

Regional Summary for the Western Pacific Region

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The Western Pacific Region

The Western Pacific Region, one of the six regions of the World Health Organization (WHO), was delineated during the First World Health Assembly in 1948. There are 37 Member States and areas in the Region, which stretches from China and Mongolia in the north and west, to New Zealand in the south, and French Polynesia in the east. Today, it is home to approximately 1.6 billion people, nearly one-third of the world's population. Culturally, politically, economically, and socially diverse, it simultaneously presents great challenges and immense opportunities in tobacco control.

Issues

Tobacco as a major risk to health in the Western Pacific. Of the non-infectious causes of death and disease, tobacco use is the most damaging and prevalent. Tobacco-attributable mortality continues to rise in a disproportionately rapid manner: over the past 50 years, the global annual death toll from tobacco-related diseases rose more than 14 times, from an estimated 0.3 million deaths in 1950 to 4.2 million in 2000. Recent data disclosed a further increase in annual tobacco-related mortality, to nearly 5 million in 2002. The Western Pacific Region accounts for almost 20% of these deaths, losing one person for every five lives claimed by tobacco.¹

Tobacco use contributes significantly to the disease burden of the Region. The World Health Report 2002 identified tobacco use as among the top three major risks to health in its analysis of both the developed and developing countries within the Western Pacific. Among the developed countries

(Australia, Brunei Darussalam, Japan, New Zealand and Singapore) tobacco ranks as the leading health risk factor, accounting for over 50% of the population attributable fraction for chronic obstructive pulmonary disease and cancers of the lung, trachea and bronchus. In these countries, tobacco use also plays a role in the causation or aggravation of ischaemic heart disease and cerebrovascular disease, which are two leading diseases that make up over 15% of disability adjusted life years (DALYs). Among the Region's developing countries, tobacco use adversely impacts five of the top 10 diseases and injuries: cerebrovascular disease, lower respiratory infections, chronic obstructive pulmonary disease, ischaemic heart disease and tuberculosis, which together account for over 18% of years of healthy life lost for the people in these countries.² Clearly, tobacco exacts a tremendous price from the Western Pacific; ironically, the Region's tobacco-related illness and death are entirely preventable.

Tobacco use and the Region's youth. Because of the long lead time between exposure to tobacco and the onset of disease, most of the disease burden reflected in the statistics above is borne by adults, who began smoking or chewing tobacco many years ago. Data from the Global Youth Tobacco Survey (GYTS) on the current number of children and young people already using tobacco imply a future health cost to the Region of greater magnitude (Table 1).³ Results of the GYTS within the Western Pacific reveal an alarmingly high rate of tobacco use among schoolchildren aged 13-15, with 58.5% of schoolchildren surveyed in Palau and 62.4% in the Northern Marianas islands currently smoking. Many of

Table 1. Selected indicators, Global Youth Tobacco Survey among participating Western Pacific countries

Country	Year of survey	Current smokers (%)	Smoking before age 10 (%)	Smoke >6 cigarettes daily (%)	Currently use other tobacco products (%)	Exposed to others' smoke at home (%)	Desire to stop (%)
Fiji	1999	15.1	21.6	10.8	7.9	49.4	78.0
CNMI*	2000	62.4	31.0	6.8	52.7	64.9	80.7
Palau	2000	58.5	31.9	16.0	53.5	46.0	76.8
Philippines	2000	23.3	14.1	6.5	11.1	58.2	85.2
Singapore	2000	9.4	22.7	21.3	NA	35.1	61.9
China: Chongqing	1999	14.6	39.2	7.1	9.6	56.8	72.4
China: Guangdong	1999	10.3	37.7	19.4	6.7	49.4	62.5
China: Shandong	1999	8.6	20.5	3.3	6.9	48.9	86.9
China: Tianjin	1999	9.7	27.3	10.8	4.9	59.1	86.9

*CNMI: Commonwealth of the Northern Mariana Islands.

Note: The GYTS is a school-based survey carried out among school children aged 13-15.

Source: Tobacco Control, August 2002.

these children started smoking before the age of 10; for instance, in Chongqing, China, of the schoolchildren currently smoking, 39% reported starting before reaching 10 years of age. An overwhelming majority of these children want to quit tobacco use but are unable to do so, presumably because of nicotine addiction. Exposure to second-hand smoke both at home and in public places remains disturbingly high.

The tobacco industry targets this age group through direct and indirect marketing and promotions. The industry also promotes “youth smoking prevention” programmes through schools and civic groups in several of the Region’s Member States and areas, including Australia, Guam, Japan, Lao PDR, Malaysia, Papua New Guinea, the Philippines, and Vietnam. Close scrutiny of these “prevention” programmes reveals that they utilize strategies shown to be ineffective and, in some cases, counter-productive in preventing tobacco use.⁴

Trends in tobacco consumption. Currently, one in three cigarettes is consumed in the Western Pacific Region. On the average, 60% of the Region’s men and 6% of the women currently smoke, with Chinese men making up the largest pool of smokers. Of the five largest countries by population in the Region, only Japan and the Republic of Korea are experiencing declines in tobacco use prevalence. Among the more developed countries in the Western Pacific, where tobacco use among adults is generally lower than the Regional average, a disturbing trend of increasing consumption by young women is emerging. In the rest of the Region rates of tobacco use are still high, with increases noted particularly among the young.⁵ Maintaining and expanding this consumer base is a prime objective of the multinational tobacco industry.

Politics, economics and the tobacco industry. Controlling the tobacco epidemic within the Region remains politically challenging, because tobacco use is often perceived by Governments as contributing significantly to national revenues. China and Japan continue to hold majority stake in their domestic tobacco industries, and in the Indochina countries and the Philippines, tobacco agriculture and manufacturing provide jobs and funnel investment dollars to the local economies. However, tobacco’s perceived financial benefits mask the true costs of poor health, increasing disease burden, premature mortality, and the impact on long-term national productivity. In the Philippines, for example, the tobacco industry provided total earnings of approximately 26 billion Philippine pesos to the government, but drained the country of 47 billion Philippine pesos in health care costs and lost productivity.⁶

Regional expansion by the tobacco industry continues in several countries within the Western Pacific. In Lao People’s Democratic Republic, the industry reportedly plans to increase tobacco leaf production six-fold in ten years, with a projected increase in crop area from the current 675 hectares to 4000 hectares by 2011 and a corresponding increase in tobacco leaf production from 810 tonnes in 2002 to 64,000 tonnes by 2011.⁷ Very recently, in the Philippines, Philip Morris International inaugurated a new US\$300 million cigarette manufacturing plant that is envisioned as the company’s Southeast Asian hub, producing 40 billion cigarette sticks annually.⁸

Underlying these seemingly benevolent capital investments in developing countries is an effective strategy to preempt attempts to increase taxes on tobacco products – under the Association of South East Asian Nations (ASEAN) Free Trade Agreement (AFTA), cigarettes made in ASEAN countries using at least 40% of raw materials from the ASEAN subregion qualify as local products, and are therefore subject to the tariff reduction scheme mandated in the trade agreement. Already, Malaysia has lowered tariffs on tobacco products in line with the AFTA.⁹

While globalization in general is politically desirable, globalization of tobacco trade can work against tobacco control, by lowering prices through tariff reductions and increasing the availability of tobacco and tobacco products under the banner of trade liberalization, unless Governments recognize the inherently dangerous nature of tobacco to human health as a basis for restricting trade in tobacco. The tobacco industry and its allies are quick to seize opportunities to expand their markets under the banner of globalization. For instance, when China recently joined the World Trade Organization, entry into the Chinese market of foreign cigarette brands was one of the key areas negotiated by the major world economies with China.

Action for a Tobacco-free Region

The international Framework Convention on Tobacco Control – a Rallying Point for tobacco control in the Western Pacific

The WHO envisions the international Framework Convention on Tobacco Control (FCTC) as a crucial vehicle to control tobacco use globally, while strengthening the efforts of individual Governments to protect their population from the adverse effects of tobacco. However, while the FCTC provides the guidelines for action against tobacco, ensuring that these guidelines are brought to fruition can only happen at the national level. Thus, the success of the FCTC will depend almost entirely on countries’ abilities to implement and

enforce the Framework's provisions. Building national capacity must happen in parallel with efforts to ensure that the FCTC is ratified, because Member States need to have attained readiness for implementation when the Convention enters into force. This requires long-term political commitment to a dynamic process for developing and sustaining country capacity to respond effectively to the tobacco epidemic. Unless this happens, the FCTC will be incapable of helping countries to achieve the desired reductions in tobacco use and years of healthy life lost due to tobacco. The majority of the Western Pacific Member States and areas recognize this, and are working to make it happen.

The process of developing and negotiating the FCTC has been a catalyst in the Western Pacific. A total of 24 WPR Member States were actively involved in the finalization of the FCTC Text, concluding four years of work to produce an international tobacco control treaty. Directly as a result of this, several countries have established interministerial and multi-sectoral committees to oversee national tobacco control efforts. Working in partnership with WHO and other local and international agencies involved in tobacco control, progress in national capacity building was enhanced in these Member States, as exemplified by the following:¹⁰

- Cambodia put in place a partial tobacco advertising ban, and is working towards a complete advertising ban within the next two years. Its smoking cessation programme among monks is being expanded to cover other sectors of the population. A pilot project combining livelihood generation, health promotion and tobacco control is likewise being stepped up gradually because of its initial success.
- China has finalized its National Plan of Action for Tobacco Control and is in the implementation phase for several of its activities. A Tobacco Control Office within the China Centers for Disease Control was recently established, with WHO support. Pilot community-based smoking cessation projects in Beijing and Chengdu, and activities to ensure smoke-free environments for children in several cities are currently under implementation.
- The Cook Islands has developed an updated Comprehensive Act on tobacco control, which is being readied for legislative passage later in 2003.
- Kiribati developed its own advocacy campaign using local young sports champions to campaign for a healthy, tobacco-free lifestyle.
- Lao People's Democratic Republic recently instituted its official Interministerial Committee for Tobacco Control, and is finalizing its National Policy and Plan of Action. Smoking cessation training workshops have been initiated for health

professionals and health workers, and a smoke-free workplace policy is undergoing finalization.

- Malaysia has initiated a review of the feasibility of earmarking tobacco and alcohol taxes for financing its domestic tobacco control programme. Also, a comprehensive tobacco advertising ban is now in effect nationally.
- Niue has prepared a draft tobacco control law, with WHO support, which is expected to undergo legislative review and adoption later this year.
- The Philippines is undertaking an innovative approach to developing a strong legislative base to ensure smoke-free public places, through partnerships and technical assistance to local government units for the enactment of local ordinances in line with the country's Clean Air Act.
- Viet Nam successfully spurned the tobacco industry's efforts to penetrate the youth market through deceptive "smoking prevention" educational programmes. An official tobacco-free policy is now in place for the 2003 South-East Asia Games to be held in the country. A pilot project to ensure healthy, tobacco-free environments for children is also underway.
- Development of more comprehensive tobacco control legislation is underway in Brunei Darussalam, Kiribati, the Republic of Korea, Mongolia, and Palau.

Future

While these represent progress made in combating the tobacco epidemic, the Region still is faced with enormous challenges and obstacles. The critical challenges for the Region include ensuring the FCTC's entry into force and sustaining tobacco control efforts after the FCTC has entered into force. Because the FCTC's entry into force depends on how speedily Governments ratify the treaty, it is crucial to extend advocacy efforts to include political mobilization by nationals so that the FCTC is readily passed by each country's legislative body. Finding credible local champions for tobacco control can expedite this process, because these champions can generate popular support for the treaty, as well as mobilize a mass base for the implementation of specific tobacco control interventions. The experience in the Republic of Korea illustrates how having the "right" champions can lead to measurable declines in tobacco consumption over time.¹¹

It should be expected that attempts by the tobacco industry to oppose or circumvent national and regional tobacco control efforts will escalate as the entry into force of the FCTC nears. Already, Member States, WHO and other partners should strengthen their alliance to ensure that the industry is not allowed to weaken tobacco control efforts and sabotage

the process of ratification and entry into force. Strategic collaboration with other sectors within Governments, related international agencies and nongovernmental organizations is needed as well, to safeguard the FCTC and national tobacco control efforts.

Clearly, if progress is to be sustained in tobacco control, future resources need to be redirected to Member States, particularly those where tobacco consumption is high, and where the tobacco industry maintains a strong presence. Having country-based tobacco control staff who are competent in both the technical and managerial aspects tobacco control programmes can boost the likelihood of successful programme development and implementation. Securing this type of national expertise should become a priority for the future.

In responding to the issue of tobacco as a major risk to health, with a significant contribution to several of the major non-communicable and communicable causes of death and illness within the Region, it is essential to frame tobacco use as a public health problem that intersects the major areas of general public health. This will pave the way for integrating tobacco control into core public health programmes, such as health promotion, control of non-communicable diseases, adolescent health, and environmental health. The prevalence of second-hand smoke exposure, especially among children, needs to be addressed through policy and advocacy; combining efforts with the newly established Healthy Environments for Children Alliance provides an attractive option to pursue this particular area of work. In all cases, opportunities to integrate and complement existing or newly created health programmes should be utilized to ensure that tobacco control is gradually incorporated into the mainstream of public health. This will also help augment resources for tobacco control.

Finding sustainable financing for tobacco control remains a major challenge for many countries, particularly in the Western Pacific. Member States need to explore creative ways to support tobacco control efforts. The feasibility of increasing taxes on tobacco and tobacco products and funneling the revenues generated into health promotion and tobacco control should be actively explored, as this represents an effective mechanism to reduce tobacco consumption while providing for tobacco control activities.

A major issue that needs to be addressed definitively is that of globalization and its implications in opening up markets for tobacco trade. Another contentious issue is the effect of stringent tobacco control measures in countries that derive a substantial proportion of their gross national income from tobacco growing and/or manufacturing. The combined expertise of the Food and Agricultural Organization, the

International Labour Organization, the World Bank, the World Trade Organization and other related agencies need to be integrated into WHO's efforts to control the tobacco epidemic.

Finally, extending the existing surveillance mechanism to include general population data on tobacco consumption patterns and behaviours will provide countries with a more complete picture of their progress in the fight to curb the tobacco epidemic. Using the survey instruments and database as tools to monitor progress and guide future programme development must occur, if WHO and its Member States are to move ahead in their desire to achieve real and measurable health impacts as a result of their tobacco control efforts.

Unlike most other public health problems, there are no easy and quick solutions to the tobacco epidemic. Tobacco control is the marathon in public health. WHO and its Member States need sustained commitment to work progressively to secure a Western Pacific Region that is safe, healthy and tobacco-free.

References

1. Mackay, J., Eriksen, M. *The Tobacco Atlas*. World Health Organization, 2002.
2. World Health Organization. *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. World Health Organization, 2002.
3. The Global Youth Tobacco Survey Collaborative Group. Tobacco use among youth: a cross country comparison. *Tobacco Control* 2002; 11:252-270.
4. Tobacco Free Initiative WHO-WPRO. *Seeing Beneath the Surface: The Truth About the Tobacco Industry's Youth Smoking Prevention Programmes*. World Health Organization Western Pacific Regional Office, 2002.
5. Tobacco Free Initiative chapter, *The Work of WHO in the Western Pacific Region 1 July 2001-30 June 2002 (Report of the Regional Director to the Regional Committee for the Western Pacific, Fifty-third Session)*. World Health Organization Regional Office for the Western Pacific, 2002.
6. Dans, A., et al. Monograph on cigarette smoking in the Philippines. Report submitted to TFI-WPRO, 2000.
7. Tobacco industry set for massive ten-year expansion: lao cigarettes, tobacco products for export. *Vientiane Times*, 4-6 December 2001.
8. Marlboro man adapts to a world hostile to smokers. *The Philippine Star*, 12 May 2003.
9. ASEAN Secretariat website at: http://www.aseansec.org/economic/afta/agr_shs.htm Special Protocol on the Special Arrangements for Sensitive and Highly Sensitive Products.
10. Tobacco Free Initiative chapter, *The Work of WHO in the Western Pacific Region 1 July 2002-30 June 2003 (Report of the Regional Director to the Regional Committee for the Western Pacific, Fifty-fourth Session)*. World Health Organization Regional Office for the Western Pacific, 2003.
11. Tobacco Free Initiative WHO-WPRO. *Progress in South Korea brochure*. World Health Organization Western Pacific Regional Office, 2002.