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Tobacco or Health: Status in the Americas

Introduction

The Pan American Health Organization recently published *Tobacco or Health: Status in the Americas*[1]. The document is comprised of individual reports on smoking and health for nations, territories, and other political entities in the Region of the Americas. The purpose of this Report was to compile available information on tobacco use, tobacco related disease, and tobacco-use prevention and control efforts for each of these political entities as of late 1990.

The Region of the Americas is heterogeneous with respect to tobacco use, tobacco economics, tobacco-related disease impact, and tobacco control measures. However, several common themes emerge from the individual country reports. Although these common themes are covered in more detail in the 1992 Report of the Surgeon General on Tobacco and Health in the Americas *(1)*, some of them are summarized below.

Sociodemographic Changes

Several important sociodemographic changes are noted in each country, especially for the more developed ones. These include decreases in all-cause mortality rates, infant mortality rates, and fertility rates, as well as increases in life expectancy at birth and aging of the population. These changes result from general improvement of health conditions, control of infectious diseases, and progress against maternal and child health problems. They facilitate the emergence of chronic diseases as the dominant cause of disease, disability, and death in most countries of the Americas. In addition, urbanization, increased literacy, and the entry of women into the work force have facilitated the adoption of consumer patterns more akin to those in developed countries; these patterns include among others increased tobacco use. However, most countries, especially those in Central and South America, report severe economic crises in the late 1980s that may be associated with decreases in per capita consumption of manufactured cigarettes. It is clear that higher prices have reduced demand among smokers in South America and the Caribbean. In fact, the effects of increased prices on decreased consumption have been cited as the basis for including increased tobacco taxes as health policy in the Third World *(2)*.

The Tobacco Industry

It is clear that the multinational tobacco companies have established market dominance in most countries of the Americas and that recent sociodemographic changes in these countries have facilitated the expansion of markets for manufactured cigarettes. Prior to the widespread diffusion and adoption of manufactured cigarettes made with blond tobacco (for example, Virginia blend, bright tobacco, light tobacco, *tabaco rubio)*, the consumption of dark tobacco (for example, black tobacco, *tabaco negro)*, was dominant in the Americas. In most countries, particularly in South America, dark tobacco consumption is decreasing and that of blond tobacco is increasing. Cigarettes containing blond tobacco now dominate most markets in the Americas, and the marketing and advertising of manufactured cigarettes made with blond tobacco proliferated in the years of 1970s and 1980s.

Today, multinational tobacco companies saturate environments throughout the hemisphere with tobacco product advertising. In addition, tobacco companies use cultural and sports events, and even health care, to promote good will and product identification. Recently, some nations have moved to limit tobacco product advertising. Canada has banned all forms of advertising, but this ban is being challenged in the courts. Venezuela banned television advertising of tobacco products, but found it necessary to shut down television stations when indirect advertising (logo presentation without mentioning tobacco) was used by tobacco companies to subvert the intent of the regulation.

The economic impact of the tobacco industry in various countries ranges from negative, due to a negative balance of trade for tobacco products and goods used in tobacco production and manufacture, to substantial, for countries such as Brazil with major tobacco manufacturing and exporting industries. Most countries report minimal percentages of the agricultural and industrial work forces being involved in tobacco production and manufacturing. It is impossible to conduct cost-benefit analyses of tobacco use in countries of the Americas because the costs, in terms of health care for tobacco-related diseases, disability, premature mortality, lost productivity, and diversion of expenditures from other products, have not been examined fully.

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[1] *Tobacco or Health: Status in the Americas. A report of the Pan American Health Organization.* Washington, DC, PAHO Scientific Publication No. 536, 1992. ISBN 92 75 11536 2. Published also in Spanish (1992) under: *Tabaco o salud: Situación en las Américas. Un informe de la Organización Panamericana de la Salud.* OPS, Washington, DC(Publicación Científica 536) ISBN 92 75 31536 1.

Tobacco Use

Although PAHO sponsored a standardized survey of tobacco use and its determinants in eight cities of Latin America in 1971 *(3)*, few of such studies of adult and adolescent tobacco use are reported for the Americas outside of Canada and the United States. Most surveys cover individual cities, urban populations, or specific subgroups such as health department employees. Thus, few reported data are nationally representative or comparable. However, several general statements can be made regarding smoking in countries other than the United States and Canada. Smoking is more prevalent in urban as opposed to rural areas, is more common among groups in the upper socioeconomic level than among those with the least education and economic capability, and is decreasing somewhat among men but increasing substantially among women. In general, smokers in Latin America and the Caribbean smoke fewer cigarettes per day than do smokers in the United States and Canada. Cigarette consumption data reported by the United States Department of Agriculture *(4)* and other sources probably substantially underestimate true consumption because of unreported sales, illegal trade in cigarettes, and substantial duty-free sales (particularly in the Caribbean).

Few countries report nationally representative data on tobacco use among adolescents, and most surveys have been performed on school populations only. Tobacco use by adolescents is included on several drug use surveys by countries in Latin America and the Caribbean. In general, adolescents report low percentages of daily cigarette use. However, initiation and experimentation with cigarettes appear to be most common in the middle and late teenage years, just as in the United States and Canada.

In general, the few surveys that covered attitudes, beliefs, and knowledge about tobacco and its health effects in countries in the Americas other than Canada and the United States reported widespread knowledge of the health effects of smoking. However, a tolerance of smoking and a lack of concern for personal risk were also evident. For most countries of the Americas, smoking still appears to be socially acceptable.

Smoking and Health

Because of limitations in the quality of mortality data for many countries in Latin America and the Caribbean, trend analyses, proportionate mortality analyses, and smoking-attributable mortality calculations are difficult to interpret. When mortality data were adequate (such as in Uruguay and Canada), estimates of smoking-attributable mortality, that is the proportion of deaths preventable in the absence of smoking in a population, were found to be similar to those in the United States (where 20 percent of all deaths are attributable to smoking). Using cancer registry data, some countries or areas were able to demonstrate mortality rates increasing over time for lung and other cancers related to smoking. These patterns are typical of populations heavily exposed to tobacco during the previous 20 to 30 years.

Several countries reported lung cancer mortality rates for men and women aged 45 to 54 and 55 to 64. In these age groups, it is unlikely that anything but smoking caused lung cancer deaths. Thus, these data may help demonstrate the impact of smoking in populations where mortality reporting is incomplete or inaccurate. Most countries reporting such data show increasing lung cancer mortality rates for men but not for women.

Cardiovascular disease appears to be one of the most common causes of death in countries of the Americas. Much of this mortality is due to lifestyle factors such as smoking, but it is impossible to separate the effects of the various risk factors and improvements in medical management without longitudinal studies in defined populations. Nonetheless, past increases in cigarette use in the Americas contributed to the expression of these diseases in the 1980s, but to a lesser extent than to lung and other cancers. Mortality rates for cardiovascular disease are beginning to decrease in some Latin American countries and the Caribbean, as they have in the United States and Canada. The decline in cardiovascular disease mortality in the United States and Canada has been attributed to declines in smoking as well as to changes in other lifestyle related risk factors and to improvements in medical management *(5)*.

Smoking Prevention and Control Activities

For most countries of the Americas, tobacco use has not been assigned the same status as a public health problem as has the control of infectious diseases or maternal and child health problems. A few countries have established Government structures tor the control of tobacco use, but in general, these efforts have been poorly funded and staffed. In some cases, cigarette tax revenues have been used to fund research on or interventions against smoking. In many countries, NGOs such as medical associations, anticancer associations, and churches have provided leadership in policy, school-based education, and public information on tobacco-related issues. Specific evaluations of the effects of these programs have been rare, owing in part to the lack of data on tobacco use in targeted populations.

In general, most countries have in place a basic structure to assume a public health approach to tobacco prevention and control. Many have enacted laws designed to limit smoking in public places, tobacco product advertising, and access to tobacco by young persons. However, in general, compliance with these

laws is unsubstantiated. The very presence of these efforts to control tobacco use, whether educational or legislative, indicates a favorable environment for changing the current social norms that support smoking. Additional financial and personnel resources as well as improved data collection are essential to strengthen these efforts.

Summary and Recommendations

This Status Report has collected information from hundreds of individuals and documents that has never appeared before in a single publication. The process of data collection and collaboration by so many diverse agencies, Governments, and individuals has in itself served to increase the awareness that tobacco is one of the most important health issues in the Americas for the 1990s. In recent decades, the international public health community has focused most of its attention on communicable and childhood diseases, but it is clear from this Report that chronic noncommunicable diseases, especially those caused by smoking, will need to be addressed more aggressively by Governments and international health agencies.

This Report will serve as a baseline data source, particularly for Latin American and Caribbean nations as they address the complex issues involved in preventing and controlling tobacco use. Certainly the epidemic of lung cancer and other diseases caused by tobacco use that has been painfully evident in the United States and Canada does not need to be repeated throughout the hemisphere before primary prevention is enacted. Countries of the Americas can learn from each other, and they can join in combatting an industry that thrives on complacency and economic dependence.

Impressive progress against public health problems caused by infectious diseases and maternal and child health problems has been made in recent years in the Americas. However, these public health problems were never a source of profit for multinational corporations and governments, nor were they supported by extensive advertising expenditures and the promotion of social activities such as sports and cultural programs. It was relatively easy to identify these problems as harmful to national progress, personal well-being, and productivity. It is more difficult to identify tobacco use as a public health problem when positive images associated with smoking are common in television and radio advertising and on billboards, street signs, and kiosks throughout the hemisphere. Many governments, farmers, and retailers depend on taxes and profits from tobacco.

In several countries, individuals with the most education and income (including physicians), who are presumably the change agents for healthy lifestyles, smoke at higher rates than those in lower socioeconomic strata. The health consequences of smoking may not be as apparent in Latin America and the Caribbean because insufficient data are available to demonstrate the effects of smoking on the population's health. In addition, insufficient data are available to demonstrate changes in behaviors and attitudes necessary to diminish tobacco use. Finally, resources and personnel are not often assigned to the issue of tobacco and health, even when health indicators increasingly show the potential for substantial disease effects.

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

1. Data collection on behavior, attitudes, knowledge, and beliefs associated with tobacco use should be improved and standardized. These data should be published regularly and used to help support changes in public opinion and political action against tobacco use.

2. Data on mortality and morbidity should be improved, collected, and analyzed systematically in nations of the Americas to understand and communicate fully the current and future burden of smoking-related diseases. Without such data, policy makers and the public will not appreciate the public health burden of tobacco use.

3. Efforts to divert economic and human resources away from dependence on tobacco production and manufacture should be supported, even though short-term costs for this diversion may be appreciable.

4. Policies and legislation that prohibit smoking in public places, advertising and promotion of tobacco products, and access to tobacco by young persons should be strengthened and enforced. These actions serve to decrease the social acceptability of smoking and are essential to changing individual behavior.

5. Ad valorem taxes on cigarettes should be increased substantially and periodically as a means of decreasing consumption.

6. Public health agencies should increase monetary and personnel resources dedicated to the prevention and control of tobacco use. Increasing the stature of tobacco control efforts is essential to changing individual behavior and preventing chronic diseases associated with tobacco use.

References

(1) U.S. Department of Health and Human Services. *Smoking and Health in the Americas -- A Report of the*

Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; Publication DHHS (CDC) 92-8420, 1992.

(2) Warner, K.E. Tobacco taxation as health policy in the third world. *American Journal of Public Health* 80(5):529-530, 1990.

(3) Joly, D.J. *Encuesta sobre las características del hábito de fumar en América Latina.* Washington, DC: Pan American Health Organization, Pan American Sanitary Bureau, Scientific Publication 337, 1977.

(4) U.S. Department of Agriculture (Unpublished data). Washington, DC: Tobacco, Cotton, and Seeds Division, Foreign Agricultural Service, U.S. Department of Agriculture, April 1990.

(5) Rothenberg, R.B. and Koplan, J.P. Chronic disease in the 1990s. *Annual Review of Public Health 11:267-296, 1990.*

(Source: Summary prepared by Health Promotion Program, PAHO.)

Calendar of Courses and Meetings

International Course in Surveillance and Applied Epidemiology for HIV and AIDS

The Centers for Disease Control, United States Public Health Service is sponsoring the International Course in Surveillance and Applied Epidemiology for HIV and AIDS, to be held at the Center for Disease Control, in Atlanta, Georgia, USA, on 13 September through 1 October, 1993.

The purpose of this course is to develop basic skills in epidemiology, surveillance and the development of prevention strategies for HIV and AIDS. This course is designed for public health and medical officials from developing countries responsible for surveillance and epidemiologic assessment of HIV and AIDS.

The participants will train to understand the epidemiology of HIV and AIDS, and apply basic epidemiologic skills to organize and present scientific data; conduct surveillance of AIDS, including development and use of case definitions, establishment of a reporting system for notification of AIDS cases, and the analysis and interpretatrion of surveillance data; condut surveillance of HIV infection, including establishing a sentinel HIV surveillance system and the analysis and interpretation of surveillance data; carry out basic epidemiologic studies, including identification of risk factors and investigation of unusual episodes of infection and disease, and the monitoring and evaluations of surveillance and intervention programs; apply HIV and AIDS surveillance data in the development of prevention strategies. The course will be conducted in English. Working knowledge of English is necessary to enroll in the course.

All requests for application forms and communications concerning the course organization should be directed to: Yvonne Chrimes, Conference Planner, Pace Enterprises, 17 Executive Park Drive, Suite 200, Atlanta, Georgia, 30329, USA. Phone 404-633-8610, FAX 404-633-8745.

Thirteenth Scientific Meeting of the International Epidemiological Association

The International Epidemiological Association is conducting its Thirteenth Scientific Meeting of the International Epidemiological Association, in Sydney, Australia, from 26-29 September 1993.

The program is designed to bring participants up to date with the major international developments in epidemiology. The program will consist of plenary sessions on topics of major importance and interest delivered by speakers acknowledged to be experts in their field, and presentations to be selected by the Program Committee from submitted abstracts. The official language of the conference is English. All conference sessions will be conducted in that language without translation.

All enquiries and conference correspondence should be directed to: IEA Conference Secretariat, P.O. Box 746, Turramurra NSW, 2074, Australia. Telephone 612-449-1525, fax 612-488-7496.