HOW MUCH DO YOU KNOW ABOUT TOBACCO AND THE MILLENNIUM DEVELOPMENT GOALS?

- FACTS AND FIGURES ON TOBACCO USE IN LOW- AND MIDDLE-INCOME COUNTRIES

THE BURDEN OF TOBACCO USE

Tobacco is the number one cause of preventable death in the world today. Tobacco related illnesses already kill 5.4 million people a year. If current patterns persist, smoking will kill more than 8 million a year by 2030, of which more than 80 per cent will occur in low- and middle-income countries [1].

Non-communicable diseases are becoming more prevalent, with tobacco related diseases projected to increase significantly over the coming years. Non-communicable diseases already account for the major share of the mortality burden in all World Bank regions (e.g. Europe and Central Asia, East-Asia and Pacific, Latin America and Caribbean, Middle East and North Africa and South Asia) except in Sub-Saharan Africa [2].

Tobacco consumption causes respiratory and lung disease, several cancers, cardiovascular disease and stroke. The use of pesticides for tobacco growth can cause respiratory, nerve, skin and kidney damage. Children who work in tobacco farming may experience stunted growth [3]. In India, smoking already accounts for 900.000 deaths a year [4]; and in China, as many as 100 million Chinese men currently under age 30 will die from tobacco use unless they quit or never start smoking[1].

Tobacco use is growing fastest in low-income countries. Data from many countries show that the poor are most likely to smoke. Smoking use deepens poverty as money spent on tobacco is money not spent on basic necessities such as food, shelter, education and health care.

'The average amount spent on tobacco by the poorest 10 million male smokers could buy an additional 1400 calories [7-8 cupes] of rice per day, or significant amounts of protein for each family. If these men quit, and put 70 per cent of their saved income into food, this would provide enough calories to save 10.5 million Bangladeshi children from malnutrition'[3].

THE COST OF TOBACCO CONSUMPTION TO SOCIETY

Tobacco growth and use pose a heavy burden on governments. Tobacco use hugely increases healthcare costs, imported cigarettes lead to the loss of foreign exchange, and tobacco growth diverts land that could otherwise grow crops. The impact of tobacco use and cigarette smoke also impacts on employees' absenteeism due to sick leave and decreases workers' productivity [5].

According to one report 'Chronic disease: an economic perspective' - Oxford Health Alliance, chronic diseases already pose a heavy burden in both low- and middle-income countries, where about 80 per cent or more of DALYs (disability-adjusted life year) occur before age 60. 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[2,3,1].

Tobacco-control interventions are the second most effective way to spend health funds, after childhood immunisation [6]. Measures to tackle tobacco use, such as tax increase, restrictions on advertising and promotion, smokefree workplaces and public places , are cost-effective and do not require large investments of capital.

TOBACCO CONTROL AND THE MILLENNIUM DEVELOPMENT GOALS

MDG1. ERADICATING EXTREME POVERTY AND HUNGER

• In Indonesia, where smoking is most common among the poor, the lowest income group spends 15% of its total expenditure on tobacco.
• In Egypt, more than 10% of household expenditure in low-income homes is on tobacco.
• The poorest 20% of households in Mexico spend nearly 11% of their household income on tobacco.
• In Bangladesh, an absence of household tobacco use corresponds to an increase of 500 calories to children's diet
• In Uganda, 50% of men smoke, while 80% of the population lives on less than $1 a day

MDG2. ACHIEVE UNIVERSAL PRIMARY EDUCATION

• Poverty and child labour are key reasons why children are not sent to school. The tobacco industry employs child labour in cultivation and production of tobacco
• The poorest households in Bangladesh spend 10 times as much on tobacco as on education

MDG3. PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

• The number of women smoking is set to increase from 218 million in 2000 to 259 million in 2005
• Aggressive marketing and advertising strategies are explicitly targeted at women

MDG4 & MDG5. REDUCE CHILD MORTALITY & IMPROVE MATERNAL HEALTH

• In the United States, second hand smoke is responsible for an estimated 430 cases of sudden infant death syndrome, 24,500 low-birth-weight babies, 71,900 pre-term deliveries and 200,000 episodes of childhood asthma.
• In India, parent smoking is associated with lower likelihood of immunisation for children and higher likelihood of acute respiratory infection, malnourishment, and to death before age 1

MDG6. COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

A recent study carried out in India found that among men in the study who died at ages 30-69, smoking caused about:
• 38% of all deaths from TB
• 31% of all deaths from respiratory disease
• 20% of all deaths from vascular disease
• 32% of all deaths from cancer

MDG7. ENSURE ENVIRONMENTAL SUSTAINABILITY

• Globally, 5.3 million hectares of arable land are currently under tobacco cultivation – land that could feed 10-20 million people

MDG8. ESTABLISH A GLOBAL PARTNERSHIP FOR DEVELOPMENT

• The potential benefits of implementing tobacco control measures are extensive and would contribute to the implementation of a long-term strategy for growth and sustainable development

(Source: WHO, The Millennium Development Goals and tobacco control, Geneva, 2005; WHO, WHO report on global tobacco epidemic, Geneva, 2008; Prof Prabhat Jha et al A nationally representative case-control study of smoking and death in India, New England Journal of Medicine, 358, 2008)

THE FRAMEWORK CONVENTION ON TOBACCO CONTROL

The Framework Convention on Tobacco Control is the world's first international public health treaty, which became international law in February 2005. As of 29 February 2008, 152 countries have become parties – 25 of the EU 27 and the European Commission, along with the entire western pacific WHO region, 35 Afro countries, 10 countries from South-East Asia and 35 from the Americas.

The FCTC encourages low-, middle- and high-income countries to protect citizens' health against the burden of tobacco use, to promote economically viable alternatives for tobacco growth and to implement effective measures to eliminate illicit trade and counterfeiting of tobacco products. Other key provisions include implementation of measures on taxation, regulation of tobacco products, liability, advertising and labelling. However, Framework conventions and protocols are legally binding only on countries which ratify them.

Protocols and guidelines have been and will be developed in order to support the implementation of the Treaty. It is up to national governments and national civil society organisations to ensure that the Treaty provisions are effectively implemented and enforced.

WHAT NEEDS TO BE DONE:

The European Commission is a Party to the FCTC. It is therefore crucial that the EC supports the implementation of the FCTC in all countries that have ratified the Treaty[1] and fulfil its financial and technical assistance obligations under the Treaty by making resources available and promoting best practices around the globe.

This could be achieved by:

- Acknowledging the immense social and economic burden of tobacco use to low- and middle-low income countries
- Acknowledging and promote the role of tobacco control measures to advance economic growth and the Millennium Development Goals agenda
- Promote implementation and enforcement of International Treaties such as the FCTC by investing more on capacity building of national authorities and civil society organisations and promote exchange of best practice

[1] Art 152 of the EC Treaty obliges the EC to ensure a high level of public health across all Community policies and activities. In order to achieve this objective the Commission should complement Member states activities and foster coordination between member States and cooperation with third countries and the competent organisations in the sphere of public health.

SOURCES:

[1] World Health Organisation, WHO report on the global tobacco epidemic, Geneva, 2008

[2] The Oxford Health Alliance, Chronic disease: an economic perspective, London, 2006

[3] World Health Organisation, The Millennium development goals and tobacco control, Geneva, 2005

[4] Prof Prabhat Jha et al A nationally representative case-control study of smoking and death in India, New England Journal of Medicine, 358, 2008

[5] ACS & UICC, the Tobacco atlas, 2nd edition, 2006

[6] European Commission, Tobacco or Health in the European Union: past, present and future, Luxembourg, 2004

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The **Smokefree Partnership** (SFP) is a strategic, independent and flexible partnership between Cancer Research UK, the European Heart Network, the European Respiratory Society and the Institut National duc Cancer. 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.