Tobacco consumption is increasing in developing countries, which will bear the brunt of the tobacco epidemic in the 21st century. If current smoking patterns continue, 7 of the world's 10 million annual deaths from tobacco in 2025 will occur in developing countries.

Compared with developed countries, more men and fewer women currently smoke in developing countries, but smoking among girls and women is increasing.

While indigenous tobacco production and consumption remain a major problem, of particular concern is the penetration by the transnational tobacco companies, bringing with them denial of the health evidence, sophisticated advertising and promotion, threats of trade sanctions based on tobacco trade, and opposition to tobacco control measures, in particular promotional bans and tobacco tax policy.

Developing countries must urgently devise and implement national tobacco control policies, but many governments have little experience in the new non-communicable disease epidemic or in countering the transnational tobacco companies.

With the decrease in smoking prevalence in developed countries, the multinational tobacco companies are now moving massive resources to boosting sales in developing countries (see both Daynard and Pollock in this issue). In some developing countries, indigenous tobacco production and consumption present major problems. Many people and governments in these countries are not yet fully aware of the risks and lack the resources to counter ruthless marketing by the industry. If not prevented, there will be an appalling future increase in tobacco-related disease, disability and death.

History

Columbus brought information on smoking tobacco to Europe in 1492. The habit was later found to be extensive in South America. In 1558, the tobacco plant itself reached Europe where pipe smoking spread rapidly. By 1525 tobacco trade had already been established between the
Caribbean and India, extending soon afterwards to China, Japan and the Malay peninsula\textsuperscript{3,4}. About the same time, the Portuguese and Spanish brought tobacco down the east coast of Africa, and by 1560 it was being used in Central Africa\textsuperscript{5} also. By the 17th century, tobacco was being produced in Russia, Persia, India and Japan\textsuperscript{6}.

The invention of the cigarette machine in the early 20th century created further interest in the large potential markets for tobacco in developing countries. On hearing of its invention, James B. Duke (1865–1925), the tycoon who established British American Tobacco (BAT), said: 'bring me the atlas'. He looked at the population figures and noted: 'China: 430,000,000. That', he said, 'is where we are going to sell cigarettes' and 'that' was China\textsuperscript{7}.

By the beginning of this century, BAT was advertising throughout China\textsuperscript{8}. By 1911, there were huge and widespread BAT posters\textsuperscript{8} and even sponsored theatre performances\textsuperscript{9}. By the 1920s, BAT awarded university scholarships in Hong Kong\textsuperscript{10}.

Chinese Government opposition, based on its own tobacco monopoly, was countered through action via the American and British governments\textsuperscript{8}. Chinese annual consumption of cigarettes had risen from the negligible level of the 1890s to 100 billion cigarettes in the 1930s, a rise ascribed to the business practices of the cigarette industry\textsuperscript{11}. When forced in 1952 to leave China, BAT forecast 'we will be back'—and so they are\textsuperscript{12}.

Following recognition of the lethal effects of tobacco, the potential threat to developing countries was dubbed, in an editorial in the \textit{British Medical Journal} in 1971, as 'exporting tobacco slavery'\textsuperscript{13}.

The difficulties in countering the threat were recognised and addressed in the 1983 World Health Organization report \textit{Smoking Control Strategies in Developing Countries}\textsuperscript{14}; they were also emphasized in the 1983 report of the Royal College of Physicians of London\textsuperscript{15}. Yet 2 years later, Brazil earned the dubious distinction of being the first developing country in which smoking was labelled by WHO as the leading cause of death\textsuperscript{16}.

In 1985, 73\% of the world's tobacco was grown in developing countries\textsuperscript{17}, using land that could otherwise be used to grow food. Yet 63\% of developing countries were spending more on importing tobacco than exporting it\textsuperscript{18}. Although the epidemic lagged behind western countries, at a 1987 WHO Western Pacific Regional meeting on Tobacco or Health, it was emphasized that heart, circulatory disorders and cancer—all tobacco-related—were already the most common causes of death in Asia. Tobacco was causing developing countries twin problems—health and economic—that persist to this day.

During the last decade, as markets began to decline in developed countries, the transnational companies have been looking even harder towards developing countries. Glowing accounts of successful tobacco marketing in Asia, and the future potential there, have been given by the
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major companies: Philip Morris\textsuperscript{19}, British American Tobacco (BAT) and Rothmans (annual reports).

One tobacco industry executive summed it up succinctly: "you know what we want? We want Asia\textsuperscript{20}. It would hardly matter whether all smokers in a country with a small population like Britain stopped smoking tomorrow, if the tobacco companies could capture the massive third world markets.

\section*{Review of present situation}

Basic epidemiological information is lacking in many developing countries, some of which have still not undertaken a national survey on smoking prevalence. Of those that have, few reliable or country-wide surveys were done earlier than 10 years ago, so that information on trends is scanty.

In general, patterns of smoking are different in developing and developed countries: more men (50–60\%) but fewer women (2–10\%) smoke in developing countries compared with developed countries, where approximately 25–30\% of both men and women smoke\textsuperscript{21}. But, as in developed countries, smoking starts among young people and for much the same reasons\textsuperscript{22}.

Girls start smoking later than boys and smoke fewer cigarettes; smoking has been considered socially unacceptable for women (with exceptions, such as certain areas of India, Nepal, Papua New Guinea, northern Thailand, and for Maoris); there may be religious constraints, for example in Muslim countries; women have had less spending power than men to buy cigarettes; rural women adhere to traditional methods of smoking, e.g. hubble-bubble pipes, and are therefore exposed to a lower dosage of tobacco; and in some areas, such as parts of India and the Middle East, women use tobacco in other forms, such as chewing tobacco (see Pershagen in this issue). There may be significant under-reporting of smoking among women in countries where it is culturally less acceptable for women to smoke.

Because of poverty in Africa, many smokers can only afford a few cigarettes per day (see Amos in this issue). Even in Asia, smokers smoke on average fewer cigarettes than in western countries. For example, smokers in China smoke on average 11–15 cigarettes daily.

In Africa, more girls and women are taking up the habit\textsuperscript{23}. In many areas of India, while only 3\% of women smoke manufactured cigarettes, 50–60\% chew tobacco\textsuperscript{21}. In South America, while cigarette smoking is lower among women (20\%) than among men (37\%), there is a wide variation in prevalence of smoking among women, from 3\% in La Paz,
Bolivia to 49% in Buenos Aires, Argentina. In the eastern Mediterranean, approximately 40–50% of men smoke, but smoking by eastern Mediterranean women is often considered to be vulgar and improper, even immoral. Female smoking is still low but increasing in professionals in the Middle East and North African region (Sherif Omar, personal communication).

Future trends

Between 1986 and 1991, world per capita consumption decreased by less than 1%. The Food and Agriculture Organisation of the United Nations estimates that between the years 1984–86 and 2000 tobacco consumption in developed countries will decrease by 11% but in developing countries it will increase by 10%. Of total world consumption in 1974–76, 49% was in developing countries. This rose to 61% in 1984–86 and is estimated to rise to 71% by the year 2000.

Between 1986 and 1991, per capita consumption declined in Africa by 11%, in North America by 13%, in South America by 7% and in the European Community by 3.5%. Only in Eastern Europe and Asia did per capita consumption increase, by 2% and 13.5%, respectively. Asia already accounts for about half the world cigarette consumption and this share is increasing at a much greater rate than the total world growth. The transnational companies have estimated that the market for cigarettes in Asia will grow by 33% between 1991 and the year 2000. This is compared with the predicted global increase of 5.2% in volume and 4.4% in monetary value (although, excluding China, global sales would actually fall in volume).

The numbers of smokers will increase for several reasons: (i) increase in population in the Third World, from 4.5 billion to 7.1 billion by 2025; (ii) increase in smoking prevalence, especially in the young, and especially in towns, initially in the better educated, and as a result of increasing affluence; (iii) a likely increase in smoking among women, owing to intensive tobacco marketing and to decrease in the social taboo for women; (iv) ignorance of the health risks, particularly among the rural and uneducated, but even among health professionals; (v) the lack of funding for control measures and the difficulty in implementing these, especially in rural areas; and (vi) above all, the intensive and ruthless marketing by multinational tobacco companies.

Not all these factors apply to all developing countries, but most apply to most. This likely explosion of tobacco consumption, unless prevented, will result in not only a human but also an economic burden of medical and health costs, lost productivity, loss of the use of land that could be
used to grow nutritious food, loss of foreign exchange if cigarettes are imported, environmental costs including costs of fires, use of wood to cure tobacco, smokers' litter, as well as the costs to the individual smoker and his/her family.

On present trends worldwide, annual deaths from cigarettes are expected to rise from the current 3 million to about 10 million by 2025, and 7 million of these deaths will be in developing countries. Two million will be in China alone.

**National action**

**Background**

Developing countries are at very different stages in the development of the tobacco epidemic and in actions to counter that epidemic. If a country has yet taken little action the first essential is to recruit medical interest in the problem. This can be done via visiting foreign consultants. Oncologists, cardiologists or respiratory physicians, invited for their general expertise, can strongly emphasize the importance of smoking and help to create a responsible medical climate locally.

A similar influence can derive from international meetings of the relevant specialty where smoking problems are given a significant place. Once interested, the doctors, with their prestige and social standing, can then influence opinion and decision makers in their country to take up the problem.

WHO and international non-governmental organisations (NGOs) may then be able to help: WHO working through government contacts, NGOs through their national affiliated body or bodies and professional groups. Dr H. Mahler, a previous Director General of WHO, called this 'the pincer movement'.

**National tobacco control policy**

The key to tobacco control lies in prevention. The essential elements of a national tobacco control policy are the same for all countries.

*Data collection* Conclusive world data on the hazards of tobacco already exist on which developing countries can base preventive public health action now, without waiting for any further research. However, surveys on tobacco prevalence; mortality and morbidity related to tobacco use; attitudinal surveys; the economic impact of
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Such national data are useful in order to convince opinion leaders, politicians and the general public of the importance both of the problem and of the urgent necessity to address it. While many developing countries have not yet done a national prevalence survey, even fewer have even partially evaluated the cost of tobacco to their economy. Data are particularly lacking for Africa.

In September 1995, WHO held a meeting on global standardised guidelines for studies, including core questions, for simple studies for developing countries which are:

**If only 1 question can be asked:**
1. Do you now smoke daily, occasionally or not at all?

**If 2 questions can be asked:**
1 above and a 2nd Q on EITHER on daily consumption OR on previous history:
1. (above)
and
2a. How many of the following items do you smoke, chew or apply each day?
   ..... manufactured cigarettes
   ..... hand-rolled cigarettes
   ..... bidis
   ..... pipefuls of tobacco
   ..... betel quids
   ..... snuff
OR:
2b. Have you ever smoked daily, occasionally, or not at all?
   ..... daily
   ..... occasionally
   ..... not at all or less than 100 cigarettes in your lifetime

**If more questions can be asked:**
1. Have you ever smoked? (Y/N). If yes, go to next question.
2. Have ever smoked at least 100 cigarettes or the equivalent amount of tobacco in your lifetime? (Y/N)
3. Have you ever smoked daily? (Y/N)
4. Do you now smoke daily, occasionally, or not at all?
   (D, O, Not at all)
5. On average, what number of the following items do/did you smoke per day?
   ..... manufactured cigarettes
   ..... hand-rolled cigarettes
   ..... bidis
   ..... pipefuls of tobacco
   ..... cigares/cheroots/cigarillos
   ..... goza/hookah
6. How many years have you smoked/did you smoke daily?
7. For ex-smokers: How long has it been since you last smoked?
   — less than one month
   — one month or longer but less than six months
   — six months or longer but less than one year
   — one year or longer but less than five years
   — five years or longer but less than ten years
   — 10 years or longer

*Establishment of a national tobacco control policy programme and national coordinating organization* WHO has recommended the establishment of a national focal point to stimulate, support and coordinate all anti-tobacco activities. Many developing countries have established such organizations over the last decade, either within Ministries of Health or by non-governmental organizations (NGOs). World experience has shown the vital importance of government commitment, funding and action in establishing a national programme to reduce the tobacco epidemic.

*Health information and education* The enormous difference in funding available for health education in comparison to the money spent on promotion by the tobacco companies remains an unsolved problem in all developing countries. In contrast to the attractive images used by the tobacco companies, many health educators have used depressing, even boring health statistics and finger-wagging ‘don’t smoke’ messages which may encourage adults to quit, but seem to have little effect in preventing young people from starting smoking. But it is still not known whether this more authoritative approach works better in countries where teaching is more traditional and teachers are respected by students. Health education in developing countries, especially that geared for youth, is now beginning to move towards positive, healthy lifestyle images, and teaching young people how to say no.

Health education is expanding. In 1993, 31 out of the 35 countries in the WHO Western Pacific Region celebrated World No Tobacco Day on 31 May.

*Legislation* Legislation also has an important role to play. Its desirable components are now well recognised (see Reid in this issue). We comment below on individual items from the point of view of developing countries. Legislation will only be enacted after appropriate build up of national opinion, especially among decision makers. If the law is to be effective, it is essential that a government department be made responsible for monitoring its implementation and prosecuting for breaches of the law. Penalties for breach must be sufficiently substantial.
to deter even very rich multinational companies, e.g. very high fines, banning that company’s imports for a specific number of months. A combined approach of health education and legislation, such as in Singapore and Hong Kong, is particularly effective.

1. Ban on tobacco promotion. Studies have shown that children are aware of and are influenced by tobacco advertising\textsuperscript{30,31}. By 1991, 27 countries had total bans on advertising, 12 had strong partial bans, and many countries had moderate partial bans\textsuperscript{32}. Partial bans have only partial effects, and even developing countries with comprehensive bans find these are frequently circumvented by ingenious indirect advertising and sponsorship. This includes sponsorship of sports, arts, TV and radio programmes, medical establishments and pop concerts; ‘infomercials’ (adverts that are dressed up as public affairs shows, as broadcast on television in China); product placement in films (e.g. Hong Kong) and other goods (virtually all countries) abound. Dealing with this is one of the major problems for developing countries. Satellite broadcasting is only one particular problem.

2. Discouraging smoking among youth. Few developing countries ban sales to minors, probably because of the difficulties envisaged in enforcing the law. This is the one and only tobacco control law supported by the tobacco industry in developing countries, a sure indication of its ineffectiveness.

3. Effective, rotating health warnings. By 1991, 70 countries worldwide required health warnings on cigarette packets\textsuperscript{32}. With few exceptions, such as Thailand, health warnings in developing countries (for those that have any) are single and feeble.

4. Limits on harmful substances. Lowering the very high tar levels (e.g. average over 30 mg) found in cigarettes in developing countries can prevent about one third of lung cancer. A ceiling of about 10–15 mg of tar per cigarette is recommended\textsuperscript{33}, below which smokers compensate by smoking more cigarettes, drawing more often on each cigarette, inhaling more deeply and smoking further down each butt. Smokers have an exaggerated perception of the benefits of low tar cigarettes, so the tobacco companies should never be allowed to suggest that a lower tar cigarette is a ‘safe’ cigarette. The goal should always be to quit. An appropriate warning system would be to label cigarette categories as ‘Dangerous’, ‘Very dangerous’ and ‘Most dangerous’, or a visual warning, such as the picture of a skull and crossbones.

5. Smokeless tobacco (see Pershagen in this issue). In India, where chewing tobacco is a long-established custom, community programmes have been successful in reducing chewing tobacco among rural women\textsuperscript{34,35}. New forms of manufactured tobacco products are
constantly being launched, such as chewing and sucking tobacco, and tobacco sweets\textsuperscript{36,37}. Several developing countries in the Western Pacific region, where chewing tobacco has never been a popular habit, have taken the opportunity to ban smokeless tobacco before it became established on their markets.

6. Creation of smoke-free areas. As it is now known that tobacco smoke is not only unpleasant to non-smokers but may also cause them to develop cancer\textsuperscript{38}, many developing countries have banned smoking in public areas, public transport and places of work, especially in health premises, schools and government offices. Two thirds of all adults and virtually all young children in developing countries are non-smokers; thus the freedom of the majority to breathe clean air is a more vital consideration than the freedom of smokers to smoke in public places. Virtually all flights within Asia are now smoke-free, as are some long-haul flights from Asia.

\textit{Tobacco price and taxation policy} Progressive increase of tax on cigarettes above the rates of increase for inflation and for disposable income is a very effective way of both discouraging smoking and also increasing government revenue (see Townsend in this issue). Smokers polled in developing countries give cost and health as their two main reasons for quitting. Increasing tax has a particularly beneficial effect upon young people and the poor, who have less money to spend, and are therefore more likely to quit. While in the USA, for example, for every 10\% tax increase there is a 4\% decrease in smokers\textsuperscript{39}, and a 14\% decrease in teenage smokers\textsuperscript{40}, a study from Papua New Guinea suggests that this resulting decrease in smoking may be even greater in developing countries\textsuperscript{41}. WHO has noted that ‘millions of lives could be saved if steep taxes were imposed on tobacco’\textsuperscript{42}. Care needs to be exercised in increasing taxes so that these are not seen as punitive or ‘anti-smoker’, and also that it does not place too harsh a burden on lower-income smokers who are unable to quit. Finance Ministers need to be reminded that they will gain, not lose, revenue by increasing tobacco tax (see Townsend in this issue).

Another method of utilising tobacco taxation as a means to improve health is to implement differential taxation on higher tar cigarettes.

Very few developing countries have earmarked any percentage of tobacco tax revenue to fund anti-tobacco activities. An exception is Peru, where a percentage of tobacco tax is used for anti-cancer activities, research and treatment.

\textit{Litigation} Although successful litigation based on the harmfulness of both active and passive smoking has been undertaken in developed countries, there has not yet been a successful case brought against the
tobacco industry or an employer in any developing country (see Howard in this issue). Where there are state tobacco monopolies, suing the tobacco industry would involve the unlikely situation of an individual suing the government of that country. It would also require funding and expertise far beyond the means of many individuals or health societies in developing countries. Nevertheless, rulings in developed countries have been used in developing countries. For example, information on successful court cases based on passive smoking in the workplace can encourage employers in other countries to take action to provide a safe, smoke-free work environment.

**International strategies relevant to developing countries**

**Role of international and regional health agencies**

World Health Organization (WHO)  The WHO Representative and office may be the only long-term major international health organization permanently present in a developing country. WHO has effective access to the Ministries of Health and WHO policy statements are powerful: the knowledge that a suggested item of tobacco control legislation is a WHO recommendation can carry great weight in developing countries. WHO can also provide some funding for country projects, including research, meetings, seminars and visits by experts. The 1983 WHO Report *Smoking Control Strategies in Developing Countries* remains a very useful guide.

The Western Pacific Regional Office of WHO has been particularly active in tobacco control, convening three working groups to advise on the problem, and producing two 5-year Action Plans (1990–1994 and 1995–1999). The latter calls for all governments (and all countries in the region except Australia, Japan and New Zealand are developing countries) to implement comprehensive tobacco control measures by 1999. These include a national policy and central coordinating agency on tobacco or health, health education, comprehensive tobacco control legislation and pricing policy. Highlights include:

- A call for a ‘Tobacco advertising-free Region by the Year 2000’ as part of comprehensive legislation on tobacco or health.
- The recommendation that a percentage of tobacco tax should be used to fund sports, arts and health promotion, so that sports and arts organisations do not suffer from the ban on tobacco sponsorship.
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- Introduction of health information and advocacy on tobacco or health into medical curricula.
- Compliance with the International Civil Aviation Organization resolution that all airlines become smoke-free by 1996.
- Involvement of religious and other community groups in tobacco or health activities.
- The goal, for countries and areas with a long history of tobacco or health action, to decrease their tobacco consumption by at least 1–2% per annum.
- The goal, for countries and areas that had not previously taken significant action on tobacco or health to implement national action (with a view to reducing consumption during the next 2000–2004 Action Plan on Tobacco or Health).
- The goal, for all countries and areas, to prevent a rise in smoking among women.

Some developing countries have shown that tobacco control measures are not the prerogative of western nations; they can be implemented in developing nations; they can be implemented quickly; and they can be effective. For example, Singapore and Thailand in the Asia-Pacific region, and Botswana in Africa, have implemented comprehensive tobacco control measures.

International/regional non-governmental organizations (NGOs) International organizations like the International Union Against Cancer (UICC), the International Union Against Tuberculosis and Lung Disease (IUATLD) or Consumers International (CI) can encourage their member organizations in developing countries to take a public and political stand on the tobacco epidemic, and also can fund projects, research, meetings and the visits of experts.

Regional organizations are particularly useful, such as the Latin American Coordinating Committee on Smoking Control (LACCSC), or the Asia Pacific Association for the Control of Tobacco (APACT). Both these organizations hold annual regional meetings. Delegates, especially from the poorer countries, find the smaller regional meetings more supportive than the large, international conferences. Following the first ‘All-Africa Tobacco Control Conference’ in 1993, a Tobacco Control Commission of Africa was formed in 1994, to coordinate regional efforts and implement the recommendations of the 1993 conference (Dr Yussuf Saloojee, personal communication).

Representatives of the 6 different developing regions of the world met in special sessions at the 9th World Conference on Tobacco or Health in 1994 to discuss regional developments and plan future strategy.
Trans-national issues and strategies

Trans-national strategies  It is imperative that the health organisations, develop trans-national strategies, including those countering tobacco industry strategies, as the tobacco industry already has developed global, regional and national strategies (see articles by Chapman, by Pollock and by Daynard in this issue), which include:

- Denial of the health evidence.
- Promotion (see below).
- Attempts to prevent national governments taking tobacco control measures.
- Strategies for ‘dealing with anti-tobacco pressure groups’.
- Strategies for handling litigation.

Global aspects of promotion
- Satellite television promotion, especially sports sponsorship, cigarette ‘holidays’, on Internet etc.
- Overlap of broadcasting and tobacco advertising to neighbouring countries.
- Tobacco product placement in TV and cinema films, either produced in one country but shown throughout the world, or (already confirmed) in films made in developing countries.
- Coordinated circumvention of the spirit of promotion bans.

Smuggling  In 1992, the export of 171 billion cigarettes was recorded that were not accounted for in any recorded, legitimate imports. Between 10–35% of the world’s cigarettes in international trade are smuggled. Transborder smuggling is a global problem of advantage to the cigarette companies:

- It softens a market ahead of penetration.
- It circumvents any volume restrictions on imports (e.g. in China prior to 1995).
- The transnational tobacco companies still sell the cigarettes, so they do not lose financially (unlike the government, which loses tax).
- The transnational tobacco companies can use the smuggling argument to persuade governments not to raise cigarette taxes.
- It occurs especially across borders where there are large differentials in prices. In developing regions, the major problem lies between China and Hong Kong, but occurs in many other areas. To counter smuggling, countries can insist on package health warnings in the
local language (as in Thailand) or a stamp on each package to indicate that tax has been paid.

Agriculture and production  Most tobacco is smoked in the country of origin, but the remainder constitutes inter-country tobacco trade\textsuperscript{18}. The western tobacco industry has begun switching farming and production to developing countries where there are cheaper labour costs.

Suggested global actions

1. An International Convention or Code on Tobacco or Health, similar to other international conventions such as those of the International Labour Organisation (ILO), is needed. This is especially important since global legislation, e.g. advertising regulations or laws, does not exist. UN resolutions on tobacco would be the appropriate first step in this process.

2. All UN agencies should produce recommendations, including tobacco in Children's Charters, Bills of Rights, International Civil Aviation Organization (ICAO), Food and Agriculture Organization (FAO) and World Bank resolutions and recommendations, etc., where these have not already been issued and, specifically, that FAO and the World Bank should give assistance with alternative crops.

3. Model tobacco control recommendations (UICC\textsuperscript{33}) and draft legislation (WHO) should be issued and re-issued, as a template for action by national governments. Model country examples, like Singapore, should be circulated to other countries.

4. Developing countries should have ready access to global sources of information, e.g. those from WHO, UICC, Globalink, IATH, 'Tobacco Control', etc. (see below).

5. An International Coalition of Non-Governmental Organizations for Tobacco Control was established at the 9th World Conference on Tobacco or Health in 1994. Members include the International Union Against Tuberculosis and Lung Disease (IUATLD), the International Union for Health Promotion and Education (IUHPE), the International Union Against Cancer (UICC), International Doctors Against Tobacco (IDAT), Consumers International (CI), the International Society and Federation of Cardiology (ISFC), the International Agency on Tobacco and Health (IATH), the International Network of Women Against Tobacco (INWAT) and others. The aim is to present a cohesive and common front on specific issues and to avoid duplication of effort.

6. Each international NGO should, in addition to encouraging action by their member organisations, agree upon a specific task. For instance,
UICC has addressed national tobacco-control policy and the IUATLD has researched and issued guidelines for incorporating tobacco into medical school curricula.

7. WHO and various NGOs should cooperate at international, regional and national level; for example, a regional conference or workshop could derive greater strength from the input of several organizations.

8. There should be a Plenary Session on tobacco in every conference organised by relevant NGOs, as well as these meetings being decreed ‘smoke-free meetings’.

9. Other NGO agencies need to be mobilised, for example, youth, women’s, environmental, religious and other community groups.

10. International networks of lawyers, doctors and others, including members from developing countries, should be established. Three international organisations, International Network of Women against Tobacco, Doctors against Tobacco, and Dentists against Tobacco have recently been initiated.

11. Information links, including electronic links, should be strengthened and developed, such as Globalink and the International Agency on Tobacco or Health.

**Relevant sources of information**

The following may be found useful by those working in developing countries:

1. Your local WHO Representative: you could trace this source through your Ministry of Health.
2. Your Regional WHO Office.
3. The WHO Tobacco or Health Unit, Geneva. (Director, WHO Programme on Tobacco or Health, Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland. Tel: 41-22-791-3493, Fax: 41-22-791-4851).
5. Globalink, centralised at UICC. (Globalink System Manager, UICC, Rue du Conseil-General 3, 1205 Geneva, Switzerland. Tel: 41-22-320-1811, Fax: 41-22-320-1810). Globalink is the International Computer Network of the International Union Against Cancer, that can be accessed with a personal computer, a modem and a standard telephone line from anywhere in the world. It provides e-mail, news
bullets, electronic conferences and several databases. Hard copies of regional monthly news bulletins are available in some regions for those without electronic access.

6. The International Union Against Tuberculosis and Lung Disease (IUATLD). (Executive Director, International Union Against Tuberculosis and Lung Disease, 68 Boulevard Saint-Michel, 75006 Paris, France. Tel: 33-1-46.33.08.30, Fax: 33-1-43.29.90.87).


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