IT CAN BE DONE
A smoke-free Europe
Their future health
Our present responsibility
Fresh air free from tobacco smoke is an essential component of the right to a healthy and unpolluted environment.

Every child and adolescent has the right to be protected from all tobacco promotion and to receive all necessary educational and other help to resist the temptation to start using tobacco in any form.

All citizens have the right to smoke-free air in enclosed public places and transport.

Every worker has the right to breathe air in the workplace that is unpolluted by tobacco smoke.

Every smoker has the right to receive encouragement and help to overcome the habit.

Each citizen has the right to be informed of the unparalleled health risks of tobacco use.
It Can Be Done . . .

. . . This was Dr Kjell Bjartveit's conclusion when he gave an overview at the Conference of anti-smoking measures that have been successfully implemented. This slogan was later referred to throughout the Conference, and is now used as the title of this book.

Mr Dick Dowler, who for many years has worked with Dr Bjartveit and illustrated his presentations, undertook the artwork and layout for this book. Some of Dr Bjartveit's illustrations from his presentation in Madrid and elsewhere are included here.

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 32 active Member States and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples, and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages—English, French, German and Russian—and applications for rights of translation into other languages are most welcome.

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IT CAN BE DONE
A smoke-free Europe

Report of the first European Conference on Tobacco Policy
Madrid, 7–11 November 1988

Organized jointly by
The WHO Regional Office for Europe
The Ministry of Health and Consumer Affairs of Spain
The Commission of the European Communities
In collaboration with
The International Agency for Research on Cancer
The International Union Against Cancer

WHO Regional Publications, European Series, No. 30
These booklets describe the Regional Office's 5-year Action Plan, and study nine topics on the subject of tobacco. They were provided to the Conference as background documentation.
Both as a personal and as a public health issue, tobacco use presents us with a number of paradoxes. We are living at a time when a greater interest in personal health expresses itself in increased sales of products such as dietary supplements, slimming preparations and books about reducing stress. Yet by far the greatest step any smoker can take to reduce the risk of serious illness, and to increase the probability of living a long and healthy life, is to stop smoking.

These days, millions of dollars are given both by public authorities and by ordinary citizens for research into the causes of and cures for cancer. Yet a formidable body of research has already shown us that in developed countries tobacco smoking causes about one in every three deaths from cancer, as well being a major cause of cardiovascular and chronic respiratory diseases.

Recent years have brought about an unprecedented level of concern about the effect of the environment on our wellbeing. Yet prolonged involuntary exposure to cigarette smoke represents a much more serious and widespread threat to health than other indoor air pollutants to which individuals are involuntarily exposed.

As we prepare to enter the twenty-first century, Europeans are becoming more aware of their power as consumers and are demanding that manufacturers provide products that are safe and healthy. Yet what saleable item can rival cigarettes, a product responsible for the deaths of one in four long-term users, in respect of the hazards involved? Equally, it is difficult to understand the willingness of consumers to accept this level of danger. What woman would knowingly use, for example, a cosmetic product that promised glamour but which at the same time might lead to
a shortening of her reproductive life, endanger the health of her unborn child, or even increase the risk of cervical cancer? Yet we see both men and women – or, more accurately, boys and girls – pursuing the advertisers’ image of adult sophistication by taking on this potential burden of illness and early death.

The contradictions implied in this state of affairs are compounded by the fact that there are really no technical or scientific obstacles to ending the smoking pandemic. As you will read in this report, with present trends about 100 million of the 850 million people currently alive in the Member States of the European Region of WHO will be killed by tobacco. A sizeable number of these people will lose many years of life or will suffer needlessly. And the reason they and their families will suffer is that we have so far lacked the political will and the organizational ability to tackle the extremely serious problem that tobacco represents in our society.

I believe that we have reached a turning point in the history of tobacco in Europe, and that our politicians and opinion leaders are now ready to act. The adoption in the autumn of 1987 of the 5-year Action Plan on Tobacco by the Regional Committee, the “health parliament” covering the 32 Member States of the WHO European Region, was an expression of political will at the highest level. The deliberations and decisions of the conference reported on here mapped out policies that Europe’s greatest experts in this field think will radically reduce tobacco use on our continent. In that sense, this conference was not the culmination of 25 years’ experience of fighting the tobacco pandemic in Europe, but a new beginning that will see technical and scientific knowledge coupled with political action at the international, national and local levels to eliminate our largest public health problem.

J.E. Asvall
WHO Regional Director for Europe
Motivated by a desire to promote their common health policy, the strategy for health for all and its 38 targets, the Member States of the WHO European Region decided to launch a pilot project that would concentrate on a specific issue of health for all policy. The purpose of this project was to forge new alliances and open up avenues of communication throughout Europe and to show that, by working together, people in Europe could solve common public health problems.

The European Region was given a clear indication of the issue on which it should concentrate its efforts when the World Health Assembly gave a very strong directive in the latest of its resolutions on tobacco (WHA40.38). Following the lead of the Health Assembly, the WHO Regional Committee for Europe, at its thirty-seventh session, passed resolution EUR/RC37/R9 approving an Action Plan on Tobacco. One of the provisions of this Action Plan was that a European conference should be held to provide Member States with a set of guidelines on tobacco policy and to launch a promotional campaign.

The first European Conference on Tobacco Policy, which this report describes, was organized by the WHO Regional Office for Europe, the Ministry of Health and Consumer Affairs of Spain and the Commission of the European Communities, with the support of WHO headquarters, the International Agency for Research on Cancer and the International Union Against Cancer. Participants from 27 Member States of the Region and four countries outside Europe met for five days to discuss all aspects of a tobacco control policy, and the measures that could be taken immediately to promote such a policy. As a result of their deliberations they endorsed a charter recognizing people's moral right to be protected not only from the diseases tobacco causes but also from the pollution created by tobacco smoke.

*Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series No. 1).*
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Each citizen has the right to be informed of the unparalleled health risks of tobacco use.
To make it possible for every person in Europe to enjoy the rights set out in the charter, the Conference participants recommended ten strategies to be followed.

**Ten strategies for a smoke-free Europe**

1. Recognize and maintain people's right to choose a smoke-free life.  
2. Establish in law the right to smoke-free common environments.  
3. Outlaw the advertising and promotion of tobacco products and sponsorship by the tobacco industry.  
4. Inform every member of the community of the danger of tobacco use and the magnitude of the pandemic.  
5. Assure the wide availability of help for tobacco users who want to stop.  
6. Impose a levy of at least one per cent of tobacco tax revenue to fund specific tobacco control and health promotion activities.  
7. Institute progressive financial disincentives.  
9. Monitor the effects of the pandemic and assess the effectiveness of countermeasures.  
10. Build alliances between all sections of the community that want to promote good health.

The Conference participants felt that a tobacco control policy that encompassed these ten strategies, coupled with the more specific areas covered by the Action Plan on Tobacco and the recommendations contained in the booklets specially prepared for the Conference, could bring about a significant reduction of tobacco consumption in Europe and could eventually eliminate the diseases tobacco causes.
Half a millennium ago, sailors acting in the service of a Spanish Queen introduced to Europe a substance that was to cause the greatest plague the continent has ever known. The substance brought back by those explorers in the New World was, of course, tobacco. It was all the more appropriate, then, that the first major meeting of European countries to explore ways to act together to eliminate the epidemic of tobacco-induced diseases should be opened by a Spanish Queen.

Her Majesty Queen Sophia of Spain presided over the opening of Europe’s first Conference on Tobacco Policy, which was attended by participants from 27 Member States of the European Region of the World Health Organization and from four countries outside Europe. At the opening ceremony, held in the Spanish Ministry of Health and Consumer Affairs, the host government was represented by the Minister, Professor Julian García Vargas, Dr Jo E. Asvall, WHO Regional Director for Europe represented the World Health Organization, and Mr Manuel Marin, Vice-President of the Commission of the European Communities represented the other Conference co-organizer. The International Union Against Cancer and the International Agency for Research on Cancer also sponsored the Conference.
In 1984, the 32 Member States comprising the European Region of WHO adopted a common policy for attaining health for all in Europe by the year 2000. This European strategy is part of a worldwide movement, “Health for all by the year 2000”, which calls for improvements in environmental health and in lifestyles, as well as advocating changes in health services and in the training of health workers and improvements in health information systems.

The Action Plan is a five-year strategy that aims to help countries adopt comprehensive policies designed to diminish tobacco use. The Action Plan seeks to locate itself within the health promotion movement and is built on ideas defined by health for all and reinforced by the Ottawa Charter for health promotion. The Action Plan urges much greater cooperation between those working at the local, national and international levels, and between individuals and groups. Its emphasis is on the efficient use of existing resources by pooling knowledge and experience of successful projects and by encouraging cooperation to increase the effectiveness of individual measures.

It seemed to the countries, however, that merely formulating this policy was not enough; they realized what might be achieved if all concerned worked together to make health for all a reality. They proposed that a campaign be mounted to encourage and support a widespread, concerted movement throughout Europe on specific areas of the policy. It was decided first to look at the lifestyle issues where the choices available to people concerning the way they live can greatly affect their wellbeing. The first theme selected was tobacco, and in the autumn of 1987 an Action Plan on Tobacco was adopted by the countries.

The Action Plan’s initial stage of planning and laying the groundwork for greater cooperation between organizations culminated with the opening of the first European Conference on Tobacco Policy. We now stand at the threshold of an era offering new opportunities to work together to make a healthier life possible for all the people of Europe.
Cigarette smoking is the main cause of avoidable disease and premature death in Europe, as in much of the rest of the world. Yet, although knowledge of the disastrous health effects of tobacco has existed for decades, the enormity of this burden has never been fully perceived outside a narrow section of the community.

Perhaps it is precisely because cigarette smoking is such a common cause of death that it roused relatively little general interest. It is the dramatic, unexpected events such as air crashes that attract attention and overshadow this quiet epidemic that each year wastes more than three quarters of a million lives in Europe alone. Yet an equivalent number of deaths would be caused if six jumbo jets crashed every day of the year, killing all on board!

Over the past quarter of a century every country in Europe has taken some steps to prevent this senseless loss of life, but for the most part these isolated efforts, however good in themselves, have not been adequate to tackle the difficult and widespread problem of tobacco use. Experience has shown that the most promising way of reducing any country’s tobacco consumption is to adopt tobacco policies that coordinate a wide variety of collective and individual measures at community and national levels. What is clear is that widespread changes will not come about through the efforts of any single government ministry, health service or public interest group. A common effort must be made.

Few changes in the policies of either public authorities or private organizations will occur unless there is public awareness of the gravity of the tobacco problem and widespread support for measures to tackle it. Even when policy changes are achieved, many will not be accepted by the public if there is no consensus that the health and social consequence of tobacco use are intolerable.
It was with this in mind that this Conference was organized. It aimed to bring together policymakers and administrators, public interest groups such as consumer organizations, and professional interest groups such as health personnel, teachers, journalists, economists, social scientists, lawyers, agriculturists and trade unions. Tobacco is not a problem that confines itself to national borders; thus international organizations, which have an important and specific role to play, were also represented at the Conference.

These are the people who will articulate the need for policy changes; in other words, those who will start to build a consensus, those who will plan the policy changes or those who will carry them out. The Conference aimed to provide a forum where these groups could find ways of exchanging knowledge and resources, agree on a model tobacco control policy, and decide on specific actions to be taken immediately and in the near future to raise awareness about the tobacco problem and to promote policies that make some headway against it.

**PAST & FUTURE DEATHS DUE TO CIGARETTES**

Estimated* worldwide totals in millions.
(Assuming no further large change in proportions of young adults who become regular smokers.)
Sources: Richard Peto

---

Annual deaths attributable to tobacco use

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Millions</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
<td>2.0</td>
<td>2.5</td>
<td>3.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

---

2025

2050

Pulling together. To reduce an increasing death toll a common effort is needed on community, national and international levels.
The participants at the Conference were among the most experienced scientists, social scientists, and experts on health education and public health policy in Europe. It was the view of the organizers that it would be a great waste if these people came to Madrid to be the passive auditors of yet another set of speeches on tobacco. For that reason, working groups of participants became the core of the Conference about which everything else revolved.

Seven working groups had a gruelling schedule of sessions through which they were to hammer out the main objectives of a tobacco control policy for Europe. The groups were mixed according to nationality and knowledge with a view to giving each group the benefit of the widest possible experience. All the other elements of the Conference were intended to feed information into these groups and stimulate their discussions.

Each of the first four days of the Conference had a broad theme: health; information and education; enforced smoking; and tobacco economics. The other parts of the Conference, listed below, were arranged to provide the relevant information on the appropriate day.

Plenary sessions

The more traditional conference presentations were balanced with two round-table discussions. In these Mr Peter Taylor, a very experienced broadcaster and journalist who is also the author of one of the most widely read and respected books on the politics of tobacco, used his own extensive knowledge about the subject to lead a panel of seven members through a wide-ranging discussion. In addition to this, he called on those in the audience whom he knew had relevant experience, responded to other comments and questions, and generally guided nearly 200 enthusiastic people through two 90-minute debates with humour and skill.
Supporting documents

All participants received nine booklets, the so-called “Smoke-free Europe” series, each addressing a particular aspect of a tobacco policy. Intended for the non-specialist reader, the booklets give a concise and up-to-date view of a particular tobacco control issue, and point readers in the direction of further reading should they be interested in pursuing the subject. Many of the authors of these supporting documents were available to attend any working group where it was felt their expertise was needed.

For more information on these invaluable booklets and their content, please see pages 66 and 67.

A marketplace

Participants could attend poster presentations and see videos and other exhibition material supplied by different countries in the European Region. Also available in the marketplace was a small reference library on tobacco, and facilities for searching computerized tobacco data bases. A librarian was present to help the working groups with any enquiries.

Each working group was led by a team of two rapporteurs and a group leader.

In the evening, after the close of the working group sessions, these teams met with the Conference rapporteurs and other members of a drafting committee to begin work on the Conference statement and report. The following morning the rapporteurs gave their summary of discussions back to the working groups for further comment. The organizers hoped that this working method would ensure that the results, including this report, were a true reflection of the participants’ views.
The most striking and sobering statement of the Conference was the confirmation that Europe, like the rest of the world, is in the steeply increasing phase of a pandemic of immense size. In the countries of the WHO European Region tobacco now causes about 800,000 deaths a year.

This appalling situation will become much more grave. With present smoking patterns, at least 100 million of the 850 million people now living in Europe are likely to be killed by tobacco. By the year 2025, the deaths of about two million Europeans will be caused each year by tobacco. About a half of these deaths will occur in middle age (40-69 years). For those who die in middle age the loss of life expectancy is considerable - about 20 years!

It is important to remember that these figures are not just sets of numbers but represent the lives of real people. The people who will die in middle age in 2025 are already alive as the children and young adults of today. Based on current smoking habits, the predicted annual mortality from smoking in the second quarter of the next century for those who are now the world's children will be about 10 million. That is 10 million deaths a year caused by tobacco worldwide if - and only if - there is no increase in current tobacco consumption levels.

We know that in all likelihood the reality will be worse. Although per capita cigarette consumption is falling in some countries, including Ireland, the Netherlands and the United Kingdom, it continues to increase in parts of southern and eastern Europe. The situation for the developing world is even more serious, as tobacco consumption seems set to continue to rise sharply in these economically deprived countries.

The data given above were taken from the presentation by Mr Richard Peto, ICRF Reader in Cancer Studies, Radcliffe Infirmary, Oxford, United Kingdom.


From "The economic significance of tobacco and the future outlook", the paper presented by Mr S.P. Malhotra, Senior Commodity Specialist, Food and Agriculture Organization of the United Nations, Rome, Italy.
EUROPE 1983-1985: TOTAL ANNUAL MORTALITY FROM TOBACCO (MILLIONS)

<table>
<thead>
<tr>
<th></th>
<th>Female cancer</th>
<th>Male cancer</th>
<th>Total cancer</th>
<th>Other diseases caused by smoking (e.g. heart or chronic lung disease)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.04 M</td>
<td>0.36 M</td>
<td>0.4 M</td>
<td>0.4 M*</td>
<td>0.8 M</td>
</tr>
</tbody>
</table>

* Estimated as approximately equal to the total number of cancer deaths caused by tobacco (and not, as in UK, by a larger number).

PREDICTED MORTALITY PATTERNS IF THERE IS NO CHANGE IN CURRENT SMOKING PATTERNS

<table>
<thead>
<tr>
<th>Region</th>
<th>Current population of children (i.e. aged under 20 in 1985) BILLIONS</th>
<th>Predicted annual deaths from tobacco when these reach middle age (in about 2025) MILLIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>0.25</td>
<td>2</td>
</tr>
<tr>
<td>Other developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(chiefly N. America, Japan)</td>
<td>0.1</td>
<td>1</td>
</tr>
<tr>
<td>China</td>
<td>0.4</td>
<td>2</td>
</tr>
<tr>
<td>India</td>
<td>0.4</td>
<td>?1</td>
</tr>
<tr>
<td>Other Asia</td>
<td>0.4</td>
<td>?1</td>
</tr>
<tr>
<td>Other less developed (chiefly S. America, Africa)</td>
<td>0.4</td>
<td>?1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2 B</td>
<td>8 M/year*</td>
</tr>
</tbody>
</table>

* Note: Most now aged 0-19 will die during the second quarter of the next century (2025-2049), when annual mortality from tobacco may, if present smoking habits persist, be about 10 million per year. Hence, about 200 million of them will be killed by the habit.

PREDICTION FOR EUROPE IN 2025 IF CURRENT SMOKING PATTERNS PERSIST

<table>
<thead>
<tr>
<th></th>
<th>Attributed to tobacco</th>
<th>Other deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths in middle age (40-69)</td>
<td>1 M*</td>
<td>2 M</td>
</tr>
<tr>
<td>Deaths in old age (70+)</td>
<td>1 M</td>
<td>8 M</td>
</tr>
</tbody>
</table>

* The people dying in middle age in 2025 are already alive (born 1953-1985) as the children and young adults of today.

DEATHS FROM TOBACCO DURING THE PERIOD 2025-2050 (i.e. when children born in 1985 are aged 40-65)

<table>
<thead>
<tr>
<th>Region</th>
<th>Growth in population of males aged 60 or over* (ratio, 2050/2025 population)</th>
<th>Predicted** annual deaths due to tobacco (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a) in about 2025</td>
<td>(b) in about 2050</td>
</tr>
<tr>
<td>Europe WHO</td>
<td>1.0</td>
<td>2</td>
</tr>
<tr>
<td>Other developed (chiefly N. America, Japan)</td>
<td>1.0</td>
<td>1</td>
</tr>
<tr>
<td>China</td>
<td>1.3</td>
<td>2</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>?1</td>
</tr>
<tr>
<td>Other Asia</td>
<td>2</td>
<td>?1</td>
</tr>
<tr>
<td>Other less developed (chiefly S. America, Africa)</td>
<td>2</td>
<td>?1</td>
</tr>
<tr>
<td>World total</td>
<td>1.6</td>
<td>about 8 M</td>
</tr>
</tbody>
</table>

Predicted average rate during 2025-2050 about 10 M

* Infants in the late 1980s will be in their early 60s in 2050, and may be nearing retirement.
** Predicted assuming no large change in the proportions of young adults who become regular smokers (but with continued replacement of traditional forms of tobacco by manufactured cigarettes).

Source for all tables on this page: Richard Peto.
A crisis in leadership

Given the enormous number of early deaths and the appalling catalogue of disease caused by tobacco use, why has so little been done? In his opening address, Dr Asvall put his finger on the problem when he said the tobacco pandemic indicated not only a crisis in health but also a crisis in leadership, in professional responsibility and in organizational capacity. He laid the blame directly at the door of the politicians and public health administrators who had failed in their duty to protect the rights and defend the welfare of the people; and at the public health sector that, despite having the information about the dire health consequences of tobacco use, had for the most part failed to force the community to confront the problem. It was also, he said, a “gross embarrassment” for millions of health personnel who for so many decades had failed to act on their knowledge to advise their patients and communities.

His words were echoed by other speakers. Given the enormity of the tobacco problem and the potential for prevention, one might have expected a comprehensive worldwide public health programme aimed at eradicating this man-made health problem. With few exceptions, the response to this human tragedy has been “characterized by a paralysing passivity on the part of the health profession, bureaucrats and the decision makers”.

But the picture is not all grim. In a number of countries control measures have been introduced that have successfully reduced tobacco consumption and that are feasible in all countries.

These measures are clearly meant to respond to different aspects of tobacco control, but one common by-product of the measures is that they all contribute to the erosion of the social acceptability of the tobacco habit. Public health strategy must aim at changing the climate of opinion and reversing the social profile of smoking – from a habit that is perceived as being adult, sophisticated and glamorous to one that gives a more realistic impression of a product responsible for the death of one in four of its regular users. What the success of these individual measures tells us is:

IT CAN BE DONE!

*Dr Kjell Bjartveit, Chairman of the Norwegian Council on Smoking and Health, in his Conference speech “The anti-tobacco cocktail”.*
A change in political climate

Although the successful implementation of single tobacco control measures is highly encouraging on a practical level, the indication of a heightened awareness among decision-makers and the creation of a new political will to tackle the tobacco pandemic is even more exciting for those concerned about the health of Europe. What characterizes this change is both the perception that the tragic human waste caused by tobacco is a problem shared by all the countries of Europe and the understanding that we must all work together if a solution is to be found.

This belief was endorsed by 32 countries when the WHO Regional Committee for Europe unanimously adopted the five-year Action Plan on Tobacco in 1987, creating what Dr. Asvall called an "unprecedented public mandate" to push ahead with a broad-scale effort to reduce tobacco use throughout Europe. It has also been underlined by the European Community's "Europe Against Cancer" programme, which likewise brings together governmental and nongovernmental organizations to pursue a common goal.
Europe Against Cancer

Speaking as Vice-President of the Commission of the European Communities, Mr Manuel Marin said frankly that there was strong opposition from certain quarters to any action by the European Community to try to decrease demand for tobacco. But the weight of scientific evidence was such that the Commission could not in all conscience refuse to take up the challenge of reducing the number of smoking-induced deaths in Europe.

Acting on this duty, the European Council launched the Europe Against Cancer programme in 1985 and designated 1989 as European Cancer Information Year. By 1987, the Commission’s committee of cancer experts had approved a European code against cancer. This code enumerated ten recommendations for action to reduce cancer mortality in Europe by 15% by the year 2000. The first article of the code is: Don’t smoke. Smokers, stop smoking as soon as possible but if you do smoke, don’t do it in the presence of others. The Council of Ministers provided 31 million ECU to fund the programme for the period 1987-1989.

The Commission has been working towards harmonizing tobacco-related policies in the member states of the Community, especially in view of the Single Act for Europe due to come into force in 1992. It will first try to get agreement by the end of 1989 on a directive to standardize tobacco product labelling, including health warnings. A second directive will try to set a ceiling on permissible “tar” emission levels, aiming for a maximum content of 15 mg per cigarette in 1992 with a reduction to 12 mg per cigarette in 1995.3

Mr Marin was unambiguous about the political difficulties inherent in any action taken by the European Community to decrease tobacco consumption. Widespread cultivation of tobacco had been practised in Europe long before the Treaty of Rome was ratified. There were currently about 215 000 workers employed in tobacco growing and some 200 000 hectares under cultivation in the member states. Moreover, tobacco was an important crop in some of the most economically disadvantaged areas of the Community.

ANNUAL CANCER DEATHS FROM TOBACCO:
360 000 EUROPEAN MALES IN MID-1980s

<table>
<thead>
<tr>
<th>Certified cause of death</th>
<th>Total (WHO Europe)</th>
<th>Not attributed to tobacco</th>
<th>Attributed to tobacco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung cancer</td>
<td>250 000</td>
<td>20 000</td>
<td>230 000*</td>
</tr>
<tr>
<td>Cancer of mouth, oesophagus, pharynx or larynx</td>
<td>80 000</td>
<td>20 000</td>
<td>60 000*</td>
</tr>
<tr>
<td>Other or unspecified types of cancer</td>
<td>510 000</td>
<td>440 000</td>
<td>70 000**</td>
</tr>
<tr>
<td>All cancers</td>
<td>840 000</td>
<td>480 000</td>
<td>360 000</td>
</tr>
</tbody>
</table>

* By subtraction from total of ACS non-smoker rates.
** Estimated as 30 000 bladder and pancreas, 20 000 other specified sites, 20 000 unspecified sites.

ANNUAL CANCER DEATHS FROM TOBACCO:
40 000 EUROPEAN FEMALES IN MID-1980s

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th>Non-smoker rates (ACS)</th>
<th>Attributed to tobacco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total lung cancer deaths</td>
<td>50 000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number expected at US female non-smoker rates (ACS)</td>
<td>20 000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximate number of female lung cancer deaths attributed to tobacco</td>
<td>30 000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximate number of female deaths from other types of cancer attributed to tobacco</td>
<td>1/3 extra</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total female cancer deaths attributed to tobacco</td>
<td>40 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Richard Peto.

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3 Participants showed considerable concern that the product modification issue had been used by the tobacco industry to convey the idea that there could be a “safe” cigarette, and to distract governments from taking effective tobacco control measures. See the discussion under “Tar levels” on page 40.
Considering their diversity in cultural and professional backgrounds, the high level of agreement of the Conference participants was remarkable. But there was also a mood of frustration, and even anger, discernible among them. Some of those present had worked for over 20 years to bring about a reduction in tobacco-induced diseases. Despite the advances that had been made, everyone present realized how much was left to achieve and how much could be achieved if the will existed. They felt the time had come to defend the health rights of the individual against the corporate freedom of the tobacco industry, and to assert the nonsmokers' right to air free from the hazards of tobacco smoke. As Dr Asvall said in his keynote address, “Hasn't the time come to say loudly and clearly . . . give every European a breathing space?".

The Conference proposed the following Charter to establish the moral right to a smoke-free life.

Charter against Tobacco for Europe

★ Fresh air free from tobacco smoke is an essential component of the right to a healthy and unpolluted environment.

★ Every child and adolescent has the right to be protected from all tobacco promotion and to receive all necessary educational and other help to resist the temptation to start using tobacco in any form.

★ All citizens have the right to smoke-free air in enclosed public places and transport.

★ Every worker has the right to breathe air in the workplace that is unpolluted by tobacco smoke.

★ Every smoker has the right to receive encouragement and help to overcome the habit.

★ Every citizen has the right to be informed of the unparalleled health risks of tobacco use.

Giving every European a breathing space!
The Conference proposed ten strategies that must be pursued now to ensure that the rights set out in this Charter might be widely recognized and respected. After their deliberations, the working groups made recommendations to pursue each of these basic strategies.

1 Recognize and maintain people’s right to choose a smoke-free life

By far the most striking change in the campaign against tobacco-induced diseases is the emergence of smoking as an environmental issue. Prior to this decade some scientists had considered it plausible that even low levels of tobacco smoke in ambient air could be harmful; furthermore, the health damage sustained by children exposed to their parents’ tobacco smoke had been extensively documented before the 1980s. But it was only with the publication of evidence that breathing other people’s tobacco smoke increases the risk of lung cancer in nonsmokers that the public’s concern began to make itself felt.

Not surprisingly, the tobacco industry disputes the scientific evidence on enforced smoking, just as it absurdly persists in denying the overwhelming evidence on the effects of active smoking. However, the weight of independent research showing a relationship between exposure to environmental tobacco smoke and lung cancer in nonsmokers is growing steadily. The combined results of 14 reports – 11 case-control and 3 cohort studies – show a statistically significant increase in lung cancer in nonsmokers involuntarily exposed to tobacco smoke. Major scientific committees reviewing the evidence, including the United States Surgeon General, a special scientific committee of the US National Research Council and the International Agency for Research on Cancer, have concluded that environmental tobacco smoke ought to be considered a public health problem.

Many will argue that the world is full of hazards and so will question the seriousness of the health risks of environmental tobacco smoke. Although the risk of lung cancer to nonsmokers from involuntary smoking is small, it is not insignificant when compared to other environmental hazards widely considered as unacceptable. Sir Richard Doll has estimated that the risk of lung cancer from passive smoking is some 50-100 times greater than the risk of lung cancer from exposure to asbestos particles in buildings containing asbestos materials. And although the risk to nonsmokers through passive smoking is very much smaller than that experienced by smokers through active smoking, it is a general principle of public health that the hazards to which we are involuntarily exposed should be much smaller than those undertaken voluntarily.

Therefore, the case for people to demand protection from employers, public authorities and services against contamination of their air seems undeniable. Given the overwhelming evidence of the health damage to children from environmental tobacco smoke, it is crucial that measures be taken to protect them. This must include an effort to inform all adults, and particularly parents, of the special vulnerability of children.

Every country should work towards establishing a smoke-free environment in all enclosed public places, particularly where the duration of exposure

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4 From "Health effects of exposure to environmental tobacco smoke", a presentation by Dr Elio Riboli, International Agency for Research on Cancer, Lyons, France. See also Tobacco or health (Smoke-free Europe No. 4) described on pages 66 and 67.


6 Riboli, E. op. cit.
is likely to be extensive, such as at work. It is important, too, to give special consideration to enclosed spaces where the circulation of air is limited – on transport, for example, and especially in aircraft. Our duty to protect our children from indoor air contamination should be exercised in all public places, but especially in schools, youth clubs and other child care facilities.

Clean air at work

The workplace has attracted special attention in the call for smoke-free spaces. Many people spend more of their waking time at work than at any other place, and those who work in offices or other places where smoking is not confined to break-time can be exposed to environmental tobacco smoke for the duration of their working day. Considering that many people have a working life of 40 or more years, one's lifetime exposure to tobacco smoke at work can be considerable. Nor should it be forgotten that in addition to the discomfort experienced by many nonsmokers in these circumstances, breathing other people's tobacco smoke can cause acute distress and illness to those who suffer from certain conditions such as asthma or allergic complaints.

The participants at this Conference strongly expressed the need for policies to control smoking in the workplace. One important function of a policy was that it was the most effective way of protecting the right of employees to clean air while acting to resolve any possible conflicts which might arise between these rights and the privileges to which smokers had become accustomed.

Negotiation of a successful smoking policy in the workplace should be preceded by an effort to inform both management and workers of the health effects of environmental tobacco smoke, of proposals for restricting smoking, and of the possibilities of help for those employees who might wish to give up smoking. It was emphasized both in the round-table discussion and in the working groups that a change in the rules about smoking at work should be negotiated sympathetically, with both smokers and nonsmokers having the opportunity to express their views. A workplace policy is a health promotion exercise for both nonsmokers and smokers. While protecting nonsmokers, a no-smoking policy ensures that smokers will cut down and it will almost certainly encourage some of them to quit. In many cases the workplace is an excellent venue for providing easy access to help and support to stop smoking. Many participants felt that a policy to restrict smoking could be an important part of a workplace health promotion effort that addressed lifestyle as a whole.
Health premises

It goes without saying that it is crucial to impose strict limits on smoking in all health premises, not only for the comfort and safety of patients but also for its symbolic impact. It was felt that smoking in hospitals should in general be very severely restricted, but that some exceptions might be made for long-stay patients and the terminally ill, and in psychiatric wards.

A consciousness on the part of health professionals of their responsibility to set a good example in this respect should extend itself to health administration offices, health ministries and voluntary health organizations such as national medical associations. As a minimum, any organization concerned with health should ensure that anyone who is working directly with or who is visible to the public should never be seen smoking at work, and staff who smoke should be encouraged and helped to stop. Public areas, including reception areas, elevators, corridors and possibly canteens, should be smoke-free zones. Smoking should not be allowed at any meeting held by a health or medical association.

RECOMMENDATIONS FOR STRATEGY 1

1. Every country should begin now to establish a smoke-free environment in all enclosed public places, particularly worksites, transport, schools, and child care and health care facilities.

2. Children are particularly vulnerable to environmental tobacco smoke. Special measures should be taken to protect children and to make parents and the public at large more aware of their special vulnerability.

3. Employers and workers, trade unions and occupational health officers should be informed of the health consequences of exposure to other people’s tobacco smoke. Workplace policies to ensure a smoke-free working environment should be sympathetically negotiated, and help and encouragement given to employees who wish to stop smoking.

4. Health professionals have a special responsibility to see that health premises, health administration offices and meetings of professional associations should be smoke-free. Health care workers must be sensitive to their exemplary role and should not smoke in public.
Establishing a legal right to a smoke-free environment has several benefits. Such legislation contributes to the social unacceptability of smoking by signalling that not smoking is normal social behaviour: smoking is therefore exceptional behaviour that may be indulged in only under certain conditions. This expression of the social norm of a nonsmoking environment extends itself to circumstances – such as creating a demand for no-smoking areas in restaurants – that may not be covered by the legislation.

Another advantage of this type of legislation is that it can actually lead to fewer conflicts between smokers and nonsmokers by clearly defining the conditions under which smoking is permissible. This will only be the case, however, if the introduction of legislation has been preceded by an information and education campaign to inform both smokers and nonsmokers of the risks of breathing other people’s tobacco smoke, to explain why legislation is necessary and fair.

A third advantage of legislation is that it gives nonsmokers an avenue of redress if they feel their rights to a smoke-free environment are being infringed. This is especially important in the workplace. In a number of countries, workers have sought a solution to their problems through existing legislation to guarantee safety at work. This type of legislation is usually intended to protect workers from occupational hazards that do not include tobacco smoke. Norway found the experience of trying to use such legislation unsatisfactory and in 1988 amended its Tobacco Act to restrict smoking in public places and work premises.

A by-product of smoking restrictions in public places is that these measures can cause considerable inroads to be made into tobacco consumption. Thus, any national or local authority contemplating
regulations of this type must expect vigorous opposition from the tobacco industry and its allies. The tobacco companies have even more at stake than changes that will tarnish their product’s image: as long ago as the mid-1970s, one senior executive from an American tobacco company calculated that if such measures caused every smoker to smoke one cigarette less a day, his company would stand to lose US $92 million in sales annually.

At one time, a law to restrict smoking in public places was considered one of the most difficult types of tobacco control legislation to enact. The public demand for smoke-free space has increased so dramatically in recent years that these laws are now the most successful. Finland was a pioneer with this type of legislation, but in recent years wide-ranging laws have been enacted in Belgium, Iceland and Norway. Seventeen of the 32 countries of the European Region have enacted some type of legislation to restrict smoking. Elsewhere, most remarkably in the United States, regulations to limit smoking in public places have been successfully implemented at state and local level.

For a discussion of legislation concerning smoking in public places, see Legislative strategies for a smoke-free Europe (Smoke-free Europe No. 2) described on pages 66 and 67.

**RECOMMENDATIONS FOR STRATEGY 2**

1. European countries must enact legislation to protect the health of nonsmokers and ensure their right to breathe clean air. Such legislation should be in addition to other legislation on the protection of public health. These laws should:
   - provide that the air in premises and means of transport to which the public has access should be smoke-free;
   - provide for the complete protection of non-smokers from tobacco smoke in meeting rooms and premises where two or more people are gathered;
   - provide that smoking may be permitted only in designated areas.
Some few European countries have banned advertising as part of a tobacco policy and still others have no advertising of any product. But the advent of new forms of communication media and attempts by the tobacco industry to avoid advertising restrictions by using other methods of promotion mean that even these countries cannot be confident of remaining untouched by tobacco promotion.

Those who have studied the subject of tobacco control have for many years been convinced that tobacco advertising promotes not only the individual products but the habit of tobacco use itself. By using compelling imagery, tobacco advertising can promise glamour, excitement, and social and sexual success to current and prospective customers. These appealing and pervasive images work to undermine the credibility of health education campaigns about smoking. Furthermore, tobacco promotion impedes the flow of information because many magazines and newspapers tend to ignore the tobacco issue or to minimize its importance for fear of offending advertisers.6

Children are, of course, the prime marketing target for the tobacco industry. As long-term smokers are killed off by their habit and increasing numbers of the survivors give it up, the pool of smokers must be replenished in order to maintain the profits of the industry. The new smokers who are recruited are almost exclusively children and adolescents, and advertising is an important element in promoting and influencing smoking among the young.

Research reported on in the background documentation for this Conference shows that children become so well acquainted with the particular imagery and style of cigarette brands that they can name the specific product being advertised in advertisements that do not show the brand name. They can also identify cigarette brands being surreptitiously promoted by brand stretching – using other goods and services, such as sports clothes, shoes or holidays, to promote cigarette brands – and through sports sponsorship.

These results and those of similar research projects are reinforced by the experience of Iceland and Norway, which have both observed a significant decline in smoking by adolescents since all forms of tobacco advertising were banned.

6 For an overview of the arguments about tobacco advertising and a review of the evidence, see Pushing smoke: tobacco advertising and promotion (Smoke-free Europe No. 8) described on pages 66 and 67.
Obstacles to a tobacco advertising ban

It has often been observed that the reason the industry so vigorously resists any restriction of its licence to advertise is not to defend some principle of freedom of expression, but because advertising is such an effective way of promoting smoking. (Some commentators have noted wryly that the best way to assess the effectiveness of any tobacco control strategy is to measure the degree of industry opposition to it.) In any event, the right of children to grow up free of the pressure to take up a life-endangering habit must outweigh the leave that the tobacco industry currently enjoys to promote its products almost without restriction.

The record of the tobacco companies that have "voluntarily" undertaken to curb tobacco promotion is such that no one can seriously consider self-regulation by the industry to be a serious option. The examples of industry violations of the agreements it makes with governments have been copiously documented. Indeed, the Swedish government is so concerned about efforts to market products that act as hidden advertisements for cigarettes that it has appointed a Royal Commission to study this and other shortcomings of its tobacco policy with a view to possible legislation. The chief ways tobacco companies have of getting round restrictions is through "brand-stretching" mentioned above, "product placement" – paying to show cigarette brand names prominently in films or in advertisements for other products – and sponsorship. By sponsoring arts groups or sports, a company can associate tobacco with prestige cultural events or with the excitement and healthy image of sport. Using the proceeds of a special levy on tobacco to support these groups when sponsorship is banned is discussed elsewhere in this report and was heavily endorsed by Conference participants.

The question of restricting the advertising of tobacco products is really an international one. Smaller countries, such as Iceland, already experience the problem of advertising overspill. Although Iceland has banned tobacco advertising, the majority of the magazines read there are printed abroad and must be excepted from the rules. But the new mass communications media such as cable and satellite television are a greater cause for concern. Some European countries – Italy, for example – already experience a degree of cigarette advertising being beamed to their television screens from abroad, but it is possible that this problem will become much more widespread with the proliferation of satellite television. Conference participants were most anxious that international agreements should ensure that the tobacco industry would not be able to use this medium for advertising.

International agreement should also guarantee that the industry should not use international events such as the football World Cup, and especially the Olympic Games, to promote tobacco. Acceptance of sponsorship from tobacco companies is against the Olympic Charter, but the Olympic Movement should go further and promote the health of athletes, officials and observers by making the Games a smoke-free event, following the model of the Calgary Winter Olympic Games in 1988.

\[\text{Roberts, J.L. Code busting by tobacco companies. United Kingdom, Health Education Council and North Western Regional Health Authority, 1986.}\]
All countries where advertising is permitted should legislate to ban all promotion of tobacco products by direct and indirect means. This entails prohibiting the advertising of tobacco products, “brand stretching” to other products and services, “product placement”, and sponsorship of sporting and cultural events or other institutions by tobacco companies.

International agreements should guarantee that satellite television and other international communications media are not used to violate national restrictions on tobacco promotion.

Every sporting event should be smoke-free and free from all tobacco advertising and promotion. The Olympic Games are particularly important in this respect; all future Games should follow the practice of smoke-free events established by the 1988 Calgary Winter Olympics.
No one seriously advocates a general prohibition on tobacco sales (although most people agree that children should not be sold tobacco). This is not only because tobacco prohibition would be unworkable (like the prohibition of alcohol sales in the United States in the 1920s) but also because the great majority of people would defend the principle that individuals should be free to smoke if they so choose. But there is a difficulty in this dictum that revolves around the notion of choice: it is hard to characterize a choice made in childhood involving the use of an addictive substance as some sort of expression of self-determination. It is clear that this is also a consumer issue, and that consumers must have the freedom to make informed decisions; they have the right to be fully informed of the safety standards of tobacco products.

Public information campaigns have several functions: they help change public opinion and encourage a climate that is opposed to tobacco and in favour of nonsmoking; they encourage smokers to give up and reinforce the decisions of ex-smokers; and they build understanding and support for public health legislation and other measures.

The importance of health messages about tobacco cannot be underestimated. (This is discussed further in the following section on smoking cessation.) There are, however, a number of widespread misconceptions about these. The first is a belief that smokers understand the risks of smoking, and that their continued smoking indicates that they are unbothered by the chances they are taking. Research contradicts this view.\(^2\) Even in countries where anti-tobacco campaigns have been carried out for years and where many smokers will know that tobacco is connected with lung cancer, far fewer are aware of the other major diseases caused by tobacco – heart disease and chronic obstructive lung disease. In any event, even if smokers know that tobacco causes diseases, it is clear that they have little conception of the size of the risk; they may know smoking is dangerous, but not just how dangerous.

\(^2\) Millwood, D. & Gezelius, H. op. cit.
A second erroneous belief connected to the underestimation of risk is that “fear arousing” health messages do not work. This view is not supported either by social science research or by an examination of the evidence of declines in tobacco consumption. Between 1962 and 1971, both the United Kingdom and the United States experienced immediate drops in tobacco consumption following publication of major health reports. A similar phenomenon was experienced in Finland and Norway in the 1970s during the public debate surrounding the passage of their Tobacco Acts, and in Canada in 1986-1987 during discussion of that country’s tobacco advertising ban.

Furthermore, research on mass media smoking cessation campaigns aimed at adults in both Australia and the United Kingdom suggests that advertisements intended to promote the positive image of the nonsmoker were largely ignored by smokers. An evaluation of “health scare” advertisements in Australia showed they were significantly more effective in prompting smokers to make an attempt to stop.

It seems clear then that the health message is not played out. It is, however, incumbent upon anti-tobacco campaigners and health educators to think of new and attractive ways of presenting health information. Certainly, there is much to be said about the diseases caused by smoking of which the public is largely unaware. The disablement caused by chronic obstructive lung disease or peripheral vascular disease, which can lead to leg amputation, is most likely to capture the public’s attention.
Novel ways must be found to present information such as Richard Peto's calculation on British male smokers: “Out of every 1000 young males who smoke at least a pack of cigarettes a day: one will later be murdered; six will die in a traffic accident; 250 will die before their time from the effects of smoking”. Presentations of local statistics, e.g. the number of people in your city who this year will die from lung cancer because they smoked, capture the community’s imagination in a way that national figures fail to do. Moreover, opportunities can be found for striking calculations. For example, the organizers of Britain's national no-smoking day calculated at 60,000 the number of babies likely to be born in 1988 who would later die from smoking if present trends continued. They did this by taking the expected number of births in 1988 (700,000) and dividing it by the current United Kingdom rate of adult cigarette smoking prevalence (33%) and then by four, since one in four smokers is likely to die from the effects of smoking. Simple steps like these are appealing to the news media and can attract a great deal of public attention at very little cost.

For guidance on using local epidemiological data, see The physician’s role (Smoke-free Europe No. 1) described on pages 66 and 67.
Anti-tobacco education directed at children

Children's decisions to smoke or not to smoke are made on the same basis as adults' decisions to continue to smoke or to try to quit. They are influenced by the price of cigarettes, what they understand to be the health consequences, and what they believe to be the advantages of smoking (i.e. making them look sophisticated, helping to control mood swings or weight increases) or the disadvantages. It is therefore a mistake to contemplate programmes for young people in isolation. Components of a comprehensive anti-tobacco policy likely to affect adults' habits – restrictions on smoking in public, price increases or promotion bans, for example – are likely to affect young people's habits just as much or more.

Small-scale anti-smoking programmes for children have been popular through the years largely because they are politically attractive; they offend no one. They are also popular with the tobacco industry because they have very little effect on tobacco consumption or smoking prevalence. An educational programme on tobacco should recognize that children learn at school, at home and in the community.

A properly supported school education programme can be a significant contribution to tobacco control. It is at school that children can learn about tobacco and its effect on their bodies and can acquire the social skills to learn to say no. But if smoking education is done in a haphazard way, which is often the case, it will not be effective. School initiatives should start with baseline information and materials. School curriculum time must be set aside and teachers should be adequately trained to educate youngsters about tobacco. Furthermore, school programmes should link with the community and involve parents and children's out-of-school activities. Above all, educational measures must be part of an effort to create an environment in which children will find it easy to say no to smoking.

The Conference participants thought that non-smoking education should be a mandatory part of curricula in schools throughout Europe and that education authorities should be required to guarantee that curriculum time would be set aside for that purpose. These authorities should also be required to provide training support during both undergraduate education and in-service teacher training.

Tobacco sales to children

Closely allied to the issues of information and education directed at children is the question of allowing children to buy tobacco. There was less unanimity on this question than on any other raised at the Conference.

Advocates of a ban on sales to minors thought that one of its effects was to signal clearly to children and adults that public authorities recognized that smoking was something uniquely dangerous from which children should be protected. Furthermore, the existence of a ban would deter some children from starting to smoke. On the other hand, opponents of sales bans suspected that these measures merely made smoking look more desirable to a child by establishing it as part of the adult world and giving it a "forbidden fruit" aspect. Many took the view that sales bans were unenforceable in any event.

The consensus among the working groups was that tobacco sales to children should be banned. Some felt that a ban on sales should be concurrent with a ban on vending-machine sales, and active enforcement of any law was stressed by all participants.

a Planning for a smoke-free generation (Smoke-free Europe No. 6) and The dying of the light (Smoke-free Europe No. 7) described on pages 66 and 67.
Health warnings

Placing numerous rotating and frequently renewed health warnings on tobacco packages is an important ingredient of a comprehensive tobacco policy. Sweden pioneered the system of rotating health warnings which allows for a greater variety of health messages and attracts greater attention. Since 1977 Swedish cigarette smokers have been exposed to 61 different warnings, referring not only to smoking but also to smokeless tobacco and passive smoking.

A significant refinement to the system has been made by Iceland. There, written warnings are accompanied by a pictorial representation; each of eight warnings is printed with its own drawing in different colours. These are large and are printed on the front of the pack. One transnational company was so reluctant to have the image of its cigarettes interfered with in this way that it withdrew two of its best-known brands from the Icelandic market.

“Tar” levels

Participants were by no means unanimous in their advocacy of a policy of gradual reduction in maximum levels of harmful substances in tobacco. A reduction in maximum tar yields will reduce the incidence of lung cancer, although it is likely to make little difference in the other major diseases caused by tobacco. But many public health workers feel uneasy with this proposal because they have seen how it has been used by the tobacco industry to divert government attention from measures that will reduce tobacco consumption and smoking prevalence. Moreover, advertising for low-tar cigarettes has been used to foster the erroneous belief that some cigarettes are safe.

Participants, with caution, advocated programmes to reduce maximum levels of harmful constituents in tobacco smoke such as that established by the Finnish Tobacco Act and in line with the proposal of the Commission of the European Communities mentioned above.

RECOMMENDATIONS FOR STRATEGY 4

1. Nonsmoking education should be a mandatory part of school curricula throughout Europe. Education should start well before adolescence and should be age-specific. Education authorities must ensure that teachers receive the proper training to teach young people about tobacco.

2. Tobacco sales to minors both through direct sales and through vending machines should be banned.

3. Health warnings should use rotating messages and be clearly legible. As a minimum, all Member States of the European Region of WHO should adopt the measures contained in the European Community’s directive on health warnings.

4. An upper limit on cigarette tar deliveries, such as those proposed by the Commission of the European Communities, should be introduced.
The most coherent theory for why so many people start to smoke and why so many give it up is that it is a reasoned choice. People weigh up the costs and benefits of smoking or not smoking and, even if their perceptions of these are wrong, they try to act accordingly. As an extension of this theory, giving up smoking is no longer thought of as an event when one is cured of a tobacco habit. Instead it is now seen as a process through which smokers' changing beliefs about smoking—the degree of health risk, the possible benefits of giving up, the social acceptability of the habit, and so on—bring about a change in attitude through which they form an intention to stop. The smoker's chances of success are favourably influenced by confidence and, surprisingly, recent (albeit unsuccessful) attempts to quit.

The benefit of this theory, apart from its obvious appeal to common sense, is that it gets away from the unhelpful divisions of advice and treatment, failure and success. Thinking of smoking cessation as a process brings the realization that many factors are part of the cure. Changes in attitude and belief will be influenced by all sorts of things—health information, smoking restrictions in public places and at work, tobacco tax increases, bans on tobacco promotion.

Large-scale smoking cessation

Perhaps it is too obvious to say that most smokers who give up the habit stop on their own without recourse to group therapy, hypnosis, acupuncture or any other treatment. One has only to consider the millions of ex-smokers worldwide and compare that figure with the tiny number who pass through smokers' clinics and other treatments to be assured that this is the case. It is reasonable, then, that authorities looking for cost-effective ways of achieving large-scale smoking cessation will not at first look to intensive methods that reach only small numbers of smokers.

The effect of publicity and information campaigns in motivating smokers to try to stop has been written about elsewhere in this report. Participants emphasized the importance of finding new and imaginative ways, such as national no-smoking days, of encouraging smokers to make an attempt to stop. British participants said that their annual no-smoking day costs as little as US $270 000 to organize and may encourage up to 50 000 smokers to give up permanently.
Advice from health professionals

Another way of reaching large numbers of smokers is through people who come in frequent contact with smokers through their work. Health professionals are most conspicuous in this respect. General practitioners are often trusted givers of advice. They have the added advantage of reaching patients at special risk, such as people with a smoking-induced disease, pregnant women, women taking oral contraceptives, those waiting for an operation, or parents of young children.

A short booklet that provides a clear, simple and concise aid for the busy primary health care doctor. The booklet was the product of a joint WHO/International Union Against Cancer project to draw up smoking cessation guidelines for health professionals. Although the potential for health professionals to promote smoking cessation is considerable, their intervention has not yet been a significant cause of a decline in smoking in any country. It seems clear that further encouragement to professionals and the provision of training programmes to teach them how to advise their patients are necessary.

RECOMMENDATIONS FOR STRATEGY 5

1 Most smokers will need only advice and encouragement to give up smoking. Effective smoking cessation means that a variety of smoking cessation facilities – booklets, health professionals’ advice, workplace programmes, telephone advice – should be widely available through schools, health premises, worksites, pharmacies and other appropriate places. Specialist clinics and more intense therapy should also be available for the small minority of smokers who have great difficulty in giving up.

2 New approaches should be found such as national no-smoking days, which are a particularly effective method of encouraging large numbers of people to give up.

3 Training programmes should be available to all health professionals to teach them to counsel their patients or clients to give up smoking.

General practitioners also have more contact with people from lower socioeconomic groups, who are notoriously difficult to reach through health education. Research has established that advice from general practitioners can motivate at least 5% of the smokers they counsel to give up for good. Small-scale studies have also been done with community and hospital nurses and pharmacists, and in the United Kingdom studies to investigate the effects of anaesthetists’ advice to the 650 000 smokers who annually undergo surgery in that country are now under way.

A number of sources of guidance on helping patients give up are now available for the primary health care team. One of the documents written specially for the Conference was the core text for

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6 The physician’s role (Smoke-free Europe No. 1) described on pages 66 and 67.

One of the most popularly endorsed proposals of the Conference was that a special tax should be levied on tobacco products and earmarked for funding anti-tobacco activities. Arguments in favour of this proposal maintain that it has the advantage of promoting the health policy it is intended to support. It also avoids taking money from other programmes financed by already tight public health budgets.

A policy of this sort has been successfully implemented in Australia. Legislation in two Australian states specifies that the proceeds of a special state tax on tobacco should be offered to sporting and cultural groups to replace sponsorship from tobacco companies. The amount of money made available through this mechanism is of undreamed-of proportions in any tobacco control programme. In the state of Victoria, with a population of only 3.3 million, this levy yields some US $18.8 million annually. This sponsorship buy-out has robbed the tobacco industry of a powerful weapon in its arsenal: the ability to buy allies in the theatre, music or sports world through the sheer size of its promotional budgets.

**RECOMMENDATIONS FOR STRATEGY 6**

1. A 1% levy should be imposed on all tobacco sales in every country in addition to existing and future taxation; the proceeds of this levy should be used for health promotion and tobacco control.

2. Links between tobacco and sports and the arts should be broken. Funds from the special tobacco levy should be used to buy out sponsorship agreements involving the tobacco industry.

*From "Consumers' rights and tobacco control"; the paper presented by Dr. Simon Chapman, Consultant to the International Organization of Consumers Unions.*
7 Institute progressive financial disincentives

The tobacco control strategy on which there was universal agreement was that all countries should institute a programme of regular price increases for tobacco products. Tax increases should be large enough to raise the real price of tobacco at a rate faster than predicted increases in real disposable income. Studies in several countries have shown that demand for cigarettes varies inversely with price: when tobacco becomes cheaper, consumption goes up and vice versa. The average price response from these studies is an approximately 0.5% decrease in smoking for every 1% increase in real price, and a 0.5% increase in smoking for every 1% decrease in real terms.

Research in the United States indicates that teenagers and young adults are much more responsive to price than older adults. This is of special importance because it is in the teenage years that the great majority of lifetime smokers are recruited to the habit. A coherent tobacco price policy is, therefore, likely to have a greater effect on young people and may well deter some of them from becoming smokers.

A special study undertaken for the Conference analysed cigarette consumption and price variations in 19 European countries. Price was found to be a major determinant of smoking levels in Europe. The estimated price elasticity of demand for cigarettes was -0.38, meaning that a 1% increase in cigarette prices in a country will lower demand by 0.38% on average.

The study estimated the income elasticity of demand for cigarettes between European countries to be 0.46. In other words, every 1% rise in real incomes in Europe, all other things being equal, would result in an average 0.46% increase in cigarette consumption. This implies that as real incomes rise in Europe, cigarette consumption will rise unless there are other factors, such as price increases, to modify consumption.

It is sometimes argued that tax increases will cut tobacco consumption so much that the government will lose tax revenue, but that has not been the experience of any government. It is estimated that government tax revenue will rise in real terms in all European countries if cigarette tax is increased in real terms. Likewise, revenue is estimated to fall in real terms if cigarette tax is reduced, or allowed to decline in real terms.

*Tobacco price and the smoking epidemic (Smoke-free Europe No. 19) described on pages 66 and 67.*
Tobacco in the retail price index

Critics of tobacco tax increases argue that such rises are inflationary. Increases in tax are of themselves not necessarily inflationary but rises in the price of cigarettes or any consumer product which is included in the retail price index could be inflationary. In some countries wage bargaining, social security or pension increases are based on the retail price index. Therefore, any price increases, including those caused by tax increases, could add to inflation.

For this reason, the Commission of the European Communities publishes a retail price index that excludes alcohol and tobacco. France also publishes a series of retail price indices that exclude tobacco prices. Use of such a series to index social security payments and wages would largely stop any inflationary effect of cigarette price increases.

Tax harmonization in the European Community

There is at present a very wide difference in cigarette prices throughout Europe, varying tenfold in the European Region of WHO and sixfold within the countries of the European Community. While realizing that countries that currently have the lowest levels of tobacco tax will have to make the greatest adjustments when fiscal policies on tobacco are harmonized within the Community, other countries will have to lower their tobacco taxes if the proposals currently being discussed are finally agreed.

Participants from those countries facing a fall in tobacco taxes were very concerned about the rise in cigarette consumption and the resulting increases in morbidity and mortality that will be entailed. They were most anxious that international agreements relating to tobacco tax should not lead to a reduction of tobacco price in any country.

RECOMMENDATIONS FOR STRATEGY 7

1. All countries should institute a policy of regular increases in tobacco taxation. Increases in tax on tobacco should be large enough to increase the real price at a rate faster than predicted increases in real disposable income.

2. Tobacco should be removed from the retail price index.

3. A range of econometric studies should be undertaken in each Member State to assess the impact of tobacco taxation on government revenue, employment and tobacco consumption, and on the resulting mortality and morbidity. The relationship between tobacco price, income, consumer price, consumption, advertising expenditure and health education investment should also be studied.

4. Duty-free sales of tobacco products should be abolished.

The physician's role (Smoke-free Europe No. 1) described on pages 66 and 67.
One of the most distinctly voiced concerns of Conference participants was that the tobacco industry should not be allowed to encourage new forms of tobacco use such as smokeless tobacco. These products are associated with an increased risk of contracting oral cancer and other diseases of the mouth. While the use of oral snuff is traditional in some Scandinavian countries, use of oral tobacco is almost unknown in most of Europe. Some participants, particularly those from countries such as Ireland, Norway, Sweden and the United Kingdom where the tobacco industry had made efforts to promote smokeless tobacco, felt very strongly that pre-emptive action should be taken in Europe to prevent this novel form of nicotine administration.

The experience of Sweden is salutary in this respect. The practice of snuff “dipping” (placing a piece of moist snuff between gum and lip) was widespread in the nineteenth century but had almost disappeared by the 1960s. However, after renewed marketing efforts by the Swedish Tobacco Company, which included large-scale promotion and new, attractive packaging, consumption doubled between 1968 and 1988. Instead of being a fading habit of older rural men, snuff dipping became a young man’s habit.

Although some industry sources would like the public to believe that smokeless tobacco should not be a source of concern, since less is known about the dangers of oral tobacco than about those of smoking, surveys in Sweden have shown that nearly half of snuff dippers also smoke cigarettes. Research also indicates that many young men begin their tobacco habit with snuff before moving on to cigarettes.

Sweden’s experience has been mirrored in the United States, where a variety of smokeless tobacco products has been actively promoted and advertised by people, such as sports stars, who are admired by the young. Other European countries were encouraged to avoid these problems and follow the lead of Ireland, which in 1988 banned the sale, manufacture and importation of oral smokeless tobacco products.

Speakers warned Conference participants that the tobacco industry would be alert to identifying ways of keeping nicotine on the market and free from any restrictions. A variety of smokeless tobacco products was the industry’s response to the growing social taboo against smoking in public. The so-called smokeless cigarette, which was developed at vast cost, and a type of nicotine-containing tablet, flavoured with cinnamon and looking much like a child’s sweet, are being marketed in the United States as a more socially acceptable way to administer nicotine.

**RECOMMENDATIONS FOR STRATEGY 8**

1. The participants endorsed the recommendations of the WHO Study Group on Smokeless Tobacco Control and urged Member States to use these recommendations as a basis for action. Particularly important are the Study Group's recommendations for a smokeless tobacco programme:
   - where smokeless tobacco is not used, prevent its introduction, with special emphasis on preventing its use by children;
   - where smokeless tobacco is already used, act to reduce the prevalence of use in the population;
   - establish or maintain a social climate unfavourable to smokeless tobacco use.

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Monitor the effects of the pandemic and assess the effectiveness of countermeasures

If monitoring and evaluation is one of the less exciting aspects of tobacco control, it is certainly among the most basic and pervasive. Participants discussing all other aspects of a policy emphasized the need to monitor policies carefully so as to have a clear view of where new action was needed and to assess the effectiveness of the measures that had been taken.

Monitoring and evaluation indicators fall into three categories:

- **essential indicators**: the indispensable basic data such as mortality rates, tobacco consumption, smoking prevalence and smoking control policies;

- **recommended indicators**: data necessary to monitor changes in smoking prevalence (percentages of ex-smokers, never-smokers, smokers with breakdown for age, sex, socioeconomic group, educational level, etc.);

- **facultative indicators**: for monitoring changes in smoking prevalence in key populations and using morbidity data to monitor the development of national programmes.

One of the booklets in the Smoke-free Europe series discusses guidelines for monitoring public programmes on tobacco. It looks at the scope and value of both qualitative and quantitative studies and includes model questionnaires that have been developed by WHO. These models are important because they assist countries to cooperate to ensure that evaluation methods are uniform. It is only with such methodological uniformity that comparisons can be made between countries. Such cross-country comparisons provide unique information on the value of tobacco control strategies.

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RECOMMENDATIONS FOR STRATEGY 9

1 Evaluation is needed as a part of a comprehensive tobacco policy and must be done at regular intervals. Per capita consumption should be determined and regular prevalence surveys of the general population, as well as of special groups such as children, physicians and teachers, must be carried out. It is also important to evaluate attitudes and changes in health knowledge. Public opinion on tobacco control issues should be monitored.

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*The evaluation and monitoring of public action on tobacco* (Smoke-free Europe No. 3) described on pages 66 and 67.
When we talk about enacting a comprehensive tobacco policy we are also talking about changing the ways our society views tobacco. This change creates a climate of opinion that will give public support to measures taken by institutions and local authorities and, moreover, by national governments, where many politically difficult decisions must be made. Obviously, such a sweeping social movement must be carried forward by many partners in action, but an alliance for action to stem the tobacco pandemic must start with the medical profession. In all countries it is individual physicians who are in the forefront of those demanding coherent public health policies to combat tobacco use. Those countries where the medical profession has been most active are those that have been the most successful at reducing smoking prevalence and tobacco consumption. They are also, not coincidentally, the countries that have the lowest prevalence of smoking among doctors.

The first step on the road to a tobacco policy is to encourage doctors to be nonsmokers. (Doctors who do not smoke are much more likely to advise their patients not to smoke and to be active in the anti-tobacco campaign.) The Regional Office has provided medical associations with a sample questionnaire to survey members' smoking habits and has provided advice on how to use and publicize the information gathered. Through its regular meetings with national medical associations, the Regional Office is encouraging and supporting the efforts of associations to follow these guidelines. Raising doctors' awareness of the importance of their role must begin in medical training and be reinforced by continuing education through medical associations and in postgraduate training.

There is no room for complacency in this regard: a survey of medical students' attitudes to tobacco conducted in 14 European countries by the International Union Against Tuberculosis and Lung Disease found alarming deficiencies, particularly in knowledge. For example, less than 30% of final year medical students knew that smoking was a major risk factor for coronary heart disease. Clearly, there is much to be done!

The medical profession is only the starting point for an alliance against tobacco. Another obviously concerned group is parents and teachers, who will want to ensure that their children are properly informed about tobacco and are free of the pressure to start using it. Parents' organizations will want to protect children from the health risks of environmental tobacco smoke and to guarantee smoke-free spaces for children to grow up in.

Health professionals other than doctors have an important role. The public respects health advice from pharmacists and nurses, and these groups could use their position to give patients encouragement and help to give up. Allied professions such as anaesthetists, physiotherapists, psychologists and social workers also have a role and a responsibility in this respect. Their professional associations could join with others to press politicians to advocate smoking control measures.

There are many other groups that are or should be concerned about tobacco: consumers' groups may well want to promote the introduction of no-smoking policies or to support smokers' product liability claims against tobacco manufacturers; trade unions and employers will want to act to protect workers from environmental tobacco...
smoke at work; cancer and heart organizations will want to see that the knowledge that has come from medical research they have funded is used to prevent disease; environmental groups may be concerned about the use of scarce woodlands as fuel for tobacco curing. And we should remember that any one person is probably a member of several groups: environmentalists, nurses and teachers may also be parents, consumers or members of voluntary organizations or trade unions.

The scope for action for an organization such as a medical association is great, but it is much greater if a network of organizations can work together towards common goals. A loose confederation of public interest groups can together develop a cohesive mechanism to build public support for tobacco control. Such has been the practice in the United Kingdom, where representatives of statutory bodies, medical charities, public health advocacy groups, consumers groups and others discuss current tobacco control strategies at regular meetings coordinated by the British Medical Association. Through these meetings the organizations concerned have been able to avoid duplication of effort, have shared work and have produced coherent and sustained campaigns on smoking control issues.

RECOMMENDATIONS FOR STRATEGY 10

1. Steps should be taken to reduce smoking among physicians. This will be facilitated by better training for medical students, encompassing information on the health, psychological and political aspects of tobacco as well as the importance of the exemplary role of physicians.

2. Activities should be found to increase awareness among key professionals, including those working in health, teachers, trade unionists, journalists, social scientists and social workers. These activities include:
   - development and publication of surveys of smoking habits among members of the profession;
   - efforts to coordinate activities with professional groups already working in the field;
   - the involvement of professional associations in publicizing information about tobacco and making their views about tobacco control issues known to the public and to decision-makers.

3. Continuous education on tobacco should be offered through professional associations.
The first European Conference on Tobacco Policy concluded with a ministerial round-table discussion. Joining Dr Jo E. Asvall were Mr Philippe Busquin, Minister of Public Health and the Environment, Belgium; Mr Macario Correia, Secretary of State for the Environment, Portugal; Mrs Tove Strand Gerhardsen, Minister of Health, Norway; Professor J.F. Girard, Director-General of Health, France; Mrs Elena Marinucci, Under-Secretary of State for Health, Italy; and Professor J. Vargas, Minister of Health, Spain.

The ministers heard the conclusions of the Conference from the two Rapporteurs, who sketched out the strategies for achieving a smoke-free Europe and read out the draft Charter against Tobacco. Mr Peter Taylor then led the ministers through a free discussion of the provisions of the Charter and the political feasibility of the strategies that need to be followed if Europe is to end the tragic waste of life that will be caused by tobacco now and for many years to come.

The round-table discussion centred on the key issues of tobacco control, but first Mr Taylor asked if it was not too dangerous for a politician, even a health minister, to try to act in a way that would offend the powerful tobacco industry. The consensus among the ministers was that the political tide was turning; in many countries the weight of public opinion was shifting, so that it was now possible for a politician to act decisively against tobacco and for public health and still survive politically.

The ministers talked about the most politically difficult tobacco control issues: tobacco promotion, economics and smoking restrictions. Except for Norway, which had banned all tobacco advertising in its comprehensive Tobacco Act, all the countries represented had serious problems with their current approaches to counteracting tobacco promotion. One of the main concerns was about indirect advertising through sponsorship, brand stretching or other promotional means. Mrs Marinucci said this sort of hidden advertising was a serious concern in Italy. The tobacco industry had recently used a loophole in the Belgian regulations to recycle forbidden cigarette advertisements as a promotion for matches, and Mr Busquin acknowledged this as a problem which he thought should be confronted at the European Community level. Mr Correia concurred, and pointed out that tobacco sponsorship of sporting events was becoming more and more an international problem in Europe.

Professor Vargas said that the Royal Decree passed in March 1988 was a significant step for tobacco control in Spain; it had already initiated action on the measures being proposed by the European Community’s directives on tobacco. Pressed by Mr Taylor, Professor Vargas said that his long-term goal was a complete elimination of tobacco promotion in Spain.

Tobacco economics was a subject that would continue to be of great importance. All the countries represented at ministerial level, except Norway, would be affected by the fact that from 1992 tobacco taxation would be decided at European Community level. All the ministers agreed to discuss with colleagues the removal of tobacco from their national retail price index, and this had already been considered at cabinet level in Belgium. The question of earmarking a portion of tobacco tax for health promotion activities and countering tobacco sponsorship was interesting to the ministers, and several said they would take this proposal forward.
Not surprisingly, all the ministers agreed on the importance of protecting nonsmokers from other people's tobacco smoke. Smoking in the workplace was felt to be of special importance, because nonsmokers had less freedom of choice in this situation than in others. Legislation to restrict smoking in public places enacted in Belgium and Norway was an indication of the important steps that had already been taken in this area. Professor Girard said he felt that attempts at persuasion were not sufficient and that legislation to protect nonsmokers at work would have to be pursued. Commenting on the experience of the Regional Office, Dr Asvall said that of course national legislation was the ultimate goal, but in the mean time individual institutions could begin immediately to protect the health of employees. A carefully considered no-smoking policy, accompanied by help for those who wished to stop smoking, had been successfully implemented at the Regional Office. This had been of benefit not only to the health of the nonsmokers in the Office, but also to those smokers who had stopped as a result and to those who, although they continued to smoke, now smoked much less.

It was generally concluded, both by the ministers present and by the Conference participants, that it was this very issue – the protection of nonsmokers and their basic right to smoke-free air – that was the watershed of effective smoking control policies. Dr Asvall pointed out that if political agreement could be reached on the first principle of the Charter – that people have a fundamental moral right to breathe air free of tobacco smoke – this would legitimize political action to control tobacco and end the tobacco pandemic.

The Conference thus ended on a strong note of optimism. Participants felt that after many frustrating years of endeavour, Europe could now move forward to eliminate the tobacco pandemic. Several factors encouraged the belief that tobacco could be successfully rooted out of Europe. A new expression of political will had been signalled, both by the unanimous adoption of the Action Plan on Tobacco by the WHO Regional Committee for Europe and by the important initiatives of the Commission of the European Communities in its Europe Against Cancer programme. Increasing public demand for protection from environmental tobacco smoke was also giving national politicians a mandate for action. Moreover, those who had carried on the struggle against tobacco were finding themselves joined by new allies from all walks of life.

For many of those present at the Conference this was their first opportunity to discuss tobacco control at such length with people of widely divergent cultural and professional backgrounds. What emerged from these discussions was a degree of unanimity that many found remarkable and encouraging. It was clear that the knowledge and experience to frame and implement tobacco control policies already existed in Europe, and that understanding was being carried forward into the political arena.

The concluding sentiment of the Conference had been expressed on the first day:

**IT CAN BE DONE!**
Each one of us has some responsibility for being healthy and for the promotion of good health and wellbeing in the community. Many people are prepared to accept responsibility for more than just their own health, perhaps for their children or for people at work. If these people accept what we now know about the poor health and early deaths that follow the use of tobacco, we can work together to create a healthier community.

It is the will of many individuals, alone or combined, that will stop the promotion of tobacco and the death and damage caused by its use. Governments of all types are sensitive to the will of the people when it is expressed coherently and forcefully. The checklist has been designed for people in all sections of the community. It has been drawn up from the detailed comments of the working groups at the Conference. It is not a complete and final list of the discrete steps that will stop tobacco use, but it is a base from which to start.

A campaign is a dynamic succession of events in which the optimum action at any time depends both on what has gone before and what can be perceived of the present circumstances and future trends. No campaign can ever be mapped out wholly in advance and cannot be controlled by any one person. But, guided by a shared ambition, individuals and groups can achieve their common target by many different routes. A popular movement to rid Europe of tobacco-related disease will be irresistible.

In other words, the actions listed here can be applied by individuals and organizations in all aspects of the life of the community and will interact to build a formidable attack on the death and disability caused by tobacco.

The actions listed under different organizations are deliberately repetitious where they could be undertaken alone or in combination. The actions are not ordered in any particular priority as local and national circumstances vary; what is urgent in one country may already have been dealt with in another. These variations are not important if the checklist is read with imagination and determination.
1 Individuals

1.1 NONSMOKERS

✓ Take part in maintaining a fresh air norm – an atmosphere free of tobacco smoke – at work and at home.
✓ Protect children from the effects on their health of enforced breathing of tobacco smoke, and from the damaging behavioural effects of association with role models who use tobacco.
✓ Obtain information about tobacco control issues from consumer groups and voluntary organizations, and use this to press local and national elected representatives for effective action.
✓ Press political parties to include tobacco control in their manifestos.
✓ Monitor the actions of governments and local authorities and comment publicly on compliance with tobacco control measures, for example to achieve a safe healthy environment and to discourage young people from starting to smoke.

1.2 SMOKERS

✓ Accept the responsibility not to damage the health of other people.
✓ Ensure that children are not exposed to tobacco smoke in the home.
✓ Avoid conflict with nonsmokers by accepting the need for public policies to create a healthy smoke-free, fresh air environment.

1.3 HEALTH WORKERS, TEACHERS AND PARENTS

✓ In their role as opinion formers in the community, health workers and teachers should not smoke.
✓ Parents, teachers and health workers should share knowledge about children in their community, using this checklist effectively to discourage young people from starting to smoke, stop retail outlets from selling tobacco products to children, and stop local activities to promote tobacco.
✓ Each health worker and teacher should be aware of the consequences of tobacco use.
✓ Doctors should promote smoking cessation by positively helping their patients to stop.

“Today, the tobacco industry spends an amount of money on publicity alone that is three times larger than the budget of the World Health Organization – a staggering figure of some two and a half billion US dollars per year.”

Jo E. Asvall,
WHO Regional Director for Europe

“We firmly believe that smoking is part of the culture of the past.”

Manuel Marin,
Vice-President,
Commission of the European Communities
“With few exceptions, the fight against this human tragedy has been characterized by a paralysing passivity on the part of the health profession, the bureaucrats and the decision-makers.”

Kjell Bjartveit, Chairman of the Norwegian Council on Smoking and Health

Doctors should assess the individual needs of patients who smoke for various methods of quitting, such as self-help, stop-smoking advice, stop-smoking booklets, telephone advice lines, group therapy, or referral to smoking cessation clinics.

Teachers should introduce positive health education about good health and the bad consequences of tobacco use.

Health workers and teachers should report infringements of advertising and promotional bans that affect their patients and students.

Non-smoking policies should be adopted at work.

Teachers should develop methods of communicating the fresh air norm effectively to both non-smoking and smoking students.

Health education should encompass the development of a wide variety of approaches and cover media relevant to all groups of society.

1.4 POLITICIANS AND OTHER OPINION LEADERS

Accept a no-smoking leadership role in promoting the good health of the community.

Facilitate action by individuals and organizations within their constituencies to promote good health and combat the use of tobacco.

Accept the need to include tobacco control in their party manifestos.

1.5 TOBACCONISTS AND OTHER RETAIL TOBACCO OUTLETS

Accept the scientific evidence of nicotine addiction and the diseases that flow from the use of tobacco products.

Obey statutory or voluntary restrictions on the sale of tobacco products to children and young people.

Broaden the range of products sold through each tobacco outlet to reduce the proportion of revenue derived from tobacco products.
2 The **local community**

2.1 LOCAL AUTHORITY

- Ban advertising on sites controlled by the authority.
- Control tobacco advertising in shop fronts and in shops where this breaches statutory regulations or voluntary codes.
- Refuse permission for tobacco-sponsored events on sites controlled by the authority.
- Where local authorities have responsibility for education, ensure that students work in a smoke-free, fresh air environment.
- Enforce existing legislation or regulations prohibiting the sale of cigarettes to minors.
- Enforce existing legislation or regulations prohibiting the sale of smokeless tobacco products.

> "Cigarette smoking is the most addictive and dependence producing form of object-specific behaviour for self-gratification known to man."

*Michael Russell,*
*Addiction Research Unit, London*

2.2 LOCAL BUSINESS ASSOCIATIONS

- Find alternative sponsorship for local sporting, artistic and community events.
- Recognize the consequences for health of tobacco use and do not oppose elimination of tobacco advertising and promotion at a local level.
- Support the fresh air norm in enclosed public places and in local commercial and industrial premises.

> "Future generations would be aghast that we did so little to curb smoking."

*Sir George Godber,*
*former Chief Medical Officer, United Kingdom, 1983*

2.3 TRADE UNIONS

- Political parties should be pressed to include tobacco control in their manifestos.
- Organize education for women trade unionists on the dangers of cigarette smoking and the methods used by the tobacco industry to recruit smokers.
- Find other industries that could make use of tobacco workers' skills. Ensure that workers will not oppose tobacco control measures by making it clear that it is increased mechanization that has caused job losses in tobacco manufacturing.
- Ensure that apprentices and new members of trade unions are educated about the dangers of cigarette smoking and the methods used by the tobacco industry to recruit smokers.
"The notion of freedom of choice the industry tries to appropriate to satisfy its ever more comfortable shareholders in the world's richest countries, is a truly pathetic attempt to dignify the promotion of what, at the end of the day, is simply an attempt to market an addictive, deadly, environmentally destructive, polluting and wasteful product." 

Simon Chapman, Consultant, International Organization of Consumers' Unions

2.4 COMMERCIAL AND INDUSTRIAL ORGANIZATIONS

✓ Agree fresh air policies with unions and staff organizations and implement these effectively.
✓ Establish no-smoking rules at places of work.
✓ Utilize smoking cessation packages as part of an occupational health programme for employees who wish to stop smoking.
✓ Support a healthy workforce in cooperation with local health promotion agencies.

2.5 LOCAL PRESS, TELEVISION AND RADIO

✓ Separate decisions about editorial coverage of tobacco control activities from commercial decisions relating to advertisements placed by the tobacco industry.

2.6 SCHOOLS AND OTHER EDUCATIONAL INSTITUTIONS

✓ Teach students social skills so they can avoid pressure to start smoking or using tobacco products. "It is OK to say NO!"
✓ Develop local health education material to reinforce national information on good health and the bad consequences of tobacco use.
✓ Develop local health education material to reinforce national information on the effects on health of tobacco smoke in the environment.
✓ Agree no-smoking policies with staff organizations for all employees of the institution.
✓ Key groups of students (including medical students, trainee teachers, student nurses and other health and social workers in training) should be taught about the consequences for health of tobacco use.
✓ Key groups of students (including medical students, trainee teachers, student nurses and other health and social workers in training) should be taught the communications skills necessary to impart information about good health and the consequences for health of tobacco use to other people in the community.

2.7 VOLUNTARY ORGANIZATIONS

✓ Provide services to facilitate assessment of the individual needs of smokers for various methods of quitting, such as self-help, stop-smoking advice, stop-smoking booklets, telephone advice lines, group therapy, or referral to smoking cessation clinics.
Research and act as a public source of information on all aspects of tobacco control to support the efforts of individuals and other local organizations.

Communicate information about the effects on health of tobacco smoke in the environment to local and national media.

Provide specific briefing for ministers, other politicians and policy-makers on the economic aspects of tobacco policy to assist them in combating pro-tobacco propaganda.

Monitor actions of government and local authorities and comment publicly on compliance with tobacco control measures, for example to achieve a safe environment and the discouragement of young people from starting to smoke.

2.8 LOCAL CONSUMER GROUPS

Monitor actions of other organizations such as local authorities, chambers of commerce, local health services and small companies, and publicize conformity with or deviation from the strategies and actions in this report.

2.9 LOCAL HEALTH SERVICES

Agree fresh air policies with unions and staff organizations.

Utilize smoking cessation packages as part of an occupational health programme for employees who wish to stop smoking.

Establish no-smoking rules at places of work.

Provide services to facilitate assessment of the needs of patients who smoke for various methods of quitting, such as self-help, stop-smoking advice, stop-smoking booklets, telephone advice lines, group therapy, or referral to smoking cessation clinics.

Provide specific briefing for elected representatives, including ministers, other politicians and policy-makers, on the economic aspects of tobacco policy to assist them in combating pro-tobacco propaganda.

Provide information to the media about the advantages of good health and the wellbeing that people demand from living and working in smoke-free, fresh air environments.

Inform politicians with local constituencies of the consequences for health of tobacco use and people's desire for smoke-free fresh air.

“No-one 40 years ago could possibly have anticipated that smoking could be related to so many diseases, relieving a few, being coincidentally associated with others through associated patterns of behaviour and causing or aggravating many more”

Sir Richard Doll

 “[Tobacco use is] tantamount to slow motion suicide”

Halldan Mahler, WHO Director-General, 1988
3 Nongovernmental organizations

3.1 MEDICAL ASSOCIATIONS
✓ Using the WHO model questionnaire, conduct regular surveys of members’ smoking habits. Publicize the results.
✓ Develop and implement smoking cessation programmes for use by doctors with their patients.
✓ Inform elected representatives in national and local government of the importance of a fresh air environment and the consequences for health of tobacco use.
✓ Inform the public of the medical consequences of tobacco use.
✓ Provide information to the media about the advantages of good health and the wellbeing that people demand from living and working in smoke-free, fresh air environments.
✓ Cooperate with other health professionals to ensure the effective communication of a single message about the consequences for health of tobacco use.

3.2 NURSING AND OTHER HEALTH PROFESSIONAL ORGANIZATIONS
✓ Develop and use smoking cessation programmes with patients who wish to stop smoking.
✓ Communicate the medical consequences of tobacco use to the public.
✓ Cooperate with other health professionals to ensure the effective communication of a single message about the consequences for health of tobacco use.

3.3 EDUCATIONAL ORGANIZATIONS
✓ Develop links with “youth idols” from sport, pop music, the communications media and the arts to take part in promoting the fresh air norm and tobacco control activities.
✓ Develop and implement smoking cessation programmes targeted at children and young people.

3.4 CONSUMER GROUPS AT NATIONAL LEVEL
✓ Provide specific briefing for ministers, other politicians and policy-makers on the economic
aspects of tobacco policy to assist them in combating pro-tobacco propaganda.

- Inform the public of the consequences for health of tobacco use.
- Maintain and reinforce public opinion about the fresh air norm.
- Research the ways in which tobacco advertising and promotion create an impact on children.
- Assist in the introduction of a ban on the sale of cigarettes to children where this is not already in force.
- Publish surveys of public opinion on tobacco control policies to encourage political and corporate measures that may lag behind popular support.
- Support product liability claims where there are reasonable prospects of success.
- Monitor action taken by government and large companies, and publicize conformity with or deviation from this checklist.
- Inform politicians of the consequences for health of tobacco use and the desire of people for a smoke-free, fresh air environment.
- Develop specialist information services on the risks of environmental tobacco smoke to assist employers, trade unions and their legal representatives.
- Provide support to use the legal sanctions that can be applied at present to protect workers and others from exposure to environmental tobacco smoke.
- Arrange consultancy services for all those who wish to provide smoke-free public places, with assistance at all stages.

4 International nongovernmental organizations

- Provide information to the media about the advantages of good health and the wellbeing that people demand from living and working in smoke-free, fresh air environments.
- Put the issue of women and smoking on the agenda of all nongovernmental organizations, in particular women's organizations and organizations with an interest in women's affairs such as national and international consumer organizations.

“I hope that by the end of this century, smoking will be a habit indulged in by consenting adults in private”

Sir George Young, Parliamentary Under-Secretary for Health, United Kingdom, 1979

“Against the barrage of highly skilled professional [tobacco] promotion, the occasional low-budget anti-smoking campaigns of ministries of health or others are more like symbolic band aids on our social conscience, alleviating our sense of guilt when things are getting too bad”

Jo E. Asvall, WHO Regional Director for Europe
If cigarette prices throughout the European Region [of WHO] were raised to the levels presently pertaining in Norway, cigarette smoking throughout the Region would fall on average by 40%.

Joy Townsend, Northwick Park Hospital, United Kingdom

The solution to many of today's medical problems will not be found in the research laboratories of our hospitals, but in our parliaments. For the prospective patient, the answer may not be cure by incision at the operating table, but prevention by decision at the cabinet table.

Sir George Young, Parliamentary Under-Secretary for Health, United Kingdom, 1979

5 National governments

- Introduce legislation to prohibit all advertising and promotion of tobacco products.
- Introduce legislation to ban the sale of tobacco products to children and young people.
- Introduce legislation to prohibit the sale of smokeless tobacco products.
- Enforce high visibility warnings on tobacco packaging, using words and symbols that communicate effectively and are changed at frequent and irregular intervals.
- Take administrative action to prohibit tobacco advertising or promotion in government publications.
- Impose a 1% levy on all tobacco sales in addition to existing taxation, the proceeds of the levy to be used for health promotion and tobacco control.
- Break the link between sport and the arts and tobacco use. Funds from the tobacco levy should be used, after a ban on future agreements has been implemented, to buy out existing sponsorship agreements involving the tobacco industry.
- Disseminate national smoking prevalence figures that use adequate sample sizes, in order to determine the influence of factors such as age, sex and socioeconomic position on tobacco consumption.
- In countries where the rates of smoking among young women are increasing, fund research to investigate the reasons for this increase so that appropriate and effective health promotion programmes can be developed.
- Legislate to ensure that women, and particularly girls and young women, cannot be targeted by the tobacco industry through media such as women's magazines.
- Assess, using the available econometric models, the impact of various levels of EC harmonized tobacco tax to show the effect on total government revenue, on tobacco consumption, on mortality and morbidity, and on employment.
- Set a minimum price for the sale of tobacco to avoid the tobacco industry undercutting the price controls introduced by higher taxation.
- Implement public education programmes on the risks of environmental tobacco smoke, with special emphasis on the protection of children.
Establish smoke-free environments in all enclosed public places, particularly worksites, transport, health care facilities, schools and child care facilities.

Fund the preparation and implementation of smoking cessation programmes for young people.

Exclude tobacco products from calculation of the retail price (cost-of-living) index.

Introduce legislation or regulations to eliminate tobacco vending machines.

6 Intergovernmental organizations

6.1 WORLD HEALTH ORGANIZATION

Support Member States in the implementation of the Action Plan on Tobacco by the promotion of action at regional and local levels.

Promote and coordinate the activities of medical associations in tobacco control.

Arrange for rapid exchange of information on new laws on tobacco control, so as to assist countries that are considering innovations in this field and to avoid loopholes that are being exploited by the tobacco industry.

Create a greater awareness of the issue of women and smoking, in particular the increasing smoking rates among young women, the reasons for this rise, and strategies for altering this trend.

Ensure that future conferences on tobacco and health directly address the issue of women and smoking.

The WHO Regional Office for Europe and the European Community should organize a conference for employers, employees and trade unions on the issue of smoking in the workplace. Detailed briefing should be provided for the participants along the lines of that provided for the present Conference.

6.2 OTHER INTERGOVERNMENTAL ORGANIZATIONS

Coordinate the discussion of health matters to ensure a higher priority for the promotion of good health and the achievement of a no-smoking norm throughout Europe.

Endorse the WHO strategy for health for all in Europe.

No country should lower the price of tobacco in the process of intergovernmental harmonization.

"It is not enough to offer young children and adolescents the choice between tobacco or health; for the sake of their health, it is necessary to guide them in making the choice. Every child should have the right to grow up without tobacco."

Hiroshi Nakajima, WHO Director-General

"Public information and health promotion campaigns will not only reduce smoking in their own right, but will also pave the way to make cigarette tax increases, for health reasons, politically acceptable."

Joy Townsend, Northwick Park Hospital, United Kingdom
The export of tobacco from Europe to developing countries should be prohibited.

- Continually reassess tobacco support policies in the light of expected decreases in consumption.
- Eliminate duty-free provisions relating to tobacco products.
- Establish international labelling requirements to ensure users are warned of the damaging consequences of tobacco use.
- Require the manufacturers of cigarettes and other nicotine-containing substances to accept commercial liability for their products.
- Liaise with member states to remove tobacco from national retail price indexes.

6.3 FOOD AND AGRICULTURE ORGANIZATION OF THE UNITED NATIONS

- Promote the plan to assist in crop substitution in areas where tobacco is grown.

6.4 INTERNATIONAL LABOUR ORGANISATION

- Develop strategies for redeploying workers in tobacco companies.
- Provide information to national trade unions about the advantages of good health and the wellbeing that people obtain from living and working in smoke-free, fresh air environments.

6.5 INTERNATIONAL OLYMPIC COMMITTEE

- All sporting events, and particularly the Olympic Games, should be smoke-free and free from all tobacco advertising and sponsorship. Special efforts should be made to ensure that the 1992 winter and summer Olympic Games are smoke-free and free from all tobacco advertising and promotion, following the example set by the 1988 Calgary Winter Olympics.
A 5 year action plan

Although the health hazards of smoking have deserved much publicity, the anti-smoking campaigns have been largely fragmentary and uncoordinated. The Action Plan on Tobacco for a Smoke-free Europe will for the first time help intergovernmental organizations, countries, groups and individuals to coordinate a concerted attack on the smoking epidemic. To do this, all the elements necessary for a successful campaign, i.e. public information and support, a tobacco price policy, training of health personnel, restrictions on tobacco production, distribution and promotion, control of smoking in public places, and evaluation mechanisms, must be put into effect at the same time in a coordinated way. The Action Plan is the sign of a new European unity in health policy on the road to Health for All.

Booklet No 1
The physician’s role
Physicians can do more than most to promote non-smoking. There are three main ways they can do it; they can increase their colleagues’ awareness of the tobacco issue and encourage smoking colleagues to give up; they can influence, advise and help patients to stop smoking; and they can make the views of the profession better known to decision-makers and the public.

Legislative strategies for a smoke-free Europe
Legislation is a powerful tool in the field of smoking control, influencing both active and passive smoking. Legislative strategies can bring about changes in production, advertising and sale of tobacco, as well as smoking practices in general. Not least important, legislation can be used to mandate health information and ensure smoke-free environments to non-smokers.

The evaluation and monitoring of public action on tobacco
When launching a national programme to control tobacco use, it is essential to evaluate and monitor progress. To do this, appropriate health and smoking indicators are needed. The quantitative surveys are carried out to see how the rate of smoking is changing, and qualitative surveys to find out why. This booklet suggests standardized ways to conduct surveys.

Tobacco or health
Using tobacco is incompatible with maintaining good health. Tobacco causes cancer, cardiovascular disease and lung disease. It can damage unborn babies. Many of the chemicals in tobacco smoke are cancer causing, and therefore, even passive or involuntary smoking puts people at risk.

Helping smokers stop
Stopping smoking is the quickest way to reduce smoking-related diseases. The booklet describes methods for giving practical help to smokers in their attempts to stop. What is the process to becoming a non-smoker?

Planning for a smoke-free generation
Why do some children start smoking? Well planned actions can help young people to stay non-smokers. A coordinated national policy strengthens the effectiveness of local efforts. Up-to-date effective educational programmes, the involvement of teachers and parents, higher tax on tobacco, restriction of sales of tobacco to the young, advertising bans, and smoke-free public places are essential ingredients.

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Single booklets or the entire "Smoke-free Europe" series can be obtained on request from:
World Health Organization, Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen, Denmark.
Please state language required (English, French, German, Russian).
To the many passive and indifferent politicians throughout Europe,
we throw down this challenge.

*In your hands lies the power to mitigate a vast human tragedy
and thereby save countless human lives.*

*With the will to act the scourge of tobacco can be wiped out.
Do not shirk your responsibility.*

To the army of frustrated and dispirited health workers who daily have to face
the grim results of tobacco use, we provide a strong ray of hope.

*Things are on the move in many countries.*

*There is a rapidly growing understanding worldwide of the urgent need
for positive action. Don't despair!*  

*The Madrid Conference will prove to have been the turning point
in the fight against tobacco.*

And to the myriad smokers now motivated to rid themselves
of perhaps the most pernicious and addictive habit ever to have afflicted humankind,
we offer this encouragement.

*You too can win through.*

*Thousands before you have already broken the habit
that was slowly destroying their health.*

*The rewards are great both for your future wellbeing, life expectancy and personal economy.
And no more the nagging worry of some dreaded self-inflicted disease looming ahead.*

*Throughout Europe, politicians, health authorities and other interest groups
are now banding together to provide practical assistance
to smokers who wish to stop.*

*Help is at hand should you need it. Why not make a start by having a talk
with your family doctor?*

To all these groups and to all thinking people concerned with the saving and not the destruction of human
life, the message from the First European Conference on Tobacco Policy is clear. Target number one is
a smoke-free Europe. Though of many languages, the delegates were of one voice:

**IT CAN BE DONE!**