TOBACCO
A global problem requires a global response!

No 168
January-March 2000

TOBACCO: A GLOBAL PROBLEM REQUIRES
A GLOBAL RESPONSE!

2 Editorial
3 Introduction
   The global epidemic
   WHO initiative
5 Experiences
   Tobacco: role of the church
   and religions
9 Experiences
   U.S. religious groups
   challenge companies
   involved in tobacco
10 Alternatives
   Tobacco in low-income
countries
12 Alternatives
   Women and tobacco
14 Alternatives
   Education for kids
   Alternatives
   U.S. tobacco litigation
16 Resources
18 Update
   Hospice Uganda
20 Networking
   Letter and announcements
The May 1990 issue of Contact entitled “Tobacco and Health: Behind the Smokescreen” was devoted entirely to tobacco. The publication pointed out that tobacco was the most commonly used and widely distributed drug in existence. The issue laid out all the known health hazards, the appalling behaviour of the tobacco companies, the transfer of the epidemic to developing countries, and the rationale for the involvement of all religions in withstanding this global threat — the body-mind-soul belief that the body is the temple of the soul and should be looked after in a healthy way; the history of religions in caring for the sick; protecting health (including the foetus); saving the environment; and standing up against exploitation and injustice.

Ten years on, the epidemic has turned out to be even worse than was ever imagined. Predictions for the numbers of smokers and deaths from tobacco were too conservative: instead of 8 million deaths by 2030, WHO now predicts the figure will be 10 million, as Derek Yach explains. Instead of tobacco killing one in every four smokers, we now know it is closer to one in every two long-term smokers.

Roberta Walburn highlights the deception of the tobacco industry, now revealed by the “Minnesota documents” — showing how the tobacco industry has consistently lied to governments, the media and their own customers about many issues, including the health effects.

The tobacco companies also shamelessly use religious symbols to promote tobacco, such as the “Madonna” calendars in the Philippines, which even non-Christians find extremely offensive. Pictures of Buddhist temples appear on the cigarette packet in some Asian countries.

Yussuf Saloojee gives many other examples of the exploitation of poor countries by the tobacco industry, and Lezak Shallat highlights the increasing issue of women smoking. Both of these issues carry severe economic consequences for smokers, for business and for countries.

Have we moved on?

Historically, the first documented tobacco regulation was in Bhutan in 1729 — which forbade tobacco use in all religious places, a regulation that is still observed today.

Harley Stanton and Michael Crosby highlight action within a religious framework over the last 10 years. In addition, ‘Tobacco and Religion’ has been discussed at many international conferences, there have meetings between health advocates and elders of all religions, and there is lively debate on the UICC’s Globalink special web section on religion and tobacco.

Yet, in spite of centuries of knowledge and decades of action, multiple World Health Assembly resolutions, world conferences and many regional, national and sub-national meetings, the number of smokers is increasing; more are dying; children are still taking up the habit and more than 40% are exposed to environmental tobacco smoke; the economic costs are escalating. In addition, the epidemic is being transferred to developing countries so that by 2030 only 15% of the world’s smokers will live in developed countries.

Much more will need to be done. The Framework Convention on Tobacco Control represents the first time international law will be used to further public health. It deserves the full and dedicated support of all religions.

Judith Mackay
Chairperson
Policy, Strategy Advisory Committee for Tobacco Free Initiative, WHO
INTRODUCTION

THE GLOBAL EPIDEMIC: WHO INITIATIVE

_Derek Yach_, WHO’s Executive Director in charge of the Tobacco Free Initiative says that developing countries will account for 70 per cent of the 10 million annual tobacco deaths expected by the late 2020s. Yet, the tobacco epidemic can be overcome. Yach recommends strong medicine for this wide-spread epidemic.

**Contact:** Why has WHO taken a leading role in controlling tobacco?

_Derek Yach:_ WHO has a global mandate to focus on major public health problems. Since 1970, member states have adopted 17 resolutions of the World Health Assembly calling for strong policies and actions against tobacco: thus the WHO secretariat is instructed to act!

**Contact:** Where does tobacco fit into the agenda for health and development?

_Derek Yach:_ Tobacco kills many people in middle age, robbing them of many productive years of life. In many countries, tobacco kills a higher percent of poor people than richer people.

In Poland and in the UK, tobacco is a major cause for the difference in life expectancy between the highest and lowest social classes. It imposes a high cost to the health services and has multiple environmental effects.

**Contact:** Ten years ago Contact did an issue on tobacco. What have been the major developments with regard to smoking and tobacco use in the last decade?

_Derek Yach:_ Over the last decade there has been a sustained increase in tobacco use world-wide. We now have 1.2 billion smokers. This figure could increase among women.

With 4 million deaths a year now, tobacco is emerging as one of the major causes of death. If trends continue, we anticipate about 10 million deaths a year by the late 2020s of which 70% will occur in developing countries.

**Contact:** Have there been any positive developments?

_Derek Yach:_ Many countries have introduced comprehensive tobacco control policies. We know that increased excise taxes, a ban on advertising and promotions of tobacco, providing smoke-free areas combined with access to effective means of quitting, restricted youth access and school and community-based counter-advertising programmes works — and works at a low cost.

**Contact:** And what are the areas of concern?

_Derek Yach:_ The tobacco industry has enormous influence on the policy process in many countries. This impact is rarely discussed openly and represents a serious threat to the ability...
of many governments to introduce public policies for better health. While we have long suspected that the ethical behaviour of the tobacco industry was not what is expected of most commercial sectors, we did not know the extent of their ability to use front groups, bogus science, and a wide range of practices aimed at sowing doubt about the benefits of tobacco control. In recent years the USA litigation has yielded millions of documents that make public the details of these behaviours.

Contact: What effective global, national and organizational responses from civil society, the churches, NGOs and health workers will lessen the impact of tobacco on public health?

Derek Yach: WHO has recognized the need in developing the FCTC and the new Tobacco Free Initiative to build as wide a strategic base of support as possible among the NGO world. This includes health professionals, faith-based groups, the women's movement, human rights groups and the more traditional public health groups.

The voice of civil society is essential to keep the key reason for the FCTC, tobacco deaths and disease, clearly in the mind of policy makers. WHO has also built a strong partnership within the UN family and with selected private companies and academics.

The key point is that everyone has a role. From the smokers whom we urge to quit for their health and the health of others around them; non-smokers, who need to be less passive about their exposure to tobacco smoke; the media — who need to reduce their addiction to tobacco funds that often lead to self-censured debate on tobacco — and on to faith-based groups. The WHO convened a meeting on religion and tobacco and the need for a coalition of religions emerged strongly.

Derek Yach, WHO Executive Director, Incharge of Tobacco Free Initiative, WHO, Geneva. Tel: 41 22 791 2736 Fax: 41 22 791 4832 E-mail: yachd@who.ch

The Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) is the first instance in which WHO has used its treaty-making right to tackle a public health problem. One hundred and ninety one Member States will negotiate a legally binding convention which is expected to be ready for signature by Member States by 2003.

It is likely that the FCTC will focus on critical transnational aspects of tobacco control — such as advertising, sponsorship of tobacco and smuggling — which are often not protected by national laws. Additionally, it can address issues such as agricultural diversification, excise tax levels or treatment of tobacco dependence.

Derek Yach says, “the governments have been largely supportive: the real test though comes when a legally binding text is being developed. Then we will see the real hand of the tobacco industry.”

Why have the FCTC?

A global problem requires a global response. The tobacco industry is immensely powerful, enormously rich, global in its operations and global in its impact. The industry employs more consultants and lobbyists, has more experience and is willing and able to spend more money than most governments for whom tobacco is a new subject.

Dealing with the tobacco problem in piece meal fashion, country by country, will only play into the hands of the industry. Experience has shown that restrictions in one part of the world will only mean a doubling of industry’s efforts in another. Strong rules in one country will mean an exploitation of weak rules in another.

The FCTC will allow countries to benefit from an international pool of experience and expertise. The FCTC will provide countries with an opportunity to learn from each other which laws work and which laws don’t in specific settings and circumstances. An international legal team of experts from the major legal traditions of the world will help those countries that request help in drafting laws.

There will be one uniform set of rules, negotiated and agreed to by national governments, that will protect people and countries from the tobacco epidemic.

Raise excise taxes, ban advertising and promotions of tobacco and provide smoke-free areas.
“Tobacco is only one of our many national contradictions. We need milk, not tobacco. We want life not death.” These words of Bishop Prado of Pelotas, in the south of Brazil, echo the dilemma faced by many churches on tobacco. Churches can and must play a significant role in reversing the global injustice of tobacco’s devastating impact on health.

At a recent Lambeth Conference Christopher Hall said, “The Anglican Church played an important role in ending the great London cholera epidemic. Dr John Snow noticed that the residents who drew their water from the Broad Street pump died from cholera at a greater rate than residents did elsewhere. With no knowledge of the microbiology of cholera, Dr Snow wanted to remove the handle from the pump but was violently opposed by local residents who did not want to have to travel further for their water. The local parish priest supported Dr Snow and quelled the residents. The handle was removed and the cholera epidemic was broken.” Similar action is required today in support of the global efforts to reduce tobacco use and its promotion of early death and debilitating disease.

**Loosing the bands of injustice: poverty and tobacco**

Biblical justice commends the loosing of injustice and the removal of oppression (Is. 58:6-11). Tobacco is not wealth-generating for the great majority of people. A small minority gains some financial advantage from tobacco production, manufacture and sale. However, tobacco is often a key factor in producing poor health outcomes for the poorest and most marginalized within a country.

The church is interested in achieving wholeness and well-being, both for its members and for the larger community.

**Truth stranger than fiction: consumer deception and the tobacco companies**

The Church has a responsibility for honesty and truth in communication. The tobacco industry has been one of the most deceptive and manipulative industries in corporate history. The tobacco industry documents reveal deliberate attempts to subvert information, to mislead consumers and the community and to buy the favour of politicians and administrators in opposing regulation and legislative change. Such injustice requires
that the church responds in effective ways to confront this issue.

**Churches can be catalysts for healthy change**

In Australia, when the groundbreaking Tobacco Act was being debated in the Victorian Parliament in 1987, the support of Archbishop Frank Little of the Catholic Archdiocese of Melbourne, was pivotal. The Archbishop contacted key parliamentarians encouraging support for the legislation.

In New South Wales, the passage of a bill introduced by the Reverend Fred Nile, (the NSW Tobacco Advertising Prohibition Act 1991) was only possible when the bishops of the Ecumenical Council and other church leaders supported the passage of key legislation. The New South Wales legislation in 1991 was a rather remarkable achievement because it pitted the health lobby against the most influential lobbyists of the tobacco industry and their powerful allies in politics. The support of the bishops was crucial in getting the legislation, which had been strongly opposed by the government, passed with the support of all parties. The politicians could not afford to oppose both the health and the religious sections of the community.

**Mobilizing religious support globally**

In many developing countries around the world, mobilizing the church and religious agencies to support health priorities is possible. Church and religious groups often have dedicated leaders, who are well-known and accepted within the community. They often communicate with people regularly as well as in a personal way. Another example of work by religious communities is that of Reverend Jesse Brown, Jr., who led non-smoking initiatives in Philadelphia.

Organizations such as The Inter-Religious Coalition on Smoking and Health in Washington have been active in advocating and lobbying positions with governments and administration in the U.S.

Other religious groups and non-government agencies can expand the role of churches. For example, the Adventist Development and Relief Agency has assisted government initiatives in the Asia-Pacific to build upon the church’s work in assisting smokers to stop.

**Investing church resources in ethical companies**

The attitudes of religious organizations towards the use of tobacco, investment in tobacco, ensuring smoke-free workplaces, acceptance of advertising or sponsorship from tobacco interests and impressions of whether religious agencies were silent or vocal on the issue of tobacco vary considerably. No religious organizations surveyed had received money from tobacco companies or been feted by them. However, the position on investments was not so clear. Some organizations had clear “screens” on tobacco stocks that were seen as a “sin stocks.” The evidence for such a screen was strongest among the Protestant groups.

It would contribute to the global efforts if the Investment Guidelines of the National Conference of Catholic Bishops took a position on tobacco. The Vatican committee on Social Responsibility and Advertising has advocated the removal of advertising for products such as tobacco because of their deleterious impact.

One Presbyterian leader wrote, “We can no longer just say it’s a smoker’s right to die and pretend it doesn’t concern us. To turn our backs on them is to deny Christ. Can’t we do something more than pass toothless overtures?”
What can churches do?

While there are no simple solutions to the problems tobacco brings, churches can pursue the following:

- Discourage or ban smoking on church premises and in church meetings;
- Educate the youth, mens’ and womens’ groups on the undesirable social, economical ethical and health effects of tobacco;
- Develop position papers for discussion and action at the various committees or councils of the church on the vital moral issues that tobacco raises;
- Develop and enunciate clear positions on the impact, promotion and use of tobacco, including public health information as well as religious values. Disseminate this widely, and recommend the support of these by politicians as public policy;
- Provide support and counselling to those wishing to stop using tobacco;
- Develop healing and wholeness materials to assist members and congregations on the issue of smoking and nicotine addiction;
- Contact local WHO or public health agencies to offer support for strategies and initiatives that are likely to reduce tobacco use;
- Have features in church programmes that expose the aggressive export and marketing of tobacco by the international tobacco companies;
- Develop information packages on the nature and impact of tobacco use, especially with emphasis on preventing youth use;
- Provide training and education for those involved in drugs counselling and rehabilitation; and
- Encourage tobacco-producing communities to explore the development of alternatives.

Tobacco challenges the church

My experience in some 50 countries has given me an opportunity to see the significant challenge that tobacco is to the church. In many Pacific Island countries the level of smoking among ordained ministers is high. It is unlikely that they will assist their members and community until they also see the personal importance of tobacco.

In many other developing countries the poor often sell tobacco singly on the streets and this meagre income provides the subsistence income for survival. Such issues cannot be ignored. But it would be an untenable dilemma for the Christian in public health to suggest that the street vendors and small markets be encouraged in selling tobacco to sustain their livelihood. Many of these same people are also significant users. This would be like destroying health to maintain living.

Support from other religions

While most Buddhists do not consider smoking as breaking the Fifth Precept, that “prohibits the use of substances that alter consciousness,” they do regard it as unwise. In Thailand, a Buddhist leader, Dr Pramaha Chanya Khonchinda has been able to use Buddhism in

Young cigarette vendor, Western Kosovo (1999).
 applying their teaching to tobacco control. Using the four noble truths of Buddhist teaching, Dr Pramaha has encouraged some 500 Buddhist temples in Thailand to follow smoke-free policies in their teaching and practice.

Islamic religion has often taken strong positions against tobacco. The position of many within Muslim countries is that smoking should be seen as forbidden, (haram) rather than permissible (halal). In practice smoking is a much greater problem in Muslim countries than might at first appear. Some Islamic teachers have suggested that there is "a responsibility on the Muslim world to utilize the Islamic principles and values for the elimination of tobacco from society."

What will it achieve?

The key to success will often reside in the ability to construct, inspire and sustain networks of people committed to making this most important change for health and the public good.

Harley Stanton, PO Box 2014 Wahroonga 2076, Australia. Tel: 61 29 847 3223. Fax: 61 29 489 0943. Email: HStanton@compuserve.com

We [cannot] ignore the global forces that make it more lucrative for rural families and communities to be involved in agriculture related to illicit drugs, tobacco, distilled and fermented alcoholic beverages, rather than in food production. As the problem is a multi-dimensional one — physical, familial, social, psychological, socio-political, economic, pharmacological, educational, pastoral and spiritual — it needs to be recognized, addressed and confronted from all these perspectives.

Christian communities are also called to take a prophetic stance against the injustices of political and economic systems that help perpetuate some of the physical, emotional and environmental causes of addiction. Market forces, vested interests and unjust structures need to be seen for what they are and where necessary condemned...

Life and health are God’s gifts, to be treasured, nurtured, protected.

Church communities can play a crucial role in influencing public policy, protesting against unscrupulous advertisements, and in working with secular agencies in combating some of the socio-political forces that contribute to the problem or are at the root of it.

Extracted from Alcoholism and drug addiction: challenges to the church, a consultation document affirmed by the Central Committee of the WCC in September 1995.
U.S. religious groups challenge companies involved in tobacco

Michael H. Crosby, Tobacco Coordinator of the InterFaith Center for Corporate Responsibility, New York recounts how religious groups, as shareholders, have been able to challenge tobacco corporations to change their behaviour.

Protestant and Roman Catholic groups in the United States have tried to “bring good news to the poor” by challenging US-based corporations tied to tobacco. While many of these groups have divested themselves of their tobacco stock or have developed “screens” to keep out tobacco companies from their portfolios, others are choosing to use their stocks to try to change tobacco companies’ behaviour. I have led this effort for the InterFaith Center on Corporate Responsibility the action-arm of religious groups (about 275), for almost 20 years.

The first religious group to challenge the multinational tobacco companies as shareholders was my own Province of St. Joseph of the Capuchin Order. In 1980, on visiting our friars working in Nicaragua (where all the ads promoted the Sandinista revolution) and then going to Costa Rica (where so many ads promoted tobacco), I decided something had to be done. I asked our Provincial Treasurer to purchase 10 shares each of Philip Morris and R. J. Reynolds. We filed resolutions calling on the companies to describe Third World regions where they operated, their sales, market size and share. We asked for the companies’ policy regarding the WHO’s recommended ban on promotion of tobacco, limiting Third World tar and nicotine to U.S. levels, and informing Third World consumers regarding the health risks associated with tobacco use.

We began in the late 1980s to include issues related to the U.S. market — the addictiveness of nicotine and the way companies were marketing to young people here and abroad.

Finally, in 1992 Philip Morris agreed to our request to label all its cigarette packages with warnings throughout the world. Other companies followed suit. This was our first “victory.” Others soon followed for members of ICCR who used their shares to pressure companies, along with others, to bring about change:

1993: Eastman Kodak stops making filter tows for cigarettes. It spins off the entity.
1995: Kimberly Clark stops its involvement ($400 million annual) in making reconstituted tobacco for cigarettes and cigars as well as supplying paper for the cigarette companies. It spins off the entity.
1996: 3M makes a policy not to feature any tobacco products on its billboards world-wide.
1998: Sara Lee stops its involvement ($300 million annual) in tobacco through its Dutch subsidiary, Douwe Egberts Van Nelle Tobacco. It sells the unit to Imperial Tobacco Group.
2000: Philip Morris agrees to support legislation to ban self-service displays of tobacco products in retail outlets.

We have contributed to some successes to curb the tobacco pandemic, but we have a long way to go. As St. Francis of Assisi, the founder of my community of Capuchin Franciscans said: “My brothers let us begin, for up to now we have done so little.”

Michael H. Crosby OFM Cap, Tobacco Coordinator, InterFaith Center for Corporate Responsibility, 1015 N. 9th St., Milwaukee, WI 53233, New York. Tel: 414 271-0735 Fax: 414 271-637. E-mail: mikecrosby@aol.com
TOBACCO IN LOW-INCOME COUNTRIES

Yussuf Saloojee from the National Council Against Smoking in South Africa warns that low-income countries will suffer the worst of all worlds — diseases of poverty compounded by diseases of lifestyle.

Local production means cheaper cigarettes and more people smoking.

The future of the wealthy transnational tobacco companies lies in the poor countries of the world. Between 1970 and 1990, while tobacco consumption fell by 10% in high-income countries it increased by 64% in lower-income countries. British American Tobacco (BAT) sells about 70% of its cigarettes in low-income countries. The US-based tobacco giant, Philip Morris, earns two-thirds of its tobacco revenues outside the USA. For these two companies and Japan Tobacco their future profits lay in exploiting the growing markets in the world’s poorest and most populous nations.

Between 1970 and 1990, while tobacco consumption fell by 10% in high-income countries it increased by 64% in lower-income countries.
Control is essential if the time bomb of disease primed by the tobacco industry is to be diffused.

Perhaps the greatest impediment to the implementation of tobacco control policies in Africa is the widely held perception that tobacco provides jobs and contributes to the national economy.

For Zimbabwe and Malawi this is true; tobacco leaf exports are the main foreign currency earners. However, Africa as a whole has a negative balance of trade in tobacco. In 1992, out of 27 African countries — for which data was available — 21 (77%) spent more importing tobacco than they earned from exporting the crop.

The expansion of tobacco also threatens food security. For example, Senegal, which in 1988 received 117 000 tons of cereals in food aid, spent $28 million importing tobacco and cigarettes. It is the manufacturers who obtain the lion’s share of the profits. The growers are at the margins of the process.

John Angiopado, a Ugandan farmer, is probably typical of the 10,000 tobacco farmers under contract to BAT in that country. In 1990, he sold 200 kilos of tobacco for about US$100. For this, he and his family laboured for nine months. He regarded this income as a pittance. “I don’t know what to tell my children and wife who worked so hard to produce the tobacco.” Tobacco clearly does not create wealth but increases poverty in low-income countries.

Yussuf Saloojee, Council Against Smoking, PO Box 23244, Joubert Park 2044, South Africa. Tel: 27 11 643 2958. E-mail: ysalooje@iafrica.com

A poisoned blessing

Since the introduction of British American Tobacco in 1952, tobacco farming has brought both fortune and misfortune to the peasants of Aru in north-eastern Congo. Tobacco farming affects human life directly and indirectly as it causes health to deteriorate and degrades the environment.

Health effects

Food crops have been abandoned, resulting in malnutrition and poor health. Women and children whose labour is the most exploited are the most affected. The demand for labourers results in early marriages, school-dropouts and polygamy in many families.

According to research done by Awuma, a student from Institut Supérieur Pédagogique de Bunia, in Zaki, the number of smokers has increased to 85% of the population — ranging from twelve-year-olds to sixty-year-olds. Farmers have little control over their children who smoke the locally produced cheap cigarettes. Tobacco is a cash crop whose income is exclusively managed by men. After sale, farmers receive their pay during Christmas. Many prostitutes migrate during Christmas to this region resulting in a rapid spread of AIDS among peasants. Of the 800 patients admitted in 11 health centres in Aru, 20% had respiratory problems and sudden death was five times higher among smokers than among others.

Environmental degradation

The consumption of wood has grown from 16,384 tons in 1988 to 53,120 tons in 1999. Indigenous species of trees and of the fauna and flora have almost disappeared. Chemical fertilizers have made some areas non-productive. The farmers say that they have no choice. Farmers know the dangers of tobacco farming but they have no alternative.

Way Alege, Institut Panafricain de Sante Communautaire, P.O. Box 151, Paidha, Uganda
Lezak Shalat, a journalist based in Santiago, finds out why young women and health professionals in Chile are neither informed about nor interested in the fact that heavy smoking alters healthy reproductive functions.

The dramatic rise in smoking — especially among women — over the past 20 years is a reproductive health concern that no one talks about. Cigarette brands targeted at young women invoke images of slimness, glamour and zest. Yet none of these carry the warning label that smoking may make it harder to conceive or carry a baby. Nor do all inserts to birth control pills— easily purchased over-the-counter — alert smokers, especially older ones, to the increased likelihood of cardiovascular problems.

In addition to cancers and heart disease, smoking causes a host of gender-specific ills that research is now linking to cigarettes. These include more menstrual pain, higher risk of reproductive tract infections and cervical cancer, impaired fertility, more miscarriages, earlier menopause and, with it, greater susceptibility to brittle bones.

Despite the evidence that heavy smoking alters healthy reproductive functions, in Chile, neither women nor their doctors seem overly concerned — a fact that frustrates Dr. Cecilia Sepulveda, head of the Health Ministry’s Tobacco Programme. Because she is also in charge of the ministry’s Cancer Programme, she spends “a lot of time talking to gynaecologists. But when I bring up the subject of smoking, their eyes go blank.”

Dr. Andrés Morales, recently returned to Santiago after conducting research abroad on women’s smoking, worries that Chilean health professionals are “neither informed nor interested.” While pointing an accusatory finger at the political clout of tobacco companies, he’s also puzzled by individual reactions:

Several women meet in a Santiago coffee shop. Comfortably settled in the “Smokers Welcome” area, they light up. One among them entertains the others with her tribulations on a recent trip abroad, where the “intolerance” of non-smokers sent her sneaking outside for a puff, just as she had as a teenager. In Chile, where 40% of men and 27% of women smoke, social sanctions against this most sociable of habits are few. But when the mother-to-be among the group pulls out her pack, both smokers and non-smokers protest.

By 1996, 35% of Chilean women in their twenties smoked.

Many well-educated Chilean women smoke.
“Tell someone that smoking is bad for them, and they get mad, as if they’d been insulted.”

In 1971, one-quarter of Chilean women aged 25-39 smoked, making them the heaviest women smokers in Latin America. By 1990, more than one-third of adult women smoked. 1995-96 figures reveal that 35% of women in their twenties smoke and 40% of women in their thirties do.

Would young women be more willing to stop, cut down or never start if they knew that cigarettes make it harder to get pregnant? “At age 10 or 15, you don’t care about your fertility,” says Azún Candina, 26 and a smoker for ten years. A self-defined “solitary” smoker who lights up to study, law student Emiliana O’Brien, 24, says she knows “more than I’d like to” about the impact of smoking on her reproductive well-being. She tried, unsuccessfully, to encourage her mother to kick the habit while pregnant with her youngest brother. The possibility of addiction concerns her, but not as urgently as the need to get through exams.

Motivated for others

Having children is associated with parents ceasing to smoke. To quote a recent British study, among women, “each extra child was associated with an increment in the probability of quitting.” Protecting the health of younger children (and nagging by one’s older children) were cited as reasons. On the other hand, the study noted, fewer poor women, “caring for more and living on less” attempt, and fewer succeed in, giving up smoking.

A new phenomenon in smoggy Santiago is that “mothers send husbands outside to smoke and declare the children’s room a ‘smoke-free zone’,” says anti-smoking campaigner Dr. Maria Inés Salas. In homes where 20 cigarettes or more are smoked, children have 55% more acute respiratory problems and 85% more colds than in non-smoking homes.

When it comes to their own health, however, women are harder to motivate. For many, breaking for a cigarette is a way to relax. In a study of Chilean and British women, psychiatrist Morales found failure to quit smoking during pregnancy to be an early indicator of post-partum depression. Of the nearly 60% of Chilean woman who smoked before pregnancy, all but 5% gave up while expecting. Chilean non-quitters were more likely to have used tranquilizers and been treated for psychological problems. “Inability to quit is linked to stress,” says Morales, “and may be an indicator of future psychiatric risk.”

Outside of pre-natal programmes, women who want to quit may find it hard to find the specialized support. Chile’s reproductive health activists tend to avoid the issue. But like many well-educated Chilean women, many of them smoke. (Women in health professions are among heaviest smokers in Chile, with rates bordering on 50%, according to a 1990 study.) They criticize anti-smoking campaigns for “blaming the victim” and failing to understand the reasons that keep women smoking.

Chile’s ineffective 1996 tobacco law does mandate some sort of anti-smoking education in schools. Programmes now being designed will have a “gender focus,” officials promise. Says public health specialist Salas, “Let’s provide the necessary information. But at the same time, let’s build young women’s confidence in their capacity to face life without a cigarette to lean on.”

This article was originally written for the Panos Reproductive Health Programme of the Panos Institute in London.

Let’s build young women’s confidence in their capacity to face life without a cigarette to lean on.
EDUCATION FOR KIDS

“Keifa!” said the kids. “Cool! Neat!” They were watching a drama designed by the Seedlings children’s drama group, using a scenario developed by United Methodist Committee on Relief (UMCOR) Armenia. In the scenario, Senor Nicotine seduces Miss Cherry, and then she realizes she doesn’t feel well when she spends time with him and she’s smelly and looks bedraggled. She wants to leave him, but she is caught. The Army of Fruits (which are a powerful symbol of health and prosperity in Armenia) rescues Miss Cherry from Senor Nicotine’s grip, captures the Cigarette Army, and grinds them up to be used as pest poison – the only useful way to dispose of tobacco. Smoking is

U.S. TOBACCO LITIGATION:

Roberta Walburn, an attorney at Robins, Kaplan, Miller & Ciresi., LLP who represented landmark litigation against U.S. based tobacco companies, describes the effort.

When we filed a suit in 1994 representing the State of Minnesota, [along with Blue Cross and Blue Shield of Minnesota, the state’s largest private insurer], there had been no successful case against the tobacco industry for four decades. We said, “You may have a legal product. Under US law it is legal to sell cigarettes but you are selling in an illegal way.”

Discovering documents

When we read the documents that had been produced since 1954 when litigation first started, we realised that it was the tip of an iceberg. To prove our case we devoted our energy to getting the documents out of the tobacco company’s secret files. (The pre-trial “discovery” process in the US, entitles you to get documents from your adversary.) We asked, whether the tobacco companies knew about the health effects of tobacco and what they did about it. Instead of getting the documents, we got mounds of objections — for example, that they did not know what was meant by a “minimum dose of nicotine”.

In just our state the tobacco companies had more than a thousand people and more than thirty law firms working against us. One company was spending more than one million dollars each week. But in the end the trucks started moving into Minnesota [with the documents]. In the end it was about thirty-five million pages.

We found that despite the tobacco companies’ knowledge for decades about the health risks and addictiveness of tobacco, they had publicly maintained that cigarettes did not
UMCOR Armenia has also promoted anti-smoking education with the local NGO, People for a Healthy Lifestyle (PHL), developer of a booklet about the effects of tobacco. Rather than telling what not to do, the booklet tells what to do.

Because reading three languages is prestigious, PHL used Armenian, Russian and English for the poems, illustrations and stories that carry the messages. The booklet appeals to adults by containing scientific information as well as stories. It teaches those living in a home where there is smoking how to advocate for clean air in their own surroundings without showing disrespect. This booklet was distributed to over 5000 children attending summer camps in Armenia, and in public schools.

As UMCOR Armenia has fine-tuned messages to children, effectiveness has increased. The 1999 summer camp evaluation showed improvements up to 35% in children’s understanding of how they are lured to smoking, what the health risks are, and the effects of passive smoking.

**Actions speak louder than words**

UMCOR Armenia enforces a clean air policy in its offices, vehicles and workshops.

---

**MINNESOTA AND ONWARD**

The State of Minnesota, and Blue Cross and Blue Shield of Minnesota in the recent

cause health risks and that cigarettes were not addictive. We started trial in January 1998. After four months we were doing the closing arguments.

On the day the case was to be submitted to the Jury for private deliberation to reach a decision, the tobacco company called for a settlement. According to the settlement the State of Minnesota will receive payments in perpetuity. The payment over a twenty-five-year period is estimated to be $6.1 billion.

In addition, one of the tobacco company’s main trade groups, the Council for Tobacco Research was disbanded. They were prohibited from certain types of marketing and promotional activities. Billboards came down in Minnesota. All across the US they were not allowed to place advertisements in movies. Various types of cigarette paraphernalia, caps and jackets were banned from Minnesota. They were not allowed to advertise, promote or market cigarettes to target children.

Under the settlement, millions of dollars is being dedicated to public health purposes and to the establishing of a non-profit foundation to do tobacco control research and tobacco cessation research. It is a sobering message.

While we achieved what we were seeking — including the public release of the documents — it is not the end of the tobacco control story.

We learnt how powerful the judicial arm of the government can be in addressing some of the problems that tobacco has caused.

---

Despite the tobacco companies’ knowledge for decades about the health risks and addictiveness of tobacco, they had publicly maintained that cigarettes did not cause health risks and that cigarettes were not addictive.
This is a listing of key international organizations involved with anti-tobacco activities. There are also several very effective anti-tobacco groups in several countries.

CONTACTS

Douglas Bettcher  
**Tobacco Free Initiative**  
World Health Organization  
20 Avenue Appia, 1211  
Geneva 27, Switzerland  
Tel: 41 22 791 2151  
Fax: 41 22 791 4832  
Email: bettcherd@who.int  
Website: http://www.who.int/toh/

**GLOBALink**  
3, rue du Conseil-General  
1205 Geneva  
Switzerland  
Tel: +4122 809 1850  
Fax +4122 809 1810  
E-mail: globalink@uicc.org  
Website: http://www.globalink.org

**Tobacco and health: behind the smoke screen,** *Contact* No. 114, 5/1990, highlights the health hazards of tobacco, and marketing strategies of the tobacco companies.

**International Non-Governmental Coalition Against Tobacco (INGCAT)**  
The International Network of Women Against Tobacco (INWAT) – The International Network of Women Against Tobacco, shares strategies to counter tobacco advertising and promotion and supports the development of women-centred tobacco use prevention and cessation programmes.

RESOURCES

Karen Bissell, ING CAT  
68, boulevard Saint-Michel  
75006 Paris, France  
Tel: +33 1 44 32 04 41  
Fax: +33 1 43 29 90 87  
Email: info@ingcat.org  
Website: http://www.ingcat.org

Bonnie Kantor, INWAT  
P.O. Box 224, Metuchen  
NJ 08840 USA  
Tel: 17 32 549 9054  
Fax: 17 32 549 9056  
E-mail: bonnie@inwat.org  
Website: http://www.inwat.org/

**WCC PUBLICATIONS**

**Nanda Chandrasekharan**  
World Council of Churches (WCC), P.O. Box 2100, 1211, Geneva 2, Switzerland  
Tel: (41 22) 791 63 24  
Fax: (41 22) 791 03 61  
E-mail: fch@wcc-coe.org


**The framework convention on tobacco control:** technical briefing series. WHO/NCD/TFI/99.5


**Global tobacco control law** — papers from a conference in New Delhi, 7-9 January 2000.

**OTHER PUBLICATIONS**

**The World Bank**  
1818 H Street, N.W  
Washington, D.C. 20433  
U.S.A, Tel: 12 02 477 1234  
Fax: 12 02 477 6391  
E-mail: books@worldbank.org  
Website: http://www.worldbank.org

**Curbing the epidemic: governments and the economics of tobacco control** by Prabhat Jha and Frank J. Chaloupka examines the cost-effectiveness of tobacco control policies. The World Bank, Washington 1999.

<table>
<thead>
<tr>
<th>No</th>
<th>Date</th>
<th>TITLE/AUTHOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>114</td>
<td>5/90</td>
<td>Tobacco and Health: Behind the Smoke Screen - C. Corey, J. Mackay, P. Pradervand</td>
</tr>
<tr>
<td>115</td>
<td>7/90</td>
<td>Kanak: The People of New Caledonia Struggle to Hold on to their Culture and their Healing Tradition - E. Senturias</td>
</tr>
<tr>
<td>11610/90</td>
<td></td>
<td>We have done it Ourselves!: Community-based health care programme in the Machakos District of Kenya - J. Crowley</td>
</tr>
<tr>
<td>11712/90</td>
<td></td>
<td>AIDS: What are the Churches doing? - G. Williams, B. Rubenson, E. Senturias, J. Galvao, H. Sobel</td>
</tr>
<tr>
<td>119</td>
<td>4/91</td>
<td>Health in a Search for Wholeness: The Journey of the Medical Mission Sisters - M. Pawath, S. Summers</td>
</tr>
<tr>
<td>120</td>
<td>6/91</td>
<td>Health in the Workplace: It’s Everybody’s Business - J. Bookser-Feister, L. Wise, P. Marin, IOHSAD, CMC</td>
</tr>
<tr>
<td>121</td>
<td>8/91</td>
<td>Children: Agents of Change in the Restoration of Their Own Rights, including Health - A. Swift (UNICEF), R. de Souza Filho, Z. de Lima Soares, Child-to-Child Trust, CMC, CREARQ Foundation</td>
</tr>
<tr>
<td>12210/91</td>
<td></td>
<td>The Hospice Movement: Providing Compassionate and Competent Care for the Dying - C. Saunders, T. Kashwagi, T. Banks, A. Merriman</td>
</tr>
<tr>
<td>12312/91 &amp; 2/92</td>
<td></td>
<td>Saying No to the Debt - C. Jagel</td>
</tr>
<tr>
<td>124</td>
<td>4/92</td>
<td>Health Development Among the Nomadic Peoples of East Africa - G. Kimirei, E.M. Nangawe, Mark L. Jacobson, A. Wohlenberg, F. Ogujawa, CMC</td>
</tr>
<tr>
<td>125</td>
<td>6/92</td>
<td>(Re)training Doctors for Community Medicine to Meet the Health Needs of the Majority - E. Senturias, C. Andrew Pearson</td>
</tr>
<tr>
<td>126</td>
<td>8/92</td>
<td>AIDS: A Community Commitment - E. Senturias, B. Shenk, CMC</td>
</tr>
<tr>
<td>12710/92</td>
<td></td>
<td>Leadership &amp; Community Participation for Health (Part I) - C. Jagel, M. Sköld, D. Kaseje</td>
</tr>
<tr>
<td>12812/92</td>
<td></td>
<td>Community-determined Health Development: A Vision of the Future from Zaire - P. Nickson, D. Smith</td>
</tr>
<tr>
<td>129</td>
<td>2/93</td>
<td>Leadership &amp; Community Participation for Health (Part II) - C. Jagel</td>
</tr>
<tr>
<td>130</td>
<td>4/93</td>
<td>Popular communication for health: Letting people speak for themselves - INCUPO, EPES</td>
</tr>
</tbody>
</table>
UPDATE

131 6/93  Supporting Women: Fighting discrimination to improve health
132 8/93  Participatory evaluation: The Patna experience - M.-T. Feuerstein
13310/93  Campaigning for breastfeeding: Church and community action - E. Senturias, D. Smith, D. Arcoverde
13412/93  Resource centres: Building living libraries - AHRTAG
135 2/94  Population: Sharing in wiser policies - D. Smith, A. van der Hart, A. Ortiz, S. Ravindran
136 4/94  Writing about health: Say what you mean and mean what you say - F. Savage and P. Godwin, B. Scott, B. Booth
137 6/94  Coordinating agencies: Churches working together for health - S. Kingma, M. Morgan, F. Winnubst, D. Mukarji
138 8/94  Community action for health: Let’s get organized! - International PHC/NGO Group, EPES, C. Tusubira
13910/94  Rational use of drugs (Incorporating AGuidelines on Equipment Donations) - R. Laing, O. Lanza, F. Mugo Ng’ang’a, P. Brudon-Jakobowicz, E. Ombaka, HAI
14012/94  Youth and health: Taking the lead today for a better tomorrow - Youth to Youth in Health, WORD, N. Waithe
141 2/95  Financing health care: Strengthening partnerships to protect the poor - David Werner, World Bank, WHO, Sigrun Mogedal
142 4/95  Healthier tourism: Struggling for development with dignity - Edward Cumberbatch, Peter Holden, Jacky Bryant
143 6/95  District health systems: Decentralizing for greater equity - WHO, Matomora Matomora
144 8/95  Women and AIDS: Building healing communities - Erlinda Senturias, Anne Skjelmerud, Yupa Suta (presented by Mary Grenough)
14510/95  Tackling malnutrition: Can community initiatives work? Kenneth Bailey, David Morley, IBFAN
14612/95  Health financing crisis: Can communities afford to pay? EPES, David Werner, Daleep Mukarji, Carl Salem, Eva Ombaka
147 2/96  Alcoholism and Drug Addiction - What is the Christian Response? - J. Gnanadason, BLESS, Prisquilas Peter and Darlena David Titus, HAIN
148 4/96  Reconstructing Peace: Together we can overcome Violence! - Salpy Eskidjian, Anthony Zwi, Elizabeth Sele Mulbah, Natasa Jovicic, Eduardo Campana
149 6/96  Migration and Health: Caring for those in our Midst - Helene Moussa and Patrick Taran, Dr Paola Bollin and Dr Harald Siem, White Rakuba, Gabriela Rodriguez, Asian Migrant Centre, Rabia Chamoun and Aline Papazian, Mukam MicCruman
150 8/96  Health in the North: Learning from the South - Christoph Benn, Daisy Morris, Kofi Yamgnane, David Cowling, Eva Ombaka
15110/96  Healing Traditions: Finding Answers in Gospel and Cultures - Guillermo Cook and Diana Smith, Eugenio Poma, Tara Tautari, Darlena David, Hakan Hellberg
15212/96  Healing Community: Caring is part of the Cure! - David Hilton, Erlinda Senturias, Ricus Dullaert, Paul-Hermann Zellfelder-Held, Pierre Strasse, Michael Lapsley, Marion Morgan
153 2/97Ethics: Taking Sides in Health Care – Christoph Benn, Lucy Muchiri, Sally Timmel, WCC Consultative Group on AIDS
154 4/97  Indigenous Peoples: Their Health, Their Solutions – Erlinda Senturias, International Institute of Sustainable Development, Maggie Hodgson
157 12/97  Sustainability: Issues in Church-related Health Care – Daleep Mukarji, Sigrun Mogedal, Kofi Asante, Pat Nickson, Marta Benavides, John M Grange
158 2/98  Globalization: What does it mean for Health? – Konrad Raiser, Diana Smith, Maria Hamlin Zuniga, Sara Bhattacharji, Marion Morgan
159 4/98  Community-determined Health Care: The experience of rural Cameroon – Patricia Nickson, Ruby N Elaison, Protestant Church of French Polynesia and Hiti Tau, Rakiya Booth
160 6/98-8/98  The CMC Story - Diana Smith, Gillian Paterson
161 10/98  Trade or Health? – Eva Ombaka, James Love, Darlena David, Hans-Martin Hirt, Keith Lindsey, Gabriel Ugoiri
162 3/99  A Jubilee Assembly: an agenda for healing – Konrad Raiser, Darlena David, Christoph Benn, Erlinda Senturias, Patricia Nickson, Eunice Santana, Jonathan Granaadam, Gwen Crawley
163 6/99  Facing Death: discovering life! Can we strengthen our response? – Rainward Bastian, Veronica Moss, Sr. Mary Grenough, Lazarus Koech, Peter Bellamy, Usha Jesudason, Elisabeth Schlunk, Christina de Vries
164 9/99 Reforming Health in China: strengthening the weak? – Wenzao Han, Shenglan Tang, Yu Qun, Fan Jie, Wang Jianshen, Zan Jianquin, Faye Pearson, Li Enlin, Chen Xida, Christoph Benn
In 1991, when I was working in the Nairobi Hospice, then only the second hospice in sub-Saharan Africa, Dame Cicely Saunders asked me to write about our work (Contact 122: The Hospice Movement: Providing Compassionate and Competent Care, October 1991). Prompted by the article, individuals from several African countries wrote asking me to help them start similar services for people living with cancer and AIDS.

In December 1991, I found myself at a crossroad. Praying and trying to discern God for me, I saw the great need for a “model hospice” as envisioned by the WHO in 1986, sensitive to the spiritual, cultural, economic and community needs of African countries. While 70% of all cancers occur in developing countries less than 5% of the resources for cancer are in these countries.

Hospice Africa and Hospice Uganda:

We chose Uganda because of the great need, its rising economy that allowed us to solicit overseas funds and the support from the minister of health. It is estimated that Uganda with a population of 20 million has 20,000 new cases of cancer each year. There is only one chemotherapy unit. Most families, even if they can afford to pay for transport to reach the chemotherapy unit in Kampala, cannot afford the expensive chemotherapy. The treatment gets interrupted as the machines in the only radiotherapy unit are often out-of-order. Again most people never reach there.

It is estimated that 57% of the population never see a health-worker in their lives. How do we reach this 57% when they develop cancer? When ill, they first use herbal medicine or meet the traditional healer. In 1993, we started Hospice Africa in Uganda to:
- establish a model hospice providing palliative care service to patients and families
- train health professionals
- train initiators from other African countries who could begin such service in their own countries.

The hospice began with a 10 year-old Land Rover donated by the British High Commission, enough funding to cover running costs for three-months, no place to live or work from and a lot of faith!

Now, almost seven years later, we have looked after 2200 patients and have 335 patients on the programmes in Uganda. There are 43 Ugandans in the team and four expatriates. We have two satellite hospices in the districts of Hoima, 200 kilometres north-west of Kampala and in Mbarara 280 kilometres to the south-west.

Training

We have trained 620 health professionals and 300 other professionals. We are also training palliative care personnel for each of the 43 districts in Kampala using the facilities in each district and the health professionals already working there. Since 1993, we have been teaching medical undergraduates at the Makerere University and since 1998 at the Mbarara University medical schools. All doctors being trained in country are receiving knowledge of palliative care before they graduate. We are also teaching undergraduate nurses and pharmacists.

The way ahead

Although the primary aims have been met, we still have a long way to go. Blessed with a very committed team who are receiving in-service training, we are trying to make palliative care sustainable in Uganda. We are also being asked advice on bringing palliative care into neighbouring countries.

Anne Merriman, Hospice Uganda, PO Box 7757, Kampala,
LETTERS

I first read Contact — an excellent Christian medical journal — in the 1960s while working as a doctor with the Medical Missionaries of Mary in a mission hospital in Nigeria. I recently heard that Contact has moved from the WCC and that it may be discontinued. You have been doing a wonderful job, because of your commitment and the wide circulation, reaching the poorest areas. I pray that you will be able to sustain your efforts. The world needs your contribution. Please take encouragement from this story:

God bless you for being there when God needed you to help me!

Anne Merriman, Hospice Uganda, Kampala, Uganda.

Darlena David responds:

We are glad to inform readers that a partnership of four organizations, WCC; DIFÄM, the German Institute for Medical Missions in Tübingen; and MCS, the Medical Coordination Secretariat of the Netherlands have joined hands to continue to produce Contact from outside Geneva! This issue, Contact 168 is the sixth issue produced from New Delhi.

As Editor, I am amazed at the sentiment Contact evokes. Time and again we have heard of programmes that have been inspired by articles written in Contact. I hope that many more readers will share their experiences. The forthcoming themes of Contact will be:

Contact 169: Lifestyles and health; Contact 170: Water for health; Contact 171: Faith and healing, Contact 172: Health by the people

USEFUL PUBLICATIONS

Beyond impunity: an ecumenical approach to truth, justice and reconciliation

This book by Geneviève Jacques, former member of international relations team and currently director of the Cluster on Relations of the World Council of Churches, challenges churches to let the victims of violence tell their stories. Truth must emerge before relationships can be re-established and healing begin. ISBN: 2-8254-1321-6. 61 pp. Sfr.9.90, US$6.50. Contact Nanda Chandrasekharan at WCC.

ANNOUNCEMENTS

Breastfeeding it’s your right!, World Breastfeeding Week Pack now available!

The World Alliance for Breastfeeding Action (WABA) is raising awareness on breastfeeding as a human right during this year’s World Breastfeeding Week (1-7 August). The theme is significant given the inflow of women into the workforce. The pack contains a poster, an action folder, a press release and other items to help you organize your own activities. Readers can use or adapt the WABA materials to produce t-shirts, buttons, puppets, mugs, balloons, songs, skits and dances. A special exhibition kit, which can be set up easily, is also available.

WABA, PO Box 1200, 10850 Penang, Malaysia Tel: 60 46 584 816, Fax: 60 46 57 2655, E-mail: secr@waba.po.my Website: http://www.waba.org.br

Contact is the health and community development magazine of the World Council of Churches. The publication deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing. Contact is published by a partnership of the World Council of Churches (WCC); Christian Medical Association of India (CMAI); German Institute for Medical Missions in Tübingen (DIFÄM), and Medical Coordination Secretariat of the Netherlands (MCS). It is published four times a year in English, French and Spanish. Present circulation is approximately 15,000. Articles may be freely reproduced, providing that acknowledgement is made to: Contact, the publication of the World Council of Churches. A complete list of back issues is published in the first annual issue of each language version. Editorial Committee: Rainward Bastian, Christoph Benn, Manoj Kurian, Cherian Thomas, Darlena David, Christina de Vries, Elizabeth Moran. For this issue we acknowledge the contribution of Miriam Reidy-Prost, Alexander Belopolsky, Catherine Alt, Barbara Zolty, Douglas Betcher, Marcel crozet and Jenny Roske. Editor: Darlena David; Design: Indira Mark; Mailing List: Indira Mark. Printed on woodfree paper by Impulsive Creations. Mailing list: Christian Medical Association of India, 2, A-3 Local Shopping Centre, Janakpuri, New Delhi 110 058, India. Tel: 91 11 5599991/2/3, 5521502. Fax: 91 11 5598150. E-mail: subscribe@cmai.org Contact is also available on the World Council of Churches’ website http://www.wcc-coe.org/wcc/news/periodicals The average cost of producing and mailing each copy of Contact is US $2.50, which totals US $10 for four issues. Readers who can afford it are strongly encouraged to subscribe to Contact to cover these costs.