ANNEXE 6 - A

LES MESURES POUR REDUIRE LE TABAGISME, LE POINT DE VUE INTERNATIONAL

1. Les quinze (15) dernières années ont vu une mobilisation des plus grandes institutions de santé publique et des organismes internationaux de la planète voués à la protection de la santé.

ORGANISATION MONDIALE DE LA SANTE

2. Déjà en 1986, grandement préoccupée par le problème du tabagisme, l'Organisation mondiale de la santé[1] (l'**OMS**) adoptait sa résolution WHA39.14 du mois de mai 1986 qui énonçait:

> *« 2. DEMANDE qu'au niveau mondial on adopte maintenant une démarche et des mesures de santé publique pour combattre la pandémie du tabagisme;*
>
> *(…)*
>
> *3. PRIE INSTAMMENT les États Membres qui ne l'ont pas encore fait d'appliquer des stratégies de lutte antitabac, qui devraient, au moins, comporter les éléments suivants :*
>
> *1) des mesures visant à garantir aux non-fumeurs la protection efficace à laquelle ils ont droit contre l'exposition involontaire à la fumée de tabac, dans les lieux publics clos, les restaurants, les moyens de transport, et les lieux de travail et de divertissement;*
>
> *2) … l'usage du tabac de manière à protéger les enfants et les jeunes contre le risque de dépendance;*
>
> *3) des mesures visant à ce qu'un bon exemple soit donné dans tous les locaux à vocation sanitaire et par tous les personnels de santé;*

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[1] The World Health Organization was established in 1948 as a specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health, a responsibility that it fulfils in part through Its extensive program of publications.
The Organization seeks through its publications to support national health strategies and address the most pressing public health concerns of populations around the world. To respond to the needs of Member States at all levels of development, WHO publishes practical manuals, handbooks and training material for specific categories of health workers; Internationally applicable guidelines and standards; reviews and analyses of health policies, programs and research; and state-of-the-art consensus reports that offer technical advice and recommendations for decision-makers. These books are closely tied to the Organization's priority activities, encompassing disease prevention and control, the development of equitable health systems based on primary health care, and health promotion for individuals and communities. Progress towards better health for all also demands the global dissemination and exchange of information that draws on the knowledge and experience of all WHO's Member countries and the collaboration of world leaders in public health and the biomedical sciences.
To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures the broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease throughout the world, WHO's books contribute to achieving the Organization's principal objectlve - the attainment by all people of the highest possible level of health, dans ED-32 Guidelines for controlling and monitoring the tobacco epidemic, World Health Organization, Geneva, 1998

4) des mesures conduisant à une élimination progressive des incitations socio-économiques, comportementales et autres qui entretiennent et favorisent l'usage du tabac;

5) l'apposition, bien en évidence, de mises en garde pouvant préciser que le tabac engendre la dépendance, sur les paquets de cigarettes et les emballages de tous les types de produits du tabac;

6) l'établissement de programmes d'éducation et d'information du public sur les questions relatives au tabac et à la santé, notamment de cures de cessation de l'usage du tabac avec l'engagement actif des professions de santé et des médias;

7) la surveillance des tendances en matière d'usage du tabac sous toutes ses formes, de maladies liées au tabac et d'efficacité des mesures nationales de lutte antitabac;

8) la promotion de solutions de remplacement économique visibles viables à la production, au commerce et à la taxation du tabac;

9) la création d'un point focal national pour stimuler, soutenir et coordonner toutes les activités susmentionnées. »[2]

3. Constatant les progrès résultant de l'application de ces mesures, mais consciente de la complexité du problème auquel elle s'attaquait, l'OMS travailla à la mise en ouvre de stratégies globales et multisectorielles de lutte antitabac et à l'élaboration d'une Convention-cadre internationale de lutte antitabac (Framework Convention) impliquant la participation d'autres organisations du système des Nations-Unies et permettant un usage optimal de ressources et une action intégrée et compréhensive.[3] [4] [5] [6] [7] [8] [9]

4. L'OMS décrit ainsi l'objectif de sa démarche:

« 2. Objectives

The overall objective of the current project is to intensify national and international efforts to control the global tobacco epidemic through the development of an International Framework Convention for Tobacco Control in response to requests by Member States, also reflected in the World Health Assembly resolution WHA49.17 (25 May 1996).

Part of the framework convention strategy is to encourage Member states to move progressively towards the adoption of comprehensive tobacco control

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[2] ED-44/ED-45 Résolution de l'Assemblée mondiale de la santé WHA39.14, 14 mai 1986

[3] ED-42 Résolution de l'Assemblée mondiale de la santé WHA43.16, «Tabac ou santé» 17 mai 1990

[4] ED-39 Résolution de l'Assemblée mondiale de la santéWHA45.20 «Collaboration multisectorielle concernant le programme «tabac ou santé» de l'OMS», 13 mai 1992

[5] ED-40 Résolution de l'Assemblée mondiale de la santé WHA48.11, «Stratégie internationale de lutte antitabac», 12 mai 1995

[6] ED-34/ED-35 Résolution de l'Assemblée mondiale de la santé WHA49.16, «Programme «tabac ou santé»» , 25 mai 1996

[7] ED-30/ED-31 Résolution de l'Assemblée mondiale de la santé WHA52.18, «Vers une convention-cadre de l'OMS pour la lutte anti-tabac», 24 mai 1999

[8] ED-28/ED-29 Résolution de l'Assemblée mondiale de la santé WHA53.16, «Convention-cadre pour la lutte antitabac», 20 mai 2000

[9] ED-25 Résolution de l'Assemblée mondiale de la santé WHA54.18, «Transparence de la lutte antitabac», WHA 54.18, 22 mai 2001

policies and also to deal with aspects of tobacco control that transcend national boundaries. » [10]

5. Cette Convention-cadre contemple à la fois l'adoption de mesures financières et fiscales de même que des mesures autres visant le tabagisme passif, la réglementation de la composition des produits du tabac, la réglementation des informations à faire figurer sur les produits du tabac, le conditionnement et l'étiquetage, l'éducation, la formation et la sensibilisation du public, ainsi que la publicité, promotion et parrainage, à quel égard l'on prévoit:

a) interdire toutes les formes directes et indirectes de publicité en faveur des produits du tabac, et de promotion et de parrainage dans ce domaine, visant les personnes âgées de moins de 18 ans;

b) imposer des restrictions strictes à toutes les formes directes et indirectes de publicité en faveur des produits du tabac, et de promotion et de parrainage dans ce domaine, visant les personnes de 18 ans et plus, y compris les incitations telles que les cadeaux, les coupons, les réductions, les concours et les programmes de fidélisation, en vue de réduire l'attrait des produits du tabac pour tous les groupes sociaux;

c) exiger des sociétés du tabac qu'elles dévoilent toutes les dépenses consacrées à la publicité et à la promotion, et qu'elles rendent ces chiffres accessibles au public;

d) adopter des mesures nationales et imposer des restrictions réglementaires appropriées afin que la publicité, la promotion et le parrainage ne contribuent pas à promouvoir un produit du tabac par des moyens fallacieux, tendancieux ou trompeurs, ou susceptibles de donner une impression erronée quant aux caractéristiques, effets sur la santé, risques ou émissions du produit;

e) adopter des mesures et imposer des restrictions réglementaires appropriées afin de parvenir à une élimination progressive du parrainage d'événements sportifs et culturels par l'industrie du tabac;

f) adopter des mesures nationales et coopérer en vue de l'élimination progressive de la publicité, de la promotion et du parrainage transfrontières, y compris, plus particulièrement, la publicité, la promotion et le parrainage sur la télévision par câble et par satellite, sur Internet et dans les journaux, les revues et la presse écrite d'une manière générale. [11] *(p. 5)*

Ces mesures furent par la suite complétées et précisées. [12]

6. Cette démarche de l'OMS compte sur l'appui de nombreux États membres[13] [14], notamment des pays d'Afrique[15] [16] et de ceux de l'Asie du Sud-Ouest qui adoptent une Déclaration en octobre 2001 énonçant:

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[10] ED-36/ED-33 World Health Assembly Resolution WHA49.17 "International Framework Convention for Tobacco Control", May 25 1996:

[11] ED-26 Organisation Mondiale de la Santé, Organe Intergouvernemental de Négociation de la Convention-cadre de l'OMS pour la Lutte Anti –Tabac, deuxième session, «Convention-cadre pour la lutte anti-tabac: texte du Président», 9 Janvier 2001

[12] ED-24 World Health Organization Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control. Fourth Session Provisional Agenda for WHO Framework Convention on Tobacco Control. Co-chairs' working papers: final revisions, A/FCTC/INB4/2(a), January 24 2002

[13] ED-7 WHO South-East region moves forward on the first public health treaty on tobacco control, Press release, April 11, 2001

Resolve to

- *Support the objectives of the Framework Convention on Tobacco Control (FCTC), which are currently being negotiated by the nations of the world, under the auspices of the World Health Organization;*

Recommend that,
the FCTC, in its final form, should contain :
(A) Public health measures, for tobacco control, that include :

- *Strengthening of educational programmes to enhance community awareness of the hazards of tobacco consumption and the benefits of tobacco cessation;*
- *Protection of non-smokers from hazardous exposure to passive smoking;*
- *A ban on all forms of tobacco advertising (direct and indirect/surrogate), and promotion;*
- *Prohibition of sale of tobacco products and materials to persons below the age of 18 years, and*
- *Regulation of tobacco product packaging and labelling to ensure adequate health warnings and disclosure of toxic constituents.*

(B) Financial measures for tobacco control, that include :

- *Price and tax-based mechanisms for reducing tobacco consumption, by progressively raising the purchase price of tobacco products;*
- *Elimination of all forms of subsidy for growth and manufacture of tobacco, and*
- *Support for activities related to the economic transition of persons engaged in tobacco agriculture or manufacture into alternative occupations.*

(C) Global support mechanisms for tobacco control that include :

- *The creation of a multilateral global fund which will assist the developing countries in undertaking activities in accordance with the objectives of the FCTC;*
- *International scientific cooperation, especially to provide technical assistance to the developing countries and for facilitating surveillance of the dimensions, determinants and consequences of tobacco consumption; and for strengthening tobacco control programmes;*
- *International legal and administrative cooperation to curb illicit trade of tobacco products and raw tobacco materials, as well as to curb trans-border advertising of tobacco products, and*
- *Strengthening the role of WHO in carrying forth the mandate of the Framework Convention on Tobacco Control.*[17]

7. En 1996, l'OMS faisait le point sur la situation globale du tabagisme et publiait «The Tobacco Epidemic: A Global Public Health Emergency»[18]. Elle y souligne la nécessité d'adopter des mesures législatives et réglementaires pour arriver à une politique compréhensive de lutte au tabagisme, notamment en ce qui a trait aux éléments suivants:

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[14] ED-5 Pacific Islands-healthy Islands Sydney Statement on Tobacco Control, October 12-13, 2001
[15] ED-8 Johannesburg Declaration on the Framework Convention on Tobacco Control, March 14 2001
[16] ED-6 Projet de Déclaration d'Alger sur la Convention Cadre pour la Lutte Anti-Tabac, 4 Octobre 2001
[17] ED-4 Thimphu Declaration on the Framework Convention on Tobacco Control, October 30-31, 2001
[18] ED-37 WHO/Organisation mondiale de la santé «The Tobacco Epidemic: A Global Public Health Emergency. First Global Report on Tobacco, May 23 1996

« Many elements of an effective comprehensive tobacco control policy will eventually involve some form of legislative action, whether in the form of adopting or amending laws, regulations or government decrees. These include :

- *protection for children from becoming addicted to tobacco;*
- *effective protection from involuntary exposure to tobacco smoke;*
- *prominent health warnings on tobacco product packaging;*
- *progressive elimination of tobacco advertising;*
- *the use of financial measures, such as higher tobacco taxes, to discourage tobacco consumption. »* (p. 24)

8. L'OMS fait les constats suivants eu égard à deux (2) des neuf (9) stratégies déjà préconisées dans sa résolution WHA39.16:

« TOBACCO CONTROL MEASURES

Prominent health warnings on tobacco product packaging

In the early 1990s, about 80 countries required health warnings to appear on packages of tobacco products. However, is most countries the warnings are small, inconspicuous and provide little information about the many serious health consequences of tobacco use. Evaluation studies have found such warnings to be ineffective.

By the mid-1990s, however, a number of countries had adopted much more stringent warning systems, involving direct statements of health hazards, multiple messages, as well as large and prominent message display. Such warnings are now required in a number of countries including Australia, Canada, Iceland, Norway, Singapore, South Africa and Thailand. Greatly enhanced effectiveness has been found with legislated health warning systems that have the following characteristics :

10) *multiple warnings, with each appearing in approximately equal proportion on packages of tobacco products;*
11) *warnings on all kinds of tobacco products, with the text appropriate to each product;*
12) *strong, uncompromising messages in the text of each warning, such as ²Smoking harms your family², ²Smoking causes cancer², ²Cigarettes are addictive², ²Smoking causes heart disease² and ²Tobacco smoke causes fatal lung disease in non-smokers²;*
13) *display in black-on-white or white-on-black format, occupying 20% or more of the largest surfaces of packages of tobacco products.*

Progressive elimination of tobacco advertising

A number of countries have successfully passed laws to ban all or nearly all forms of tobacco advertising as part of comprehensive tobacco control measures. Frequently, however, further legislative action has been necessary to tighten the restrictions on advertising as bans on tobacco advertising are frequently circumvented by the use of indirect advertising an other means. A 1976 French law apparently banned tobacco advertising. However, tobacco advertisements were simply replaced by advertisements for matches and lighters bearing the names, trademarks and logos of tobacco products. A 1991 revision of the law much more explicitly banned all direct and indirect forms of

tobacco advertising, with only limited and explicit exceptions at points of purchase. Other countries have had similar experiences of revising legislation before arriving at a satisfactory ban on tobacco advertising.

It has been reported that as of 1990, 27 countries had total or near-total on advertising. Since then, however, the umber has declined to 18. While Australia and Kuwait recently implemented bans on tobacco advertising, tobacco advertising bans that had been in place became inoperative in Canada and the newly independent states of Central and Eastern Europe. However, Canada and many Central and East European countries are considering draft legislation to re-establish bans on tobacco advertising.

Experience with partial bans on tobacco advertising has shown them to be less effective than first envisioned. For example, tobacco advertisements were banned from radio and television in the United States in the early 1970s, but later analysis showed that total tobacco advertising volume and expenditure continued to increase. Advertising placements were simply transferred to other media. » (p. 27)

9. Et l'OMS de conclure ainsi:

« WHO has recommended that all Member States implement comprehensive tobacco control policies and programmes that include at least the following components :

- *continuous monitoring of the tobacco epidemic;*
- *protection for children from becoming addicted to tobacco;*
- *effective protection from involuntary exposure to tobacco smoke;*
- *effective programmes of health promotion, health education and smoking cessation;*
- *prominent health warnings on tobacco product packaging;*
- *progressive elimination of tobacco advertising;*
- *the use of financial measures, such as higher tobacco taxes, to discourage tobacco consumption.*

There is and urgent need for all countries to take action now to implement tobacco control policies and programmes based on these principles. Only when they do so will significant progress be made in combatting what has become a truly global epidemic. » (p. 35)

10. Aux fins de faciliter et d'accélérer la mise en place de cette politique compréhensive multisectorielle de lutte au tabagisme, l'OMS publiait deux ans plus tard, soit en 1998, «Guidelines for Controlling and Monitoring the Tobacco Epidemic»[19]. Forte des connaissances sans cesse accrues sur la question, elle y réitère et renforce les éléments d'une telle politique:

« The following elements, derived from World Health Assembly resolutions and recommendations from other international and intergovernmental bodies, should be part of comprehensive national tobacco control programmes. (They are in no particular order of priority.)

[19] ED-32 Guidelines for controlling and monitoring the tobacco epidemic, World Health Organization, Geneva, 1998

1. Establishment and maintenance of an active national focal point to stimulate, support and coordinate tobacco control activities.
2. Establishment of an adequately financed and staffed national coordinating organization on tobacco and health issues.
3. Monitoring of trends in smoking and other forms of tobacco use, tobacco-related diseases and effectiveness of national smoking control action.
4. Effective promotion and education programmes aimed at smoking prevention and cessation of smoking.
5. Effective protection from involuntary exposure to tobacco smoke in transit vehicles, public places and workplaces.
6. Health care institutions that are smoke-free, and health care workers who set a good example by not smoking, and through their own training, and counselling and advocacy activities, emphasize the benefits of a smoke-free life.
7. Tobacco taxes that increase faster than price and income growth.
8. A portion of tobacco taxes used to finance tobacco control measures and to sponsor sports and cultural events.
9. A ban on all forms of tobacco advertising, promotion and sponsorship.
10. A legal requirement for strong, varied warnings on cigarette packages.
11. Restriction of access to tobacco products, including a prohibition on sale of tobacco products to young people.
12. Effective and widely available support of cessation of smoking.
13. Limitations on the levels of tar and nicotine permitted in manufactured cigarettes.
14. Mandatory reporting of toxic constituent levels in the smoke of manufactured tobacco products;
15. Strategies to provide economic alternatives to tobacco agricultural workers. » (p. 10)

11. L'OMS élabore sur la nécessité d'adopter des mesures législatives et réglementaires aux fins de rendre plus efficaces les mesures préconisées:

*“**Legislative measures***

A number of World Health Assembly resolutions call for comprehensive tobacco control measures. Many analysts have concluded that, ultimately, the most effective action on these kinds of measures will require the creation of legislation (see Box 5). Countries have been specifically counselled against accepting voluntary regulation of advertising and package labelling from the tobacco industry. Resolution WHA43.16 specifically urges consideration of legislative, rather than voluntary, controls on tobacco advertising.” (p. 20)

*“**Box 5. Key legislative measures needed for comprehensive tobacco control***

Legislation is critical to comprehensive tobacco control. The range of legislative measures is necessarily board, given the number of things which must be done in order to achieve effective control of the tobacco epidemic. The necessary measures are such that it can be best to take the position followed by many governments when dealing with other drugs and have a single piece of legislation giving broad regulatory control over all aspects of tobacco manufacturing, importation, marketing and use. Alternatively, it may be necessary to pass several different laws. In any case, the relevant laws can give authority for the following:

. The accessibility of tobacco products should reflect the gravity of harm associated with their use. This effort should include:

- *a taxation law that reduces affordability;*
- *an end to tobacco sales in health care, educational and athletics facilities;*
- *an end to tobacco sales in vending machines and from self-service displays;*
- *the effective elimination of tobacco sales and distribution to children.*

. There should be full and free consent among users and potential users of tobacco products. This would entail the following:

- *an end to all direct and indirect forms of tobacco advertising, because tobacco advertising is inherently misleading;*
- *an end to the misleading messages conveyed on tobacco labelling and packaging;*
- *prominent, detailed and frequently updated health information on (and possibly in) tobacco packaging and at point of sale;*
- *full public disclosure of all product toxins and additives;*
- *mandated public health education efforts, including efforts to educate the public about the role of the tobacco industry;*
- *guarantee assistance to those who wish to cease using tobacco products, and assistance for tobacco users seeking compensation for their harm.*

. There should be protection for the health, rights and well-being of those who do not use tobacco products. This should include:

- *a guarantee of smoke-free public spaces, workplaces and public transit;*
- *guarantee and simplified methods of redress for those harmed by environmental harm caused by tobacco products.*

. The legislation should control the product itself. It should include:

- *the ability to ban specified categories of any nicotine delivery products;*
- *control over allowable levels of toxic ingredients found in tobacco products;*
- *the ability to require modification in tobacco products." (p. 21)*

12. L'OMS soulignant enfin que:

« The following are key points to remember when preparing plans of action for comprehensive tobacco control :

. Establish a national tobacco control policy and organization.
. Implement a national programme with the following key components :

- *health education, including assistance with cessation;*
- *legislation to ban sales of tobacco products to children and direct and indirect advertising of tobacco products; prominent health warnings on tobacco products; guarantee of smoke-free public spaces, workplaces and public transit; legislation to establish control and require reporting of levels of toxic ingredients found in tobacco products;*
- *tax and price policies, including making tobacco products less affordable by increasing taxes above the rate of inflation, and earmarking a portion of tobacco taxes to fund health promotion activities and sponsor sports and cultural events.*

. Develop human, financial and structural resources with long-term sustainability to support tobacco control.
. Where possible, monitor and evaluate tobacco control programmes. » (p. 25)

13. Au-delà de l'élaboration d'une politique compréhensive multisectorielle de lutte au tabagisme, la communauté internationale doit également composer avec l'interférence de l'industrie du tabac pour miner ses efforts. Un comité d'experts mandaté par l'OMS[20] ayant procédé à la révision de documents internes des compagnies de tabac, rendus publics dans le cadre du U.S. Master Settlement, a constaté que:

> *"The documents reveal that tobacco companies viewed WHO as one of their leading enemies, and that they saw themselves in a battle against WHO.*
>
> *According to one major company's master plan to fight threats to the industry, "WHO's impact and influence is indisputable," and the company must "contain, neutralize, [and] reorient"[1] WHO's tobacco control initiatives. The documents show that tobacco companies fought WHO's tobacco control agenda by, among other things, staging events to divert attention from the public health issues raised by tobacco use, attempting to reduce budgets for the scientific and policy activities carried out by WHO, pitting other UN agencies against WHO, seeking to convince developing countries that WHO's tobacco control program was a "First World" agenda carried out at the expense of the developing world, distorting the results of important scientific studies on tobacco, and discrediting WHO as an institution.*
>
> *The tobacco company documents reviewed by the committee of experts reveal that tobacco companies have focused significant resources on undermining WHO tobacco control activities and have used a wide range of tactics to achieve their goal.*
>
> - *Establishing inappropriate relationship with WHO staff to influence policy*
> - *Wielding financial power to influence WHO policy*
> - *Using other UN agencies to influence or resist WHO tobacco control*
> - *Discrediting WHO or WHO officials to undermine WHO's effectiveness*
> - *Influencing WHO decision making through surrogates*
> - *Distorting WHO research*
> - *Media events " (p. 1-4)*

14. Ce qui précède démontre le double volet de la lutte au tabagisme: d'une part adopter des mesures compréhensives pour réduire la consommation du tabac et d'autre part palier aux efforts de l'industrie pour contrecarrer ces démarches. Comme le disent les auteurs du rapport de ce comité d'experts:

> *"At the most fundamental level, this inquiry confirms that tobacco use is unlike other threats to global health. Infectious diseases do not employ multinational public relations firms. There are no front groups to promote the spread of cholera. Mosquitoes have no lobbyists. The evidence presented here suggests that tobacco is a case unto itself, and that reversing its burden on global health*

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[20] ED-27 Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization, Report of the Committee of Experts on Tobacco Industry Documents, July 2000

will be not only about understanding addiction and curing disease, but, just as importantly, about overcoming a determined and powerful industry." (p. 244)

LES NATIONS-UNIES

15. En raison de l'approche multisectorielle préconisée par l'OMS, les Nations-Unies ont sollicité les appuis et coordonné les efforts de ses organismes et d'organismes internationaux dans l'élaboration des politiques de lutte au tabagisme et de la mise en œuvre de la Convention-cadre de l'OMS et ont créé pour y arriver le «United Nations Ad Hoc Interagency Task Force on Tobacco Control».[21] [22] [23] [24] [25] [26] [27]

    Ses membres incluent la Banque Mondiale, le Fonds Monétaire International, l'Organisation Mondiale du Commerce ainsi que quinze (15) organisations des Nations-Unies, soit:

« Annex

List of collaborating organizations

Department of Economic and Social Affairs of the United Nations 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 (IMF)

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 Health Organization (WHO)

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[21] ED-23 United Nations Economic and Social Council Resolution 1993/79 "Multisectorial collaboration on "Tobacco or health"" July 7 30 1993

[22] ED-21 United Nations Economic and Social Council Resolution 1994/97 "Multisectorial collaboration on tobacco or health, July 29 1994

[23] ED-19 United Nations Economic and Social Council Resolution !995/62 "Tobacco or health", July 28 1995

[24] ED-13 United Nations Economic and Social Council resolution 1999/56 "Tobacco or health", July 30 1999

[25] ED-22 United Nations Economic and Social Council, Report of the Secretary-General E/1994/83 "Progress made in the implementation of multisectoral collaboration on tobacco or health", June 27-July 29 1994

[26] ED-20 United Nations Economic and Social Council, Report of the Secretary-General E/1995/67 "Progress made in the implementation of multisectoral collaboration on tobacco or health", 26 June-28 July 1995

[27] ED-14 United Nations, Note by the Secretariat E/1999/114 "Tobacco or health", July 29 1999

World Intellectual Property Organization (WIPO)

World Trade Organization [28].

16. Dans son rapport sur l'avancement des travaux ayant mené à la création de ce Task Force, le Secrétaire-général des Nations-Unies notait en 1997 les progrès effectués à l'échelle mondiale à cette époque:

> *"50. Over the two-year period under review, a number of important events have contributed to a significant change in the international tobacco control situation, the most important of which is growing public awareness of the public health risks associated with tobacco consumption, which has led Governments, especially in the advanced countries, to adopt stronger legislation on tobacco production, processing, marketing and use, especially in public places.*
>
> *51. A turning point was reached recently in the international struggle to control the operations of the biggest tobacco multinationals, when a number of major tobacco transnationals - some of which have recently admitted that tobacco is addictive and causes cancer and heart disease - met with anti-smoking groups and officials of the Government of the United States of America to discuss the terms of a settlement on a very large number of liabilities. According to reliable press sources, those multinationals are willing to accept government regulation, and would be prepared to pay as much as $300 billion over the next 25 years in the form of a fund under which smokers could seek compensation.*
>
> *52. So too, newly industrialized countries and countries with economies in transition have become more sensitized to the dangers of tobacco, and in many of them the media are actively promoting the adoption of stricter legislation. Moreover, the statistical evidence points to a growing pandemic of health risks related to tobacco consumption, as multinational tobacco companies seek to expand their markets in countries of the developing world to compensate for the loss of traditional markets in the developed countries."*[29] *(p. 12)*

17. À sa deuxième session, le Task Force faisait rapport sur le travail de ses membres, notamment de l'OMS et la Banque Mondiale:

> *"The recent WHO conference on "Advancing knowledge on regulating tobacco products" held in Oslo 9-11 February 2000 brought together public health experts, regulators and policy-makers to define core public health goals and areas of research needed to consolidate the scientific basis of tobacco product regulation. During this conference it was generally agreed that transnational approaches are vital; that there is no "safe cigarette"; that the addictiveness of nicotine and the toxicity of tobacco products provides the rationale for a regulatory framework, and that the provision of consumer information plays a fundamental role in product regulation strategies. It was also observed that the FTC/ISO methods currently in use are not intended to measure the biological or epidemiological impact of tobacco products, but rather measure the*

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[28] ED-10 United Nations – Economic and Social Council – Ad Hoc Inter-Agency Task Force on Tobacco Control – Report of the Secretary-General, May 21 2000

[29] ED-18 United Nations Economic and Social Council, Report of the Secretary-General E/1997/62 "Progress made in the implementation of multisectorial collaboration on tobacco or health", June 30 - July 25 1997

*performance of tobacco products. **Moreover, it was stressed that regulatory agencies should be prepared to evaluate and to respond to changes in tobacco product design, and to assess their health impact**. It was recommended that a WHO group of experts be convened to guide international policy development with regards to the regulation of tobacco products."*

*The World Bank's work on tobacco control is being conducted in close partnership with WHO's Tobacco Free Initiative, and with other organizations, including the US Centers for Disease Control and Prevention Office of Smoking and Health, the IMF, the UN Foundation, FAO and other organizations. Given the World Bank's comparative advantage in economics and policy dialogue, the Bank's efforts are focused on the economics of tobacco control, including taxation, the economic and social impact of tobacco control measures, including the impact on the poor, and the cost-effectiveness of interventions. **The following is a partial list of the World Bank's tobacco-related work:***

- ***Disseminating the messages and recommendations in "Curbing the Epidemic" through the World Wide Web, television-public service** announcement, print translations into 11 languages, journal articles, and presentations at regional and country meetings.*
- *Discussions with economists at the Bank and IMF to get their help in carrying the dialogue at country level.*
- *Analyses of the economics of tobacco are underway in Estonia, Latvia, Indonesia, Turkey, Poland, China, and are planned in South Africa, Sri Lanka, Zimbabwe, Venezuela (to be funded by the Pan American Health Organization of WHO), and India (to be Funded by the South East Asian Regional Office of WHO).*
- *Model terms of reference have been prepared to help guide the work, and for others to use who wish to carry out similar work.*
- *A tool kit is under preparation, that will provide detailed guidance and assistance to researchers/analysts wishing to conduct economic analysis in their own country.*
- *Analytic work on the links between poverty and tobacco, using rich household data sets for several countries, will commence soon.*
- *Thus far, 12 Bank-funded projects in 11 countries have included tobacco control activities, and several more are currently under preparation."[30] (p. 2)*

18. À sa troisième session, le Task Force faisait rapport sur l'évolution de ses démarches et notait plus particulièrement ce qui suit eu égard à la nécessité de réglementer les produits du tabac:

*"One of the major outcomes of the tobacco litigation in the USA is that companies now have a reason to compete on health grounds or alleged health grounds. **Tobacco companies are stepping up their research and development into new products, and will start making health claims or quasihealth claims as they try to develop some of these new products.***

…, the Director-General of WHO, Dr Brundtland appointed a scientific advisory committee on tobacco product regulation, which held its first meeting in October 2000. The committee is composed of international and national experts. The committee's work focuses on product modification, disclosure of

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[30] ED-11 United nations Ad Hoc Interagency Task Force on Tobacco Control – Report of the Second Session – India Room FAO Rome, March 7 2000

contents, measurement of contents, nicotine regulation, and the communication of risk that comes out of looking at data on tar and nicotine levels. The committee's work will be closely aligned with the European Union in its implementation of the new directive on product regulation, which is currently being discussed in Brussels."[31] *(p.12)*

19. À sa dernière session en date des présentes, le Task Force élaborait ainsi sur la question de réglementation des produits du tabac:

> *"Dr da Silva e Costa described the importance of product regulation. Any product of the society needs to be regulated to protect people from risks of harm, facilitate commercial trade and marketing and contribute to the evolution of better products. The context of tobacco regulation is different because it is very harmful and practically unregulated.*
>
> ***Tobacco is excluded from consumer protection laws; for example, there is no disclosure of the contents of the cigarette product, also, there is little information about the ingredients delivered from tobacco smoke. Product regulation needs to address these issues.*** *The approach of tobacco regulation is very different from country to country and there should be a framework policy that addresses different components of tobacco product regulation.*
>
> *In response to the problem, WHO has created a Scientific Advisory Committee on Tobacco Product Regulation (SACTOB) to collect inputs and information from the main experts in the area of product regulation. The committee is composed of 20 international and national experts on product regulation, smoking cessation and policy making; the committee tries to have a regional and gender balance among its components. Three meetings have been held to date and a fourth will take place in Oslo, Norway from 4-6 February 2002.*
>
> *The expected outcomes from the committee should provide Member States with scientifically sound recommendations in product regulation, policies at country/regional level (regulatory agencies, litigation, laboratory structure, regulatory framework), programmatic recommendations (not to mention "mild" and "light", cigarette package labeling with ingredients) and discussions on the standards to adopt (ISO adoption of WHO standard). WHO launched a monograph on Advancing Knowledge on Regulatory Tobacco Products during its last World Health Assembly, which reported on the outcomes of the first meeting of SACTOB. Another activity of the committee involves discussions and issuing of recommendations on national/international reports and laws that address product regulation issues (The Institute of Medicine [USA] report, EU Directive, National Cancer Institute [USA] report on tar and nicotine).*
>
> *Also, the committee invites various tobacco companies of the region to receive an update on their efforts to reduce the production of harm caused by tobacco products. It is important to note that this invitation should not reflect any partnership, collaboration or dialogue between WHO and the tobacco industry."*[32] *(p. 12)*

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[31] ED-9 United Nations Ad Hoc Interagency Task Force on Tobacco Control - Report of the Third Session – Global Videoconference, December 8 2000

[32] ED-3 United Nations Ad Hoc Interagency Task Force on Tobacco Control – Report of the fourth Session – Kobe, Japan, December 5 2001

20. On voit de ce qui précède la vaste étendue des différents sujets et aspects examinés dans l'élaboration des mesures de santé publique et de lutte au tabagisme par la communauté internationale.

U.S. FOOD AND DRUG ADMINISTRATION

21. Concurremment à l'élaboration de la Convention-cadre et aux travaux du Task Force, le U.S. Food and Drug Administration adoptait en 1996 les «Regulations restricting the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents»[33]. Parmi les mesures de santé publique préconisées, l'on identifie comme essentielles des restrictions à la publicité des compagnies de tabac:

> ***"VI. Advertising***
>
> *B. The Need for Advertising Restrictions*
>
> *In the preamble to the proposed 1995 rule, FDA tentatively asserted that a preponderance of the quantitative and qualitative studies of cigarette advertising suggested: (1)* ***A causal relationship between tobacco advertising and tobacco use by young people****, and (2)* ***a positive effect of stringent advertising measures on smoking rates and on youth tobacco use****.*
>
> *In arriving at this tentative finding, FDA relied heavily on the National Academy of Sciences Institute of Medicine's (IOM's) Report entitled Growing Up Tobacco Free, Preventing Nicotine Addiction in Children and Youths, Washington, DC 1994 (the IOM Report) and the Department of Health and Human Services' (DHHS') Center for Disease Control and Prevention's (CDC's) Report entitled Preventing Tobacco Use Among Young People, A Report of the Surgeon General (1994) (1994 SGR).* ***Both indicated that advertising was an important factor in young people's tobacco use, and that restrictions on advertising must be part of any meaningful approach to reducing smoking and smokeless tobacco use among young people****. In addition, FDA was careful to note that industry statements and actions and examples of youth oriented advertising and marketing campaigns lent support to the agency's findings.*
>
> ***Many studies have demonstrated that young people are aware of, respond favorably to, and are influenced by cigarette advertising****. (p. 44475)*
>
> *FDA agrees that none of these studies individually in sufficient to: (1) Establish that advertising has an effect of directly causing minors to use tobacco products; (2) determine directionality – that is, did advertising cause the observed effect, or are smokers more observant of advertising (the Klitzner, Aitken, et al., and Alexander studies attempted to control for his effect); or (3) define terms or disprove the influence of peer pressure in smoking behavior. (p. 44476)*

[33] ED-47 U.S. Food and Drug Administration. Regulations restricting the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents. Final Rule. Federal Register, Vol. 61, no. 168, August 28 1996, 44396-45318

> ***FDA recognizes that advertising may not be the most important factor in a child's decision to smoke; however, the studies cited by the agency establish that it is a substantial, contributing, and therefore material, factor**. (p. 4476)*
>
> *FDA's review and consideration of the comments received has led the agency **to conclude that advertising plays a material role in the decision by those under 18 to use tobacco products**. (p. 44466)*

22. La FDA explique l'attrait et l'impact de la publicité sur les jeunes:

> *"1. Advertising and Young People*
>
> *a. Function of advertising. Advertisers use a mix of advertising and promotional vehicles to call attention to the product they are selling – to describe its properties, to convey its superiority over other products, and in some cases to give it an allure above and beyond the qualities of the product itself. (A red convertible can be a mode of transportation; it can also tell people a lot about who you are, or who you think you are or want to be).*
>
> *Advertising creates a matrix of attributes for a product or product category and beliefs about the product and its possessor. It can serve to convey images that are recalled later when an event prompts the consumer to think about a purchase. Consumers, as a general rule, overestimate the effect that advertising has on the market in general, but they routinely underestimate its effect upon them and their own purchasing choices. (p. 44466-44467)*
>
> *Every presentation can add to and build upon the imagery and appeal created for a product category or a particular brand. Print advertising, direct mail, and outdoor advertising help to create an image of the brand (and sometimes an image of the brand's user) and provide information about price, taste, relative safety, and product developments for current or prospective users. (p. 44467)*
>
> *Imagery also enhances the ability of advertising to communicate more quickly in low involvement situations and in quick exposure contexts." (p. 44467)*

23. La FDA s'attarde également à l'argument des compagnies de tabac voulant que suivant leur théorie du "mature market", leurs dépenses de plusieurs milliards de dollars en publicité n'ont pas pour effet d'accroître la taille du marché, mais uniquement de maintenir leur part de marché. Elle constate à la fois l'illogisme d'un tel argument et la preuve empirique démontrant le contraire:

> *"In the preamble to the 1995 proposed rule, FDA stated that perhaps the most compelling piece of evidence supporting restrictions was that these products were among the most heavily advertised and widely promoted products in America. The agency cited the most recent Federal Trade Commission (FTC) figures of overall expenditures for 1993, that indicated that over $6.1 billion had been spent by the cigarette and smokeless tobacco industries to promote their products in diverse media. These include magazines, newspapers, outdoor advertising, point of purchase, direct mail, in-store, dissemination of nontobacco items with brand identification, and sponsorship of cultural and sporting events. (p. 44475)*

> ***In addition to logic, there is empirical evidence that advertising can expand demand in a so-called mature market and in fact has done so in the cigarette market before**." (p. 44495)*

24. Les conclusions de la FDA sont le fruit d'un examen rigoureux de toute la littérature alors disponible sur le sujet dont elle traitait, y compris le jugement rendu dans RJR MacDonald 1995:

> *"… FDA relied on the research and expert opinion of consumer psychologists, business and marketing experts, economists and social science researchers as well as medical experts. Moreover, FDA has relied on two outstanding reports issued in the past few years that specifically addressed the issue of young people's use of tobacco—the 1994 SGR (U.S. Surgeon General Report) and the IOM (the National Academy of Sciences Institute of Medecine's) Report. Both commented extensively on the role that advertising plays in young people's smoking behavior and use of smokeless tobacco and both recommended strongly that a comprehensive plan to attack the problem of youth tobacco use include stringent advertising restrictions.*
>
> *Moreover, of the 15 members of the IOM committee, 7 were expert in the fields of behavioral sciences, including psychology, psychiatry and public policy, anthropology, and economics. Similarly, the contributing authors to the 1994 SGR included experts in economics, social research, marketing, and business administration. Finally, the comments submitted include additional empirical evidence, the expert opinion of the American Psychological Association, 155 and the words of the tobacco industry itself, all of which are referred to in this document. (p. 44487)*
>
> ***Considered together, these studies offer a compelling argument for the mediated relationship of cigarette advertising and adolescent smoking**. (p. 44488)*
>
> *"FDA does not find the decision of the Canadian court to be countrary to its findings. **The Canadian court did recognize that image or lifestyle advertising can affect overall consumption.**" (p. 44483)*

25. C'est sur la base d'un corps d'opinion émanant de diverses sources et revêtant diverses formes que la FDA en est venu à conclure que la publicité infuençait les jeunes et qu'il y avait lieu d'intervenir:

> *"In point of fact, tobacco advertising has an effect on young people's tobacco use behavior if it affects initiation, maintenance, or attempts at quitting. The **evidence that FDA has gathered in this proceeding establishes that cigarette and smokeless tobacco advertising does have such an effect**. While not all the evidence in the record supports this conclusion, **there is more than adequate evidence**, that when considered together, supports a conclusion that advertising, with the knowledge of the industry, does affect the smoking behavior and tobacco use of people under the age of 18. This behavior includes the decision whether to start using cigarettes or smokeless tobacco, whether to continue using or to increase ones consumption, when and where it is proper to use tobacco, and whether to quit. This evidence includes:*
>
> *Expert opinion*
> *Advertising Theory*

Studies and Surveys
Empirical Studies
Anecdotal Evidence, and Various
Advertising Campaigns Successful with
Young People
Industry Statements
Consensus Reports (p.44488 ss)

26. Et reprenant le thème de la nécessité de mesures compréhensives pour en maximiser l'efficacité, la FDA d'ajouter:

> *"**FDA has concluded that restrictions on advertising and promotion are necessary to reduce the appeal of tobacco products to young people**. Such restrictions will protect the access restrictions that the agency is adopting from being undermined and thereby the health of young people. **To be effective, these restrictions must be comprehensive, that is, they must apply to the many types of media currently used in a coordinated way to advertise cigarettes and smokeless tobacco**. (p. 44489 ss)*
>
> ***FDA concludes that sponsorship of events and sponsored teams and events** is an advertising medium that **is effective in influencing young people's decision to engage in smoking behavior and tobacco use**." (p. 44533)*
>
> *"…FDA has attempted to tailor its advertising restrictions as narrowly as possible consistent with its purpose of reducing young people's attraction to and use of tobacco. Thus, rather than banning all advertising, the proposed regulations retain the **informational function of advertising** by permitting text-only advertising while removing color and imagery from those advertisements to which young people are unavoidably exposed." (p. 44469)*

27. La FDA n'est pas la seule à avoir conclu à l'existence d'un lien entre la publicité du tabac et la consommation des produits du tabac. En 1991, les auteurs Andrews & Frank[34] concluaient que:

> *"The results of the study indicate that there is a significant relationship between advertising and cigarette consumption across studies, independent of study design factors" (p. 96).*

28. De même, le rapport « Effect of tobacco advertising on tobacco consumption : a discussion reviewing the evidence – Economics & Operational Research Division – Department of Health, 1992 » concluait ainsi son analyse statistique sur le lien entre la publicité et la consommation des produits du tabac:

> *« ii <u>year-to-year variations in advertising expenditure within countries</u> :*
>
> *… Some studies have found that advertising has a statistically significant effect on consumption; others, including our own study, have not. There are several possible reasons for failure to fond a statistically significant effect of advertising, including data imperfections and the inherent difficulty of identifying the separate effect of advertising when this is only one of many potential influences on smoking behaviour. **Taken together, however, the studies***

[34] D-150 "The Determinants of Cigarette Consumption: A Meta-Analysis" 1991

__point to a more decisive result__. Because the studies differ in specification and data, a range or results is always to be expected. If, however, advertising genuinely has no effect on consumption, it would also be expected that the numbers of studies reporting positive and negative results would be much the same; in other words, some studies would show that advertising increases consumption, but others that advertising reduces consumption. In practice this symmetry is not observed : ***the great majority of results point in the same direction – towards a positive impact****. The balance of evidence thus supports the conclusion that advertising does have a positive effect on consumption.*

iii advertising bans in other countries :

… effect on smoking may be due to these additional measures. The impact of advertising bans has been assessed in four countries – Norway, Finland, Canada and New Zealand. Though there are qualifications (for example, the bans in Canada and New Zealand are relatively recent and so may not yet have had their full impact), the current evidence available on these four countries indicates a significant effect. In each case the banning of advertising was followed by a fall in smoking on a scale which cannot reasonably be attributed to other factors. »

BANQUE MONDIALE

29. À la lumière de tout ce qui précède, il n'est pas surprenant que la Banque Mondiale dans son rapport intitulé «Curbing the Epidemic: Governments and the Economics of Tobacco»[35], fasse les constations et recommandations qui suivent:

« Measures to reduce the demand for tobacco

Nonprice measures to reduce demand

Beyond raising the price, governments have also employed a range of other effective measures. These include comprehensive bans on advertising and promotion of tobacco; information measures such as mass media counter-advertising, prominent health warning labels, the publication and dissemination of research findings on the health consequences of smoking as well as restrictions on smoking in work and public places.

This report provides evidence that each of these measures can reduce the demand for cigarettes. For example, "information shocks," such as the publication of research studies with significant new information on the health effects of smoking, reduce demand. Their effect appears to be greatest when a population has relatively little general awareness of the health risks. Comprehensive bans on advertising and promotion can reduce demand by around 7 percent, according to econometric studies in high-income countries. Smoking restrictions clearly benefit nonsmokers, and there is also some evidence that restrictions can reduce the prevalence of smoking.

Models developed for this report suggest that, employed as a package, such nonprice measures used globally could persuade some 23 million smokers alive in 1995 to quit and avert the tobacco-attributable deaths of 5 million of

[35] ED-16 World Bank, Development in practice. "Curbing the Epidemic: Governments and the Economics of Tobacco", 1999

them. As with the estimates for tax increases, these are conservative estimates. (p. 7)

The report has two recommendations:

*1. Where **governments** decide to take strong action to curb the tobacco epidemic, **a multi-pronged strategy should be adopted**. Its aims should be **to deter children from smoking, to protect nonsmokers, and to provide all smokers with information about the health effects of tobacco**. The strategy, tailored to individual country needs, would include:*
*(1) raising taxes, using as a yardstick the rates adopted by countries with comprehensive tobacco control policies where consumption has fallen. In these countries, tax accounts for two-thirds to four-fifths of the retail price of cigarettes; (2) publishing and disseminating research results on the health effects of tobacco, **adding prominent warning labels to cigarettes, adopting comprehensive bans on advertising and promotion**, and restricting smoking in workplaces and public places; and (3) widening access to nicotine replacement and other cessation therapies.*

*2. **International organizations such as the UN agencies** should review their existing programs and policies to ensure that tobacco control is given due prominence; they should sponsor research into the causes, consequences, and costs of smoking, and the cost-effectiveness of interventions at the local level; and they should address tobacco control issues that cross borders, including working with the WHO's proposed Framework Convention for Tobacco Control. Key areas for action include facilitating international agreements on smuggling control, discussions on tax harmonization to reduce the incentives for smuggling, and bans on advertising and promotion involving the global communications media.*

The threat posed by smoking to global health is unprecedented, but so is the potential for reducing smoking-related mortality with cost-effective policies. This report shows the scale of what might be achieved: moderate action could ensure substantial health gains for the 21st century. (p. 10)

Nonprice measures to reduce demand: consumer information, bans on advertising and promotion, and smoking restrictions

*There is extensive evidence from the high-income countries **that the provision of information to adult consumers about the addictive nature of tobacco** and its burden of fatal and disabling diseases **can help to reduce their consumption** of cigarettes. In this section, we review what is known about the effectiveness of a range of types of such information, including publicized research into the health consequences of smoking; **warnings on cigarette packs** and on advertisements; and counter-advertising. We shall also summarize what is known about the effects of the tobacco advertising and promotion activities, and what happens when these activities are banned. Because the different types of information are often available to consumers concurrently, **it is difficult to disaggregate their individual effects,** but the growing body of research and experience in high-income countries suggests that each can have a significant impact. Importantly, the impact appears to vary across different social groups. In general, young people appear to be less responsive to information about the health effects of tobacco than older adults, and more educated people respond more quickly to new information than those with no or minimal education. An awareness of these differences is useful for policymakers when planning a mix of interventions that is tailored to the particular needs of their own country. (p. 45)*

Warning labels
Even in countries where consumers have had reasonable access to information about the health effects of smoking, the evidence suggests that there are widespread misperceptions about these effects, due, in part, to cigarette packaging and labeling. For example, in the past two decades, many manufacturers have labeled certain classes of cigarette as “low tar” and “low nicotine.”
Many smokers in high-income countries believe that these brands are safer than other cigarettes, although the research literature concludes that no cigarettes are safe. Studies suggest that many consumers are confused about the constituents of tobacco smoke, and that packaging fails to give them adequate information about the products they are buying. Since the early 1960s a growing number of governments have required cigarette manufacturers to print health warnings on their products. By 1991, 77 countries required such warnings, although very few of these countries insisted on strong warnings with rotating messages, such as the one illustrated in Figure 4.3. A study from Turkey suggests that health warnings caused consumption there to fall by about 8 percent over six years. In South Africa, when serious warning labels were introduced in 1994, there was a significant fall in consumption.
More than half (58 percent) of smokers questioned for that study said they were motivated by the warning labels to quit or reduce their smoking.
However, one key weakness of warning labels is that they will not reach some poorer individuals, particularly children and adolescents, in low-income countries. Among such consumers, it is common to buy cigarettes singly rather than in packs. It has sometimes been argued that, in the more informed populations where smoking has been widespread for many decades, smoking prevalence is unlikely to fall much lower than it has already as a result of cigarette pack warning labels. However, evidence from Australia, Canada, and Poland suggests that such labels can still be effective, provided that they are large, prominent, and contain hard-hitting and specific factual information.
In Poland in the late 1990s, new warning labels that occupy 30 percent of each of the two largest sides on the cigarette pack have been found to be strongly linked with smokers’ decisions to quit or cut down their smoking. Among Polish male smokers, 3 percent said they had quit following the introduction of the labels; an additional 16 percent said they had tried quitting, and a further 14 percent said they understood the health effects of smoking better because of the warnings. Among women, the effects were similar. In Australia, warning labels were strengthened in 1995.
The impact appears to have been greater in inducing smokers to quit than when the older, less strongly worded labels were used. In Canada, a survey in 1996 suggested that half of smokers intending to quit or cut back their consumption were motivated by what they had read on their cigarette packs. (p. 47)

The impact of advertising bans
***When governments ban tobacco advertising in one medium, such as television, the industry can substitute advertising in other media with little or no effect on overall marketing expenditures**. Accordingly, studies that have examined the effect of partial cigarette advertising bans have found little or no effect on smoking. However, where there are multiple restrictions on advertising in all media and on promotional activities, there are relatively few alternative outlets for the industry. Since 1972, most high-income countries have introduced stronger restrictions across more media and on various forms of sponsorship. A recent study of 22 high-income countries based on data from 1970 to 1992 concluded that comprehensive bans on cigarette advertising and*

promotion can reduce smoking, but more limited partial bans have little or no effect. If the most comprehensive restrictions were in place, the study concluded, tobacco consumption would fall by more than 6 percent in high-income countries. Modeling based on these estimates suggests that the European Union's ban on advertising (see Box 4.2) could reduce cigarette consumption within the European Union by nearly 7 percent. Another study of 100 countries compared consumption trends over time in those with relatively complete bans on advertising and promotion and those with no such bans. In the countries with nearly complete bans, the downward trend in consumption was much steeper (Figure 4.4). It is important to note that, in this study, other factors may also have contributed to the decline in consumption in some countries.

***Beyond the economic literature**, meanwhile, **there are other types of research, such as surveys of children's recall of advertising messages, that conclude that advertising and promotion do indeed affect demand for cigarettes and attract new recruits**. Children's attention is attracted by such advertising, and they remember its messages. There is also growing evidence that the industry is directing increasing shares of its advertising and promotion activity toward markets where there is judged to be growth or potential for growth, including some youth markets and specific minority groups among whom smoking has until recently been uncommon. This noneconomic body of research may be of particular interest to policymakers concerned about smoking trends within specific groups in the population. » (p. 50)*

Box 4.2 THE EUROPEAN UNION'S BAN ON TOBACCO ADVERTISING AND PROMOTION

In 1989, as part of a wider initiative against cancer, the European Commission proposed a directive to restrict the advertising of tobacco products in the press and by means of billboards and posters. The European Parliament amended the Commission's proposal in 1990 and voted for an advertising ban.

The Commission observed that it could only secure agreement for a partial ban at the time, but added that a new proposal for a total ban might be made, depending on progress achieved by individual member states. In June 1991 the Commission introduced a modified proposal for a directive on tobacco.

In the period between 1992 and 1996 no progress was made in implementing the proposal because of opposition from at least three member states , Germany, the Netherlands, and the United Kingdom. However, opposition in the United Kingdom collapsed in 1997, when the Labour Party won the general election, with a manifesto commitment to introduce a tobacco advertising ban. The text of the proposed directive was finally adopted by the Commission in June

- **All member states** of the European Union must introduce national legislation not later **than 30 July 2001.**
- **All advertisements in the print media must cease within one further year.**
- **Sponsorship** (with the exception of events or activities organized at a **global level) must cease within two further years**.
- **Tobacco sponsorship of world** events, such as **Formula One motor** racing, may continue for a further three years, **but must end by 1 October 2006**. During this period of phaseout, there must be a reduction in overall sponsorship support as well as voluntary restraint on tobacco publicity surrounding these events.
- **Product information is allowed at points of sale**.
- **Tobacco trade publications may carry tobacco advertising**.
- Third-country publications, not intended specifically for the European Union market, are not affected by the ban.

This directive is now under implementation.

> 1998. **The directive stipulates that all direct and indirect advertising (including sponsorship) of tobacco products will be banned within the European Union, with full and final enforcement of all provisions by October 26**. Its key points are as follows:
>
> **Recommendations**
> This report makes two recommendations:
>
> 1. Where *governments* decide to take strong action to curb the tobacco epidemic, a multipronged strategy should be adopted. Its aims should be to deter children from smoking, to protect nonsmokers, and to provide all smokers with information about the health effects of tobacco.
> The strategy, tailored to individual country needs, would include:
> (1) **raising taxes**, using as a yardstick the rates adopted by countries with comprehensive tobacco control policies where consumption has fallen. In these countries, tax accounts for two-thirds to four-fifths of the retail price of cigarettes;
> (2) **publishing and disseminating** research results on the health effects of tobacco, **adding prominent warning labels to** cigarettes, **adopting comprehensive bans on advertising** and promotion, and restricting smoking in workplaces and public places;
> and (3) widening access to nicotine replacement and other cessation therapies.
>
> 2. *International organizations* such as the United Nations agencies should review their existing programs and policies to ensure that tobacco control is given due prominence; they should sponsor research into the causes, consequences, and costs of smoking, and the cost-effectiveness of interventions at the local level; and they should address tobacco control issues that cross borders, including working with the WHO's proposed Framework Convention for Tobacco Control. Key areas for action include facilitating international agreements on smuggling control, discussions on tax harmonization to reduce the incentives for smuggling, and bans on advertising and promotion involving the global communications media.
>
> The threat posed by smoking to global health is unprecedented, but so is the potential for reducing smoking-related mortality with cost-effective policies. This report shows the scale of what might be achieved: moderate action could ensure substantial health gains for the 21st century. (p. 82)

U.S. SURGEON GENERAL REPORTS

30. Probablement plus que tout autre organisme ou ouvrages sur la question de mesures de santé publique pour enrayer la consommation de tabac, font autorité en la matière les U.S. Surgeon General Reports sur les conséquences sur la santé découlant de l'usage du tabac, publiés suivant Loi du Congrès américain à intervalles d'environ 16 à 18 mois[36] .

31. Dans son rapport de 1988[37], le Surgeon General concluait que:

> "• *Cigarettes and other forms of tobacco are addicting.*
> • *Nicotine is the drug in tobacco that causes addiction.*

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[36] Témoignage de Ronald M. Davis, Q. 300, p. 3300, Q. 315, p. 3308

[37] D-141 1988 Surgeon General's Report "The Health Consequences of Smoking: Nicotine Addiction"

- ***The pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine.**" (foreward)*

32. Toujours dans le même rapport, le Surgeon General recommandait, entre autres, ce qui suit:

> *"Public information campaigns should be developed to increase community awareness of the addictive nature of tobacco use. A health warning on addiction should be rotated with the other warnings now required on cigarette and smokeless tobacco packages and advertisements. Prevention of tobacco use should be included along with prevention of illicit drug use in comprehensive school health education curricula. Many children and adolescents who are experimenting with cigarettes and other forms of tobacco state that they do not intend to use tobacco in later years. They are unaware of, or underestimate, the strength of tobacco addiction. Because this addiction almost always begins during childhood or adolescence, children need to be warned as early as possible, and repeatedly warned through their teenage years, about the dangers of exposing themselves to nicotine." (p. vi)*

33. Dans son rapport de 1989, le Surgeon General constatait les progrès réalisés depuis son premier rapport en 1964, vingt-cinq ans auparavant, mais soulignait aussi le travail énorme qui restait à accomplir pour enrayer le fléau que constitue le tabagisme[38].

34. En 1992 le rapport du Surgeon General[39] examinait la situation prévalant particulièrement dans les Amériques. Parmi les constatations et les mesures préconisées suite à cet examen se trouvaient les suivantes:

> *« 5. Commitment to surveillance of tobacco-related factors – such as prevalence of smoking; morbidity and mortality; knowledge, attitudes, and practices; tobacco consumption and production; and taxation and legislation – is crucial to the development of a systematic program for prevention and control of tobacco use. » (p. 10)*
>
> ***"Advertising restrictions are generally associated with declines in consumption and, hence, are an important component of tobacco-control programs.** "*
>
> *"2. The need is now recognized, and work is under way, for developing a comprehensive, systematic approach to the surveillance of tobacco-related factors in the Americas, including the prevalence of smoking; smoking-associated morbidity and mortality; knowledge, attitudes, and practices with regard to tobacco use; tobacco production and consumption; and taxation and legislation." (p. 13)*

35. Ce rapport du Surgeon General fut préparé en collaboration avec le Pan American Health Organization, qui elle-même publiait son propre rapport[40]et concluait et recommandait ce qui suit:

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[38] D-142 1989 Surgeon General's Report "Reducing the Health Consequences of smoking: 25 Years of Progress"
[39] D-144 1992 Surgeon General's Report "Smoking and Health in the Americas"
[40] ED-48 Pan American Health Organization "Tobacco or Health: Status in the Americas", 1992

"Introduction

This document is comprised of individual reports on smoking and health for nations, territories, and other political entities in the Region of the Americas. The purpose of this Report was to compile available information on tobacco use, tobacco-related disease, and tobacco-use prevention and control efforts for each of these political entities as or late 1990. It is intended to accompany the 1992 Report of the U.S. Surgeon General, entitled Smoking and Health in the Americas, that was prepared by the U.S. Department of Health and Human Services (USDHHS) in collaboration with the Part American Health Organization (PAHO). Because so much material is available on smoking and health in the United States (more than 60,000 articles and 22 previous Reports of the U.S. Surgeon General on tobacco and health), this Report focuses on Canada, Latin America, and the Caribbean. Most of the information contained in this publication cannot be found in any other single source.

Thus, it is increasingly important that the nations of the Americas understand the historical, economic, political, and public health aspects of tobacco use and tobacco production. This understanding will facilitate planning for control measures needed to alleviate the impending burden of smoking-related diseases. (p. 12)

Summary and Recommendations

This Status Report has collected information from hundreds of individuals and documents that has never appeared before in a single publication. (p. 19)

This Report will serve as a baseline data source, particularly for Latin American and Caribbean nations as they address the complex issues involved in preventing and controlling tobacco use. (p. 19)

The Region of the Americas can use the information presented in this Status Report and the 1992 Report of the U.S. Surgeon General to build an international coalition against what may be the most important public health issue of the 1990s. Based on information in this Report, recommendations for action are as follows:

1. *Data collection on behavior, attitudes, knowledge, and beliefs associated with tobacco use should be improved and standardized. These data should be published regularly and used to help support changes in public opinion and political action against tobacco use.*
2. *Date on mortality and morbidity would be improved, collected, and analyzed systematically in nations of the Americas to understand and communicate fully the current and future burden of smoking-related diseases. Without such data, policy makers and the public will not appreciate health burden of tobacco use.*
3. *Efforts to divert economic and human resources away from dependence on tobacco production and manufacture should be supported, even though short-term costs for this diversion may be appreciable.*
4. ***Policies and legislation that prohibit smoking in public places, advertising and promotion of tobacco products, and access to tobacco by young persons should be strengthened and enforced. These actions serve to decrease the social acceptability of smoking and are essential to changing individual behavior**.*

5. Ad valorem taxes on cigarettes should be increased substantially and periodically as a means of decreasing consumption.
6. Public health agencies should increase monetary and personnel resources dedicated to the prevention and control of tobacco use. Increasing the stature of tobacco control efforts is essential to changing individual behavior and preventing chronic diseases associated with tobacco use. (p. 20)

Country collaborators are listed below:

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36. Dans son rapport de 1994[41] le Surgeon General s'attaque particulièrement à la problématique du tabagisme chez les jeunes. Il conclut et recommande entre autres:

« Chapter 5. Tobacco Advertising and Promotional Activities

*1. **Young people continue to be a strategically important market for the tobacco industry**.*

2. Young people are currently exposed to cigarette messages through print media (including outdoor billboards) and through promotional activities, such as sponsorship of sporting events and public entertainment, point-of-sale displays, and distribution of specialty items.

*3. **Cigarette advertising uses images rather than information to portray the attractiveness and function of smoking**. Human models and cartoon characters in cigarette advertising convey **independence, healthfulness, adventure-seeking, and youthful activities—themes correlated with psychosocial factors that appeal to young people**.*

*4. **Cigarette advertisements capitalize on the disparity between an ideal and actual self-image and imply that smoking may close the gap**.*

*5. Cigarette advertising appears to affect young people's perceptions of the pervasiveness, image, and function of smoking. Since **misperceptions in these areas constitute psychosocial risk factors for the initiation of smoking, cigarette advertising appears to increase young people's risk of smoking**. "*

[41] D-145 1994 Surgeon General's Report "Preventing Tobacco Use Among Young People"

“ <u>Chapter 6. Efforts to Prevent Tobacco Use Among Young People</u>

*1. Most of the American public strongly favor policies that might prevent tobacco use among young people. These policies include tobacco education in the schools, **restrictions on tobacco advertising and promotions**, a complete ban on smoking by anyone on school grounds, prohibition of the sale of tobacco products to minors, and earmarked tax increases on tobacco products.*

2. School-based smoking-prevention programs that identify social influences to smoke and teach skills to resist those influences have demonstrated consistent and significant reductions in adolescent smoking prevalence, and program effects have lasted one to three years. Programs to prevent smokeless tobacco use that are based on the same model have also demonstrated modest reductions in the initiation of smokeless tobacco use.

3. The effectiveness of school-based smoking-prevention programs appears to be enhanced and sustained by comprehensive school health education and by communitywide programs that involve parents, mass media, community organizations, or other elements of an adolescent's social environment.

4. Smoking-cessation programs tend to have low success rates. Recruiting and retaining adolescents in formal cessation programs are difficult.

5. Illegal sales of tobacco products are common. Active enforcement of age-at-sale policies by public officials and community members appears necessary to prevent minors' access to tobacco.

6. Econometric and other studies indicate that increases in the real price of cigarettes significantly reduce cigarette smoking; young people are at least as responsive as adults to such price changes. Maintaining higher real prices of cigarettes depends on further tax increases to offset the effects of inflation.” (p. 10)

37. En 2000, le Surgeon General confirme que plusieurs des mesures de santé publique identifiées précédemment se sont avérées efficaces pour prévenir l’usage du tabac chez les jeunes et à aider les usagers du tabac à cesser de fumer. Le rapport[42] constate et recommande:

« Major Conclusions

1. *Efforts to prevent the onset or continuance of tobacco use face the pervasive, countervailing influence of tobacco promotion by the tobacco industry, a promotion that takes place despite overwhelming evidence of adverse health effects from tobacco use.*
2. *The available approaches to reducing tobacco use – educational, clinical, regulatory, economic, and social – differ substantially in their techniques and in the metric by which success can be measured. A hierarchy of effectiveness is difficult to construct.*
3. *Approaches with the largest span of impact (economic, regulatory, and social) are likely to have the greatest long-term, population impact. Those with a smaller span of impact (educational and clinical) are of greater importance in helping individuals resist or abandon the use of tobacco.*

[42] D-147 2000 Surgeon General’s Report “Reducing Tobacco Use”

4. *Each of the modalities reviewed provides evidence of effectiveness :*

   - *Educational strategies, conducted in conjunction with community – and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents.*

   - *Pharmacologic treatment of nicotine addiction, combined with behavioral support, will enable 20 to 25 percent of users to remain abstinent at one year posttreatment. Even less intense measures, such as physicians advising their patients to quit smoking, can produce cessation proportions of 5 to 10 percent.*

   - ***Regulation of advertising and promotion, particularly that directed at young people, is very likely to reduce both prevalence and uptake of smoking.***

   - *Clean air regulations and restriction of minors' access to tobacco products contribute to a changing social norm with regard to smoking and may influence prevalence directly.*

   - *An optimal level of excise taxation on tobacco products will reduce the prevalence of smoking, the consumption of tobacco, and the long-term health consequences of tobacco use.*

5. *The impact of these various efforts, as measured with a variety of techniques, is likely to be underestimated because of the synergistic effect of these modalities. The potential for combined effects underscores the need for comprehensive approaches.*

6. *State tobacco control programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use. » (p. 6)*

38. C'est la Banque Mondiale, dans son Public Health at a Glance[43] qui a sans doute le mieux résumé les mesures de santé publique discutées précédemment et qui font partie intégrante d'une politique compréhensive multisectorielle de lutte au tabagisme:

[43] ED-1 World Bank - Public Health at a Glance, March 2002

Cost Effective Interventions to reduce death and disease caused by tobacco use
Measures to reduce demand for tobacco products are highly cost effective – very high on the list of public health "best buys"

Interventions	Beneficiaries/Target Groups	Process Indicators
Objective: Reduce tobacco use, to reduce death and disease caused by tobacco use.		
Higher taxes on cigarettes and other tobacco products	smokers potential smokers (especially youth)	✓ price of cigarettes/bidis etc (adjust for inflation) ✓ tax as % of final sales price
Non-price measures		
Bans/restrictions on smoking in public and work places: schools, health facilities, public transport, restaurants, cinemas etc.	non-smokers protected from second-hand smoke	✓ smoke-free public spaces and places
Comprehensive **bans on advertising and promotion** of all tobacco products, logos and brand names[1]	smokers and potential smokers (especially youth) societal attitudes to smoking	✓ laws, regulations, extent to which respected/enforced
Better consumer information: counter-advertising, media coverage, research findings	smokers and potential smokers societal attitudes to smoking	✓ knowledge of health risks, attitudes to smoking
Large, direct **warning labels** on cigarette boxes and other tobacco products	smokers	✓ % of box surface covered by label, message, color/font specifications
Help for smokers who wish to quit, including increased access to Nicotine Replacement (NRT) and other cessation therapies	smokers	✓ number of ex-smokers

Impact / surveillance Indicators for tobacco use (from survey data):

adult smoking prevalence: % of people 15 and older who use any tobacco product at least once a day (daily/regular smoker) or occasionally, % who have ever smoked

intensity: average number of cigarettes (and other tobacco products) smoked/used daily

quit behavior: % who used to smoke, but currently do not smoke at all

youth use: % of young people who currently use any tobacco product (defined as having used a tobacco product on one or more days during the past 30 days),

initiation age: age at which current and ex-smokers first started to smoke at least one cigarette a day

Note: A Global Youth Tobacco Survey is being implemented in many countries with support from WHO and CDC. See: http://www.cdc.gov/tobacco/global/GYTS.htm (CDC website)

Health warnings on cigarette packages should be large (cover at least 30% of the surface area), clear (e.g., black on white), in local languages, and have a set of specific required messages that change periodically. Information on the adverse health impact of tobacco use and the benefits of quitting should be widely disseminated.

The tobacco industry argues that **advertising and promotion** affects market share and not overall prevalence levels, but countries that have implemented comprehensive bans on all advertising and promotion have reduced tobacco use much more quickly and to lower levels than other countries. Partial bans are not effective – if only a partial ban is politically feasible, then there is a very strong case for mandating counteradvertising.

CONCLUSION

39. Il appert manifeste de ce qui précède qu'il existe un consensus global à l'échelle mondiale pour l'adoption de mesures compréhensives multisectorielles de lutte au tabagisme. Au fil des ans l'élaboration des mesures d'interventions s'est raffinée et précisée, à la lumière de connaissances accrues émanant entre autres de l'industrie du tabac elle-même.

40. En matière de santé publique, d'épidémiologie, de comportement humain, de sciences sociales, personne ne peut prétendre détenir la vérité. Les conclusions menant aux interventions se fondent sur un corps d'opinions qui tendent dans le même sens. En l'espèce, ce corps d'opinion est éloquent et il n'en existe aucun

tout aussi éloquent qui irait dans le sens inverse. Les demanderesses n'ont apporté aucune preuve positive contraire.

41. Comme le souligne le U.S. Surgeon General, il appartient entre autres aux spécialistes de santé publique d'intervenir pour élaborer les politiques réglementant la vente et distribution des produits du tabac:

> *« We as citizens, in concert with our elected officials, civic leaders, and public health officers, should establish appropriate public policies for how tobacco products are sold and distributed in our society. With the evidence that tobacco is addicting, is it appropriate for tobacco products to be sold through vending machines, which are easily accessible to children? Is it appropriate for free samples of tobacco products to be sent through the mail or distributed on public property, where verification of age is difficult if not impossible?» (p. vi)*[44]

42. L'identification de mesures telles qu'en l'espèce pour combattre le tabagisme ne se fait pas à la légère mais bien en application de modèles d'intervention utilisés couramment par les spécialistes en santé publique, en médecine préventive et en épidémiologie dont les rôles sont entre autres de prévenir et contrôler les facteurs environnementaux qui peuvent influencer négativement la santé publique[45] [46], en l'occurrence le tabac:

> *"Preventive Medicine specialists use a model of disease control that points out how they can intervene to interrupt the transmission of a disease; the model includes four (4) elements which, as applied to tobacco, include: the agent i.e. tobacco, the vector which transmits the agent i.e. the tobacco companies, the host i.e. the smoker and the environment surrounding each, part of which is tobacco advertising and promotion. Applying this model can lead to the identification of possible interventions at all of these levels, i.e. try and inoculate the potential host by reaching the kids before they become tobacco users, address the agent tobacco and regulate it as other consumer goods are regulated, address the vector and control what advertising agencies are allowed to do and address the environment in regard to tobacco advertising" (Q. 327, p. 3317; Q. 328, p. 3320).*[47] [48]

43. Les mesures d'intervention identifiées et préconisées par la communauté internationale et celles adoptées par le législateur canadien, notamment les restrictions à la publicité, s'inscrivent tout à fait dans les paramètres de ces modèles d'intervention:

> *Tobacco is the most preventable cause of death in our society, including both in Canada and the United States; hence, the implication of Preventive Medicine*

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[44] D-141 – 1988 Surgeon General's Report "The Health Consequences of Smoking: Nicotine Addiction", p. vi

[45] D-136 The American Board of Preventive Medecine, Booklet of Information, Revised March 2001

[46] D-137 "What is Preventive Medecine", presentation Powerpoint imprimée

[47] Interrogatoire de Ronald M. Davis (Q. 327, p. 3317; Q. 328, p. 3320); Résumé d'interrogatoire de Ronald M. Davis, p. 3

[48] ED-12 United Nations Ad Hoc Interagency Task Force on Tobacco Control – Report of the First Session – Maurice Pate Conference Room, UNICEF, NewYork, U.S.A., September 29-30 1999, p. 3 "In an attempt to understand the pathological chain of events leading to the diseases such as malaria the scientific community immediately turns to an analysis of the disease *vector* i.e. the mosquito. Likewise, in understanding the chain of events leading to tobacco-related diseases, *vector* analysis must also be pursued. In this case however, the disease *vector* is the tobacco industry".

specialists such as Dr. Davis to attempt to control or prevent it and in doing so the need for such specialists to look at the environment in which the agent, host and vector operate; where advertising and promotion of tobacco is ubiquitous in the United States to the tune of 8 billion dollars a year and reaches children, that's a very important environmental factor which has to be looked at and <u>*if a link is shown between that environmental influence and smoking by the population and by kids, measures must be taken to remedy that, i.e. public health officials and preventive medicine specialists have to interrupt these factors (advertising and promotion) that are impairing the health and causing the premature death of people*</u> *(Q. 1, p. 3415 to Q. 5, p. 3417).*[49] *(notre soulignement)*

[49] Résumé d'interrogatoire de Ronald M. Davis, p. 4 (Q. 1, p. 3415 à Q. 5, p. 3417 de l'interrogatoire)