D3.1 **Protecting breastfeeding**

Today nearly all governments and health-care institutions recognise breastfeeding as a health priority. Yet global breastfeeding rates remain well below acceptable levels – according to the United Nations Children's Fund (UNICEF), 'more than half the world's children are not as yet being optimally breastfed', and many children suffer from malnutrition and chronic morbidity as a consequence of sub-optimal breastfeeding. Improved breastfeeding practices could save some 1.5 million children's lives per year (WHO 2001; UNICEF 2008). One of the causes of the problem is the persistent marketing of infant formula products by commercial companies. According to UNICEF (1997): 'Marketing practices that undermine breastfeeding are potentially hazardous wherever they are pursued: in the developing world, WHO estimates that some 1.5 million children die each year because they are not adequately breastfed. These facts are not in dispute.'

Formula companies give the impression that promoting breast-milk substitutes is like any other type of advertising. However, artificial feeding products are not like other consumer or even food products. The object of artificial feeding is the replacement of a fundamental reproductive activity that destroys the natural sequence of birthing to feeding. Artificial feeding is inferior to breastfeeding, costly and, in many parts of the world, tragically harmful.

While no one would suggest a complete ban on infant feeding formula, it is imperative that women are not misled by spurious or misleading information about artificial feeding, and that health-care systems do not deliberately or inadvertently support inappropriate artificial feeding or diminish the importance of natural feeding.

The evolution of the problem

The establishment of bottle-feeding cultures is embedded in the history of the development and promotion of industrial 'replacement' products. Since the late nineteenth century, Nestlé, the world's largest producer of infant formulas, has undermined women's confidence in their ability to breastfeed and, through clever social marketing, created a benign acceptance of its products.

Initially, a lack of knowledge about the sub-optimal nutritional value of artificial milk and the important protective immunological properties of breastmilk helped create a more accepting environment for artificial feeding, especially among mothers who had to work outside the home. Marketing included the association of artificial feeding with being a good (even angelic) mother, and persuaded communities that formula milk is nutritionally better, as well as more fashionable and modern than breast-milk. Special promotions and the liberal provision of free samples drew women into the practice of artificial feeding in many parts of Asia, Africa and Latin America. By the 1970s it was estimated that only 20 per cent of Kenyan babies and 6 per cent of Malaysian babies were predominantly breastfed (WABA 2006).

Health-care workers have also been complicit. The industry has successfully established subtle and overt advertising through the health system by providing health workers with free 'gifts' that carry the logos of companies and products, publishing 'health education' materials and sponsoring health conferences. All this helps companies and their products to be identified with those who promote and protect health.

Once seduced into using artificial milk, mothers can become trapped by their decision. In poor economic situations, they can soon find themselves diluting formula milk or turning to cheap replacements to calm a hungry baby. The desperation of mothers of young babies dependent upon formula foods in New Orleans after the Hurricane Katrina disaster demonstrates that similar problems can occur in developed countries as well. Responses to humanitarian emergencies and natural disasters still often result in inappropriate donations of formula foods from governments, the public and milk companies; there have also been allegations of 'dumping' formula that is close to expiry.

The developing world, where the majority of the world's babies are born, is seen as a lucrative market for infant-food industries. The threat of undermining normal infant and young child feeding has expanded to include commercial food products to address nutrition needs of the 6- to 24-month age group. Follow-on milks were developed by companies as a

strategy to get around the restrictions of the International Code of Marketing Breastmilk Substitutes. The aggressive promotion of these milks, which are supposedly for older babies, is very confusing and health professionals all over the world have long noted how these milks inevitably end up being used as breastmilk substitutes for very young babies.

In an attempt to circumvent the strong condemnation they receive from the global health community, many companies have formed 'partnerships' with UN agencies ostensibly to combat malnutrition. No doubt these industries see good business sense in linking their brands with the humanitarian image of UN agencies in order to benefit from the billions in aid funds pouring into these agencies from donor governments. Global Alliance for Improved Nutrition (GAIN) global health partnership opens its website with the message, 'Improving nutrition can also seriously benefit your business by creating growth in new and existing markets.'

The health effects of the problem

Breastmilk is vital for mother and child health, regardless of socioeconomic setting. Although the health and development consequences of less than optimal breastfeeding are significantly worse for mothers and infants in low-income countries, research on the risks of formula feeding finds an increased risk of gastric and respiratory infectious diseases, higher levels of non-communicable diseases such as diabetes, and lower IQ capacity and visual acuity (Malcove et al. 2005; Weyerman et al. 2006; Cesar et al. 1999). Studies have demonstrated mortality rates up to 25 per cent higher for artificially fed compared to breastfed children (Victora et al. 1989; WHO 1981).

Over the past few years, milk companies have also exploited the dangers and concerns associated with HIV transmission through breastmilk (Iliff et al. 2005). Evidence, however, shows that exclusive breastfeeding for the first months of life reduces both mortality and the risk of transmission (Guise et al. 2005).

During early 2006, Botswana was battered by a diarrhoeal outbreak serious enough to require outside intervention from the Center for Disease Control (CDC) and UNICEF. Most of those affected were infants under eighteen months old. Abnormally heavy rains in the first months of 2006 resulted in flooding and dirty puddles of standing water, which combined with poor sanitation to spread the disease, killing 470 children between January and April. According to UNICEF, infant formula played a significant role in the outbreak and the CDC reports that formula-fed babies were disproportionately affected by the disease – one village, for example, lost 30 per cent of formula-fed babies. According to a report by the National

AIDS Map organisation, not having been breastfed was the most significant risk factor associated with children being hospitalised during the period of the outbreak.

The International Code of Marketing Breastmilk Substitute

When it became recognised that artificial feeding was both harmful and being promoted in ways that were unethical, a civil society campaign led by the International Baby Food Action Network (IBFAN) successfully enabled the World Health Organization (WHO) and UNICEF to establish the International Code of Marketing of Breastmilk Substitutes (the International

BOX D3.1.1 **Summary of the International Code**

1. No advertising or promotion of breastmilk substitutes to the public.
2. No free samples or gifts to mothers.
3. No promotion of products covered by the Code through any part of the health-care system.
4. No company-paid nurses or company representatives posing as nurses to advise mothers.
5. No gifts of personal samples to health workers.
6. No words or images, such as nutrition and health claims, idealising artificial feeding or discouraging breastfeeding, including pictures of infants on product labels.
7. Only scientific and factual information may be given to health workers regarding the product.
8. Information explaining the benefits of breastfeeding and the costs and hazards associated with artificial feeding must be included in any information on the product, including the labels.
9. No promotion of unsuitable products, such as sweetened condensed milk.
10. Warnings to parents and health workers that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately, and that this information is conveyed through an explicit warning on packaging.
11. Governments must provide objective information on infant and young child feeding, avoiding conflicts of interest in funding infant feeding programmes.
12. No financial support for professionals working in infant and young child health that creates conflicts of interest.

Source: IBFAN 2007.

Code) (IBFAN 2007). This was adopted by the World Health Assembly (WHA) in 1981 as a *minimum* requirement for all member states, which are required to implement it in its entirety in their national guidelines and legislation on the marketing of infant feeding formulas, bottles and artificial nipples (see Box 3.1.1).

Subsequently a number of additional resolutions have been adopted. These resolutions have equal status to the International Code and close many of the loopholes exploited by the baby food industry. Some of the resolutions include stopping the practice of free or low-priced breastmilk substitutes being given to health facilities (1992); ensuring that complementary foods are not marketed for or used in ways that undermine exclusive

BOX D3.1.2 **The International Baby Food Action Network**

IBFAN is a global network with a presence in over 100 countries. It has been successfully working since 1979 to protect health and reduce infant and young child deaths and malnutrition. Some of its priority activities include:

- Supporting national implementation of the Global Strategy for Infant and Young Child Feeding, adopted at the World Health Assembly (WHA) by a resolution in 2002.
- Monitoring compliance to the International Code of Marketing of Breastmilk Substitutes as well as subsequent relevant WHA resolutions at the country level.
- Raising awareness of and support for the human right to the highest attainable standard of nutrition and health for women and children.
- Protecting all parents' and carers' rights to sound, objective and evidence-based information.
- Informing the public of the risks of artificial feeding and commercial feeding products.
- Working to improve the quality and safety of products and protecting optimal, safe infant feeding practices through the Codex Alimentarius product standard-setting process.
- Promoting maternity protection legislation for mothers returning to work.
- Promoting sustainable complementary feeding and household food security recommending the widest possible use of indigenous nutrient-rich foods.
- Supporting and providing health worker training for the implementation of the UNICEF/WHO Baby Friendly Hospital Initiative.

and sustained breastfeeding (1996); recognising exclusive breastfeeding for six months as a global public health recommendation and declaring that there should be no infant-food industry involvement in infant nutrition programme implementation (2002).

IBFAN monitors the implementation of the Code, and their 2006 report notes that to date some 32 countries have incorporated the full Code into law; 44 countries have partially incorporated the Code into law; 21 have established the Code as voluntary guidelines (IBFAN 2006). The US and Canada have taken no action at all.

Case studies

1 *Commercial pressure: the case of the Nestlé boycott*

Nestlé is the largest baby food manufacturer in the world. For decades, as industry leader, it has led the way in aggressively marketing its products. Saleswomen were dressed in nurses' uniforms and sent into the maternity wards of hospitals throughout many parts of the world. Mothers faced a constant barrage of formula advertisements on billboards, television and radio. Aggressive marketing by Nestlé and its competitors undermined breastfeeding, contributing to a dramatic drop in rates in many countries.

In 1977, a public interest group based in Minneapolis, INFACT USA, launched a campaign to boycott the company's products. Campaigners urged the public not to buy Nestlé brands until it changed its marketing policies. By 1981, the boycott was international and the momentum it gathered contributed to the creation of the International Code. Nestlé's public image was at an all-time low. By 1984, with the boycott in effect in ten countries, Nestlé promised to halt its aggressive promotion and adhere to the International Code and the boycott was suspended. However, the IBFAN groups continued to monitor and the hollowness of Nestlé's promises soon became apparent – while some of the most obvious violations, such as sales staff dressed as nurses and babies' pictures on formula labels, had been stopped, the company had no intention of abiding by all the provisions of the International Code, particularly now the boycott had been suspended. The boycott was reinstated in 1989.

While the boycott has compelled Nestlé to change some policies, such as the age of introduction of complementary foods, and stops specific cases of malpractice if these gain sufficient exposure, Nestlé continues systematically to violate the International Code. It remains the target of the world's largest international consumer boycott, which, in this second round, has been launched by groups in twenty countries. An independent survey by GMI

found in 2005 that Nestlé is one of the four most boycotted companies on the planet (GMI Poll 2005).

Official statements from Nestlé claim that the company abides by the International Code, but only in 'developing nations'. This itself is a violation of the International Code, because, as the name suggests, it is a *global* standard and companies are called on to ensure their practices comply in every country, not just those of Nestlé's choosing.

Nestlé has also fought hard to prevent countries enshrining the International Code in legislation. For instance in 1995, the company filed a Writ Petition with the government of India that challenged the validity of proposed laws implementing the International Code. Nestlé claimed that a law implementing the International Code would restrict its marketing rights and would be unconstitutional. Nestlé battled hard in the courts to stop the Code's legislation in India, but fortunately failed to do so, and India has since passed exemplary laws, which enshrine the Code in national legislation.

2 *Commercial pressure: the case of the Philippines*

Despite the incorporation of almost all of the provisions of the International Code into domestic law in 1981, formula advertising has run rampant in the Philippines over the past two and a half decades. Advertisements on Filipino television claim that formula makes babies smarter and happier and company representatives are sent into the country's poorest slums to promote formula directly to mothers. As a result of these aggressive marketing tactics, the Philippines has some of the lowest recorded breastfeeding rates in the world. Only 16 per cent of Filipino children are breastfed exclusively at four to five months of age, and each year it's estimated that 16,000 infants die from inappropriate feeding practices (Jones et al. 2003). The Department of Health estimates that at least $500 million is spent annually on imported formula milk and over $100 million is spent promoting these products (Nielsen 2006) – more than half the total annual Department of Health budget – and where 40 per cent of the population live on less than $2 a day. To combat this national health disaster, in May 2006 the Department of Health (DOH) drafted the Revised Implementing Rules and Regulations (RIRR), which updated the 1981 law and sought to ban formula advertising altogether.

Almost immediately the formula industry fought back, using the powerful US-based Chamber of Commerce, claiming that the RIRR would illegally restrict their right to do business. In 2006, the Pharmaceutical and Health Care Association of the Philippines (PHAP), representing three US formula companies (Abbott Ross, Mead Johnson and Wyeth), Gerber (now

owned by Swiss Novartis) and other international pharmaceuticals giants, took the Filipino government to court. In July 2006, the Supreme Court declined PHAP's application for a temporary restraining order to stop the RIRR from coming into effect.

Three weeks later, in a leaked letter dated 11 August 2006, the president of the US Chamber of Commerce, Mr Thomas Donohue, warned President Arroyo of 'the risk to the reputation of the Philippines as a stable and viable destination for investment' if she did not re-examine her decision to place marketing restrictions on pharmaceuticals and formula companies and restrict the promotion of infant foods. Within a month, on 15 August, four days after the letter from the American Chamber of Commerce was received, the Supreme Court overturned its own decision by granting a temporary restraining order in favour of PHAP.

However, following an international support campaign coordinated by IBFAN and the Save Babies Coalition, in October 2007 the Supreme Court lifted the restraining order and upheld the following provisions and principles:

- The scope of the laws should cover products for older children, not just infants up twelve months.
- The right of the Department of Health to issue regulations governing formula advertising.
- The need for formula labels to carry a statement affirming there is no substitute for breastmilk, and for powdered formula labels to carry a warning indicating the product may contain pathogenic microorganisms.
- Company information targeting mothers may not to be distributed through the health-care system.
- The necessity for the independence of infant feeding research from baby milk companies.
- Companies cannot be involved in formulating health policy.
- A prohibition on donations (of covered products) and the requirement of a permit from the DOH for donations of non-covered products from companies.

The Court also ruled that the marketing of formula must be

> objective and should not equate or make the product appear to be as good or equal to … or undermine breastmilk or breastfeeding. The 'total effect' should not directly or indirectly suggest that buying their product would produce better individuals, or result in greater love, intelligence, ability, harmony or in any manner bring better health to the baby or other such exaggerated and unsubstantiated claim. (Supreme Court of the Philippines 2007)

While the Court decided not to uphold the outright ban on advertising called for by the health advocates, the committee overseeing the advertising is empowered to curtail the vast majority of it, and the enormous publicity generated by the case has hopefully helped to promote breastfeeding among Filipino mothers.

The campaign now moves to the next stage to close a loophole in the primary legislation to ban advertising completely.

3 *India's legislation on infant-milk substitutes*

The history of the battle against bottle feeding in India dates back to the 1970s when multinational companies promoted infant foods through advertisements and aggressive marketing.

In 1981, Indian prime minister Indira Gandhi made a stirring speech at the WHA in support of the International Code. Many member states agreed to invigorate a suitable national legal framework for implementation of the Code. In 1983, the Indian government launched the 'Indian National Code for Protection and Promotion of Breastfeeding'. Meanwhile several individuals and organisations like Voluntary Health Association of India (VHAI) led national advocacy initiatives with parliamentarians to enact legislation for the protection of breastfeeding.

However, due to the lobbying of baby-food companies, it took eleven years for comprehensive legislation on infant-milk substitutes to be formulated. The Infant-milk substitutes, Feeding Bottles and Infant Foods (IMS) Act came into force in August 1993. With this, India became the tenth country to pass such legislation.

However, having passed this law, India found that it was not fully equipped to implement it and curb the unlawful marketing of the milk companies. In addition there were some ambiguities in the law about the difference in the terms 'infant-milk substitutes' and 'infant food'. There were also some gaps relating to the exemption of doctors and medical researchers from the prohibition of 'financial inducements' to health workers.

The Breastfeeding Promotion Network of India (BPNI) and Association for Consumer Action on Safety and Health (ACASH) have been instrumental in exposing the unlawful practices of baby-food manufacturing companies and in pointing out loopholes that existed in the national legislation. In 1994 and 1995 the Government of India issued a notification in the *Gazette of India* to authorise BPNI and ACASH and two other national semi-government organisations to monitor the compliance with the IMS Act and empowered them to initiate legal action. For nearly eight years, effective implementation of the IMS Act has been poor, with infant-food advertisements appearing on soap wrappers, tins of talcum powder and

other unrelated products. 'I love you Cerelac' posters were widely displayed in the streets and markets; mandatory warnings were not being printed; feeding bottles were given as 'free gifts'; and government-led media also aired commercials of 'Cerelac' and nearly all television channels broadcast commercials for baby foods. The hold of the baby-food manufacturers on the health system grew. Free samples of baby food were given to doctors for 'testing'. Nestlé offered international fellowships to paediatricians and sponsored meetings and seminars. Likewise, Heinz announced sponsorship for research in nutrition.

In 1994, ACASH took Nestlé to court for advertising the use of formula *during* the 'fourth' month when the IMS Act stated that infant foods could only be introduced *after* the fourth month. In 1995, the court took cognisance of offence and admitted the case against Nestlé to face trial, saying that there is sufficient matter on record to proceed with criminal proceedings for violating the IMS Act. Nestlé has been trying since then to find some means to challenge the basic allegation. However, no higher court has so far granted an injunction.

Nestlé has since challenged the validity of the IMS Act in a petition filed in the High Court. Final decisions on this case are still awaited. Apart from Nestlé, two other companies were also taken to court for violating the IMS Act. Johnson & Johnson was the first, which faced two cases for selling feeding bottles on discount, and for the advertising of feeding bottles and promotion of a 'colic-free nipple' (teat). The company has since voluntarily agreed to withdraw completely from the feeding bottle market in India and stopped its manufacturing in late 1996, finally withdrawing completely in March 1997.

Wockhardt, an Indian manufacturer of pharmaceuticals and infant formula, was also taken to court by ACASH due to violations of the labelling requirements similar to those committed by Nestlé. Wockhardt apologised through an affidavit in the Magistrate's Court, undertook to follow the rules, and volunteered to stop using the name of its formula for other paediatric products, such as vitamin drops, which were being used for surrogate advertising of formula.

Acting on BPNI's advice, the Information and Broadcasting Ministry amended the Cable Television Networks Regulation Amendment Act 2000 and its Rules that banned direct or indirect promotion of infant-milk substitutes, feeding bottles and infant foods. Overnight, advertisements on baby food and infant-milk substitutes disappeared from Indian television channels. The action taken by this ministry was a significant victory for breastfeeding advocates and a lesson that other countries could draw on.

Based on their earlier experience, the continued violations by baby-food manufacturers, and the new World Health Assembly (WHA) resolutions, in 1994, BPNI and ACASH approached the government to amend the IMS Act in order to improve the regulation of the marketing of baby foods. The Ministry of Human Resource Development constituted a national task force consisting of experts from various ministries and departments of government as well as voluntary agencies to look into this and suggest amendments. Many meetings of this task force took place.

Workshops to sensitise the media and political leaders were organised. Finally, in 1998, the task force recommended amendments to the 1992 law. However, multinationals succeeded in ensuring that the process was stalled. With the continued efforts of the civil society groups, in March 2002 the bill was taken back to the lower house of parliament before finally being passed in both houses of parliament in May 2003 – some fourteen months after the process began.

The new law now prohibits the following:

- Promotion of all kinds of foods for babies under the age of 2 years.
- Promotion of infant-milk substitutes, infant foods or feeding bottles in any manner including advertising, distribution of samples, donations, using educational material and offering any kind of benefits to any person.
- All forms of advertising including electronic transmission by audio or visual transmission for infant-milk substitutes, infant foods or feeding bottles.
- Promotion of infant-milk substitutes, infant foods or feeding bottles by a pharmacy, drug store or chemist shop.
- Use of pictures of infants or mothers on the labels of infant-milk substitutes or infant foods.
- Funding of 'health workers' or an association' of health workers for seminars, meetings, conferences, educational courses, contests, fellowships, research work or sponsorship.

Despite legislative provisions, Nestlé and other companies have not been thwarted. Under the guise of its Nestlé Nutrition Services, Nestlé continues to sponsor doctors' meetings, and many new strategies are being used to push the company's products.

In 2005, the IMS Act as amended in 2003 was under threat. A campaign to save the Act involving both governmental and civil society organisations, with support from the media, was successful.

The Indian experience demonstrates how the sustained advocacy and action by civil society groups can influence public opinion and decision-

makers. Forging links and working with people's representatives in political parties in order to focus their attention on issues that affect their constituencies is also crucial. Campaigns and activist initiatives are doomed to fail if the political will to address a situation does not exist.

India has yet to see the impact of the IMS Act on child malnutrition. However, merely a change in legislation is insufficient. Efforts must now focus on increasing breastfeeding rates in the country.

References

Cesar, J.A., et al. (1999). Impact of breastfeeding on admission for pneumonia during postneonatal period in Brazil: Nested case-controlled study. *BMJ* 318: 1316–20.

Estavillo, M. (2006). Pharmaceutical firms protest looming ban on infant milk ads. *Business World*, 14 July.

GMI Poll (2005). More than a third of all consumers boycott at least one brand. Press release, 29 August. www.gmi-mr.com/gmipoll/release.php?p=20050829.

Guise, J.M., et al. (2005). Review of case-controlled studies related to breastfeeding and reduced risk of childhood leukemia. *Paediatrics* 116: 724–31.

IBFAN (International Baby Food Action Network) (2006). State of the code by country. Penang.

IBFAN (2007). Breaking the rules, stretching the rules. International Code Documentation Centre. Penang.

Iliff, P.J., et al. (2005). Early exclusive breastfeeding reduces the risk of postnatal HIV-1 transmission and increases IV-free survival. *AIDS* 19: 699–708.

Jones, G., et al. (2003). How many child deaths can we prevent this year? *The Lancet* 362, 5 July: 65–71.

Malcove, H., et al. (2005). Absence of breast-feeding is associated with the risk of type 1 diabetes: A case-control study in a population with rapidly increasing incidence. *Eur J Pediatr* 165: 114–19.

Supreme Court of the Philippines (2007). *Pharmaceutical and Health Care Association of the Philippines* vs *Health Secretary Franciso Duque III*. Supreme Court decision, 9 October.

UNICEF (1997). Baby milk action. Press release, 14 January. www.babymilkaction.org/resources/yqsanswered/yqacode.html.

UNICEF (2008). Breastfeeding and complementary feeding. www.childinfo.org/eddb/brfeed/index.htm.

Victora, C.G., et al. (1989). Infant feeding and deaths due to diarrhea: A case-controlled study. *Amer J Epidemiol* 129: 1032–41.

WABA (World Alliance for Breastfeeding Action) (2006). Gender, child survival and HIV/AIDS: From evidence to policy. Joint Statement from the conference at York University, Toronto. www.waba.org.my/hiv/conference2006.html.

Weyerman, M., et al. (2006). Duration of breastfeeding and risk of overweight in childhood: A prospective birth cohort study from Germany. *Int J Obes*, 28 February.

WHO (1981). International code of marketing of breastmilk substitutes. Geneva.

WHO (2001). WHA Resolution 54.2: Infant and young child nutrition. May. Geneva. http://ftp.who.int/gb/archive/pdf_files/WHA54/ea54r2.pdf.

D3.2 Tobacco control: moving governments from inaction to action

The ability of the tobacco industry to stay healthy while its customers get sick is one of the more amazing feats of the last century. In the fifty years since it was first established that cigarette smoking causes lung cancer, worldwide tobacco use has increased. Addiction, corporate power, government indifference and poorly informed consumers are among the factors responsible for the spread of the tobacco epidemic.

Every effort to regulate the industry has been met with an equal or greater effort to evade regulation. The industry has delayed, diluted or derailed tobacco control efforts in country after country. Rival companies have coordinated their efforts in opposing legislation, so that the same tactics, arguments and hired consultants have appeared in places as far flung as Canada, Hong Kong, South Africa and Sri Lanka (Saloojee and Dagli 2002).

The global strategy of the tobacco industry has elicited a global public health response. In May 2003, the World Health Assembly (WHA) adopted its first ever treaty – the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The Convention reflects agreement among WHO member states on a set of international minimum standards for the regulation of tobacco use and the tobacco trade. Its basic aim is to stimulate governments worldwide to adopt effective national tobacco control policies. Another aim is to promote collective action in dealing with cross-border issues like the illicit trade in tobacco, Internet sales and advertising.

The WHO sees the Convention as a major weapon in its counterattack against a problem that, if left unchecked, will kill 450 million people in the next fifty years. With 70 per cent of future deaths likely to occur in lower-income countries, the treaty is particularly important for these nations.

TABLE D3.2.1 **An outline of tobacco industry tactics**

Tactic	Goal
Intelligence gathering	Monitor opponents and social trends to anticipate future challenges.
Public relations	To mould public opinion using the media to promote pro-industry positions.
Political funding	Use campaign contributions to win votes and legislative favours from politicians.
Lobbying	Cut deals and influence political process.
Consultancy programme	To produce 'independent' experts critical of tobacco control measures.
Smokers' rights groups	Create impression of spontaneous, grassroots public support.
Creating alliances	Mobilise farmers, retailers and advertising agencies to influence legislation.
Intimidation	Use legal and economic power to harrass and frighten opponents.
Philanthropy	Buy friends and social respectability – from arts, sports and cultural groups.
Litigation	Challenge laws.
Bribery	Corrupt political systems; allow industry to bypass laws.
Smuggling	Undermine tobacco excise tax policies and increase profits.
International treaties	Use trade agreements to force entry into closed markets.

The WHO FCTC has become one of the most widely embraced treaties in the history of the United Nations. By January 2008, 152 parties had ratified the Convention, representing more than 80 per cent of the world's population. This chapter looks at the background to the treaty and its potential role in halting and reversing the tobacco epidemic.

Non-mandatory WHA resolutions

The WHO has long tried to get states to control tobacco. Since 1970, the WHA has adopted twenty resolutions on tobacco and repeatedly called upon member states to take action, but outcomes have been far from optimal. By 2000, about ninety-five countries had legislation regulating tobacco but most states had weak laws. Bans on sales to minors, vague health warnings on tobacco packs, or restrictions on smoking in health

facilities are measures commonly adopted. For the most part, such laws are inconsequential, neither seriously threatening the market for, nor affectng the profitability of, tobacco. On the other hand, a handful of countries with comprehensive policies did succeed in reducing tobacco consumption rapidly and significantly.

It is against this background that the WHO changed tack in 1996 by electing to use its treaty-making powers to regulate tobacco. International conventions to reduce marine pollution or to protect the ozone layer had helped states overcome powerful, organised industry resistance to regulation. Such successful environmental pacts served as precedents for the FCTC (Taylor and Roemer 1996).

The negotiations

Formal negotiations on the FCTC commenced in October 2000. The talks were arduous and highly political. An effective treaty could have quickly and readily emerged, if the talks were simply guided by the scientific evidence. Instead, it was clear early on that WHO member states had conflicting interests and obtaining agreement would be difficult. Countries that were host to the major tobacco transnationals argued for optional rather than mandatory obligations, which would significantly weaken the treaty (Assunta and Chapman 2006). As the treaty was to be finalised by consensus, the challenge for health advocates was to find the highest common denominator – to devise a treaty with meaningful policy measures that would also win wide support.

African, Southeast Asian, Caribbean and Pacific Island countries emerged as the champions of a robust treaty that incorporated international best practice. It is these countries that will bear the future brunt of the epidemic and thus it is appropriate that the FCTC reflect their needs.

Some of the keenest debates were on issues like a tobacco advertising ban and on trade. The United States, Germany and Japan opposed a total ban on tobacco advertising and promotion, arguing that it would not be permitted by their respective constitutions. Early drafts of the treaty only prohibited advertising aimed at youth. The majority of countries rejected this proposal as unworkable and ineffective.

This issue was resolved in the final hours of the negotiations, when a compromise championed by the NGO community was accepted. Tobacco advertising and promotion were banned but with a narrow exemption for countries with constitutional constraints. These states were required to take the strongest measures available, short of a total ban.

The final treaty contains significant recommendations on demand,

supply and harm-reduction strategies. Among its many measures, the treaty requires countries to increase tobacco taxes; establish clean indoor air controls; impose restrictions on tobacco advertising, sponsorship and promotion; establish new packaging and labelling rules for tobacco products; and strengthen legislation to clamp down on tobacco smuggling (WHO 2003). Mechanisms for scientific and technical cooperation, the exchange of information and reporting were also included.

Making the FCTC work

Experience with other treaties demonstrates that the dynamics of negotiation, peer pressure, creating a commonality of purpose, global standard setting and establishing institutional mechanisms all contribute to effective implementation of treaties.

The FCTC negotiations raised the profile of tobacco control among governments to a level never seen before. States that had previously ignored the issue were exposed to the scientific evidence on the health and economics of tobacco control, other countries' experiences and counter-arguments to the industry's positions on core issues. They actively debated options and agreed the content of the treaty. This generated new understandings, greater political commitment and shifts in behaviour.

The negotiations also galvanised non-governmental organisations (NGOs). Truly global NGO coalitions – the Framework Convention Alliance and the Network for Accountability of Tobacco Transnationals – emerged incorporating health, consumer, environmental and legal groups from North and South. The NGOs provided technical support, supplied detailed analyses of the draft texts and advocated key policy positions. They also played a watchdog role, by naming and shaming, or praising delegations.

To ensure that the momentum is maintained, an intergovernmental body, the Conference of the Parties (COP), is responsible for overseeing the Convention. The COP will take decisions in technical, procedural and financial matters relating to the implementation of the treaty, such as the funding and financial support and monitoring and reporting on implementation progress, and the possible elaboration of protocols, among others.

The impact of the FCTC

In international law, states are the most important actors. It is they who have to translate a treaty into national laws and develop enforcement mechanisms. International treaties provide blueprints for action, but it is

not until lawmakers get busy putting decisions into practice at home that lives will be saved.

Public monitoring of compliance with the treaty can provide a powerful incentive for countries to act. As President Mbeki of South Africa noted: 'No head of state will go to the UN and say he or she is for global warming or against the landmine treaty. However, upon returning home from New York or Geneva, under the everyday pressures of government they are likely to forget their treaty commitments.' President Mbeki suggested that it was the task of NGOs to hold governments accountable for their international obligations, so as to make a treaty a reality on the ground.

Already, several states have used the Convention as an umbrella either to introduce new legislation or to revise current laws to bring them into line with the treaty. In 2004, Ireland made history as the first country to implement a total smoking ban in indoor workplaces, including restaurants and pubs. The policy has been remarkably successful, and started a global rush to introduce comprehensive bans on indoor smoking by, among others: England, Estonia, France, Iran, Italy, Montenegro, the Netherlands, New Zealand, Norway, Scotland, Spain, Sweden and Venezuela.

In 2000, Canada became the first country to require picture-based health warnings on tobacco packaging. Countries that have since developed picture-based warnings include: Australia, Belgium, Brazil, Chile, Canada, Hong Kong, India, Jordan, New Zealand, Romania, Singapore, Switzerland, Thailand, the United Kingdom, Uruguay and Venezuela.

Other examples of legislative action in various countries include:

- In 2004, Bhutan banned the sale of tobacco products throughout the Himalayan kingdom. The predominantly Buddhist nation is the first country in the world to impose such a ban.
- Brazil has introduced anti-smuggling measures, including a mechanism for 'tracking and tracing' tobacco products.
- In Cuba, smoking was banned on public transport, in shops and other closed spaces from 7 February 2005. Cuban leader Fidel Castro kicked the habit in 1986 for health reasons.
- France raised the price of cigarettes by 20 per cent in October 2003, provoking a tobacconists' strike.
- India has banned direct and indirect advertising of tobacco products and the sale of cigarettes to children. The law originally included a ban on smoking in Bollywood films.
- In Kenya, a new Tobacco Act was passed in 2007. Among its provisions are a tax increase on tobacco and a ban on smoking in churches, schools, bars, restaurants and sports stadiums.

- South Africa is set to become the first country in the world to have a national ban on smoking in cars when children are present. The country is also set to join New York State and Canada in introducing self-extinguishing cigarettes to reduce the fire risks from tobacco smoking.
- In July 2003, Tanzania banned the selling of tobacco to under 18s and advertising on radio and television and in newspapers. Public transport, schools and hospitals were declared smoke-free zones.

A major challenge in implementing the Convention is that nations will interpret the treaty in different ways. The treaty establishes a set of minimum standards, while encouraging countries to go beyond these. Further, some treaty articles are mandatory and others are discretionary. There is therefore a danger that not all countries will adopt comprehensive tobacco control laws based on best practice, but that a diversity of laws will emerge providing uneven protection for the citizens of different countries and creating potential loopholes that the industry can exploit.

Recognising this problem, the COP will provide guidelines to support countries in drafting more stringent laws. The second meeting of the COP, held in Bangkok in July 2007, adopted guidelines for development of smoke-free legislation. The guidelines recommend the complete elimination of smoking in all indoor public places and workplaces within five years. In addition agreement was also reached to:

- begin work on a protocol to address tobacco smuggling;
- develop guidelines for eliminating tobacco advertising and sponsorship or, where this is not constitutionally permissible, regulating advertising;
- develop guidelines for cigarette warning labels;
- begin work towards guidelines on monitoring the tobacco industry, public education, and helping tobacco users quit;
- to continue initial work on tobacco product testing standards and economically viable alternatives to tobacco growing.

To help countries comply with their legal obligations the Convention includes mechanisms to share information, technology, training, technical advice and assistance. Many lower-income countries had hoped for a global fund to support them in implementing the FCTC, but after intense negotiations the donor countries resisted this idea and instead opted for a bilateral approach to funding. This is less than satisfactory from a developing-country perspective. The European Union (EU), for instance, will fund tobacco control as part of development aid. However, few lower-income countries consider tobacco to be a developmental problem, and not a single country has asked the EU to support its tobacco control programmes as

part of its development agenda. Unless donors specifically earmark funds for tobacco control activities, the latter will remain a poor cousin of other developmental aid programmes.

Conclusion

Tobacco control involves both politics and science, and until recently science has taken a back seat to politics. The FCTC promotes evidence-based measures to control tobacco. Massive challenges still lie ahead in delivering on the promise of the FCTC, but it is safe to assume that business will not get any easier for the tobacco industry.

References

Assunta, M., and S. Chapman (2006). Health treaty dilution: A case study of Japan's influence on the language of the WHO Framework Convention on Tobacco Control. *J Epidemiol Community Health* 60: 751–6.

Saloojee, Y., and E. Dagli (2002). Tobacco industry tactics for resisting public policy on health. *Bulletin of the World Health Organization* 80: 902–10.

Taylor, A.L., and R. Roemer (1996). An international strategy for global tobacco control. WHO Doc. PSA/96.6. Geneva: WHO.

WHO (2003). WHO framework convention on tobacco control. A56/8. Geneva. www.who.int/gb/EB_WHA/PDF/WHA56/ea568.pdf.