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Tobacco Control 1994; 3: 280–281

From the World Health Organisation

Spotlight on the Western Pacific region

Dr ST Han, Regional Director for the Western Pacific region of the World Health Organisation (WHO), has called for a Western Pacific region free of tobacco advertising by the year 2000. He threw down this gauntlet during a meeting of the Regional Working Group on Tobacco or Health, held from 4 to 7 April 1994 in Manila, and went on to state "I will speak to Governments (for a tobacco-ad-free region), but it will be up to Member States to implement a tobacco-ad-free Western Pacific".

The Working Group endorsed the call for a tobacco-ad-free Western Pacific and went on to recommend that a request be issued to all media, sporting and other community organisations to support public health by refusing all tobacco advertising and sponsorship. This was one of nine Working Group recommendations. All nine add up to a clear call for strong, comprehensive national tobacco control policies throughout the region.

Action cannot come soon enough for the Western Pacific. Per adult, cigarette consumption nearly doubled from 1140 cigarettes per adult per year during the period 1970–72 to 2000 cigarettes per adult in 1990–92. Some of the world's most heavily populated countries — including China, Japan, the Republic of Korea, and the Philippines — are in this region, and all four have seen smoking rise rapidly since the 1970s. Now, the proportion of men who smoke exceeds 50% in all four countries. Long ago, tobacco advertisements disappeared from radio and television in North America, Western Europe, Singapore, Australia, and New Zealand. Radio and television are still, however, very important tobacco advertising media in many countries of the Western Pacific region.

The number of cigarette smokers in China, the world's most populous country, exceeds the size of the entire population of Canada and the US combined. Tobacco consumption has been growing quickly in China, and if current smoking patterns persist, WHO estimates that, in China alone, there will be two million deaths per year attributable to smoking by the decade of the 2020s.

Unfortunately, there is potential for China's smoking patterns to not only persist, but to become even more widespread. Right now, most of the tobacco business in China is controlled by the state monopoly, the China National Tobacco Corporation (CNCT). Transnational tobacco companies do have some access to the Chinese market, however. More importantly, these companies are currently exploiting loopholes in China's tobacco advertising restrictions to promote aggressively their products that are not at present legally available to the majority of the Chinese people. Tobacco advertising by transnational companies is clearly part of a deliberate, long-term market development strategy. A senior executive for a large multinational tobacco company recently offered this comment on China:

> "Regarding China: It is the largest cigarette market in the world ... someday [it will be a free and open market] and we are preparing for it."[1]

In the Philippines, corporate concentration in the tobacco industry and aggressive tobacco marketing are impeding progress in controlling the epidemic. In spite of this, the Philippine Government did recently adopt tough new measures requiring strong health warnings, occupying 25% of the front surface of cigarette packages and advertisements. So far, the tobacco industry has simply ignored these legislative requirements. Unrestricted tobacco advertising continues; about 60% of Filipinos and 20% of Filipinas smoke cigarettes.

The Western Pacific region also offers some of the world's best models of comprehensive national tobacco control policies. Australia, New Zealand, and Singapore all have model tobacco control policies — and low and declining rates of tobacco consumption. The case of Singapore is particularly noteworthy. Singapore began implementing tobacco control policies as early as 1971, with a partial ban on tobacco advertising. More and more elements have been added to the policy over the years, to the point where Singapore now has one of the world's strongest and most effective tobacco control policies. Besides the ban on advertising which has now become a total ban, other elements include effective protection from involuntary exposure to tobacco smoke, health warnings on packages, high tobacco taxes, a ban on incoming duty-free sales of cigarettes, a prohibition on sales to minors, and strong programmes of health promotion and health education. In 1978, male smoking prevalence in Singapore was 42% and female smoking prevalence was 9.5%, among the population 15 years of age and over.[2] The effect of Singapore's tobacco control policies has been to reduce prevalence among men aged 18 to 64 to 33% in 1992. Smoking prevalence among women 18 to 64 fell to 3% in 1992.[3] Consumption of cigarettes per adult fell from 2650 cigarettes per person aged 15 and over in 1980 to 1650 in 1990.

The Working Group on Tobacco or Health that met in Manila has proposed to WHO's Western Pacific regional office a new Action Plan on Tobacco or Health for the period 1995–99. It is expected that the Plan will soon

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be made public in its final form and, through some energetic public health action during the remainder of this decade, the rest of the Western Pacific region will implement comprehensive tobacco control strategies that will come to be just as successful as Singapore's. The future health of millions of Asian adolescents depends on it.

1 Taking stock. *Tobacco Reporter*. April 1994, p 30.
2 Emmanuel SC, Chan AS, Phe A. Cigarette smoking in Singapore. *Singapore Med J* 1988; **29**: 119–24.
3 National Health Survey, 1992. Ministry of Health, Singapore, 1993.

From the International Union Against Cancer

Africa – a desperate need for data

Annie J Sasco

With such a title, in an article dealing with public health, the first topic which comes to mind is AIDS. But this is not the topic I would like to address in this column. Another huge threat to the health of Africans currently exists which could kill millions of the young people alive today and the dangers of which we know perfectly well: tobacco.

In order to implement adequate policies to prevent the further spread of the tobacco epidemic, it is crucial that simple studies be implemented rapidly so as to make a real evaluation (not based on assumptions) of the risks associated with tobacco use in the African setting. These data will not only be of scientific interest, but will also represent a real public health achievement.

Evaluation of tobacco-related mortality and morbidity in Africa

In order to evaluate this burden correctly, one needs to have precise statistics concerning three items:

1. Occurrence (mortality or preferably incidence) of cancers, cardiovascular diseases, and chronic obstructive pulmonary disease.
2. Prevalence of tobacco use in its various forms and not only manufactured cigarettes.
3. Last but not least, the precise relationship between tobacco use and disease for each specific country.

The availability of such data varies greatly from one country to another. Even data on mortality are extremely limited. It has been estimated that cancer mortality data only exist for about 9% of the African population and data for cancer incidence for 0.5%. The situation is even worse for diseases for which the diagnostic criteria are somewhat less clear than for cancer.

For cancer, some incidence data exist. In the most recently published edition of *Cancer incidence in five continents*, three African cancer registries were included. This clearly demonstrates the feasibility, in spite of many difficulties, of collecting high quality and reliable information on the occurrence of cancer in Africa. Overall cancer rates in men, after adjustment to the world population, are highest in Bamako (121.9 new cases per 100000 person-years), intermediate in Setif Wilaya (72.2), and lowest in The Gambia (59.1). The ranking is similar among women with figures of 102.9, 65.4, and 39.6, respectively. Women therefore experience lower overall cancer rates than men. A more than tenfold difference exists for the occurrence of lung cancer. The highest male incidence is found in Setif Wilaya at 11.7 per 100000 versus 2.6 in Bamako and 1.0 in The Gambia. Among women, lung cancer rates are still very low, from 0 in The Gambia to 2.6 in Bamako.

Pioneering work has started at the International Agency for Research on Cancer (IARC) to estimate the proportion of human cancer linked to tobacco use on a world scale. In eastern and western Africa and with the methodology being used, no attributable fraction due to tobacco is yet discernible. This probably reflects the low prevalence of these diseases in these populations, as well as all the uncertainties surrounding the data and the adequacy of methods for countries with low rates of the disease considered. In the rest of Africa, tobacco is already responsible for a noticeable part of these cancers, especially among men.

Preparing the ground for better data

The International Development Research Centre (Ottawa, Canada) and the International Union Against Cancer in collaboration with IARC and the World Health Organisation have recently started pilot studies in ten African countries (Egypt, Ghana, Kenya, Nigeria, Senegal, South Africa, Sudan, Tanzania, Uganda, and Zambia) in order to collect basic information on tobacco use (various forms) and possibly tobacco-related mortality and morbidity (lung cancer in particular). Finally, an economic study is also planned. These data will not only be of scientific interest, but will also provide us with the information tools we need to convince African leaders, as well as international public health experts, of the importance of promoting an active anti-tobacco policy in Africa.

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