL BEHARI VAJPAYEE,
PRIME MINISTER OF INDIA

My colleagues Shri Ram Jethmalani and Shri N.T:Shanmugham,
Dr Gro Harlem Brundtland and Dr Uton Muchtar Rafei,
Ladies and Gentlemen:

It gives me great pleasure to inaugurate the International Conference on Global Tobacco Control Law. This can assume significance on two counts. First, by aiming to focus international attention on a core issue of public health in countries across the world. Second, by seeking to formulate a comprehensive strategy for tobacco control from the developing world's perspective.

I need hardly emphasize that without the effective involvement of developing countries, there cannot be any meaningful outcome of efforts like this conference, to regulate and control global tobacco consumption.

Tobacco-related health hazards have now been scientifically established. Studies show that tobacco is the main cause of, or a major contributor to, more than 25 diseases, including cancer and heart attack. According to the World Health Organization, the annual death toll attributable to tobacco will rise from its current estimate of 4 million per year to 10 million by 2025. We are concerned by the projection that 70% of these deaths will occur in developing countries. India has specifically taken note of the WHO projection that this country will experience the highest rate of increase in tobacco-related deaths over the next decades.

The consequences of the harm caused by tobacco, however, go beyond these grim statistics. Many of tobacco's victims could die or suffer disability in mid-life, devastating their families and depriving society of their productive contribution. At another level, public health spending would have to be diverted to technology intensive and financially expensive healthcare that tobacco-related diseases demand. This bodes ill for developing economies. For, the cumulative social and economic costs will impede growth and development. Governments, especially those from developing countries, thus need to look beyond quick revenue generation from the sale of tobacco-related products.

Countries like India have to deal with the use of tobacco on a much wider scale. National surveys indicate that more than 100 million people are addicted to chewing tobacco in our country, of which 36 million are women and 17 million are aged below 25 years. We need to consider how to prevent access of tobacco products to young people. The trends of tobacco use in developed countries are different from those in developing countries. Developed nations have been witnessing a steady decline in tobacco consumption. Consequently, their production surplus has been aggressively seeking external markets. Developing countries, on the other hand, are experiencing rising tobacco consumption and shrinking export markets.

Here, I wish to point out that liberalization of international trade has led to this difference in consumption patterns. International trade agreements in recent years have liberalized trade in many goods. Cigarettes are no exception. According to a study reported by the World Bank, the consumption of cigarettes per person in four Asian economies that opened their markets in response to U.S. trade pressure during the 1980s, was almost 10 per cent higher in 1991 than it would have been if these markets had remained closed. The conclusion is clear: easy access to external markets for cigarettes manufacturers in developed countries has contributed significantly to increases in cigarette consumption in low and middle income countries. These patterns are fraught with grave consequences for the health of current and future generations in developing countries. The imperatives of public health action for tobacco control, therefore, cannot be denied or delayed.

On my part, I would like to reaffirm my Government's commitment to protect our people from the ill effects of tobacco. However, it would be

unrealistic to view tobacco purely as a health problem and ignore the economic fall-outs of tobacco control. It is necessary for the developed countries to address and allay the apprehensions of developing countries about the adverse effects that tobacco control may have on their economies.

For instance, India is the third largest producer of tobacco in the world. About one million Indians are engaged in tobacco cultivation. More than 80 per cent of the tobacco smoked in India is in the form of bidis that are manufactured by cottage units which provide employment to 4.5 million people. Similarly, the majority of the units manufacturing pan masala and gutka are in the small scale sector. The annual turnover of pan masala is around Rs. 10 billion and this sector too employs a large workforce.

Therefore, we have to bear in mind the employment and livelihood of the large numbers engaged in tobacco cultivation and production. Any curbs on tobacco consumption have to be necessarily accompanied by measures to protect their household income. Developing countries, thus, need the assistance of international agencies and developed countries for agricultural and industrial diversification projects to protect those who depend on cultivating and processing tobacco for their livelihood. If we do not conceive of tobacco control as a comprehensive package, our attempts at intervention may become self-defeating.

Madame Director-General, no one is better placed than you to understand these national and global complexities. We are confident that your experience and vision will help in formulating an effective strategy that does not hinge on law alone for tobacco control. True, legislative measures have a special place in such a strategy. But legislation cannot be effective in isolation. For a tobacco control law to be successfully implemented, it must be accompanied by alternative modes of income for those dependent on tobacco and the community at large has to be fully informed and involved.

Media, with its vast outreach and power to influence public opinion, can become a valuable partner in informing people about the impact of tobacco on health and mobilizing community support for curbs on consumption. Schools can play a contributory role by encouraging children, especially teenagers, to say NO to tobacco. Our recent success in involving students to raise public awareness about the need to check environmental pollution shows that children are effective change agents in their families and communities.

Ladies and Gentlemen,

At the dawn of the 21st century, we are only too aware that we will witness an increasingly integrated world in the years to come. In an open world economy, tobacco trade has become transnational. Satellite television overrides domestic bans on advertising tobacco products. The only way this can be controlled is through international legislation governing the use of all media, whether electronic or print, to promote the use of tobacco products. The World Health Organisation's efforts to initiate and advance a Framework Convention on Tobacco Control are welcome in this regard.

I would like to congratulate you, Madame Director General, for embarking on this global mission. But, if tobacco control has to succeed as a global mission, our commitment must be complete, action must be universal, strategies must be comprehensive and integrated, and implementation must be phased and progressive.

Tobacco control must be seen to confer on the people the riches of good health, while advancing the health of the economy. This perspective of the developing countries should be reflected in the global agenda for tobacco control. If this conference succeeds in building a consensus that can unite developed and developing nations on adopting a common approach towards tobacco control, it will mark a major milestone. I wish you all success in your deliberations. And thank you for this opportunity to share my thoughts with you.

Annex 2

TEXT OF ADDRESS
BY
DR GRO HARLEM BRUNDTLAND, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Mr Prime Minister,
Distinguished guests,

It gives me great pleasure to be in India today - this is a country and a people close to my heart. I am especially pleased to be speaking to an audience of some of the world's best legal and public health experts.

We come from a wide range of backgrounds, such as public health, medicine, law, media, economics and social sciences. What has brought us here to Delhi is our common resolve to highlight the grave problems arising from tobacco in the developing world. This meeting will explore possible means to address these problems, taking into account developing country perspectives. It will be one of many important contributions over the next months and years towards a strong international legal tool to fight tobacco, the Framework Convention on Tobacco Control.

Ladies and gentlemen,

India, with its myriad of cultures and its complex economic and social realities, in many ways mirrors our new globalized world. But despite its diversity, its disparities and its conflicts, a strong sense of unity - has kept this immense nation - which harbors nearly one sixth of humanity - together in a viable and vivid democracy.

The rest of the world is only slowly waking up to this realization that all of us, no matter the physical, cultural or economic distance, are dependent upon each other. One region's poverty is another region's lost opportunity.

One area's industry may be another area's environmental disaster, and one country's disease outbreak today, may be another country's epidemic tomorrow.

In 1987, the World Commission on Environment and Development, which I had the privilege to chair, came up with the concept of 'sustainable development'' on the basic premise that development needs of nations must be met in a way that allows future generations to fulfill their own aspirations.

Enshrined in this concept was the whole notion of solidarity, the right to knowledge and access to basic life-sustaining information for all nations and people. That idea is now institutionalized globally in a series of environmental treaties. It has entered the vocabulary of policy-makers.

We will add health to that illustrious list.

The importance of the role of health in overall development is being rapidly embraced by governments around the world. It is a conceptual shift not unlike that which took place with the environment 25 years ago. Increasingly, governments realize they need to integrate health into the broader context of development. They are also beginning to look at investments in health as more than simply a mere consumption expenditure. Instead, health is increasingly being seen as a major opportunity for growth, productivity, human progress and poverty alleviation.

My point of departure is a broad reading of the role of health in development. WHO is indeed the specialized agency on health - but the purpose of our work is not only to combat ill-health - although that remains key - it is also to promote healthy populations and communities - and indeed to demonstrate how wise health interventions can spur development.

There was a period in development thinking - not so long ago - when access to public services, such as health and education, would have to wait until countries had developed a certain level of physical infrastructure and achieved a certain level of economic strength. Once countries had become fully industrialized - large outlays on health care seemed appropriate and necessary. Indeed, it was seen as a sign of national prosperity and success.

Experience and research over the past few years have shown that such thinking was at best simplified, and at worst plain wrong.

We have seen that developing countries which invest relatively more on health in an effective manner are likely to achieve higher economic growth. In East Asia, for example, life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history. A recent analysis for the Asian Development Bank concluded that fully a third of the Asian "economic miracle" resulted from these gains.

We have also observed how health spending in some of the world's richest countries can reach very high levels and still not provide necessary and quality health services to all their citizens.

Health is not only an important concern for individuals, it plays a central role for the society in achieving sustainable economic growth and an effective use of resources. And health is even emerging as an important element of national security.

With globalization, all of humankind today paddles in a single sea. There are no health sanctuaries.

Diseases cannot be kept out of even the richest of countries by rearguard defensive action. The separation between domestic and international health problems is losing its usefulness as people and goods travel across continents. Two million people cross international borders every single day, about a tenth of humanity each year. And of these, more than a million people travel from developing to industrialized countries each week.

This is not only an issue of infectious diseases. With an explosion of international trade, travel and media, new cultural influences spread faster than ever before, driven by economic aspirations, entertainment and advertising. Many of the effects are positive, but we also see drastically negative effects, such as unhealthy changes in diet - and the rapid spread and increase of tobacco use.

Disease and death do not stop at national borders, but still our efforts to fight them are far from being sufficiently international. The time has come for

both health and foreign policy to reflect the needs of the world's public with greater emphasis on international health security and its contribution to world peace. Foreign policies and international business practices must acknowledge transnational threats of disease, the dangers of trade in products and technologies that are harmful to health, economic and health disparities between and within countries and population growth. Countries must collaborate to develop strategies that ensure sustainable human security.

As the world's leading health agency seeking value for our constituents we have chosen our setting - we will play an active role in this work; as a facilitator, as a provider of evidence and best practices - and as a moral compass.

Ladies and gentleman,

One of the most important political legacies of this century has been the universal ideal of human rights that are now irreversible as tenets of international law. The past 30 years have seen the birth of hundreds of organizations around the world that have given a voice and a focus to issues that affect our lives on a daily basis. Our search for justice is as old as we are. Our search for life in harmony with laws - whether they be natural laws or those that have developed over centuries - is as old as humanity himself. Access to basic health is, in the final analysis, a search for justice.

It is my firm belief that where there is no vision, there is no progress. The success of our vision lies in the hands of our Member States.

As nations feel increasingly compelled to co-operate with each other to solve their problems, the development of binding global public health norms and commitments will become crucial. Although international health law is still in a nascent and dynamic stage of development, it must address both the positive and negative health impact of globalization. Consequently, health development in the 21st century is likely to make wider use of international legal instruments to take advantage of the opportunities afforded by global change and to minimize the risks and threats associated with globalization.

Today, our focus is tobacco. But the work we do on tobacco has wider consequences. As the composition of the global burden of disease changes, so

must the emphasis of our work. In addition to continuing with the past century's very successful effort to limit or eliminate infectious diseases, the work we are doing on a Framework Convention on Tobacco Control stakes out the way disease must increasingly be fought and prevented in this brand-new century. This is the first time WHO is exercizing its constitutional right to negotiate a set of globally binding rules. The Framework Convention is a product and a process and a public health movement.

Turning principle into practice is not an easy task, but we will lead the way and as I said, I am counting on your help. Our task is not to produce worldwide regulations. It is to build a international legal framework which will assist and support countries in their national regulation process.

The success of our approach will depend on political commitment, capacity building in public health law and economics, public support and effective enforcement. Legislation and regulation have to strike a balance between individual freedom and public needs and interests.

For the next few days, you will hear about the science, economics and politics of tobacco control. We know that tobacco use is a risk factor for some 25 diseases. It was here in India in 1964 that the first link between oropharyngal cancer and chewing tobacco was identified. Studies from eastern India were the first in the world to link palate cancer to the chewing of tobacco.

As the recent report of the World Bank has clearly documented, the risks to health and health systems from tobacco are widely underestimated. So are tobacco industry tactics. When I first looked into the issue of tobacco use worldwide I was unprepared for what I was to learn about the extent and manner in which the tobacco industry was marketing a product that killed half of its consumers. I was appalled to see how the tobacco industry had subverted science, economics and political processes to market a lethal and inherently defective product that imposed a massive burden of disease and death on countries.

I am outraged by what I learn with each passing day about the tobacco industry from previously secret documents that have now come to light mainly due to court cases in the United States, in particular Minnesota. I want

to use this platform to call on national and international public health experts to work with their Constitutions as well as their countries' international commitments to help prevent and combat this man-made epidemic. Let us craft the world's first truly viable public health Convention.

Tobacco is freely allowed to kill one person every eight seconds. That is four million preventable deaths per year. Today in India, tobacco kills 600,000 people every year. In China, if present smoking patterns continue, about a third of the 300 million Chinese males now aged 0-29 will eventually be killed by tobacco. Countries like Canada and Sweden that had long bucked the tobacco epidemic now see it reappearing again. No country and no people are safe from the tobacco menace.

I have occasionally heard comments to the effect that smoking is mainly an industrialized country problem and that WHO should focus its energies on fighting the traditional diseases of poverty, such as malaria, tuberculosis and childhood diseases. Such comments are understandable but misinformed.

If unchecked and unregulated, by 2030, tobacco will kill 10 million people each year. Seventy percent of those deaths will occur in the developing world, with India and China in the lead. If nations do not act individually and together, in the next 30 years, tobacco will kill more people than the combined death toll from malaria, tuberculosis and maternal and child diseases. Every tobacco related death is preventable. That is our message. That is our challenge.

Fifty years ago the world found a solution for polio. Today we are on the verge of eradicating it. Fifty years ago scientists and researchers linked tobacco to cancer and other diseases. I wish I could tell you that the world has risen to the tobacco challenge as vigorously and unequivocally as it fought polio. The unacceptable reality about tobacco is that the health community has lost out to the tobacco industry aggressively seeking new markets and newer victims. The world will have little cause to rejoice over the health gains of the eradication of polio if we continue to remain unprepared for, and indifferent to, new challenges such as the one posed by tobacco.

One of the first things that I did at the WHO was to ask our Member Countries to give us a mandate to negotiate the Framework Convention. This

new legal instrument is expected to address issues as diverse as tobacco advertising and promotion, agricultural diversification, product regulation, smuggling, excise tax levels, treatment of tobacco dependence and smoke-free areas.

The Framework Convention process will activate all those areas of governance that have a direct impact on public health. Science and economics will mesh with legislation and litigation. Health ministers will work with their counterparts in finance, trade, labour, agriculture and social affairs ministries to give public health the place it deserves. The challenge for us comes in seeking global and national solutions in tandem for a problem that cuts across national boundaries, cultures, societies and socioeconomic strata.

An early ally has been UNICEF and the Convention on the Rights of the Child. While the Convention on the Rights of the Child does not explicitly include tobacco, several of its articles address overarching values essential to safe and healthy development of children and as of this year, the States' reporting guidelines have now been amended to include tobacco.

For tobacco, this means that the interests of the child take precedence over interests of the tobacco industry. Later as I share with you some tobacco industry tactics to promote tobacco to children, you will see why this is important.

Within the United Nations Family, The World Bank is an essential partner in global tobacco control. Their 1999 report effectively shows that over the long-term economies will benefit from tobacco control. They highlight a basic economic fact. If people stop spending on tobacco, they will spend on other goods and services that will generate more jobs and revenue than those from tobacco.

We also have a close working relationship with FAO. Together, we are reaching out to tobacco farmers to ensure that when successful tobacco control reduces demand for tobacco, the economic consequences will be minimized.

Our decision to use legally binding mechanisms to circumscribe the global spread of tobacco on the one hand, and to regulate the product itself

on the other, is based on sound science and irrefutable documentary evidence. The science that underpins our work is unequivocal - a cigarette is the only freely available consumer product which, when consumed as intended by manufacturers, kills. Let us never forget that.

Nicotine is addictive. A cigarette is not just tobacco leaves rolled in a strip of paper. It is a highly engineered product. The tobacco industry has studied our saliva and central nervous systems to determine the right dose of nicotine to deliver so that addiction occurs and is sustained. Other tobacco products, whether they be beedis, snuff, gutka or spit tobacco, are no less addictive - nor lethal.

Imposing international norms on a global industry that seemingly without qualms can make huge profits from a product that kills is not an easy task. It is our firm belief that to develop a truly meaningful global treaty to control tobacco, our Member States must have a clear understanding of the tobacco industry and its tactics.

Fifty years is a blink of time in a millennium, but fifty years is a long time to sustain a deliberate deception that causes death and disease. For almost fifty years, the tobacco industry has known that tobacco products cause deadly diseases. I am speaking to an audience of lawyers and public health experts - I chose my words carefully. The tobacco industry which acts as a global force is in the business of selling deception. Deception in science, public health and economics. Internal tobacco industry documents that have now become public bear eloquent testimony to this.

Tobacco litigation began in the United States in 1954. But the major breakthrough came in the 1990s - in the States of Mississippi and Minnesota - with the revelations of millions of pages of documents forced from the files of the tobacco industry and with the framing of different types of legal theories that focused on the conduct of the tobacco industry.

For us, these documents show how and why the tobacco industry has been so successful in defeating public health objectives in the past and provide valuable lessons into how the public health community must come to terms with the tobacco industry to make progress in future. We believe the tobacco industry has fractured the tobacco issue by playing different tunes in

different countries. In one it is labour, in another it is farmers, in a third it is marketing rights. We believe that through our Constitution and that of our Member States, we can restore the global and national picture so that the truth can emerge to benefit public health for all.

Consider this internal tobacco industry discussion. A document written by a tobacco industry lawyer in 1980 sets out some of the reasons for the tobacco industry's refusal to publicly admit that smoking causes disease. The document was written at a time when the British and American Tobacco Group companies were considering changing their public stance on the issue of causation of disease. The lawyer opposed such a change, and wrote:

"If we admit that smoking is harmful to 'heavy' smokers, do we not admit that BAT has killed a lot of people each year for a very long time? Moreover, if the evidence we have today is not significantly different from the evidence we had five years ago, might it not be argued that we have been wilfully killing our customers for this long period? Aside from the catastrophic civil damage and governmental regulation which would flow from such an admission, I foresee serious criminal liability problems".

Tobacco companies also denied for decades that smoking was addictive. In private, they recorded in the fifties that smoking was addictive. In 1961, a top industry scientist wrote, "... smokers are nicotine addicts" In 1963, an industry lawyer wrote, "[N]icotine is addictive. We are, then in the business of selling nicotine, an addictive drug ..." In 1979, a tobacco executive considered the hypothesis that "high profits ... associated with the tobacco industry are directly related to the fact that the consumer is dependent upon the product"

The internal documents also demonstrate that the tobacco industry intentionally designed cigarettes to exploit their addictive potential. While nicotine is a naturally occurring component of the tobacco plant, the modern cigarette is a highly engineered and sophisticated product in both manufacture and design. Decades ago, the tobacco industry began to control and manipulate the level and form of nicotine in cigarettes in a variety of ways.

Publicly, the tobacco industry maintains that it does not want youth to smoke. Privately the tobacco industry has long recognised that the preservation of its market depends upon recruiting youth. As one document stated, "Younger adult smokers are the only source of replacement smokers ... If younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle." The tobacco industry documents are replete with discussions of marketing to youth and the need to increase market shares by enlisting youth.

The documents are an underused public health tool. But that is about to change.

There is some type of tobacco litigation underway in at least 15 countries ranging from personal injury class action litigation in Australia to health cost recovery in Canada to public interest petitions in India.

Last October I called for a preliminary inquiry into whether the tobacco industry has exercised undue influence over UN-wide tobacco control efforts including interfering with WHO's work. Later this year I have called for a meeting of international regulators to set in motion the process of regulating tobacco. The jigsaw is falling into place.

One of the primary objectives of the tobacco industry is to frame tobacco use as an individual and behavioral decision. Adults can chose for themselves if they have full access to information. The same does not apply to children and adolescents. On a given day, between 82,000 and 99,000 young people - sometime as young as 8 - start smoking or chewing tobacco. Over eighty percent of smokers started before they were 18. By the time they find out, it is too late. The addiction has taken control.

The good news is that we can buck and reverse the global tobacco trend. We know what works and how. Taxes work and the young are especially susceptible to increased prices. Advertising and sponsorship bans work. Smoke free policies work.

Such policy interventions could, in sum, bring unprecedented health and economic benefits. WHO's message is that there is a political solution to tobacco and it is routed through policy interventions and political vision.

The Framework Convention on Tobacco Control is a pathfinder in public health. It will assist in placing health at the top of national and international agenda and will create a debate on the wider issues and solutions to health problems.

We owe this to ourselves. We owe this more to future generations. Let us never forget that public health is a search for equity, solidarity and justice.

Thank you.

Annex 3

TEXT OF ADDRESS
BY
DR UTON MUCHTAR RAFEI, REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA REGION

Your Excellency, the Honourable Prime Minister of India
Honourable Minister of Health and Family Welfare
Honourable Minister of Law, Justice and Company Affairs
Secretary of Health and Family Welfare of India
Director-General of Health Services
Director-General, World Health Organization,
Distinguished experts, dear colleagues, ladies and gentlemen,

In the century that just passed, humanity has, without doubt, witnessed tremendous achievements. Unprecedented scientific advances have greatly enriched human life. The discovery of antibiotics has made a significant difference in the treatment of diseases and in enhancing longevity of life. New frontiers have been explored. Formidable health and economic problems have been surmounted. Global barriers have been broken and nations have come much closer to one another and have become interdependent.

Yet, in the midst of all these achievements, there are a few dark spots. For example, mankind is yet to take concrete steps to negate the severe health and socioeconomic impact of tobacco. As we welcome the dawn of the new millennium, the world faces a formidable public health challenge posed by tobacco. Already, 800 million of the estimated 1.2 billion smokers in the world live in developing countries. In 25 years, 75% of the world's smokers will live in these countries. They will account for seven million of the global 10 million tobacco-related deaths by the third decade of this century. Today, 80% of the global tobacco production comes from developing countries. Four countries, including India, account for two-thirds of the

world's production. Developing countries, in fact, are virtually sitting on a time bomb ! The question is : can we afford such a man-made calamity in the 21st century ? The answer is an obvious NO.

Excellencies, the South East Asia Region contains a fourth of the world's population, and carries an even larger percentage of its disease burden and the poor. Yet, the Region has the unenviable distinction of having the second highest annual per capita growth in tobacco consumption among the six WHO Regions. The large populations and rapid economic growth in some countries are an irresistible magnet for the tobacco industry. Multinational companies and national tobacco monopolies are expanding their business in India, Indonesia and Thailand. As a result of the powerful advertising and marketing strategies of these companies, over one million children in India and Thailand alone take to smoking every year. The Region also reports not only one of the highest smoking rates among women but also oral cancers caused by tobacco. Cardiovascular diseases, chronic obstructive lung diseases and lung cancers are already major killers. Every year, tobacco kills an estimated 600,000 people in the Region.

We must adopt legal instruments to control tobacco or our children will accuse us of having wasted the opportunity. This is one epidemic of several illnesses which we can control and we must take action now. For many decades, the tobacco industry has used the argument that tobacco control will lead to unemployment and revenue loss for governments. But this is not true. World Bank reports clearly state that most countries will not face any significant economic repercussions or job losses if tobacco consumption is reduced or eliminated. For example, in Bangladesh, which is a net tobacco importer, elimination of tobacco consumption will increase employment by over 18%. Also, a rise in tobacco taxes, in fact, increases, rather than diminishes government revenue.

In the South-East Asia Region, tobacco disproportionately affects the poor and the most vulnerable. Over 80% of the workforce in the tobacco industry comprises women, the poor and children. It is they who till the land, pluck the tobacco leaves, cure thousands of metric tonnes of leaves in smoke-filled curing units, and spend hours in bidi rolling and gutka packaging cottage industries.

It is they who suffer from numerous occupational hazards. Their vulnerability is accentuated by the very low wages they earn from tobacco. Working in tobacco production, keeps the poor in poverty.

In many countries of the Region, about 25-30% of a poor man's income is spent on tobacco. The expenditure on diagnosis and treatment, travel for treatment, and loss of income due to absenteeism goes far beyond the means of most families.

Poverty alleviation programs are being eroded as beneficiaries spend larger proportions of their income on tobacco products than on food, shelter, education and health. In fact, the government spends more on tobacco than it receives as revenue. In the final analysis, it is the tobacco industry which grows richer, leaving the poor poorer. Today, the link between tuberculosis and tobacco needs no elaboration. Already, this region accounts for about 40% of the world's reported tuberculosis cases.

The danger facing a majority of communities exposed to the tubercolosis bacilli and now to smoking or chewing tobacco is too serious to be ignored. Excellencies, the time has come for us to respond to the urgent call to disinvest in tobacco in order to enhance the future welfare of our nations. Today is the hour, tomorrow will be too late.

The litigation against the tobacco industry in the USA holds valuable lessons for all of us. The industry cannot be allowed to continue to sell hazardous and addictive products. Nor should it be permitted to continue to lure millions of innocent children into tobacco use under the garb of trade liberalization and the right to freedom of speech. The tobacco industry knows the health hazards of tobacco and skillfully markets death. With the power of this information, we must ensure our children understand the dangers they face. We also need international laws and regulations to curb this deception, particularly in developing countries. Laws are required to protect the most vulnerable and ensure that what is not allowed in developed countries is not allowed in developing countries either.

This Conference presents a unique and timely opportunity for developing countries to shape the elements of a Global Tobacco Control Law. A law that will not only protect their economic interests but also save the lives

of millions who are, and will be, enslaved by tobacco. The challenge is obviously daunting, but it is definitely not insurmountable. With focused commitment and the determination of all governments, the world can become tobacco-free. Let us enter the new millennium with the determination and vision to liberate society from the bondage of tobacco. We owe this to posterity. Together, we can make a difference. Together, we can make it happen.

Thank you.

Annex 4

TEXT OF SPEECH
BY
SHRI N T SHANMUGAM,
UNION MINISTER OF STATE FOR HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA

Honourable Prime Minister of India,
Union Minister of Law,
Director General, WHO,
Secretary (Health), Director General of Health Services
and Regional Director, SEARO.

This is an assembly which represents expertise from all regions of the world and brings together health professionals from diverse disciplines; legal luminaries, economists, educators, health and environmental activists, friends from media as well as national and international policy-makers and administrators. The depth and diversity of this expertise reflects the multi-talented coalition that is needed to meet the multi-dimensional challenges of tobacco control. Tobacco has indeed become one of the major public health challenges of our time, with its shadow threatening to darken the present century even more than the one immediately past. Not only has it become a truly global epidemic, but increasingly draws its victims from developing countries. In another quarter century, we are likely to see tobacco claim 7 million lives annually in developing countries. These estimates are based on current patterns of tobacco consumption. If the tobacco habit becomes more widespread, due to aggressive and often unethical marketing of tobacco products, the death toll will be even higher in the developing countries.

The Indian scene is even more alarming. Estimates by the Indian Council of Medical Research indicate that about 6 lakh[1] Indians die each year due to their tobacco habit. This amounts to 2200 persons dying every day or one death in every 40 seconds. The World Health Organization predicts that between 1990 and 2020, the proportion of tobacco-attributable deaths will rise four fold in India, the sharpest rate of rise anywhere in the world. Recent estimates indicate that nearly 1950 lakh men and 450 lakh women, above the age of 15 years, use tobacco regularly in our country. Tobacco is now consumed more frequently in the rural areas and the habit is more common among the poor and the uneducated.

The diversity of tobacco-related diseases is also very large ranging from heart attacks, cancers and lung diseases to stillbirth and impotence. It has been estimated by the Indian Council of Medical Research that presently, there are 4 lakh cancer cases, 13 lakh persons with heart diseases and 70 lakh individuals with lung diseases – all directly attributable to the tobacco habit. In addition, there are likely to be many victims of passive smoking for which the numbers have not been estimated, but also contribute to the burden of disease and the demands on healthcare services. It must be clearly recognized that tobacco is an addiction, with nicotine being on par with many narcotics on the scale of addictive substances.

The healthcare costs of tobacco-related diseases are high in this country. The effects on development too are devastating, since tobacco-related diseases often strike down persons in the productive period of their life. These cumulative losses must be considered, whenever an economic argument is advanced to justify the existence or even the expansion of tobacco trade.

The Ministry of Health and Family Welfare has constituted an expert committee to study the 'Economics of Tobacco in India'. Its final report is awaited. We believe that this study will provide useful information on the economic implications of tobacco control in our setting and will enable us to argue convincingly that long-term public health and economic interest are convergent on tobacco control.

[1] 1 Lakh = 100,000

While the Ministry of Health and Family Welfare is clearly concerned about the effects of tobacco on health, it fully recognizes that tobacco control calls for a multisectoral effort linking health, agriculture, finance, commerce, industry, labour, education, law, environment, mass media etceteras. Even though the opinion of these different sectors may initially differ, we are confident that our common commitment to sustainable national development will soon lead us to align our interests and link our resources for tobacco control. The Ministry of Health has been regularly engaging the other sectors on the imperatives of tobacco control. It is as a result of such interaction that the Indian Council of Agricultural Research has decided to intensify its efforts to identify and encourage alternative crops. It has also decided to discontinue forthwith any assistance to tobacco farming.

Community education is an essential component of any tobacco control strategy. The Ministry of Health and its agencies have already stepped up tobacco-related health education. Law is a potent instrument for protecting and promoting public health. Through restrictions on advertising, a ban on sale to minors, a ban on smoking in public places and by mandating effective warnings law can provide many safeguards that are integral to tobacco control.

I am happy, therefore, to note that this conference links law and public health in its main theme, while addressing the strategies for global tobacco control. Coming as I do from the legal profession to serve now as the caretaker of the health of our people, I am personally gratified to see this close interaction between law and health. I am confident that this communion will lead to healthier laws and more judicious health action that will together promote public health.

Tobacco needs effective multi-ectoral coordination. I hope that the Honourable Prime Minister's blessings for tobacco control programmes will provide a fillip to such coordination at the highest policymaking levels. Your presence here today, Sir, strengthens our commitment and confidence in addressing the challenges of tobacco control.

The conference will also draw inspiration from the outstanding leadership of Dr Brundtland, who established the Tobacco Free Initiative as a Cabinet Project directly under her supervision. The Ministry of Health values

the partnership of WHO in all areas of health, and particularly views tobacco control as an area where strong alliance is needed to overcome the stiff challenges. We look forward to working closely with Dr Uton Rafei, Regional Director of SEARO, in strengthening the regional efforts for tobacco control.

To maintain good health, it is necessary to keep on the right side of the law. I am especially pleased that the Honourable Minister of Law, Shri Ram Jethmalani, has joined us in solidarity today.

The Ministry of Health is proud to co-host this conference with WHO. I look forward to its outcomes with great expectations and I'm confident that you will advance the agenda of global tobacco control through your deliberations over the next two days.

While 'globalization' is a relatively recent word, ancient Indian scriptures have since long stressed the concept of 'Vasudhaiva Kutumbakam' which means that the World is one family. I hope your efforts will ensure that this family will prosper and progress, tobacco-free in this new century of hope and opportunity.

Thank you.