

Spotlight on the FCTC: Tobacco and Development Policy

Articles 22 and 26 of the FCTC

ISSUE FIVE/JANUARY 2010



The Framework Convention on Tobacco Control (FCTC) is the world's first international public health treaty. It sets out legally binding objectives and principles that countries or entities such as the European Community (known as Parties) have ratified and thus agreed to implement. The Treaty protects present and future generations from the devastating health, socio-economic and environmental consequences of tobacco consumption and exposure to tobacco smoke through evidence-based policies.

How fast is tobacco use increasing in Africa, Asia and Latin America?

India, China, Indonesia, Brazil and Bangladesh are among the countries with the highest number of tobacco users. Reports show that smoking is also rapidly increasing in Africa. WHO estimates that tobacco use in Africa is increasing by 4.3% a year¹.

KEY FACTS AND FIGURES OF BURDEN OF TOBACCO TO SOCIETY IN LOW- AND MIDDLE-INCOME COUNTRIES

- In the Philippines the poorest households in 2003 were spending more on tobacco than on education, health and clothing combined¹¹.
- In Nepal, in 2000, the poorest households were spending almost 10% of their income on tobacco products¹¹.
- In Egypt, more than 10% of household expenditure in low-income homes is on tobacco².
- The poorest 20% of households in Mexico spend nearly 11% of their household income on tobacco².
- In Uganda, 50% of men smoke, while 80% of the population lives on less than \$1 a day¹.
- In March 2007, the UK newspaper The Guardian reported that the developing world boosted British American Tobacco earning per share and raised its dividends¹². In February, the Financial Times reported that Mr Camilleri, Altria chief executive, 'said the tobacco company's greatest opportunities were in developing economies such as China and India'¹³
- One in five young Nigerians smokes cigarettes, while the number of young female smokers rose ten-fold during the 1990s¹

What will be the impact of the increasing use of tobacco?

Worldwide tobacco related illnesses already kill 5.4 million people a year. If current patterns of tobacco use persist, smoking will cause more than 8 million deaths a year by 2030, of which more than 80 per cent will occur in low- and middle-income countries². Tobacco kills up to one in every two long-term users, half of these in middle age. A study carried out in India found that smoking caused a significant proportion of deaths among men between the ages of 30-69 participating in the study; specifically, 38% of all deaths from Tuberculosis (TB), 31% of all deaths from respiratory disease, 20% of all deaths from vascular disease and 32% of all deaths from cancer³.

GLOSSARY

Non-communicable diseases: a group of conditions that includes cardiovascular disease, cancer, mental health problems, diabetes mellitus, chronic respiratory disease and musculoskeletal conditions. These conditions do not result from an acute infection. This broad group is linked by common risk factors e.g. smoking, unhealthy diet and air quality among others, underlying determinants and opportunities for action. The term is used by WHO and the European Commission at international level. The term "chronic diseases" is also used to describe this group of diseases.

Risk factor: refers to an attribute, characteristic or exposure of an individual which increases the likelihood of developing a non-communicable disease.

Articles 22 and 26 of the FCTC: The FCTC recognises that technical cooperation and financial resources are key to the effective implementation of the Treaty. Parties must promote cooperation in the scientific, technical and legal fields, taking into account the needs of low- and middle-income countries, to establish and strengthen national tobacco control strategies. Furthermore, Parties should promote the use of all funding mechanisms and programmes available – multilateral, bilateral, regional and subregional channels – to promote the development and strengthening of these same strategies.

Who smokes the most?

The poorest. Studies show that the poor are most likely to smoke⁴. Smoking exacerbates poverty as money spent on tobacco is money not spent on basic necessities such as food, shelter, education and health care^{4,5}. A study in rural China found that every 100 yuan spent on tobacco was associated with a decline in spending on education by 30 yuan, on medical care by 15 yuan, on farming by 14 yuan and on food by 10 yuan⁴. Furthermore, through aggressive strategies and due to more lenient legislation the tobacco industry is exploring new markets and increasingly targeting, marketing and promoting their products to vulnerable groups, in particular women and youth².

What is the link between tobacco use and non-communicable diseases?

Smoking is a risk factor for non-communicable diseases. Tobacco use causes lung disease, several cancers, heart disease and strokes. Risk factors of non-communicable diseases are preventable and it has been estimated that their elimination would prevent 80% of heart disease, 80% of strokes, 80% of type 2 diabetes and 40% of cancer in the WHO African region⁶. Non-communicable diseases already account for the major share of the mortality burden in all World Bank regions except in Sub-Saharan Africa⁴.

What will be the burden of non-communicable diseases?

Studies show that with the ageing of the population, economic growth and changes in lifestyle in low- and middle-income countries, there will be a shift in the distribution in the cause of deaths from communicable, maternal and perinatal to non-communicable diseases, and from younger to older ages⁷. While an improvement in average life-expectancy is positive, health services will face new challenges as non-communicable diseases require long-term and often life-long treatment. Health services already overstretched will be faced with a double burden of disease as non-communicable diseases increase and the needs posed by communicable diseases remain.

What is the price of inaction?

Unless urgent action is taken, more than a billion people will be killed by tobacco use during this century². The effects of tobacco use may take years and even decades to develop. As a result, the full impact of increasing tobacco use will only be felt as the tobacco epidemic reaches its peak. Impacts are already clearly visible. In 2000, three tobacco related illnesses – heart disease, stroke and cancer – cost the Indian government \$5.8 billion. Productivity lost due to tobacco-related premature deaths is already \$2.4 billion in China. Medical costs from smoking impoverish more than 50 million people in China^{4,2,5}. Tobacco use already costs \$590.63 million (direct costs) to Nigeria⁸.

What is the solution?

The tobacco epidemic is man-made and entirely preventable. Yet, only 5% of the world's population is fully protected by key policy interventions that have shown to significantly reduce tobacco use in the countries that have implemented them. There is evidence that cost-effective interventions, which do not require large investments of capital and could be incorporated into existing structures, could address non-communicable disease in low- and middle-income countries. The FCTC recommends evidence-based social, economic and legislative measures that are key to prevent tobacco use and related morbidity and mortality. These measures are outlined in the FCTC and WHO's MPOWER² strategy.

Who has ratified the Treaty?

To date 167 countries have ratified the Treaty, the large majority in low- and middle income countries. Countries that have ratified the Treaty are legally bound by its obligations. The quick ratification of the FCTC shows governments' awareness and willingness to tackle tobacco related issues.

How is the implementation of the Treaty going to be funded?

Financial resources play an important role in achieving the objectives of the FCTC, even though large investments are not necessarily required. As a result, provisions have been included to ensure that the Treaty receives the necessary funding to become a reality. According to Article 26 *'each party shall provide financial support in respect of its national activities'*. Under this article, Parties also commit themselves to promote, as appropriate, the use of multilateral and bilateral channels to promote the implementation of the FCTC in low- and middle-income countries.

FINANCING HEALTH SYSTEMS

Romania introduced a "Tax for Health" in 2007, aiming to increase its health budget. The "Tax for Health" also known as the "sin-tax" adds EUR 0.2 to the overall price of a pack of cigarettes that is included in the excise duties. The use of a fixed amount per pack allows revenues from excise duties, which go to the Finance Ministry, to be maintained while creating a new source of revenue for health. In terms of administration, the most important aspect is that the "Tax for Health" is collected directly by the Ministry of Health. Romania has 20 million inhabitants, of whom at least five million are smokers. In 2007 and 2008 the "Tax for Health" raised approximately EUR300 million a year. The revenue was for a number of measures, namely strengthening health systems and financing national health programmes, including new high-performance equipment for hospitals and ambulances, as well as a national TB programme. Tobacco control also benefited from the "Tax for Health", the programmes for complete coverage of smoking cessation and smoking prevention were funded. Notably, the creation of the "Tax for Health" did not lead to a reduction in the total revenues from excise duties on tobacco products. On the contrary, these increased in 2007 and 2008.

Source: Ministry of Health, Romania

TUBERCULOSIS (TB) PREVENTION AND TOBACCO CONTROL IN SOUTH-EAST ASIA (WHO SEARO OFFICE)

The link between tobacco use and a range of TB outcomes including infection, development of disease, treatment outcomes, relapse as well as mortality has often been overlooked. However, recent studies show that both are significantly interlinked. The new Stop TB strategy recognizes that prevention of the most frequent risk factors e.g. smoking and poverty is an important contributor for TB control and one of its subcomponents includes a *Practical Approach to Lung Health* (PAL). PAL is a holistic approach used for managing patients in primary health care services with respiratory symptoms. Patients accessing a health facility are more likely to adopt behaviour change. Therefore, smoking cessation counselling can be very effective and have an impact on both TB and tobacco control in the long run.

Two pilot projects are currently being implemented in Nepal and Indonesia.

Source: WHO South East Office, <http://www.searo.who.int/en/Section1174/Section2469/Section2475.htm> accessed 12 July 2009

Can Official Development Assistance support the implementation of the FCTC?

Yes. While it is key that recipient countries prioritise tobacco control in their own development strategies, the European Union and its Member States can take the lead in providing the technical and financial assistance to low- and middle-income countries through its various multilateral and bilateral programmes.

What type of assistance is required by countries?

The FCTC provides the framework for action against tobacco use but it is up to national governments and national civil society organisations to ensure that the Treaty provisions are effectively implemented and enforced. Technical programmes will need to be put in place to translate the Treaty into national laws and build and strengthen capacity at national level. Thus, technical assistance and support will be required at both governmental and societal level for training and cooperation in the scientific, technical and legal fields.

Can tobacco control contribute to poverty reduction and the Millennium Development Goals (MDGs)?

Yes. Tobacco use deprives families of basic needs and furthers illness. In most African countries for which data are available, the cost of 20 Marlboro cigarettes or an equivalent brand is more than half a day's wage⁸; and in India, Vietnam and Indonesia a pack of 20 Marlboro cigarettes or equivalent costs more than 1 Kg of rice⁸. In Bangladesh it costs over 2 times more. Furthermore, tobacco cultivation is environmentally damaging and farmers regularly end up in debt¹. Recent research with children working on tobacco farms in Malawi published by Plan International shows the emotional and physical impact of this kind of work on children, some as young as five, and their families¹⁴. Smoking deprives families of an important share of income that could otherwise be used to buy food, education and health care.

Can tobacco control contribute to financing health systems?

Yes. Tobacco taxes have proved to be the single most effective intervention to prevent smoking⁹. Historically tobacco taxes have been a stable source of revenue for governments.

Increasing tobacco taxes by 10% generally decreases tobacco consumption by 4% in high-income countries and by about 8% in low- and middle-income countries, while tobacco tax revenues increase by nearly 7%.² In a time when innovative development funding is needed for health services and health initiatives, tobacco taxation can potentially raise funds for health promotion and health systems¹⁵. Most national legislation around the world already includes provisions for tobacco taxation. Structures to implement and collect the tax are already in place and there is broad political support for the FCTC, which includes provisions on tobacco taxation.

Can the FCTC contribute to rural development, economic growth and sustainable development?

Article 17 of the FCTC states that Parties shall, as appropriate, promote economically sustainable alternatives to tobacco growing. Work on this Article will be presented to Parties to the FCTC in 2010. Current experience from countries such as Brazil and Kenya show the existence of a range of profitable and sustainable alternatives to tobacco growing, which make agriculture more competitive and productive and at the same time promoting sustainable use of natural resources.

Should tobacco control become a global health priority?

Yes. Studies show that non-communicable diseases already pose a heavy burden on governments and society at large in low- and middle-income countries. Yet non-communicable diseases and their risk factors are not considered a global health priority. As a result, to date limited funding and political support has been directed towards tackling these diseases and their associated risk factors.

Are there any policy initiatives?

A number of policy initiatives already recognise the increasing burden of non-communicable diseases on low- and middle-income countries:

- The WHO Framework Convention on Tobacco Control
- the WHO 'Action Plan for the global strategy for the prevention and control of noncommunicable diseases' adopted in 2008 in which a number of indicators relate to effective tobacco control policies¹⁰
- the European Commission programme 'Investing in people' notes that *'the burden of non-communicable diseases is becoming more prevalent in developing countries, with tobacco related diseases projected to increase significantly over the coming years'*⁷

CASE STUDY: PROMOTING ALTERNATIVES TO TOBACCO GROWTH IN KENYA

Tobacco growth requires intensive farming techniques and heavy use of chemicals depleting soil resources and contaminating watercourses. Tobacco growth is not a profitable activity for farmers and the latter often find themselves deep in debt⁷.

Kenya is a tobacco growing country and the land devoted to growing tobacco continues to expand at the expense of traditional food crops and livestock activities. A large share of the tobacco production in Kenya takes place in the Southern Nyanza region. The project of the Tobacco Control Research Group is testing farmers' willingness to adopt bamboo as an alternative crop and assess marketing dynamics in the bamboo sector. Training is being provided to farmers on bamboo cultivation and farm management skills. The project is in progress but it has already led to a reduction in tobacco cultivation in the region.

Promoting economically sustainable alternatives to tobacco growing contributes to making agriculture more competitive and productive at the same time it allows sustainable use of natural resources.

Source: Kenya Tobacco Control research Group, www.tobaccotobamboo.com accessed 12 July 2009

- EC Communication on health and poverty reduction in developing countries, 2002

Is there a role for the EU and its Member States?

The EU and its Member States played an important role in negotiating the text of the FCTC. As the largest donors in the world providing over 50% of Official Development Assistance worldwide, the EU and its Member States can continue to take a leading role and, drawing on its extensive experience in tackling tobacco use, support and promote collaboration in the scientific, technical and legal fields. Through its multilateral and bilateral programmes the EU and its Member States can provide the technical assistance required and contribute to reducing the burden of non-communicable diseases on low- and middle-income countries and their health systems.

The forthcoming review of the MDGs offers an opportunity to highlight the relation between poverty and the increase of non-communicable diseases and to acknowledge how effective action to tackle the latter can contribute to reaching the MDGs' goals and objectives. In a time of economic crisis and midway towards the targets agreed in 2000, a true and holistic health partnership should be forged to ensure that the MDG targets are met and contribute to reducing poverty and improve health in low- and middle-income countries.

Is there a role for the European parliament?

The European Parliament can play a key role in promoting a holistic approach to health. Through its various fora the European Parliament can express its views through resolutions, tabling written questions to the European Commission and ensure that the EU budget reflects the EU principles and contributes to reducing poverty and improving the health around the globe.

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The **Smoke Free Partnership (SFP)** is a strategic, independent and flexible partnership between the European Respiratory Society, Cancer Research UK, the Institut National du Cancer and the European Heart Network. It aims to promote tobacco control advocacy and policy research at EU and national levels in collaboration with other EU health organisations and EU tobacco control networks.

Drafter: Margarida Silva
Editors: Jean King, Jean-Luc Eiselé, Susanne Longstrup, Florence Berteletti Kemp, Brian Ward and Sam Villiers

Smokefree Partnership
 49-51 rue du Treves, 1040 Brussels, Tel: +32 2 238 53 63
www.smokefreepartnership.eu

