Framework Convention Alliance
Building Support for Global Tobacco Control

# ALLIANCE BULLETIN

*Framework Convention on Tobacco Control ● Geneva, Switzerland ● 22 November 2001 ● Issue Twelve*

Today's Weather: Partly Sunny
High 7 C Low -1 C

Exchange Rate: 20 Swiss FR =
Algerian Dinars 910 Brazilian Reals 30.62
Pakistan Rupees 738 Australian Dollars 23.41

INB-3 THURSDAY

Inside this issue:



TODAY'S DELEGATE BRIEFINGS

PASSIVE SMOKING
**22 November 2001**
**13.00-14.00**

*(Check the Bulletin Board for location)*

DEATH CLOCK

Since the opening of the first working group for the Framework Convention on Tobacco Control on October 25, 1999,

8,361,144

people have died from tobacco-related diseases.
(At 9 am 22 November 2001)

## *Views from the Alliance:*
## Ghosts of the tobacco dead
**by Clive Bates, Action on Smoking and Health (UK)**

On 25th October 1999, the development of FCTC began in earnest. We, the NGOs, started a clock recording the global deaths caused by tobacco. At the start of the negotiations today, the toll stands at 8,361,144. Over 8 million dead and tens of million of family, friends and colleagues bereaved and grieving while we have talked for two years. Can anyone gathering today in Geneva really claim that we have given this appalling toll the priority and urgency it deserves?

We would like to recommend five concrete measures for progress for the INB-3.

1. We must break through the blizzard of brackets in the Co-Chairs' texts – these obscure and complicate negotiation. Within 24 hours, a new working text is needed to clarify substantive differences and substantive agreements and move the process forward. The Secretariat, Chair, Co-Chairs or a government delegation must take the initiative and must be widely supported.
2. Agree to a global ban on all forms of tobacco advertising – this would be the jewel in the FCTC crown. For those parties with real and tested constitutional barriers, the obligation would be to go as far as the constitution permits. There should also be blunt rejection of the tobacco industry's cynical and self-serving proposal for a global voluntary agreement.
3. Start on the long job of tackling smuggling. There should be a ban on duty free, a system for tracking and tracing tobacco products, and labelling of the destination market at the point of manufacture. These measures mark only a beginning of those needed.
4. Insist on warnings that are bold, prominent, in the right language, include pictures and cover 50 percent of the pack face. Governments should not allow misleading sneaky health claims like 'light' and 'mild' – when we know these products are no less harmful and branded that way to reassure smokers that they have no need to quit.
5. The FCTC should become the lead international convention for tobacco and its provisions should dominate other more general agreements, for example WTO treaties, when there is a conflict.

We should remember the ghosts of the eight million tobacco-dead since we embarked on the FCTC journey. Those delegates determined to block, delay, or weaken meaningful measures to control the tobacco epidemic and curtail the power and abuses of the tobacco industry should be haunted by their memory.


**In the Czech Republic, as in other countries, theMarlboro Man works hard to recruit another generation of victims.**

**FAIT A NOTER:** **Au Bangladesh comme ailleurs, plus on est pauvre, plus on risque d'être fumeur. Chez les plus pauvres, plus de 58 % des hommes fument le tabac.**

## TODAY'S NOON HOUR DELEGATES BRIEFING

*22 November 2001*

Members of the Framework Convention Alliance invite all delegates to a luncheon briefing today, Nov. 22nd, on the topic of **passive smoking**. You will hear from an international panel of tobacco control experts who will discuss and answer your questions about the importance of protecting nonsmokers from exposure to secondhand tobacco smoke.

You will hear from:

- Prakash Gupta, Action Council Against Tobacco, will discuss a recent decision by the Supreme Court of India that could lead to banning smoking in public places and transport.
- Douglas Blanke is with the American Lung Association and William Mitchel College of Law. Hear his tips for answering tobacco industry criticism and enacting local ordinances to protect nonsmokers.
- Marcus Yu, Hong Kong Council on Smoking and Health, will brief on why current efforts to expand workplace protections for nonsmokers in Hong Kong are popular with the public.

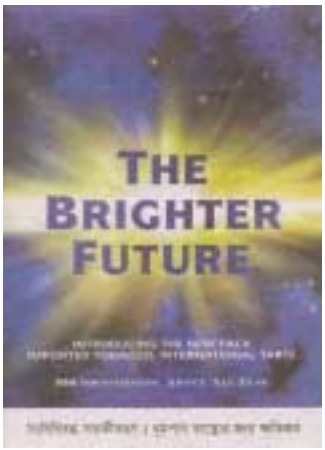
Please check the announcements board for details on room and briefing time.

The Framework Convention Alliance (FCA) is an alliance of NGOs from around the world working to achieve the strongest possible Framework Convention on Tobacco Control. Views expressed in the *Alliance Bulletin* are those of the writers and do not necessarily represent those of the sponsors.

# Informed choice: the case of BAT Bangladesh

Transnational tobacco companies often claim that they see smoking as an "informed choice made by adults only, who are in a position to balance the pleasures of smoking against the inherent risks". Let us analyse that phrase from British American Tobacco (BAT).

"*Informed*" means that potential smokers have information that allows them to decide whether or not to smoke. From where are they to obtain that information? How are they to learn about "the inherent risks"? The only information BAT gives to smokers in Bangladesh is the mandated government message, "Smoking is deleterious to health." Is that information sufficient to make a decision? How is smoking deleterious? If people smoke light cigarettes, are they less likely to get sick? What if they smoke less than a pack a day? What sorts of diseases do smokers get? Can cigarette smoke harm others? Nowhere does BAT provide any of the more specific information that would be necessary to make a truly *informed* choice.




***BAT: an example of deceptive advertising in Bangaladesh***

By "*adults*" BAT means people over the age of 18. How does one attempt to promote a product only to those over age 18? One could choose messages that are more popular among older adults than among teenagers: use of classical music, images of older smokers, avoidance of messages that have particular resonance with youth. One could regularly conduct research to see whether one's advertisements are popular with teenagers, and then, rather than increasing use of those messages, one could stop using them. None of this is happening.

"*Choice*" implies free will. But the nicotine in cigarettes is extremely addictive, and evidence shows that cigarette companies manipulate the level of nicotine in cigarettes to ensure addiction is maintained. Nicotine delivered by cigarettes is at least as addictive as injected heroin or snorted cocaine, and at least as hard to give up. Do drug addicts "choose" to use drugs, or do they use them because their addiction compels them to? Is it really possible to talk about choice when discussing an extremely addictive substance? Even a BAT scientist admitted the truth:

*"It has been suggested that cigarette smoking is the most addictive drug. Certainly large numbers of people will continue to smoke because they can't give it up. If they could they would do so. They can no longer be said to make an adult choice."* (Dr S.J. Green, BAT, 1980)

Focusing tobacco control activities exclusively on youth, and in isolation of effective measures, is a flawed approach. Beyond that, the ads that BAT is using in Bangladesh have many flaws of their own. The very nature of the ads is a problem, as it allows BAT to advertise its name on billboards, radio, and TV without a warning about the dangers of its products.

*Adapted from "BAT`s Youth Smoking Prevention Campaign: What are its true objectives?"*

*(Work for a Better Bangladesh, PATH Canada, Bangladesh Anti-Tobacco Alliance)*

# UGANDA: NON-SMOKERS' RIGHTS CASE

On World No Tobacco Day this year, The Environmental Action Network (TEAN) filed a suit in the High Court of Uganda seeking declarations that smoking in public places was a violation of the constitutional rights of non-smokers to life and to a clean and healthy environment. The action was filed against the Attorney General and the National Environment Management Authority. It was inspired by the 1999 decision from the High Court of Kerala, which banned all smoking in public places. The application relied on scientific evidence from the reports of the US Surgeon General and the US and California Environmental Protection Agencies.

An application by British American Tobacco Uganda Ltd to join the suit was rejected by trial Judge Hebert Ntabgoba, who ruled that the tobacco company had no legitimate interest in the suit. The Respondents then raised a barrage of objections, among which was that TEAN had no authority to act on behalf of all the non-smokers, and could not complain on its own as it was not a natural person and could not therefore enjoy the rights sought to be protected. In a stunning victory, the Judge dismissed all the objections and ruled that TEAN's action was a public interest lawsuit that should be heard with expediency.

Before the matter could proceed, a smoker filed an application seeking to be heard. He claimed that his rights would be infringed by the declarations sought by TEAN. He is represented by the same law firm that filed the BAT application. In support of his action, he has enlisted the help of a London firm of Solicitors with known tobacco industry links and a tobacco industry expert to challenge the scientific reports relied on by TEAN. It came as little surprise to learn that the smoker was an employee of BAT Uganda. The matter is set for further hearing on 6th December 2001.

**FAIT A NOTER:** **La fumée de tabac contient plus de 4 000 substances différentes, dont plus de 50 sont des cancérigènes reconnus.**

# Clearing the (second-hand) smoke: passive smoking and the FCTC

Smoke, smoke, everywhere – that seems to be the slogan for public places in many countries. Indeed, delegates who arrived in Geneva yesterday and dropped by the CICG conference centre got to experience it first hand: ashtrays on every table in the cafeteria, tobacco smoke throughout the lobby.

The situation is particularly serious for the hundreds of millions of employees around the world who are exposed to other people's tobacco smoke in the workplace. Even in countries with strict rules about hazardous chemicals in the workplace, second-hand smoke is often considered to be an unavoidable fact of life.

***Philip Morris presented to the UK industry their global strategy on environmental tobacco smoke. In every international area...they are proposing, in key countries, to set up a team of scientists organised by one national co-ordinating scientist and American lawyers, to review scientific literature or carry out work on ETS to keep the controversy alive. They are spending vast sums of money to do so.***

— Philip Morris, 1987

The science is clear, and agreement among public health experts is universal, that exposure to second-hand smoke is a significant and thoroughly preventable health risk to non-smokers. Numerous reports, including ones by the World Health Organisation and the Surgeon General of the United States, have documented the following dangers:

- Second-hand smoke is a known cause of disease, including lung cancer and cardiovascular disease, in adult non-smokers. Among children, an extensive body of scientific research has linked exposure to second-hand smoke as a cause of far-reaching health effects including bronchitis, pneumonia and middle ear infections. Involuntary smoking increases the frequency of episodes and severity of symptoms in asthmatic children. It is also a risk factor for new cases of asthma.

- Children are especially vulnerable to the effects of second-hand smoke. The WHO estimates that approximately 700 million, or almost half, of the world's children are exposed to second-hand smoke. It arises from smoking by adults in places where children live, work and play.

- There is no safe level of exposure to second-hand smoke. Tobacco smoke is a complex mix of over 4,000 chemical compounds, over 50 of which cause cancer and six of which are developmental or reproductive toxicants. Some of the active agents found in tobacco smoke include ammonia, arsenic, cyanide, formaldehyde and acetone. Tobacco smoke also contains large quantities of carbon monoxide, a gas that inhibits the blood's ability to carry oxygen to body tissues including vital organs such as the heart and brain.

The establishment of smoke-free environments does more than protect non-smokers. They are also among the most effective tobacco control interventions to curtail *active* smoking. Evidence evaluating the effectiveness of smoking restrictions in public places and private workplaces has found a reduction in both smoking prevalence and average daily cigarette consumption. Studies have found that overall per capita smoking was reduced by approximately 6% as a result of restrictive clean indoor air policies.

Although the tobacco industry has known for nearly 20 years that second-hand smoke poses a severe risk to health, it has done everything in its power to downplay this risk and fight measures to restrict smoking in public places and worksites.

Indeed, industry scientists have reviewed the evidence showing that non-smokers exposed to second-hand smoke suffer significant damage to the functioning of their airways and found it to be credible. As a 1980 Philip Morris document put it about one study, "I have reviewed the above paper and find it to be an excellent piece of work which could be very damaging to our business. There are several things that can be done to minimize its impact."

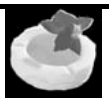
Nevertheless, in the 1990s, Philip Morris mounted a multi-million-dollar campaign to undermine a study on the dangers of second-hand smoke undertaken by the International Agency for Research on Cancer, an affiliate of the WHO. The campaign was targeted at researchers, the media and government.

Its aim, in the words of a 1993 Philip Morris document, was to "delay the progress and/or release of the study; affect the wording of its conclusions and official statement of results; neutralize possible negative results of the study, particularly as a regulatory tool; and counteract the potential impact of the study on governmental policy, public opinion and actions by private employers and proprietors."

The FCTC should encourage effective action to establish smoke-free environments. An effective Convention will reject tobacco industry proposals that would threaten the health of non-smokers and contribute to their premature death from cancer and heart disease.

Prohibiting smoking in public places and workplaces protects non-smokers from second-hand smoke and increases public awareness of the negative health effects of smoking. It also reduces the social acceptability of smoking and increases the likelihood that smokers of all ages will smoke fewer cigarettes or stop smoking entirely. The FCTC and should be a catalyst for these important public health measures around the world.

## Orchid Award



PRESIDENT MOI OF KENYA
For his courageous exposure of the harm the tobacco industry has done to his country.

## Dirty Ashtray

**PHILIP MORRIS,**
For their desperate and cynical effort to fool us by changing their name to Altria.

# THE FRAMEWORK CONVENTION ALLIANCE

The Framework Convention Alliance (FCA) is a diverse alliance of non-governmental organisations from around the world who are working jointly and separately to support the development of a strong Framework Convention on Tobacco Control, and all related protocols.

The Alliance includes individual NGOs and organizations working at the local or national level as well as existing coalitions/ alliances working at national, regional and international levels.

The Alliance was formed out of the need for improved communication among groups already engaged in work around the FCTC and the need for more systematic outreach to NGOs not yet engaged in the process, particularly in developing countries, who could both benefit from and contribute to the creation of a strong FCTC.

Our chief aim is to secure a Framework and protocols which, when taken together as a package, are as effective as possible at furthering the cause of global tobacco control. A list of our members appears below.

## FCA Member Organizations

Action Council Against Tobacco (India)
Action on Smoking and Health (Australia)
Action on Smoking and Health (Ireland)
Action on Smoking and Health (London)
Action on Smoking and Health (New Zealand)
Action on Smoking and Health (Scotland)
Action on Smoking and Health (USA)
Action on Smoking and Health Foundation (Thailand)
Adventist Development and Relief Agency (Mongolia)
Adventist Development and Relief Agency (Cambodia)
Advocacy Institute (USA)
Aer Pur Romania
African Centre for Empowerment and Gender Advocacy (Kenya)
Alcohol and Drug Information Centre (Sri Lanka)
Alcohol and Drug Information Centre (Ukraine)
American Cancer Society
American Heart Association
American Lung Association
American Public Health Association
Aparangi Tautoko Auahi Kore (Maori Smokefree Coalition) (New Zealand)
Asociación Española contra el Cancer (España)
Association for Consumers Action on Safety and Health (India)
Association of the European Cancer Leagues
Association pour la Défense des Droits des Consommateurs (Tchad)
Association Togolaise de Lutte contre l'Alcoolisme et les Autres Toxicomanies (Togo)
Association Togolaise pour la Défense du Consummateur (ASTODEC) (Togo)
Association VISA - VIe Santé (Life-Health) (Île-Maurice)
Bangadesh Anti-Tobacco Alliance
Bons Templiers Congolais
British Medical Association
Campaign Against Foreign Control of Aotearoa (NZ)
Campaign for Tobacco-Free Kids (USA)
Canadian Cancer Society – Société canadienne du cancer
Cancer Foundation of Western Australia
Cancer Institute (India)
Cancer Society of Finland
Centro de Información y Educación para la Prevención del Abuso de Drogas (Perú)
Centre for Tobacco Education and Development (Kenya)
Chinese Progressive Association (USA)
Comité national contre le tabagisme (France)
Community Health Cell (India)
Conselho de Prevencão do Tabagismo (Portugal)
Consumer Watch (Kenya)
Consumers Association of Malawi
Consumers Association of Penang (Malaysia)
Consumers International Regional Office for Asia and the Pacific
CorpWatch (USA)
Croix Bleue de la Republique Démocratique du Congo
Czech Committee of European Medical Association Smoking OR Health
Environmental Rights Action (Nigeria)
Essential Action (USA)
European Forum of Medical Associations Tobacco Control Resource Centre at the British Medical Association
European Medical Association on Smoking and Health
European Network for Smoking Prevention
European Respiratory Society
European Union of Non-Smokers
FDI World Dental Federation
Georgian Medical Association
German Cancer Research Centre
German Coalition Against Smoking
German Medical Action Group Smoking and Health
German Medical Association
Grupo Universitario Anti-Tabáquico (Uruguay)
Health 21 Hungarian Foundation
Heart and Stroke Foundation of Canada – Fondation canadienne des maladies du cœur
Heart Foundation of Barbados
Hellenic Cancer Society
Hong Kong Council on Smoking and Health
Hungarian National Tobacco Control Forum
Indonesian Association of Pulmonologists
Indonesian Smoking Control Foundation (LM3)
INFACT (USA)
InterAmerican Heart Foundation – Fundación interamericana del corazón
Interfaith Center on Corporate Responsibility (USA)
International Agency on Tobacco or Health
International Council of Women
International Network of Women Against Tobacco
International Non-Governmental Coalition Against Tobacco
International Union Against Tuberculosis and Lung Disease
IOGT Regional Council for South and South East Asia
Isfahan Cardiovascular Research Centre (Iran)
Israel Cancer Association
Janak Memorial Services Centre (Nepal)
Japan Association Against Tobacco
Japan Coalition on a Smokefree Environment
Japan Medical-Dental Association on Tobacco Control
Jordanian Anti Smoking Society
Korean Association on Smoking and Health
Medical Women's International Association
Mouvement National des Consommateurs (Cameroun)
Mutuelle Sociale de Santé (Cameroun)
National Council Against Smoking (South Africa)
National Heart Foundation (Australia)
Network for Consumer Protection (Pakistan)
New South Wales Cancer Council (Australia)
Non-Smokers' Rights Association – Association pour les droits des non-fumeurs (Canada)
OxyGenève (Switzerland)
PATH Canada (Programme for Appropriate Technology in Health)
Pakistan Society for Cancer Prevention
Philippine Cancer Society
Physicians for a Smoke-Free Canada – Médecins pour un Canada sans fumée
Public Health Initiative (Philippines)
Public Services International
REDEH-CEMINA - The Network in Defense of Humankind (Brazil)
Robert Wood Johnson Foundation (USA)
Russian Public Health Association
San Francisco Tobacco Free Coalition (USA)
Saudi Charitable Anti-Smoking Society
School of Preventative Oncology, Patna (India)
Mouvement Anti-Tabac du Sénégal
Smokefree Coalition (New Zealand)
Social Needs Network (Kenya)
Society for Research on Nicotine and Tobacco (USA)
SOS Tabagisme (Mali)
Soul City (South Africa)
Southeast Asian Tobacco Control Alliance
Sudan Committee for the Control of Tobacco Consumption
Tanzania Public Health Association
The Environmental Action Network (Uganda)
Tobacco Law Project (USA)
Tobacco-Free Las Cruces Coalition (USA)
Toombak and Smoking Research Centre (Sudan)
Turkish Committee on Tobacco or Health
Uganda Consumers Protection Association
UICC Globalink
UICC International Union Against Cancer
Unión Antitabáquica Argentina
Uruguay Anti-Tobacco Comission
Vietnam Standard and Consumer Association
Women Against Tobacco Association (Bulgaria)
Women's Environment and Development Organisation (WEDO)
Working Group on Prevention and Treatment of Tobacco Dependence, Czech Medical Association (Czech Republic)
World Assembly of Youth
World Federation of Public Health Associations
World Vision International
Zuna Women's Operation Green (Zimbabwe)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