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Ad Hoc Inter-Agency Task Force on Tobacco Control

Report of the Secretary-General

Summary

The present report responds to Economic and Social Council decision 2002/242, in accordance with which the Secretary-General would report to the Council at its substantive session of 2004 on progress made by the Ad Hoc Inter-Agency Task Force on Tobacco Control in the implementation of multisectoral collaboration on tobacco or health. First and second reports were submitted at the substantive sessions of 2000 and 2002.

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I. Introduction

1. Tobacco consumption is classified as one of the 10 leading risk factors on a global basis that account for more than one third of all deaths worldwide. Tobacco use was the second major cause of death in the world in 2000. Tobacco kills about 5 million persons every year and this figure is expected to double in 20 years. There are currently 1.3 billion smokers in the world and this number will increase to 1.7 billion by 2025 if no action is taken to curb the prevalence.

2. Tobacco use affects development and is closely linked with poverty. Poor men tend to be the most likely to smoke. Tobacco consumption increases the incidence of serious diseases, which impose a heavy financial burden on those persons who seek treatment and cannot work as a result of their illness. It also entails heavy opportunity costs to poor households, which spend a significant amount of their resources to feed their addiction instead of spending this money on other essential goods such as food, education or health care. Tobacco growing undermines the wealth of farmers too, who are often heavily indebted towards the tobacco industry and whose returns from growing the crop have fallen sharply in recent years. Tobacco growing also entails health hazards from heavy use of strong pesticides and close contact with nicotine present in the tobacco leaves. In addition to its impact on poverty, tobacco also harms the environment through deforestation to provide land and firewood for curing tobacco, as well as pesticide run-off and tobacco plants leaching nutrients from the soil.

3. Based on the above facts, reducing tobacco use would help achieve the Millennium Development Goals of reducing poverty, disease, hunger and environmental degradation. Tobacco consumption is also linked to gender-related development issues. Incorporating tobacco control into development assistance programmes aimed at the attainment of the Millennium Development Goals could provide important improvements in poverty, malnutrition and the environment.

4. The World Health Organization (WHO) Framework Convention on Tobacco Control, which was unanimously adopted by the 192 Member States of WHO during the World Health Assembly of May 2003, is the first public health treaty developed under the auspices of the Organization. Now that the Framework Convention has been adopted, the implementation of the comprehensive tobacco control provisions contained in the treaty at the country level is a priority. The expertise of each of the member agencies of the Task Force will be very useful to help build, where needed, the technical capacity for countries to support and strengthen national tobacco control programmes.

5. The Task Force members highlighted five areas of concern in which tobacco use has a significant adverse impact and which will need to be thoroughly addressed by Governments, intergovernmental agencies and non-governmental organizations while working on the implementation of national tobacco control measures. These areas are the impact of tobacco on health, economic growth, poverty, its fiscal impact and finally, the impact of globalization on tobacco use at the country level.

II. Origins of the Ad Hoc Inter-Agency Task Force on Tobacco Control and update on its mechanisms

6. The Economic and Social Council, in its resolution 1993/79 of 30 July 1993, requested the Secretary-General to establish, under the auspices of WHO and within existing resources, a focal point among existing institutions of the United Nations system on the subject of multisectoral collaboration on the economic and social aspects of tobacco production and consumption, taking into particular account the serious health consequences of tobacco use. The United Nations Conference on Trade and Development (UNCTAD) was given this responsibility. Between 1993 and 1998 the focal point submitted three reports to the Secretary-General at the substantive sessions of 1994, 1995 and 1997 of the Council (E/1994/83, E/1995/67 and Add.1, and E/1997/62).

7. In 1998, the Secretary-General agreed to the designation of an Ad Hoc Inter-Agency Task Force on Tobacco Control under the leadership of WHO, replacing the focal point arrangement located at UNCTAD. This decision was taken in order to intensify a joint United Nations response and to galvanize global support for tobacco control. The establishment of this new Task Force was endorsed by the Organizational Committee of the Administrative Committee on Coordination, at part II of its first regular session of 1999, held at Geneva on 12 and 13 April 1999 (see ACC/1999/2, sect. VII).

8. In line with resolution 1999/56 adopted by the Economic and Social Council at its substantive session of July 1999 and in which the Council endorsed the establishment of a United Nations Ad Hoc Inter-Agency Task Force under WHO leadership, the Secretary-General reported to the Council at its substantive session of July 2000 (E/2000/21) on progress made by the Task Force in the implementation of multisectoral collaboration on tobacco or health, with particular emphasis on the development of appropriate strategies to address the social and economic implications of the impact of tobacco or health initiatives. The first Task Force report by the Secretary-General was prepared subsequent to the first two sessions of the Task Force.

9. The present third report responds to Council decision 2002/242, whereby the Secretary-General was requested to submit a report on the continuing work of the Task Force at the substantive session of July 2004.

10. The first session of the Task Force was convened at the United Nations Children's Fund (UNICEF), New York, 29 and 30 September 1999. Thirteen United Nations organizations, the World Bank and the International Monetary Fund (IMF) attended the first session. The objectives of the first session were to outline current and future actions by the members of the Administrative Committee on Coordination in respect of tobacco in general and to develop an operational approach that would ensure that one United Nations voice was heard throughout the framework convention process.

11. The second session of the Task Force was convened at the Food and Agriculture Organization of the United Nations (FAO) headquarters in Rome on 7 March 2000. Ten United Nations organizations, the World Bank and the World Trade Organization participated in the session. The principal objective of the second session was to consider specific strategies and projects for strengthening and extending inter-agency collaboration among the Task Force member organizations.

12. The third session of the Task Force was organized in a global videoconference format on 8 December 2000. Eight United Nations organizations, as well as the World Bank and the World Trade Organization were linked together during the videoconference session. The session provided an update on the work of each agency related to tobacco and updated members on the discussions of the substantive session in July 2000. The members of the Task Force also focused on developing a work plan for inter-agency cooperation for 2001 and discussed technical cooperation in support of the Framework Convention on Tobacco Control.

13. The fourth session of the Task Force was held in Kobe, Japan, on 5 December 2001. Seven United Nations organizations, as well as the World Bank and the World Customs Organization, participated in the session. The fourth session focused on the drafting of the second report of the Secretary-General presented at the substantive session of the Economic and Social Council in July 2002, as well as on an update that was given on the smoke-free policies in the United Nations system. The members of the Task Force also discussed the International Meeting on Economic, Social and Health Issues in Tobacco Control, held in Kobe on the two days preceding the fourth session. At that meeting, international experts reviewed ongoing United Nations work in the area of international tobacco control and explored the economic transition issues relevant to the technical mandates and ongoing work of the members of the Task Force, in particular WHO, FAO, the International Labour Office (ILO) and the World Bank.

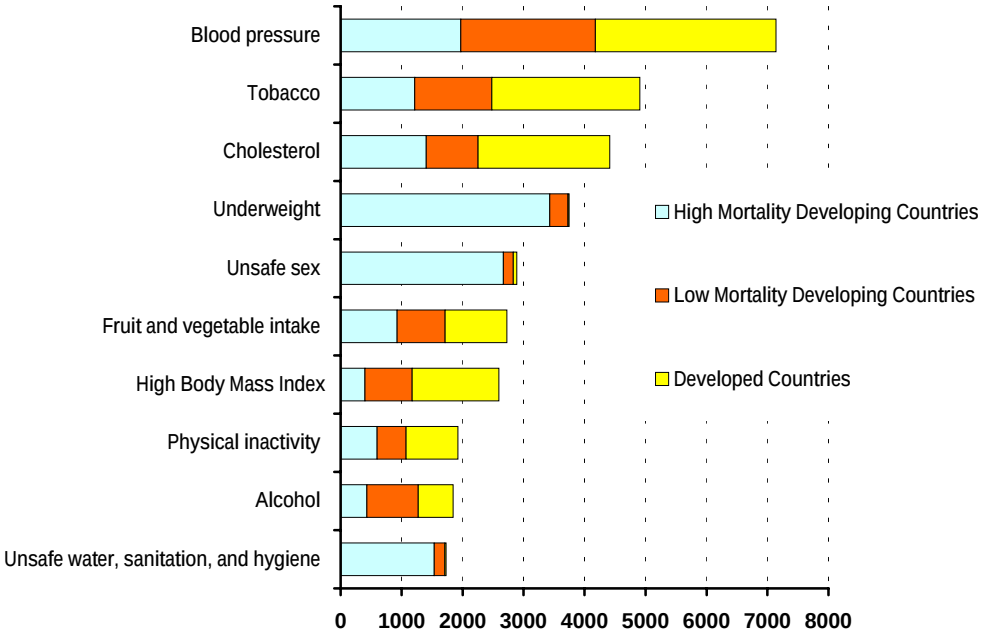
14. The fifth session of the Task Force was held on 21 and 22 October 2003, at the World Bank Headquarters in Washington, D.C. Eight United Nations organizations were present, as well as the World Bank and the International Monetary Fund (IMF). Task Force members discussed in depth the new orientation of the Task Force and the activities that it should focus upon now that the WHO Framework Convention on Tobacco Control has been adopted.

III. Tobacco use: the multifaceted aspect of the problem

A. Health

15. An extended research project reported on in the *World Health Report 2002*, compiled major global risk factors, their impact on health and ways to reduce them in order to promote a healthy lifestyle. “Risk” was defined as the “probability of an adverse outcome, or a factor that raises this probability”. Tobacco consumption was reported to be among the ten leading risk factors, globally speaking, which account for more than one third of all deaths worldwide (see figure 1). Tobacco consumption causes about 5 million deaths a year. In terms of ranking, tobacco proved to be the second major cause of death in the world in 2000. In developed countries it was the second most important cause of death, while in high-mortality developing countries it was ranked 6 and in low-mortality developing countries[1] tobacco was the second most important cause of death. In terms of risk factors for the burden of disease,[2] tobacco consumption represented the fourth highest risk at the global level. It was ranked first in developed countries, ninth in high-mortality developing countries and third in low-mortality developing countries. All these figures show clearly that tobacco consumption no longer only represents a serious health threat in developed countries but has also become a serious threat in developing countries.

Figure 1
World deaths in 2000 attributable to selected leading risk factors
Number of deaths ('000)



16. This threat is not likely to go away in the near future as global tobacco consumption has been increasing in recent decades, and a continued upward trend is expected in the next two decades. The WHO publication *Past, Current and Future Trends in Tobacco Use* estimated the actual and future consumption of tobacco at the global level and by regions. Results showed that the number of smokers in the world, estimated at 1.3 billion today (2003), is expected to rise to more than 1.7 billion by 2025 (assuming a 2 per cent increase in income and a medium population variant from the United Nations Population Division's projections) if the global prevalence of tobacco use remains unchanged. Even assuming a decrease of overall prevalence at an annual rate of 1 per cent, the number of tobacco users would still be expected to increase to 1.46 billion by 2025. This means that the economy based on tobacco production will be intact in the short to medium term. Consequently, stronger tobacco control interventions at the country level are needed, in particular in developing countries, which are becoming more and more exposed to this health threat.

17. FAO just published two studies: *Projections of Tobacco Production, Consumption and Trade to the Year 2010* and *Issues in the Global Tobacco Economy: Selected case studies*. The major conclusions in the projections paper are that global production and consumption will increase, but there will be a shift from developed countries to developing countries. In developed countries, assuming continuation of present policies and trends, tobacco leaf production will decline to below one million tons in 2010 compared to 1.2 million tons in 2000. Meanwhile, in developing countries, it is projected that tobacco leaf production will increase from close to 5 million tons in 2000 to about 6 million tons in 2010. Similar trends will be

found for consumption. Assuming no changes in tobacco control policies or in tariff and non-tariff barriers, developing countries are expected to become net exporters, while developed countries will become net importers of tobacco leaf. These results show that the fear that tobacco farmers will lose their jobs in developing countries is not an issue for the time being. The results also lead to the pressing conclusion that developing countries need to have stronger tobacco control policies to protect populations from the growing danger this product poses now and in the coming decades. *Issues in the Global Tobacco Economy* provides for a number of selected developing countries a review of tobacco production in order to better understand the economic contribution of tobacco production and the likely impact that tobacco control might have on producing and exporting countries. The study also reviews the capacity of the agricultural and other sectors to absorb labour and other resources displaced from agriculture and on the returns which can be realized in those alternative enterprises. The countries included in the study are Brazil, China, India, Malawi, Turkey and Zimbabwe.

B. Development and poverty

18. The Commission on Macroeconomics and Health was established in 2000 by the Director-General of WHO to assess the place of health in global economic development. The Commission included some of the world's leading economists and policy makers from academia, Governments and international agencies. The Commission highlighted the importance of investing in health to promote economic development and poverty reduction, in particular in low-income countries. The Commission recognized the double burden of disease — communicable diseases and non-communicable diseases are of great significance for all developing countries — and recognized tobacco as a major risk factor. The Commission released a report in 2001 and commissioned a number of papers, including a study of the impacts of trade liberalization of tobacco consumption. The Commission held a second consultation in October 2003, where discussions focused on issues related to improving the effectiveness of health delivery systems and increasing domestic and external resources to health.

19. The European Commission (EC) has specifically recognized tobacco as a development issue. The Commission held a high-level round table on "Tobacco Control and Development Policy" at Brussels on 3 and 4 February 2003. A document prepared for the meeting stated that tobacco use is increasing in many developing countries, causing an increasing death toll owing to tobacco-related illnesses. This poses a very heavy burden on developing countries, which are already struggling with the health impact of communicable diseases such as HIV/AIDS, tuberculosis and malaria. Tobacco production and consumption help to increase poverty and undermine sustainable development. Based on these arguments, the Commission confirmed during the meeting its willingness to support developing countries wishing to address tobacco control, using existing instruments of development cooperation at the country level.

20. In collaboration with the Organization for Economic Cooperation and Development (OECD) and WHO, the Development and Assistance Committee published a report in 2003 on Poverty and Health in its Guidelines and Reference Series. The report recognized that non-communicable diseases have a marked impact on the health of poor populations and that tobacco-related diseases are

strongly related to poverty. Habitual tobacco use is projected to cause an estimated 7 million deaths annually from tobacco-related diseases by 2030 in developing countries, 50 per cent of them in Asia. Tobacco has a profound effect on poverty and malnutrition in low-income countries, particularly when expenditures on tobacco products divert scarce resources that poor families might have spent on food instead. The high prevalence of tobacco use among men with low incomes and low education has serious poverty implications, because the risk of developing dangerous diseases and dying at an early age is substantially increased. In order to counter the ill effects of tobacco use, especially among the poor and in low-income countries, development agencies should use policy dialogue and technical and financial cooperation to support policy change.

21. Tobacco consumption is a major direct contributor to increasing non-communicable diseases and an associative contributor to communicable diseases such as tuberculosis. Poverty facilitates the spread of diseases and their treatment can impose a heavy financial burden on poor households. Tobacco entails heavy opportunity costs for poor households in which addicted tobacco users spend a significant amount of household resources on tobacco consumption. In developing countries, among poor families, the proportion of household expenditures used to purchase tobacco products can easily represent up to 10 per cent of total household expenditures. This means that these families have less money to spend on basic items such as food, education and health care. In addition to its adverse health effects, tobacco use can lead to increased health-care costs and premature death. It also contributes to worsened malnutrition and a higher illiteracy rate if money that could have been used for food and education is spent on tobacco instead. These findings have been highlighted in some country studies. Some facts are highlighted below:

(a) A recent study in Bangladesh showed that over 10.5 million people currently malnourished could have an adequate diet if money spent on tobacco were spent on food instead;

(b) Preliminary results from an ongoing study in 3 provinces of Viet Nam found that, over the course of a year, smokers spent 3.6 times more on tobacco than on education, 2.5 times more for tobacco than clothes, and 1.9 times more for tobacco than for health care;

(c) Some street children and other homeless people in India spend more on tobacco than on food, education or savings;

(d) Poor, rural households in Southwest China spend over 11 per cent of their total expenditures on cigarettes;

(e) Students in Niger spent 40 per cent and manual labourers 25 per cent of their income on cigarettes.

22. Tobacco and poverty create a vicious circle. Tobacco use increases poverty, and tobacco products tend to be more widely used among the poor:

(a) Of the estimated 1.3 billion smokers, 84 per cent live in developing and transitional economy countries;

(b) A study conducted in Chennai (India) in 1997 showed that the highest smoking prevalence rate among men is found among the illiterate population (64 per

cent). This prevalence decreases with more years of schooling, and goes down to less than a third (21 per cent) among those with more than 12 years of schooling;

(c) A study in Poland in 1996 showed that the contribution of smoking to the risk of premature death among males aged 35 to 69 varies by education level; the risk of dying during middle age due to tobacco-related diseases was 5 per cent among people with higher education and nearly double (9 per cent) among persons with only primary and secondary education levels.

23. Tobacco not only undermines the wealth of tobacco consumers but also tobacco producers. In some countries scarce land resources are used for growing tobacco instead of food. Also, in many developing countries small-scale farmers depend heavily on the tobacco industry, which gives them loans for their production, provides technical assistance and sets the price of the crop. This makes it hard for the farmers to have any flexibility in terms of production and possible switching, especially if they become indebted towards the tobacco industry. In addition, tobacco production entails health risks from direct contact with green tobacco leaves, which allows substantial amounts of nicotine to be absorbed through the skin (green tobacco sickness),[3] and from the use of strong pesticides without adequate protective clothing.

24. Tobacco also harms the environment. Degradation of the environment is caused by the tobacco plant leaching nutrients from the soil, pollution from pesticides and fertilizers and deforestation as a result of fire-curing of tobacco and clearing of land to grow it. A recent study that assessed the amount of forest and woodland consumed annually for curing tobacco concluded that nearly 5 per cent of overall deforestation in various tobacco-growing countries was due to tobacco cultivation.

25. Based on the evidence linking tobacco with poverty, the World Health Organization decided on the theme of tobacco and poverty for World No Tobacco Day 2004. The main message this theme will convey is that tobacco increases the poverty of individuals, families and nations. This is in contrast to over-simplistic and widespread arguments that tobacco provides wealth to Governments and growers. The World No Tobacco Day 2004 will be launched in Brazil, a country which is known for its strong involvement in tobacco control, and which places issues related to poverty alleviation high on its agenda.

26. Worldwide, tobacco consumption by males is four times higher than consumption by females. In many developed countries the difference is much narrower, as there are more and more women smoking. However, the upward trend in women's smoking is now becoming an issue in the developing world too. The tobacco industry has already understood it and is heavily targeting women to gain a part of the market that was not available in the past. Tobacco advertising vehicles images for women featuring vitality, slimness, glamour, emancipation etc. The message for men is different, as advertising focuses on male aspirations for happiness, fitness, wealth, power and sexual success. Tobacco adversely affects the health of all its users but it has also specific health consequences for men and women. Men face a risk of declines in fertility and sexual potency. For female smokers there is an increased risk of cardiovascular disease, in particular while using oral contraceptives, and higher rates of infertility, premature labour, low-birth-weight infants, cervical cancer, early menopause, and bone fractures. Smoking during pregnancy adversely affects fetal development. The new gender behaviour

can also have adverse social and economic consequences. For example, it is known that women often have less disposable income than men and are more likely to spend it on their children. When more women start consuming tobacco at a higher rate, the diversion of scarce family resources to tobacco may significantly contribute to malnutrition and higher rates of school drop-out, with potential long-term negative consequences.

27. The eight Millennium Development Goals constitute an ambitious agenda to improve the human condition significantly by 2015, by reducing poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. For each goal a set of targets and indicators has been defined and is being used to track progress in meeting the goals. Based on the facts set out above, tobacco is clearly linked to the Millennium Development Goals, in particular with regard to disease, poverty, hunger and gender issues. Therefore, the Task Force recommends that this deadly nexus is recognized in the context of development assistance programmes aimed at the attainment of the Millennium Development Goals.

IV. The World Health Organization Framework Convention on Tobacco Control

28. In May 2003, the World Health Assembly unanimously adopted the WHO Framework Convention on Tobacco Control. Negotiated among WHO Member States over four years, this international legal instrument is designed to limit the harm to health caused by tobacco products. It comprises many diverse aspects of tobacco control:

(a) The core demand-reduction provisions are contained in articles 6 to 14;

(b) Price and tax measures to reduce the demand of tobacco;

(c) Non-price measures to reduce the demand for tobacco, namely:

- Protection from exposure to tobacco smoke;
- Regulation of the contents of tobacco products;
- Regulation of tobacco products disclosures;
- Packaging and labelling of tobacco products;
- Education, communication, training and public awareness;
- Tobacco advertising, promotion and sponsorship;
- Demand reduction measures concerning tobacco dependence and cessation.

(d) The core supply-reduction provisions are contained in articles 15 to 17:

- Illicit trade in tobacco products;
- Sales to and by minors;
- Provision of support for economically viable alternative activities.

The Convention represents a global minimum standard, and the future Parties to the Convention are encouraged by provisions in the treaty to go further and implement

stricter measures. Furthermore, the negotiation of future protocols to the Convention by the Conference of the Parties will result in a treaty regime that will continue to evolve and provide for more specific obligations on certain topics. The Framework Convention is a delicately balanced evidence-based instrument adopted after vigorous negotiations, which took into account relevant scientific, economic, social and political considerations.

29. The Framework Convention was adopted by the World Health Assembly on 21 May 2003. The Convention was opened for signature from 16 June to 22 June 2003 at WHO headquarters in Geneva, and it remains open for signature at United Nations Headquarters in New York from 30 June 2003 to 29 June 2004. Countries that sign the treaty by 29 June 2004 will become parties to the Convention by ratifying, approving, accepting or formally confirming the treaty. Starting on 30 June 2004, the Treaty will be available for accession. The Convention will come into force 90 days after 40 instruments of ratification, approval, acceptance, formal confirmation or accession have been deposited with the United Nations depository. At that time, countries that have ratified, approved, accepted or acceded to the treaty will be legally bound by its provisions. As in the negotiation of the Convention, tobacco-control advocates in health professions, concerned non-governmental organizations and grass-roots groups have an important role on the international stage during the ratification process. They can continue to promote the ratification and implementation of the Convention and the introduction of effective national legislation in support of the Convention. As of 21 April 2004, 103 Member States plus the European Community had already signed and 10 Member States had ratified the treaty.

30. Now that the Framework Convention has been adopted, the implementation of comprehensive tobacco-control policies at the country level, as stipulated in the treaty, is a priority. Few countries have implemented the measures needed to create a significant decline in tobacco use. The expertise of each of the member agencies of the Task Force will be needed to build, where needed, the technical capacity for countries to support and strengthen national tobacco control programmes. The Convention is a very good example of an instrument that can be used as a baseline for the effective implementation of a national tobacco-control policy. In addition, with the adoption of the Convention, the definition of a comprehensive tobacco-control strategy has now been redefined to include the transnational components of tobacco control, complementing national and local measures.

31. The Framework Convention is a multisectoral treaty. The role of the United Nations agencies is recognized as important in the Convention. The preamble commends the “leadership of the World Health Organization as well as the efforts of other organizations and bodies of the United Nations system and other international and regional intergovernmental organizations in developing measures on tobacco control”. The preamble recalls “Article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly on 16 December 1966, which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. It also recalls that the “Convention on the Elimination of All Forms of Discrimination against Women, adopted by the United Nations General Assembly on 18 December 1979, provides that States Parties to that Convention shall take appropriate measures to eliminate discrimination against women in the field of health care”. The preamble of the Convention recalls further “that the Convention on the Rights of the Child,

adopted by the United Nations General Assembly on 20 November 1989, provides that States Parties to that Convention recognize the right of the child to the enjoyment of the highest attainable standard of health". Under the general obligations, Article 5, paragraph 5, states that "The Parties shall cooperate, as appropriate, with competent international and regional intergovernmental organizations and other bodies to achieve the objectives of the Convention and the protocols to which they are Parties".

32. In response to the global public health threat posed by tobacco use, WHO Member States exercised their treaty-making powers, under article 19 of the WHO Constitution,[4] to initiate accelerated multilateral negotiations on a WHO Framework Convention on Tobacco Control and possible related protocols. The Framework Convention is the first public health treaty negotiated under the auspices of the World Health Organization. As stated in article 3, "The objective of this Convention and its protocols is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke". The Framework Convention represents a powerful public health tool to reduce in the future the burden of disease and mortality attributed to tobacco.

33. In relation to article 24 on the secretariat, WHO has been designated by Member States as the interim secretariat of this public health treaty. In reaching the goals of the Convention, technical cooperation between WHO and other international organizations, as highlighted below, will be beneficial:

(a) Food and Agriculture Organization of the United Nations (FAO): In the preamble, the Parties to the Convention are mindful of "the social and economic difficulties that tobacco control programmes may engender in the medium and long term in some developing countries and countries with economies in transition". Also the need of those countries "for technical and financial assistance in the context of nationally developed strategies for sustainable development" is recognized. Article 17 on the provision of support for economically viable alternative activities states that: "Parties shall, in cooperation with each other and with competent international and regional intergovernmental organizations, promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers." And in article 22 on cooperation in the scientific, technical, and legal fields and provision of related expertise, paragraph 1 (b) (iii) stresses the need to assist, "as appropriate, tobacco growers in shifting agricultural production to alternative crops in an economically viable manner." Provisions of technical assistance would benefit from the input of different specialized organizations, in particular, FAO. For example, the recent FAO study *Issues in the Global Tobacco Economy* provides a review of tobacco production and the potential for diversification to alternative crops in a number of selected developing countries;

(b) International Labour Organization (ILO): Technical collaboration between WHO and ILO would be beneficial with regard to article 17 on the provision of support for economically viable alternative activities, and article 22 on cooperation in the scientific, technical, and legal fields and provision of related expertise, in particular paragraph 1 (b) (iii), which states that Parties shall cooperate

to promote plans and programmes aimed at "assisting, as appropriate, tobacco workers in the development of appropriate economically and legally viable alternative livelihoods in an economically viable manner." In article 8 on protection from exposure to tobacco smoke, paragraph 2 states that "Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places." The International Labour Organization, with its history of guiding governments, employers and workers in all matters related to the world of work through its legal instruments, research on social and labour questions in the tobacco sector, and technical cooperation programmes, is in a unique position to promote workplace action, particularly through social dialogue. Specifically, there are two means of action that ILO is using to address the protection of workers against the dangers of exposure to tobacco smoke. The first is a report entitled "Workplace Smoking Working Paper: A Review of Practical and Regulatory Measures", which will be available on the ILO web site.[5] The second is the ILO educational programme entitled "Addressing Psychosocial Problems at Work". The programme, known as SOLVE,[6] addresses workplace exposure to tobacco smoke at the workplace policy and action levels;

(c) United Nations Children's Fund (UNICEF): As mentioned above, the preamble of the Convention explicitly shows the concern of member States about the escalation in smoking and other forms of tobacco consumption by children and adolescents worldwide, particularly smoking at increasingly early ages. It would be useful to link the implementation of appropriate health provisions in the Convention on the Rights of the Child with Article 16 on sales to and by minors of the Framework Convention because tobacco is incorporated in the State reporting guidelines for the Convention on the Rights of the Child;

(d) United Nations Development Programme (UNDP): In the preamble of the Framework Convention, Parties to the Convention state they are "*seriously concerned* about the increase in the worldwide consumption and production of cigarettes and other tobacco products, particularly in developing countries, as well as about the burden this places on families, on the poor, and on national health systems". Tobacco use has a profound effect on poverty and malnutrition in low-income developing countries. In light of the Millennium Development Goals, input from UNDP at the country level to reduce tobacco use and the burden it can have on the poor can move forward the struggle against poverty;

(e) United Nations Educational, Scientific and Cultural Organization (UNESCO): Article 12 of the Framework Convention, entitled "*Education, communication, training and public awareness*" clearly states that: "Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Towards this end, each Party shall adopt and implement effective legislative, executive, administrative or other measures to promote: broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke …". Close collaboration between WHO and UNESCO at the country level would facilitate and speed access to relevant educational and public awareness programmes;

(f) United Nations Environment Programme (UNEP): Article 18 on the protection of the environment and the health of persons states: “In carrying out their obligations under this Convention, the Parties agree to have due regard to the protection of the environment and the health of persons in relation to the environment in respect of tobacco cultivation and manufacture within their respective territories.” With the collaboration between WHO and UNEP, the promotion of environmentally friendly tobacco production and manufacturing process could be enhanced at the country level;

(g) United Nations Population Fund (UNFPA): In the preamble Parties to the Framework Convention acknowledge “that there is clear scientific evidence that prenatal exposure to tobacco smoke causes adverse health and developmental conditions for children”. This is a direct area of concern for the United Nations Population Fund which supports programmes that help women, men and young people and improve reproductive health;

(h) The World Bank and the International Monetary Fund: In line with article 6 Price on price and tax measures to reduce the demand for tobacco there is an explicit recognition of the importance of tax and price increases for reduction of tobacco use which states that: “Without prejudice to the sovereign right of the Parties to determine and establish their taxation policies, each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include: (a) implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption …”. As countries ratify and prepare to comply with the Framework Convention, it will be useful for WHO to call on the economic expertise and the mandate of the World Bank and the International Monetary Fund as key collaborators in helping countries to establish and implement effective evidence based policies to reduce tobacco use. A key example would be collaboration in operational work, by participating in policy dialogue with developing country Governments, especially with Ministries of Finance, with respect to tobacco taxation;

(i) World Customs Organization: The Framework Convention includes a detailed provision on illicit trade in tobacco products (article 15), which incorporates provisions on tracking and traceability of tobacco products. The World Customs Organization is WHO’s main partner for technical collaboration in this area;

(j) World Trade Organization (WTO): The Framework Convention’s provisions intersect with a number of WTO agreements, including the Agreement on Technical Barriers to Trade (TBT); the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS); the General Agreement on Tariffs and Trade 1994 (GATT); the Agreement on Agriculture; the General Agreement on Trade in Services (GATS) and the Agreement on Subsidies and Countervailing Measures (SCM). Furthermore, the first preambular paragraph of the Framework Convention states that “The Parties to this Convention, determined to give priority to their right to protect public health ...”.

V. Key areas of concern

34. Following the conclusions approved by the Task Force members at the fifth session of the Ad Hoc Inter-Agency Task Force on Tobacco Control and summarizing the issues covered in the present report, this section highlights the key areas in which tobacco use has a significant adverse impact. These points support the argument that tobacco control needs high-level political attention. They also stress the need for strengthening national tobacco control programmes.

Impact on health

Few people now dispute that tobacco use is damaging human health on a global scale. Tobacco is the second major cause of death in the world. It is currently responsible for the death of one in ten adults worldwide (about 5 million deaths each year) and is a major source of disability. Unless available and effective interventions are urgently and widely adopted, this proportion will increase to one in six adults, or the death toll will double in 20 years. It is also important to point out that exposure to "second-hand" tobacco smoke (from cigarettes being smoked by other people) also leads to morbidity and mortality.

Impact on economic growth

Tobacco use undermines economic development. Tobacco-related diseases have an impact on labour productivity. The treatment of such diseases is very expensive for Governments and individuals. Moreover, half of the people killed by tobacco-related diseases die during their active working life, which greatly affects those family members who are dependant on their income. Their deaths also deprive society of their contributions as workers and parents.

Impact on poverty

Tobacco is closely linked with poverty. Many studies have shown that the poorest households tend to spend a relatively high percentage of their total expenditures on tobacco products. The money is often spent at the expense of other essential needs, such as food, education and health care. Tobacco affects the poor more harshly as it contributes to a higher burden of ill-health, health-care costs, premature death, worsened malnutrition and higher illiteracy.

Fiscal impact

With an ageing population (throughout the world), the demand for treatment for tobacco-related diseases may crowd out resources for primary-care health programmes and will increase demand for high-cost medical care. The global trade in tobacco products can also have an impact on the financial sector. There have been some cases of money laundering associated with illicit trade in tobacco and alleged links with terrorism have also been cited.

Globalization

Trade in tobacco products at the global level can be seen as a global "bad". Legitimate tobacco trade has negative repercussions through illicit trade, aggressive marketing and promotion and consequent increasing production and consumption of tobacco products. Regulation of this "bad", taking into account the profoundly

negative impact it produces on health, development and the environment, has to be well defined at the global level.

VI. Conclusions and recommendations

35. **The Members of the Task Force would like to present the following recommendations to the member States of the Economic and Social Council:**

(a) **Tobacco use has an adverse impact on health, poverty, malnutrition, education and environment. Consequently, tobacco control has to be recognized as a key component of efforts to reduce poverty, improve development and progress towards the Millennium Development Goals. Tobacco control needs to be included in the programmes of countries working on achieving the Millennium Development Goals. Tobacco control also needs to be a key component of development assistance programmes in general;**

(b) **Now that the WHO Framework Convention on Tobacco Control has been adopted, the issue of tobacco control has to be taken into consideration at the Resident Coordinator system level to ensure technical cooperation at the country level as countries implement the treaty in the future;**

(c) **As noted in section III of this report, the Framework Convention is the first public health treaty developed under the auspices of the World Health Organization. In addition to the public health aspect of the Framework Convention, many of its provisions overlap with the technical interests of other agencies of the United Nations and non-United Nations agencies. Some of these agencies have been more involved than others in the promotion of tobacco control. The problems tobacco use entails need to be addressed in a multisectoral approach and the commitment of the different member agencies and others is crucial. In this regard, the United Nations Development Group is a key group in bringing together United Nations entities dealing with operational issues for development. The issue of tobacco control could therefore be included in forthcoming activities of the Development Group in order to facilitate the implementation of the Framework Convention through enhanced collaboration of multisectoral intergovernmental agencies at country level. WHO, as the interim secretariat for the Framework Convention and the Chair of the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control is well-placed to spearhead such multisectoral cooperation;**

(d) **Given the multiplicity of problems it addresses, tobacco control could also be included in the agendas of the regional economic commissions. An example would be the Economic and Social Commission for Asia and the Pacific (ESCAP), which has restructured its work programmes and is now meeting along three key themes: globalization, poverty reduction and emerging social issues; all of these themes are of key importance to tobacco control.**

Notes

[1] For further information regarding the classification of each country: http://www.who.int/whr/2002/en/MembersETC.pdf.

[2] In these numbers, the disability-adjusted life year (DALY) is the unit used for measuring the global burden of disease. It is calculated as the present value of the future years of disability-free life that are lost as the result of the premature deaths or cases of disability occurring in a particular year.

[3] Common symptoms of green tobacco sickness are nausea, vomiting, weakness, headache and dizziness, and may also include abdominal cramps and difficulty breathing, as well as fluctuation in blood pressure and heart rates.

[4] Article 19 of the WHO Constitution stipulates that “the Health Assembly shall have the authority to adopt conventions or agreements with respect to any matter within the competence of the Organization”.

[5] www.ilo.org/safework.

[6] www.ilo.org/safework/solve.

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Annex

List of collaborating organizations

Department of Economic and Social Affairs of the Secretariat

Food and Agriculture Organization of the United Nations (FAO)

International Civil Aviation Organization (ICAO)

International Labour Organization (ILO)

International Monetary Fund (IMF)

United Nations Children's Fund (UNICEF)

United Nations Conference on Trade and Development (UNCTAD)

United Nations Development Fund for Women (UNIFEM)

United Nations Development Programme (UNDP)

United Nations Educational, Scientific and Cultural Organization (UNESCO)

United Nations Environment Programme (UNEP)

United Nations Fund for International Partnerships (UNFIP)

United Nations International Drug Control Programme (UNDCP)

United Nations Population Fund (UNFPA)

World Bank

World Customs Organization (WCO)

World Health Organization (WHO)

World Intellectual Property Organization (WIPO)

World Trade Organization