122nd Session
Washington, D.C.
June 1998

Provisional Agenda Item 4.6

CE122/12 (Eng.)
8 April 1998
ORIGINAL: ENGLISH

PREVENTION AND CONTROL OF TOBACCO USE

Smoking causes three million deaths a year worldwide, making it one of the world's most serious public health problems. Estimates put the total preventable tobacco-attributable deaths in the Region of the Americas at 670,000 annually. Of these, 135,000 correspond to Latin America and the Caribbean, 35,000 to Canada, and 500,000 to the United States of America.

The current level of tobacco use is associated with changes in the Region's epidemiological profile, which has been characterized by an increase in morbidity and mortality from chronic noncommunicable diseases. To date, tobacco use has not responded to the limited measures taken to combat it.

This document analyzes the current situation and provides an update on national and international activities to control smoking. It proposes lines of action for strengthening the technical cooperation of the Pan American Health Organization to reduce smoking-related problems in the Region.

The Executive Committee is requested to examine and comment on the contents of the document and approve the new guidelines for a plan of action based on up-to-date information and strategies consistent with the current situation and needs of the Member States.

CONTENTS

Page

EXECUTIVE SUMMARY

This document describes tobacco use in the Region and its serious health implications, with a view to updating the plan of action that the Organization and the Member States may adopt during the period 1998-2000 and beyond, to combat this problem more effectively. It discusses tobacco use in the Region, its health and economic costs, and actions taken in the Member States to control tobacco use. It calls attention to the fact that smoking is the leading preventable cause of death in the world and is responsible for 670,000 deaths in the Region of the Americas each year

The Executive Committee is requested to review the content and consider the plan of action proposed here, together with its scope and feasibility, in order to achieve an optimal level of tobacco control.

The following objectives are proposed for adoption within the Region:

- health ministries and the PAHO Secretariat should recognize tobacco control as a top priority;

- a full-time coordinator for tobacco control should be appointed, with adequate resources and authority, in each health ministry or other appropriate department of government;

- national tobacco control coalitions and the Latin American Coordinating Committee on Tobacco Control (CLACCTA) will be recognized by governments, and health ministries will be actively involved in tobacco control programs;

- all offices and physical facilities of the ministry of health and affiliated agencies throughout the country will become smoke-free environments;

- the prevalence of smoking among physicians will be reduced by 10% each year;

- a detailed plan will be developed, with target dates, for the elimination of all forms of tobacco promotion that influences youth;

- a comprehensive national plan for tobacco control will be developed, incorporating the elements outlined in this document.

1. Introduction

Although there is much variation within Latin America and the Caribbean, the general situation is one of fairly stable consumption levels, widespread social acceptance of smoking, a public poorly informed about the harmful effects of tobacco, deficiencies in health promotion programs, tepid commitment of both the States and health workers, and poor compliance with existing tobacco control measures such as smoke-free environments, restrictions on advertising, and prohibitions on the sale of tobacco products to children. Moreover, the advertising and promotion of tobacco, which are already intense, are likely to increase as transnational companies seek to capture new markets to compensate for their losses in industrialized countries.

Other important factors, according to the World Health Organization, will be the large size of the youth cohort, urbanization, income growth, and a convergence of male and female patterns of tobacco use. Health problems associated with lifestyles and addictions are on the increase in the developing world; tobacco is a key element in the epidemiological shift from infectious to noncommunicable diseases. Among people 35-69 years of age in the industrialized countries, smoking is responsible for 28% of all deaths (*5*). It is rightly regarded as the most important preventable cause of death. Adopting a similar perspective in Latin America and the Caribbean would be good public health policy. Fortunately, the elements of such a policy are known, effective, and feasible to implement.

2. Situation Analysis

2.1 *Prevalence and Consumption*

As the year 2000 approaches and the dangers of tobacco use are well known, it is distressing to note that tobacco consumption in the Region has declined only modestly in the past two decades. Between 1970-1972 and 1990-1992, per capita consumption in Latin America and the Caribbean declined only 11%. Meanwhile, some countries are actually increasing their production of tobacco products, despite the fact that 650 people die annually for every 1,000 tons of tobacco produced for human consumption (*10*).

Although monitoring data are of dubious accuracy, it appears that almost one-third of adults in Latin America and the Caribbean are smokers, which is the same level as in Canada and somewhat higher than in the United States of America (Table 1). Prevalence rates vary widely, from 40% in Venezuela and the Dominican Republic to 15% in Paraguay.

While the proportion of women smokers in Latin America (19%) is well below that of women in Canada and the United States (26)%, the proportion for men (40%) is

much higher than in industrialized countries (29%). Women in Latin America are likely to be a prime new target for the multinational tobacco companies, which will also want to maintain their hold on the male smokers.

Table 1. Tobacco Use in the Region of the Americas

Country	Total % of smokers	% Men who smoke	% Women who smoke	Sample, survey year	Annual number cigarettes per capita
Argentina	31	40	28	Buenos Aires, 1992	1,720 +
Bolivia	38	46	29	urban, 1986	1,750 +
Brazil	33	40	25	1989	1,500 +
Canada	30	31	29	1994-1995	2,540 +
Chile	31	38	25	1990	1,130
Colombia	27	35	19	age 12+, 1992	1,750
Costa Rica	22	33	11	age 14+, 1987	1,340
Cuba	36	49	25	1990	2,280
Dominican Rep.	40	66	14	daily, 1990	1,010
Ecuador	36	-	-	age 20+, 1988	870 +
El Salvador	25	38	12	1988	1,010 +
Guatemala	27	38	18	urban, 1989	340 +
Honduras	23	36	11	urban, 1988	850 +
Jamaica	28	43	13	1990	860
Mexico	26	38	14	urban, 1990	1,500
Paraguay	15	24	6	1990	1,100 +
Peru	27	41	13	urban, 1989	350
United States	26	28	23	age 18+, 1994	2,670
Uruguay	36	41	27	1990	1,700 +
Venezuela	40	42	39	1992	1,920

Source: WHO, *Tobacco or Health: A Global Status Report*, 1997.

1. Countries are included if they have reported prevalence since 1986 based on a national sample of adults (generally age 15+, unless noted).
2. Data for 1990-1992 based on production of importation. "+" indicates that the figure is lower than the actual consumption, due to smuggling.

The average age when smoking begins is between 15 and 17 years, and it has been falling alarmingly in the 1990s. Because nicotine is a powerful addictive drug, and early onset leads to a more tenacious addiction, the tobacco companies can be expected to continue to focus on youth through sponsorship, targeted advertising, and marketing emphasizing sports, fashion, and music.

While more adults smoke in Latin America than in Canada or the United States, they smoke less. In Latin America, smokers consume fewer cigarettes daily (12) than in Canada (19) or the United States (20), and the annual number of cigarettes smoked per capita in Latin America is less than half the level of the two more northern countries (Table 1). However, the relative advantage of Latin America is much less than 20 years ago, as is typical of developing regions throughout the world. From 1970-1972 to 1990-1992, per capita consumption fell 35% in Canada and 28% in the United States. The comparable figure for Latin America is only 11%.

2.2 Health and Economic Costs

WHO estimates put the annual number of cigarette-related deaths worldwide in 1995 at over three million. Of these, 135,000 occurred in Latin America and the Caribbean, 45,000 in Canada, and 500,000 in the United States (*12*).

In industrialized countries, where tobacco control policies began to lower smoking rates 20 years ago, smoking-related disease is now declining as a cause of death. However, there are instructive exceptions: in Canada, where women began to smoke later than men and have not yet reduced their rates to the same extent as men, lung cancer is the only form of cancer that has increased in recent years. Canadian women are now more likely to die of lung cancer than any other form, including breast cancer (*2*).

The cost of smoking is considerable: in Canada, it is estimated at US$ 7,700 million ($2,100 million in direct care in 1993) (*6*); in the United States, the figure is $68,000 million ($20,000 million in direct care in 1990) (*8*). Even though tobacco taxes are substantial, they do not cover these costs. In Canada, for example, tobacco taxes amounted to $4,200 million in 1993. This means that the excess cost of smoking for the Public Treasury is $3,500 million (*1*). The costs of smoking are so high that effective school-based smoking prevention programs are estimated to save $16 for every $1 spent to develop and deliver them (*7*). Smoking-related costs for health care and lost productivity are expenditures that developing economies do not need.

Although the World Bank has estimated, using conservative assumptions, that tobacco is a net drain on the world economy of about $200 billion per year (*10*), the true costs are much higher.

The 1994 findings of United States Environmental Protection Agency (EPA) should also be noted (*9*). It has issued warnings about the presence of nicotine and at least 43 other carcinogens in cigarette smoke, both exhaled and from direct combustion (side-stream smoke). At the same time, dozens of other toxic substances and irritants have been identified that contribute to conditions such as lung cancer, respiratory infections in children, and cardiovascular disease in adults.

Tobacco exports earn almost $1,000 million a year for Brazil and $5,000 million for the United States. Five countries of the Region rank among the world's leading producers of unmanufactured tobacco: United States (second), Brazil (fourth), Canada (fourteenth), Argentina (fifteenth), and Mexico (sixteenth). Brazil is the world's leading exporter of unmanufactured tobacco, while the United States is third. Among exporters of manufactured cigarettes, the United States ranks first in the world, followed by Brazil (sixth), Venezuela (sixteenth), Canada (nineteenth), and Colombia (twentieth). Political resistance to tobacco control can be expected in these countries from those who profit from producing tobacco or manufacturing cigarettes.

2.3 Legislation, Regulation, and Taxation

Canada has been part of a small group of countries which established national programs with effective tobacco control policies. Within the United States of America, the states of California and Massachusetts have also enacted comprehensive control programs.

All of these jurisdictions have experienced sharp declines in smoking. Among the important measures taken are the following: restrictions on advertising, controls on sales to minors, mandatory health warnings on tobacco packages, restrictions on indoor smoking, steadily increasing taxes on tobacco products, continuing health education in schools and for the general public, and support for cessation efforts.

In California and Massachusetts, cigarette taxes are the source of income for modern, effective mass communication programs and antitobacco education. Australia takes this one step further and has replaced tobacco company sponsorship with funds from cigarette taxes. Increased tobacco taxes could mean a net budgetary gain in Latin America and the Caribbean, as they were in Canada, where cigarette tax revenue almost tripled from 1981-1991 at the same time that consumption dropped 40%.

Only five countries (Canada, Cuba, Nicaragua, United States, and Venezuela) have mandated a total ban on cigarette advertising on radio and television. Most countries regulate when the ads may be broadcast, while fewer restrict their content and prospective audience (Table 2).

Table 2. Direct Advertising of Tobacco Products in PAHO Member States, Mid-1990s

Country	Broadcast (TV, Radio)			Print Media Restrictions
	Total ban	Restricted schedule	Restricted content	
Argentina		TV,R	TV,R	Banned in youth publications
Bolivia		TV		
Brazil		TV,R		Banned in youth publications
Canada	TV, R			Health warnings required
Chile		TV		Health warning required
Colombia		TV	TV	Banned in scientific publications, murals, public transport
Costa Rica		TV,R		Banned in youth publications and Sports sections of newspapers
Cuba	TV,R			Banned
Domin. Rep.		TV		
Ecuador		TV,R		Health warnings required; Targeting of children banned
El Salvador		TV	TV	
Guatemala				
Honduras				Health warning required
Jamaica				
Mexico		TV,R	TV,R	Association with sports, youth, civic activities, religion banned
Panama		TV	TV	Cannot show smokers
Paraguay		TV	TV,R	Health warning required; association with sports or children banned
Peru		TV,R	TV,R	Health warnings required
United States	TV,R			Health warnings required
Uruguay			TV,R	Health warnings required
Venezuela	TV,R			Health warnings required

Sources: *Boletín CLACCTA*: *Legislación sobre el control del tabaquismo en América Latina*, January 1997.
WHO, *Tobacco or Health: A Global Status Report*, 1997.

Even in countries where television and radio advertising is prohibited, print advertising is generally tolerated. Advertising on murals, at points-of-sale, and in magazines catering to all interests and age groups is highly visible throughout the Region. Indirect advertising, in the form of product endorsements and sponsorship of sports and cultural events, is regulated in only a few countries and is generally widespread throughout the Region.

Regulations in many countries seek to limit exposure of minors to this advertising by exclusion of positive modeling, changes in scheduling, or the banning of ads from high-risk sites. Recently, some countries such as Chile, Costa Rica, and Peru have enacted legislation that restricts the schedule and contents of cigarette advertising, requires warnings about the health risks of smoking, and requests the incorporation of educational programs in schools and communities. At least 12 Latin American countries have continued instruction on tobacco control and two of them make it optional.

While health education is useful, it is not usually sufficient to discourage smoking. The price of cigarettes has proven to be an effective deterrent in many countries, including Australia, Canada, Denmark, France, New Zealand, Norway, South Africa, the United Kingdom, and the United States.

In the Region, the amount of work at the average wage required to buy a pack of cigarettes varies widely, from 10 minutes in the United States to 160 minutes in Bolivia (Table 3). Not surprisingly, taxes make up only 30% of the price of cigarettes in the United States and 61% in Bolivia. But these countries are not the extremes in taxation, which ranges from 10% of the total price in Paraguay to 75% in Brazil and Costa Rica. Despite the efficacy of price as a tobacco control measure, no national legislation or decrees involve explicit price regulation or an increase in the tax on tobacco products.

Reducing youth access to tobacco can be effective in controlling onset of smoking and addiction, but only a few countries restrict sales to minors (Table 3). Even when restrictions are in place, however, rigorous enforcement is necessary to ensure retailer compliance and this is generally lacking. In Canada, for example, more than 50% of tobacco retailers are willing to sell to children as young as 12 or 13, although the law requires that they must be at least 18 years of age (*3*).

The vast majority of countries in the Region have some form of prohibition on smoking in public, the most commonly protected sites being health care facilities, schools, public transport, and indoor entertainment venues such as cinemas (Table 3). However, enforcement and compliance is again essential for this measure to work. Public awareness of the dangers of environmental tobacco smoke is an important stimulus to acceptance of such prohibitions.

Table 3. Tobacco Control Measures in PAHO Member States, Mid-1990s

Country	Tax as % of price, min. to buy 20 cig.	Sales to minors prohibited[1]	Public areas where smoking is banned nationally[2]
Argentina	70%		
Bolivia	61%, 160 min		health care, transport, enclosed public spaces
Brazil	75%	X	
Canada		X	transport, federal workplaces
Chile	70%		health care
Colombia		X (age 16)	health care, airplanes, schools
Costa Rica	75%, 43 min	X	transport, entertainment, government buildings, workplaces
Cuba	150 min	X (age 16)	health care, transport, some public buildings
Domin. Rep.	13%	X (age 16)	
Ecuador			airplanes
El Salvador	43%		health department offices
Guatemala			buses
Honduras			transport, entertainment, government buildings, schools
Jamaica	42%, 44 min		
Mexico			health institutes, entertainment, some government offices
Panama	60%		
Paraguay	10%		health care, transport, some offices
Peru			transport, enclosed public spaces
United States	30%, 10 min	X	transport, health department
Uruguay	60%	X	health care, transport, schools, government offices, elevators
Venezuela	50%	X	transport, schools, cinemas

Source: WHO, *Tobacco or Health: A Global Status Report*, 1997.

1. Sales prohibited to anyone under 18 unless noted otherwise.
2. Additional municipal bans exist in Argentina, Canada, Mexico, United States, and Uruguay. Many countries have restrictions (but not prohibitions), which are not shown here.

Most countries have only one or two warnings that appear all the time, and there are few regulations governing the size of the warnings or their prominence on cigarette

packaging. Wording varies from the very weak ("This product may be harmful to your health") to the very strong ("Smoking can kill you"). Only four countries in the Region require cigarette manufacturers to describe tar and nicotine levels on their packages, and only Cuba controls the amount of toxic and carcinogenic substances in tobacco products (Table 4).

Table 4. Warnings on Cigarette Cartons/Packs in PAHO Member States, Mid-1990s

Country	Warnings on Health Risks		Information on Levels of	
	Rotating[1]	Fixed[2]	Tar	Nicotine
Argentina		X		
Bolivia		X		
Brazil	X			
Canada	X		X	X
Chile	X		X	X
Colombia		X		
Costa Rica		X		
Cuba		X		
Domin. Rep.		X		
Ecuador		X		
El Salvador		X		
Guatemala		X		
Mexico	X	X	X	X
Panama		X		
Paraguay		X		
Peru		X		
United States	X		X	X
Uruguay		X		
Venezuela		X		

Sources: *Boletín CLACCTA: Legislación sobre el control del tabaquismo en América Latina, January 1997; WHO, Tobacco or Health: A Global Status Report, 1997.*

1. Rotating: different warnings appear from time in time.

2. Fixed: the same warning is issued all the time.

3. Bases for Action

3.1 *Resolutions and Plans of Action of WHO and PAHO*

During the period 1969-1997, there were 14 WHO and four PAHO resolutions that applied to tobacco control. Plans of action for WHO, PAHO, and their Member States were developed for the periods 1988-1995 and 1996-2000. These include a PAHO regional plan of action (1989) and an interagency plan (1994).

3.2 *"Tobacco or Health," the WHO Plan of Action, 1996-2000*

This plan provides for continued WHO leadership in the global reduction and prevention of tobacco use and in the promotion of tobacco-free societies. The program objectives for this period are: to promote the development and strengthening of national and international programs to prevent and reduce tobacco use; to promote the concept of tobacco-free societies; and to collect, collate, prepare, and disseminate valid information on tobacco-or-health epidemiology and on strategies to control tobacco consumption.

3.3 *Proposal for an Updated PAHO Plan of Action*

This section presents a proposed plan of action, based on seven objectives for the year 2000, and provides a framework for continued action after 2000. The plan incorporates lessons from countries and states with successful tobacco control and allows for national variations within the Region in order to address differing priorities and take advantage of local strengths.

3.3.1 *Principles and Premises*

- Smoking is the number one preventable cause of disease and death in the Region, and tobacco-related diseases are growing rapidly in importance. Further, smoking results in a net economic loss in all countries. These costs will grow in future years without effective tobacco control.

- Tobacco control programs can be effective in postponing the onset of smoking, reducing prevalence and levels of consumption, and protecting the health of children and other nonsmokers. Countries with advanced tobacco control programs show impressive decreases in smoking-related morbidity and mortality.

- A comprehensive approach to tobacco control—combining educational, legislative, regulatory, and fiscal measures—is more effective than any single measure. In particular, education on the dangers of tobacco use, while necessary, is not sufficient for effectively combating tobacco use.

- Comprehensive approaches address (a) prevention of smoking, (b) encouragement of cessation, and (c) protection of nonsmokers. Truly effective measures will achieve two or three of these outcomes simultaneously (e.g., effectively prohibiting public smoking protects nonsmokers, encourages cessation, and contributes to prevention).

- Laws to regulate the accessibility of tobacco products should reflect the gravity of harm associated with their use.

- There should be free and informed consent among actual and potential users of tobacco products.

- There should be protection of the health, rights, and well-being of those who do not use tobacco products.

- Legislation should control tobacco products themselves.

- Any measure that reduces the social acceptability of smoking contributes positively to tobacco control.

- Effective tobacco control starts with actions that are within the jurisdiction of the health ministry and progresses to actions requiring interministry and intersectoral collaboration.

- Coalitions involving governments and NGOs are essential to combat the well-organized and well-financed international tobacco industry. Effective partnerships and building local capacity in tobacco control are vital to the success of the effort.

- Additional resources will be needed to support the implementation of comprehensive national plans throughout the Region.

- International cooperation is essential to share best practices and minimize unintended consequences (e.g., when tax increases stimulate smuggling).

- The success of tobacco control in Canada, United States, and Western Europe means that strong measures are urgently needed in other areas of the world where the tobacco industry will turn for new markets.

3.3.2 *Proposed Objectives for the Year 2000*

The objectives that follow are suggested as feasible, fundamental, and urgent. Most of these objectives address essential immediate "infrastructure" needs (#1, 2, 3) while two (#4, 5) are substantive, and two (#6, 7) lay the foundation for future progress.

1. PAHO and all health ministries will recognize tobacco control as a top priority.

2. A full-time coordinator for tobacco control will be appointed, with adequate resources, in each health ministry, or other appropriate government department.

3. National tobacco control coalitions and CLACCTA will be recognized by PAHO Member States and health ministries and must be actively involved in tobacco control programs.

4. All offices of the Ministry of Health and affiliated agencies throughout the country will be smoke-free.

5. The prevalence of smoking among physicians will be reduced by 10% each year.

6. A detailed plan will be developed, with target dates, for the elimination of all forms of tobacco promotion that influences youth.

7. A comprehensive national plan for tobacco control will be developed, incorporating the elements outlined below.

3.3.3 *Elements of a Comprehensive Plan for Tobacco Control*

A comprehensive approach to tobacco control consists of education and legislative, regulatory, and fiscal measures, accompanied by a program of routine monitoring. The goal of the tobacco control measures is to prevent onset, encourage cessation, and protect nonsmokers, and all three outcomes can sometimes be approached with the same measure. For example, limiting public smoking not only protects nonsmokers from "environmental tobacco smoke," it can also encourage cessation and prevention by making smoking less convenient and less visible. Monitoring is essential to evaluate progress and guide future action.

3.3.4 *Measures Which Could Make a Difference*

The following sections describe examples of some of the measures that could be taken immediately. They are taken from the WHO publication *Controlling and Monitoring the Tobacco Epidemic* (*11*).

Measures restricting access to tobacco products: The price of tobacco products should be increased through tax changes that reduce affordability. Experience in many countries has shown that higher taxes are probably the single most effective way of reducing tobacco use. In many of the countries of Latin America, rapidly growing economies, by increasing disposable income, are stimulating consumption by making tobacco products more affordable. Ministers of health can play a key role in influencing tax policy through contacts with the ministers of finance and can encourage not only higher taxes, but an end to practices (such as tax preferences for hand-rolling tobacco) which encourage overall higher consumption.

There should be restrictions on where tobacco products are sold. Some places of sale for tobacco products are inappropriate. For instance, it is incompatible with the scientific understanding of the effects of tobacco use to allow these products to be sold in health care facilities, educational institutions, pharmacies, and athletic facilities. Such sales give the public impression that tobacco products are not such a serious cause of ill health.

There should be no self-service sales of tobacco products. Given the magnitude of harm and level of addiction associated with these products, it is inappropriate to have them available in vending machines or other self-service locations.

Tobacco sales to children should be ended. Tobacco products are addictive, which negates free will. Therefore, minors must be protected from those who would provide them with these products. This can be done through licensing and inspection of merchants and through creating financial incentives for tobacco companies to prevent children from using their products.

Measures to promote informed consent: In view of the fact that the tobacco industry creates a very false impression of the products it sells through marketing, misleading messages, as defined by special regulatory bodies, conveyed in tobacco advertising, promotions, sponsorships, labeling, and packaging, should end.

There should be prominent, detailed, and frequently updated information on (and even in) tobacco packaging and at points of sale. Preventing misleading messages needs to be supplemented with the provision of accurate information. This can be done by requiring comprehensive information, given in an appropriate cultural context, on all tobacco products.

All product toxins and additives should be fully disclosed. Consumers have a right to know what they are consuming and public health officials have a need to know what is in tobacco products in order to explain risks to the public.

Public health education efforts, including efforts to educate the public about the actions of the tobacco industry, should be mandated. With such a massive current and future disease problem, there is a need to supplement the package-based health information with wider mass education campaigns.

There should be guaranteed assistance to those who wish to cease using tobacco products and to tobacco users seeking compensation for their harm. Giving tobacco users accurate information about the effects of smoking is of little benefit if these users do not feel able to quit. Providing help to those who wish to quit, through accessible proven strategies, is important. So is the ability of smokers to seek compensation from tobacco companies for the harm these companies have caused.

Measures to protect those who do not use tobacco products: Smoke-free public spaces, workplaces, and public transit should be guaranteed. Environmental tobacco smoke (ETS) is a proven cause of disease and discomfort, and it is important to implement progressive, culturally appropriate policies to reduce exposure. Such policies often start with health, educational, governmental, public transit, and athletic facilities. Policies should also be implemented for workplaces, retail stores, and places of public assembly. These measures are both protective and educational. As the protection is offered, it educates the public about the harm of tobacco smoke and removes role models (such as teachers who smoke in the classroom).

There should be guaranteed and simplified redress for those harmed by ETS. Where the tobacco industry has misled the public about the harm of ETS, including through failure to advise of the harm, there should be simple ways for those harmed to obtain compensation from the industry. By holding the tobacco companies financially liable for misdeeds, a country creates the incentive for these companies to tell the truth.

The public should be protected from the fires and other environmental harm caused by tobacco products. Tobacco products cause environmental problems ranging from deforestation (due to wood being used to cure the tobacco leaf), to fires caused by dropped cigarettes, to littering. This can be changed through legislated changes in tobacco-growing methods and through product standards on cigarette ignition propensity. Some of these issues can also be affected through better public education.

Measures to control tobacco products: Governments should have the ability to ban specified categories of nicotine delivery products. Tobacco products are nicotine delivery devices, which are extremely “dirty.” There are other ways of giving nicotine to those who need it without nearly as great a health impact. Through control of tobacco products as drugs, something the United States is now in the process of implementing, it should be possible to gradually remove the most deadly products from the market.

Regulations are also needed to establish which additives tobacco manufacturers or importers can have in their products. Governments should also have the ability to require product changes, including the use of specified additives, where these additives could reduce tobacco's death toll. At present there is little control over what tobacco companies do in manufacturing their products. This is very different from the situation for food products or pharmaceuticals and leaves consumers at increased risk. Control over additives can prevent the addition of toxins, which add to the overall disease toll, and could force the inclusion of additives that could reduce the disease toll.

The levels of toxic ingredients found in tobacco products should be controlled. Some countries have tobacco products with extraordinarily high concentrations of carcinogens and other toxins. Countries should be able to set maximum permissible levels of such toxins as a way of reducing overall harm.

Governments should have the ability to require modification in tobacco products. Beyond limiting existing toxins, it is conceivable that new technologies could be implemented which could reduce child onset of smoking, limit exposure to known toxins, or make it easier for existing smokers to quit.

3.3.5 *Need for Expanding and Diversifying PAHO Support to Provide Effective Technical Cooperation*

The magnitude of smoking impact on health and its economic consequences should convince the Region's governments to take the initiative in the control of smoking. Only concerted public action has the scope and authority to reverse the current harmful levels of tobacco use. At the same time, this action should be promoted and supported by individuals, groups, NGOs, and bilateral and international organizations. Experience has shown the importance of adequate leadership to the success of control policies and programs at the global, national, and community levels.

It is therefore essential that the plans of action establish and strengthen the leadership of the national coalitions as proposed in the Interagency Plan on Tobacco or Health for Latin America. At the same time, it is deemed important to incorporate and coordinate activities with collaborating centers and with different groups, such as institutes for the treatment of cancer and respiratory diseases, as well as with professional societies, as counterparts and members, under the guidance and support of the ministers of health.

In order to consolidate and speed up activities geared toward the prevention and control of smoking in the Region of the Americas, in 1994 PAHO and CLACCTA formed a coalition to carry out the "Interagency Program for Latin America." The Program is currently operating under the auspices of PAHO, the American Cancer

Society (ACS), the Centers for Disease Control and Prevention (CDC), and, since 1995, the Government of Canada, which are providing technical and financial support.

In terms of resources, it is important to point out that, at present, PAHO has appointed one Regional Advisor on Tobacco or Health, within the Division of Health Promotion and Protection at Headquarters, as part of the Program on Healthy Lifestyles and Mental Health. This professional dedicates approximately 60% of his time to the management and technical support of the tobacco component, and the remaining 40% is dedicated to issues related to alcohol and psychoactive substance abuse and dependency. At the same time, there are two other intercountry consultants operating in Argentina and Venezuela, who are financed by United States and Canadian extrabudgetary funds. In addition, PAHO provides a full-time secretary and an operating budget of $30,000 annually.

It will be essential to mobilize other extrabudgetary resources to make this proposal viable. This will require solid ties with the interested agencies in Canada and the United States as part of strategic alliances to search for joint solutions at the international level.

When implementing the future plan, it will be necessary to optimize coordination within PAHO's divisions and programs such as "communicating for health," healthy schools and communities, chronic noncommunicable diseases, adolescence, and health policies.

The Executive Committee is requested to examine and comment on the contents of this document and the new guidelines for a plan of action based on up-to-date information and strategies consistent with the current situation and needs of the Member States.

References

1. MacEachern S, Stephens T, Kaiserman MJ. *The Economic Costs of Smoking: a Major Contributor to Budgetary Deficits.* Presentation to the Second National Conference on a Tobacco-free Canada, Ottawa, 1 November 1996.

2. National Cancer Institute of Canada. *Canadian Cancer Statistics, 1997*. Toronto: The Institute, 1997.

3. Nielson, A. C., Co. *Measurement of Retailer Compliance with respect to Tobacco Sales-to-Minors Legislation, Wave 3 Results, 1997*. Prepared for Health Canada, Office of Tobacco Control, 1997.

4. PAHO, *Control of Cigarette Smoking*, Resolution CD33.R22, 33rd Directing Council, September 1988.

5. Peto R, López AD, Boreham J, Thun M, Heath C Jr. *Mortality from Smoking in Developed Countries, 1950-2000*. Oxford: Oxford University Press, 1994.

6. Single E, Robson L, Xie X, Rehm J. *The Costs of Substance Abuse in Canada*. Ottawa: Canadian Centre on Substance Abuse, 1996.

7. Stephens T, Kaiserman MJ, McCall DJ, Sutherland-Brown C. *School-based Smoking Prevention in Canada: A Cost-benefit Analysis*. Accepted for publication.

8. U.S. Centers for Disease Control and Prevention. *Estimate on Tobacco Cost*. 1990.

9. U.S. Environmental Protection Agency. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*. USEPA Document No./600/6-90/006F.

10. World Bank. *Bellagio Statement on Tobacco and Sustainable Development*. June 1995.

11. WHO. *Controlling and Monitoring the Tobacco Epidemic.* In press.

12. WHO. *Tobacco or Health: A Global Status Report.* 1997.