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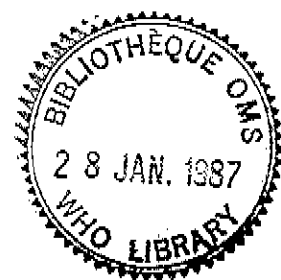
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Smoking cessation 1986

RECENT DEVELOPMENTS IN LEGISLATION TO COMBAT THE WORLD SMOKING EPIDEMIC

by

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President of the American Public Health Association



DIVISION OF NONCOMMUNICABLE DISEASES
SMOKING AND HEALTH PROGRAMME

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1. INTRODUCTION

In May 1986, the Thirty-ninth World Health Assembly adopted the strongest resolution to control the world smoking epidemic in the long history of WHO's fight against the smoking-related diseases and the harmful effects of tobacco.¹ The resolution calls for a global public health approach and action now to control cigarette smoking, responsible for about 90% of all cases of lung cancer, 75% of chronic bronchitis and emphysema, and 25% of cases of ischaemic heart disease in men under 65 years of age, as well as a number of other types of cancer, pregnancy complications, and respiratory diseases in children exposed to passive smoking.² Cigarette smoking is the major avoidable cause of ill health and premature mortality among adults in the world. The causal link between smoking and disease is incontrovertible, and evidence is growing that passive smoking or unavoidable inhalation of smoke-filled air has harmful effects on the health and wellbeing of nonsmokers.³ Affirming that tobacco smoking and use of tobacco in all its forms is incompatible with the attainment of health for all by the year 2000, the World Health Assembly urged Member States to adopt a number of essential measures in order to control the smoking epidemic. Nearly all these measures involve, in most countries, the use of legislation.

In the 16 years since WHO first launched its campaign against tobacco, its governing bodies adopted successively stronger resolutions in 1970, 1971, 1976, and 1978, which laid the groundwork and set the direction for WHO policy on smoking.⁴ The World Health Assembly resolution in 1980 led to the establishment of WHO's Programme on Smoking and Health.⁵ The 1986 resolution of the World Health Assembly, discussed above, calls on the Director-General, inter alia, to coordinate WHO's activities with those of other organizations in the United Nations system, with nongovernmental organizations, and, of course, with national smoking control efforts of Member States.

Three expert committees convened by WHO in 1974, 1979, and 1983 have made significant contributions to the evolution of WHO policy in this field.⁶ These expert committees have assessed the scientific evidence on the threat of smoking to world health and have recommended strategies for action, distilling the best thinking of experts from different disciplines and different countries.

A decade ago WHO published its first survey of anti-smoking legislation.⁷ In 1982, WHO published Legislative Action to Combat the World Smoking Epidemic, which analysed the smoking control legislation of 57 countries available up to and including 1981.⁸ Since that time approximately 15 countries are known to have enacted some form of smoking control legislation; several countries have strengthened their legislation, Argentina, Iceland, and Spain substantially and Belgium, Chile, Kenya, the Federal Republic of Germany, Portugal, Senegal, and Venezuela, to some extent; and many state and local governments have enacted legislation to control smoking in public places or the workplace.

This analysis sets out to update the world legislative picture on control of smoking. Using the same system of classification as was used in the earlier volume, we first summarize selected examples of legislation enacted before 1982, in order to provide perspective on each type of legislation. Then we turn to the recent laws and regulations, enacted in the period 1982-1986, inclusive. Annex 2 provides a tabular summary of national legislation available to WHO on 31 July 1986.

To aid countries considering the enactment of legislation, evidence evaluating the effect of legislative restrictions is reviewed as well as, where available, evidence on the effects of specific legislative interventions. Finally, some suggestions are offered on priorities for and approaches to legislative action.

This paper is a sequel to the author's Legislative Action to Combat the World Smoking Epidemic, published by WHO in 1982. It is partly based on a reference paper, "Legislative action to control smoking -- accomplishments and challenges", prepared for the International Workshop and Panel on Smoking and Health, International Congress on Alcoholism and Drug Dependence, Calgary, Alberta, Canada, 1-4 August 1985.

2. PURPOSES AND TYPES OF LEGISLATION

Legislation is a powerful tool for closing the gap between scientific knowledge about tobacco and social policy. The principal purposes of legislation in this field are:

(1) To set forth governmental policy on production, promotion, and use of tobacco. Legislation serves the established role of government to protect the public health and welfare.

(2) To encourage smokers to stop smoking and to dissuade potential smokers, particularly young people, from starting to smoke. Legislation can help high-priority groups to stop smoking — women (among whom lung cancer has now passed breast cancer as the leading cause of cancer deaths in 15 States in the United States), pregnant women whose smoking may harm the fetus, families with young children who are adversely affected by tobacco smoke, persons with certain medical problems, and workers exposed to industrial hazards. Preventing smoking by young people is particularly important because the earlier one begins to smoke the greater the risk.⁹

(3) To protect the right of nonsmokers to be free from enforced smoking and the right to breathe clean air. Nonsmokers have long considered tobacco smoke a public nuisance. Evidence of the danger to health of passive or enforced smoking is increasing.¹⁰

(4) To reduce to some extent the harmful substances in cigarettes. While no cigarette is a safe cigarette, legislation to regulate the maximum tar and nicotine contents of cigarettes is important in developed and in developing countries — where the assault of the tobacco industry has included marketing cigarettes with much higher levels of tar and nicotine than the same brands have in industrialized countries.¹¹

(5) To contribute to the development of a social climate in which smoking is unacceptable. It is widely recognized, the WHO Expert Committee on Smoking Control Strategies in Developing Countries said, that social acceptability will be the battleground on which the case for nonsmoking will be decided.¹²

(6) To provide the basis for allocating resources to support effective programmes to combat smoking. Legislation is necessary or helpful in establishing a national council on smoking and health, in authorizing funding for health education, in supporting smoking cessation programmes, in implementing restrictive measures, and in evaluating anti-smoking strategies.

Powerful evidence demonstrates the necessity for legislation if smoking and smoking-related diseases are to be reduced. One has only to compare Norway, which has strong legislation, with the United Kingdom, which still relies largely on a voluntary agreement with the industry, despite repeated pleas by influential bodies, notably the Royal College of Physicians of London, for legislative controls. Per capita tobacco consumption in Norway corresponds with the per capita United Kingdom consumption 30 years ago, and the United Kingdom lung cancer death rate for males aged 60-69 is more than three times that of the Norwegian.¹³ It is small wonder that the WHO Expert Committee on Smoking Control Strategies in Developing Countries concluded:

It may be tempting to try introducing smoking control programmes without a legislative component, in the hope that relatively inoffensive activity of this nature will placate those concerned with public health, while generating no real opposition from cigarette manufacturers. This approach, however, is not likely to succeed. A genuine broadly defined education programme, aimed at reducing smoking must be complemented by legislation and restrictive measures ...¹⁴

Legislation to control smoking may be grouped into two broad categories. One category concerns legislation to bring about changes in the production, manufacture, promotion, and sale of tobacco or what may be called the "supply" side of tobacco. The other category is designed to achieve changes in practices among smokers or what may be called the "demand" side

of tobacco. Within these two broad categories are more specific kinds of legislation. These must be examined because, as the WHO Expert Committee on Smoking Control Strategies in Developing Countries pointed out, the priority given to different kinds of legislation may vary from country to country, depending on local circumstances, legislative systems, and political realities. Accordingly, we analyse here 10 kinds of legislation — the first six on the supply or production side of tobacco and the remaining four on the demand or consumption side of tobacco.

3. THE PRODUCTION SIDE: CONTROL OF TOBACCO GROWING, MANUFACTURE, AND SALE

The laws in this category depend primarily on governmental policy, not on behavioural change in individuals. They contribute to a decline in smoking by freeing individuals from the pressure to smoke, by creating disincentives for smoking, and by fostering the development of a nonsmoking atmosphere. Legislation affecting the supply side of tobacco has the advantage of altering the external environment without the necessity for individual action, just as public health laws requiring purification of water supplies protect the environment and eliminate the need for each individual family to boil its own water.

3.1 Control of advertising and sales promotion

In 1980 the tobacco industry spent more than US\$ 2000 million worldwide to lure consumers to their products.¹⁵ These figures do not include the cost of indirect advertising through sponsorship of sports and cultural events by the tobacco companies. In Malaysia, the tobacco companies spent approximately \$5 million in 1977 to promote smoking.¹⁶ In Kenya, one company has conducted an intense advertising campaign in the rural areas by means of prominent and colourful billboard advertisements dominating the countryside.¹⁷ In the United States, the cigarette industry spends more than a billion dollars annually on advertising in newspapers, magazines, and on billboards, where it is the leading advertiser,¹⁸ and nearly a billion dollars in addition on nonadvertising promotional expenditures.^{18a}

The tobacco industry cynically contends that advertising is designed merely to affect choice of brand, not to recruit smokers. But the brazen advertising campaign directed at women, in whom the first signs of an epidemic of lung cancer have appeared in the United States, belies this contention and reflects the industry's use of advertising to maintain and extend smoking.¹⁹ The tobacco industry has stated publicly that women are the largest opportunity for the cigarette market.²⁰ In pursuit of this market, it advertises heavily in women's magazines (Good Housekeeping is the only woman's magazine in the United States that does not accept cigarette advertising) and plays on the theme of women's liberation with the slogan of one brand, "You've come a long way, baby". It is not surprising that women's magazines publish little on smoking and health, despite their extensive coverage of diet, exercise, and other aspects of health.²¹ Recent studies indicate that cigarette advertising and sponsorship of sports events by tobacco companies influence the knowledge and preferences of young people for heavily promoted cigarettes.²²

The industry also claims that advertising is necessary to promote low-tar and low-nicotine cigarettes. This is a specious contention in view of the findings that tobacco from low-yield cigarettes does not contain less nicotine than tobacco from higher-yield cigarettes and that smokers of low-yield cigarettes do not consume less nicotine than smokers of higher-yield cigarettes.²³ These findings led Claude Lenfant of the National Heart, Lung and Blood Institute at the National Institutes of Health in the United States to conclude that "despite the seductive advertisements, there is no less hazardous, safer cigarette".²⁴

Advertising of cigarettes is one of the strongest weapons of the industry in promoting smoking. It strikes a double blow at the public's health. First, it conveys the message that smoking is associated with success, pleasure, relaxation, sports, freedom, beauty in nature, sophistication, and sexuality. Second, the substantial revenues from tobacco advertising have a chilling effect on the editorial policies of newspapers and magazines that deters them from publishing articles on smoking and health.

The power and pervasiveness of cigarette advertising explain why legislation to control advertising is the leading kind of legislative control on smoking. In 1981, of 57 countries with legislation to control smoking, 45 had enacted controls on advertising.²⁵ By mid-1986, 10 additional countries had enacted legislation, and three countries, Portugal, Senegal, and Spain, had amended their laws to impose more stringent controls. Restrictions on advertising constitute the most common type of legislation to control smoking. Regulation of what Sir George Godber has termed "commercial promotion of anti-health"²⁶ may be of varying degrees of stringency. The legislation may provide for a total ban on advertising, for a strong partial ban, or for a moderate ban.

Total ban on advertising. Before 1982, 15 countries had enacted a total ban on advertising: Mozambique in Africa; Jordan in the Eastern Mediterranean Region; eight socialist countries of Eastern Europe, three Scandinavian countries (Finland, Iceland, and Norway), and Italy in the European Region; and Singapore in the Western Pacific Region.²⁷ By mid-1986, five additional countries and jurisdictions adopted total or fairly comprehensive bans on advertising: Algeria in the African Region, Sudan in the Eastern Mediterranean, and French Polynesia in the Western Pacific, while Portugal and Spain had replaced their moderate controls on advertising with a total prohibition. (The Spanish law, however, allows a two-year exemption for low-tar, low-nicotine cigarettes after their initial introduction on the market.) Thus 20 countries now prohibit all advertising of cigarettes.

The form of the recent laws enacted in the period 1982 to mid-1986 banning all advertising of cigarettes may be brief statements of prohibition or more detailed provisions. Algeria provides simply that the advertising of tobacco products is prohibited. Sudan prohibits advertising for cigarettes in the press, by radio or television, in cinema or theatre productions, by oral publicity, or any other means. This ban applies to advertising originating in Sudan or prepared for publication in the country. Spain enacted a transitional mechanism towards a total ban, providing that as soon as advertising commitments in effect at the time of the effective date of the law have terminated, and in any case within two years from the effective date of the new law, public communications media directly responsible to the State and other agencies under public law are to cease advertising intended to promote the use of tobacco. An exception is made in the case of new products with low tar and nicotine levels, as mentioned, for which advertising is allowed for two years following their introduction.

The total bans of Portugal and French Polynesia specify a further application of the ban on advertising. Portugal prohibits advertising for tobacco in the national advertising media and also by apposition of the name, brand, or symbol of a tobacco product to consumer goods which are not directly connected with the use of tobacco — a device commonly used to circumvent a restriction on advertising. French Polynesia prohibits all advertising and promotion of tobacco, tobacco products, and smokers' accessories in publications produced or printed in French Polynesia and also prohibits tobacco producers, manufacturers, importers, and dealers from sponsoring public meetings, entertainment, cultural, sporting, and charitable events.

Strong partial ban. Before 1982, 12 countries had enacted strong partial bans on advertising. One such country is Belgium, which in 1982 imposed further restrictions on tobacco advertising by limiting the contents of the advertising to the name and address of the manufacturer, importer, or distributor, the name of the product, its brand name and symbol, representations of products directly associated with smoking, tar and nicotine levels, and information on price and quality. The amount of space devoted to advertising of tobacco in newspapers and magazines is limited, and all advertisements must carry a health warning.

This category of legislation has grown only slowly. Since 1982, only Argentina, Bolivia, Gambia, Ireland, and Senegal have adopted such laws. The Argentinian Law (which was approved at the end of July 1986) lays down, *inter alia*, that tobacco advertising must not appear in publications addressed to minors, nor may such advertising be carried out in *salas de espectaculos* to which persons under 18 years of age are admitted. One interesting provision is contained in Section 2, which lays down that treatment or production processes that reduce the nicotine or tar content of tobacco products may not be presented as being beneficial or

conducive to health. The Bolivian statute requires advertisers to obtain a licence from the Ministry of Social Welfare and Public Health through its Health Education Bureau. It prohibits pictorial or theme advertising and restricts advertisements to a statement on the quality, origin, and purity of the product. Advertisements may not encourage use of tobacco on the grounds of stimulation, wellbeing, or health, or show persons inhaling or exhaling smoke, make use of adolescents, pregnant women, or children, or in any way be associated with sporting, domestic, or occupational activities.

In Ireland, the Tobacco Products (Control of Advertising, Sponsorship, and Sales Promotion) Regulations of 1986 restrict the places where tobacco advertising is permitted and the content of advertisements, and requires one of three rotated health warnings on advertisements and cigarette packages. Tobacco advertising is permitted only in newspapers, magazines, and similar publications; inside premises for retail sale of tobacco; and outside such premises where advertising existed on 31 October 1980. Tobacco advertisements are restricted to use of a plain background with one colour to prevent creating subliminal images and mental associations between tobacco and other desirable objects and activities. Tobacco companies are prohibited from sponsoring sports events in which the participants are mainly under 18 years of age, and the Regulations restrict the sponsorship of other sports events as well as the kind of advertising allowed for such events.²⁸

The Senegalese Law of 9 November 1981, as amended by a Law dated 25 February 1985, and an implementing Decree promulgated on 28 December 1985, impose stringent conditions governing the promotion and advertising of tobacco and tobacco products. It is laid down, in particular, that tobacco and tobacco products may not be promoted or advertised on television. Advertising announcements and messages for tobacco and tobacco products may not, irrespective of their form, employ the voice of or depict a person under 21 years of age. Films advertising tobacco or tobacco products may not be projected during programmes for young persons. Posters and objects advertising tobacco or tobacco derivatives may only be placed on localities and networks officially approved by the administrative authority and assigned, at the request of the latter, to approved advertising agencies. There are some significant differences between the Senegalese Law and the French Law of 1976 on which it is apparently based.²⁹

Two arguments have been offered in support of strong partial bans that prohibit pictorial or theme advertising of cigarettes. One contends that theme advertising does not interfere with commercial free speech, since it allows the tobacco companies to advertise the name and characteristics of their products. The other argument for banning pictorial or theme advertising is that such a strong partial ban eliminates a powerful influence on young people, whereas "tombstone advertisements", which would still be allowed, are of interest mainly to confirmed smokers. Both arguments are the refuge of those who doubt the political feasibility of enacting a total ban on tobacco advertising.

Moderate partial ban. Moderate partial bans on advertising existed in 16 countries before 1982. Since then five countries and jurisdictions, Argentina, Chile, Hong Kong, Lebanon, and Macao, have enacted moderate restrictions. Argentina, Chile, Macao, and Lebanon require a health warning on tobacco advertisements. An interesting restriction on advertising by a subnational unit of government is the action of the Canton of Vaud in Switzerland which authorizes the prohibition of advertising of tobacco products on the property of the state.

The 1982 law of Hong Kong provides that cigarette advertising in printed publications must carry the Government health warning and the tar group designation of the cigarettes (with certain exceptions if printed outside of Hong Kong). Advertisements on television and radio must conform to certain time and content restrictions specified by the Codes of Practice under the Television Ordinance. A bare two years after enactment of these provisions, the Government of Hong Kong has moved to consider a complete ban on tobacco advertising and in 1984 appointed a Broadcasting Review Board to make recommendations on future broadcasting policies.³⁰ Written submissions have been made to the Board, and public hearings have been held. The Tobacco Institute of Hong Kong, formed in 1983, has waged an aggressive campaign against a total ban. It claims that the principles of individual choice and individual responsibility for one's own actions are fundamental to any free society and that a cigarette

advertising ban could lead to future bans on freedom of speech and other civil liberties. In reply, the Hong Kong Consumer Council states that it is the responsibility of government to protect the health of its people. One physician in Hong Kong pleads for the freedom of children to grow up in a society without commercial pressures to smoke as a greater freedom than the freedom of a vested commercial interest to promote a product that kills one quarter of the people who use it.³¹

In connection with the hard-fought battle in Hong Kong to move from a moderate partial ban to a total ban on tobacco advertising, it should be reiterated that two countries with moderate partial bans, Portugal and Spain, have amended their laws to prohibit all advertising of tobacco.

As a conclusion to this discussion of legislation to control advertising and a prelude to a discussion of health warnings, one should note that the definition of the tobacco products covered by the legislation is important. If the term "tobacco products" is used rather than "cigarettes", it is broad enough to include cigars, cigarillos, pipe and cigarette tobacco, cigarette paper, and also smokeless tobacco or snuff. A recent development in the United States is the rise in the use of smokeless tobacco, particularly moist snuff. Tragic cases of deaths from oral cancer have been reported among users of smokeless tobacco who were unaware of its addictive properties and harmful effects.³²

In the United Kingdom, a Voluntary Agreement (involving the Health Ministers on behalf of the Government, and a major US manufacturer of smokeless tobacco) was signed on 26 February 1985. It contains a series of measures designed to limit the advertising and promotion of a particular brand of smokeless tobacco. Many of the measures are specifically directed to restricting promotional activities addressed to young people.

In Ireland, it has been reported that the Minister for Health and Social Welfare has prohibited the importation, sale, and advertising of certain smokeless tobacco products; these measures were taken in pursuance of Section 66 of the Health Act, 1947.³³

In 1986, the United States Congress passed legislation requiring health warnings on smokeless tobacco products and mandating an educational campaign.³⁴ One of the following warning notices must appear on the package: "WARNING: THIS PRODUCT MAY CAUSE MOUTH CANCER"; "WARNING: THIS PRODUCT MAY CAUSE GUM DISEASE AND TOOTH LOSS"; or "WARNING: THIS PRODUCT IS NOT A SAFE ALTERNATIVE FOR CIGARETTES". These warnings must likewise appear on advertisements for smokeless tobacco products (other than outdoor billboard advertising). This requirement for national warnings with respect to smokeless tobacco products resulted from the introduction in the legislatures of 35 States of bills requiring such warnings. Rather than comply with differing State requirements, the tobacco industry preferred to agree to uniform national warning labels on smokeless tobacco.

When the chief executive officer of a major US manufacturer of smokeless tobacco products was asked what would be the response of his company if health and regulatory pressures begin to "pinch" sales in the United States, he indicated that there would be a major focus on reorienting marketing strategies towards certain European and Asian markets.³⁵

To meet the growing epidemiological evidence on the carcinogenic effects of smokeless tobacco, legislative draftsmen may be well advised to adopt a broad definition of tobacco products that allows restrictions on advertising and requirements for health warnings to be imposed on smokeless tobacco without delay.

Experience with different types of legislation restricting advertising leads to several conclusions:

(1) Legislation is essential. Voluntary agreements with the industry, as in the United Kingdom and New Zealand, fail to restrict the promotion of cigarettes. In the United Kingdom, the industry's extensive sponsorship of sports and cultural events, and thus promotion of cigarettes, led the Royal College of Physicians of London in 1977 to issue an urgent call to substitute legislation for the voluntary agreement with the industry.³⁶ This call was repeated even more urgently in 1983.³⁷

(2) A total ban on advertising is unequivocal and more readily enforced than a partial ban. Even a strong partial ban is subject to evasion by the industry. In France the spirit of the 1976 Law was that advertising, to the extent allowed, should be informative only and should not promote consumption of tobacco. The tobacco companies, however, exploited loopholes in the law not only with respect to advertising in connection with motor-car racing, as mentioned, but also in connection with advertising in the press. One poster, purporting to be for cigarette lighters or matches, created an international confusion with brands of cigarettes by showing the images of the cigarettes on the lighters. In a lawsuit brought to stop this practice, the court held in June 1983, and was sustained on appeal in January 1984, that such advertising was a breach of the law because it conveyed to the viewer "at first sight" the well-known brand of cigarettes, and it is irrelevant that the word, "Lighters", appeared under the brand name, since

slight differences between the object, which is in fact a lighter, and a cigarette packet ... cannot be noticed 'at first sight' and, for their perception, require a person to stop and examine the poster, which the average observer does not do ...³⁸

Think of the time and money this lawsuit cost, time and money that could have been more advantageously spent in health education on smoking if the law had banned all advertising of tobacco and tobacco products. In fact, the Secretary-General of the National Anti-Smoking Committee of France, quoted above, states:

... the Law appears to be inadequate; it should be rendered more stringent, in particular by prohibiting in advertising the reproduction of anything other than the actual product. The Committee also urges that the exceptions permitted in the case of advertising at motor sports events should be abolished.

Similar evasions of bans on advertising have occurred in other countries. In Sudan, a billboard advertising lighters under the brand name of a cigarette was placed at the entrance of a training school for nurses in Omdurman. The billboard was subsequently removed.³⁹ In Norway, a series of advertisements for boots carrying the name of a well-known brand of cigarettes and resembling the advertisements for this brand of cigarettes was deemed to constitute an infringement of the ban on advertising contained in the relevant Law.⁴⁰

(3) Fortunately, the modern trend in many countries is towards enacting strong restrictions on advertising of tobacco. Significantly, several countries that first enacted moderate partial bans on advertising have replaced these restrictions with a total prohibition of all advertising of tobacco. In October 1984, the British Medical Association called for an end to all forms of tobacco advertising and promotion.⁴¹ In the United States, the American Medical Association passed a resolution in December 1985 calling for legislation prohibiting any form of media advertising of tobacco products.⁴²

3.2 Requirements for health warnings and statement of tar and nicotine contents

In 1982, 38 countries required a health warning on cigarette packages, and 12 countries required a statement of tar or nicotine contents or both. By mid-1986, 15 additional countries required health warnings, and 10 additional countries required a statement of harmful contents. Thus, 43 countries are currently known to require health warnings, while 21 countries require a statement of tar and nicotine contents.

The countries and jurisdictions that adopted requirements for a government health warning during the period from 1982 to mid-1986 are Algeria, Kenya, and Senegal in the African Region; Argentina and Uruguay in the Region of the Americas; Lebanon and Sudan in the Eastern Mediterranean; Denmark, Iceland, Portugal, and Spain in Europe; Hong Kong, Pakistan, and Macao in the South-East Asia Region; and French Polynesia in the Western Pacific.

Fewer countries require a statement of harmful contents. Those imposing this requirement in the period from 1982 to mid-1986 are Senegal in the African Region; Jordan and Kuwait in the Eastern Mediterranean Region; Norway, Portugal, and Spain in Europe; Hong Kong and Macao in the South-East Asia Region; and French Polynesia in the Western Pacific Region.

The most important development concerning health warnings is the recognition by six countries of the effectiveness of the Swedish system of alternative or rotating warnings. During the period under review, Finland, Iceland, Ireland, Norway, the United Kingdom, and the United States enacted requirements for multiple, rotating warnings on cigarette packages. These warnings contain strong, specific messages that capture the attention of the smoker, and they are changed periodically so as not to become hackneyed. As the Director-General of the Swedish National Smoking and Health Association has stated, the rotation system "evokes curiosity so that the notice is really read, not neglected".⁴³

Norway uses 12 rotating warnings that must appear on cigarette packages spread equally over time, geographic location, and brands. Regulations prescribe the way in which the symbol, warning, and declaration of contents must be displayed on the package. Examples of the Norwegian rotating warnings are:

Daily cigarette smoking is dangerous to health.
THE MORE YOU SMOKE, THE GREATER THE DANGER TO HEALTH.
The Directorate of Health Services

You who have been smoking for a long time:
IF YOU STOP SMOKING, YOU REDUCE THE RISK OF SERIOUS ILLNESS.
The Directorate of Health Services

You who are young:
THE EARLIER YOU BEGIN TO SMOKE, THE GREATER THE RISK.
The Directorate of Health Services

The eight Icelandic warnings strengthen their messages with effective depictions of the different parts of the human body affected by smoking.

The three rotating warnings required on cigarette packages and advertisements in Ireland are:

SMOKING CAUSES CANCER

SMOKERS DIE YOUNG

SMOKING KILLS!

For packages of pipe tobacco, cigars, and cigarillos, Ireland requires the warning SMOKING SERIOUSLY DAMAGES YOUR HEALTH. For packages of chewing tobacco, Ireland requires the warning THIS PRODUCT MAY CAUSE ORAL CANCER.

In the United Kingdom, a new voluntary agreement between the Government and the tobacco industry, which came into force on 1 April 1986, provides for the following six rotating warnings:

Smoking Can Cause Fatal Diseases

Smoking Can Cause Heart Disease

Smoking When Pregnant Can Injure Your Baby and Cause Premature Birth

Stopping Smoking Reduces the Risk of Serious Diseases

Smoking Can Cause Lung Cancer, Bronchitis and Other Chest Diseases

More than 30,000 People Die Each Year in the UK From Lung Cancer

In the United States, the long efforts of the Federal Trade Commission and one of its Commissioners, Michael Pertschuk, led finally to action by Congress to require four rotating warnings on cigarette packages and advertising. Effective 12 October 1985, the warnings are:

SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, and May Complicate Pregnancy.

SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health.

SURGEON GENERAL'S WARNING: Smoking by Pregnant Women May Result in Fetal Injury, Premature Birth, and Low Birth Weight.

SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.

In Australia, the Federal Minister for Health has announced that all Australian Health Ministers have agreed to a new system of health warnings for cigarettes and other tobacco products.⁴⁴ As of 1 July 1986, all packages of tobacco and advertisements were scheduled to carry one of the following four warnings:

SMOKING CAUSES LUNG CANCER AND HEART DISEASE.

SMOKING DAMAGES YOUR LUNGS.

SMOKING IS ADDICTIVE.

SMOKING KILLS.

Legislation providing for rotating health warnings is under active consideration in Canada.

While the evidence is growing that low-tar and low-nicotine cigarettes do not provide any protection for the smoker, labelling of harmful substances is nevertheless important for several reasons. It provides information to the smoker that is not otherwise available. This is needed in developing countries where cigarettes sold may yield much higher levels of tar and nicotine than cigarettes in industrialized countries.⁴⁵ Smoking low-tar cigarettes is sometimes a step towards cessation, for low-tar cigarettes may be less satisfying than cigarettes with high tar and nicotine contents.

Publicity of tar and nicotine contents has been criticized as lulling the public into a false sense of security and giving the industry an excuse for promoting smoking in its efforts to launch new low-tar brands. In their seminal book, Guidelines for Smoking Control, Gray and Daube point out, however, that governments can "ensure reduction of tar yields through legislation without publicity on 'safer smoking'".⁴⁶

Experience with health warnings and information on harmful substances on cigarette packages leads to several conclusions:

(1) Evaluations of the single warning "The Surgeon General has determined that cigarette smoking is harmful to health" and of the Swedish system of rotating warnings show the marked advantages of rotating warnings.⁴⁷ Seven countries are currently using rotating warnings.

(2) In the array of messages conveyed by health warnings, it is important to include a statement that tobacco is addictive. This explains the difficulty in stopping smoking.

(3) Where advertising is still allowed, health warnings should be required to be conspicuously displayed on all advertising.

(4) Legislation should require information on the contents of cigarettes on the cigarette package, including the levels of all harmful substances (tar and nicotine) and emissions (carbon monoxide). Labelling gives developing countries the opportunity to lower tar content by prohibiting the importation of unlabelled high-tar cigarettes.⁴⁸

(5) Where advertising is still allowed, a statement of tar, nicotine, and other harmful substances should be required on the advertisement. Moreover, no statement should "give any impression other than that all smoking is dangerous and should be avoided".⁴⁹

3.3 Control of harmful substances

In 1982 only two countries, Egypt and Finland, had enacted legislation setting maximum levels of noxious substances. Since then, Spain and Kuwait have enacted such legislation. In Hong Kong the Government Chemist is required to determine the tar group to which each brand of cigarettes belongs, and the Customs and Excise Service has authority to take samples of cigarettes for analysis by the Government Chemist. In the United Kingdom, measures to reduce the tar yield of cigarettes are being implemented under the terms of a Government-industry agreement published in April 1983.⁵⁰

An analysis by an Australian authority, Nigel Gray, has shed new light on the debate as to whether low-tar, low-nicotine cigarettes provide any protection for the smoker.⁵¹ Gray cites two recent studies showing that dose reduction by lowering tar or by lowering number of cigarettes smoked reduces relative risk, but not to the extent achieved by giving up smoking.⁵² According to Wald, Doll, and Copeland, some of the reduction in British cancer mortality may be attributed to the influence of low-tar cigarettes.⁵³ Gray concludes:

Although the desirable epidemiological comparisons can't be made I am firmly of the view that a market range of cigarettes between 5 and 15 mgs is considerably less noxious than one of 24-45 mgs. I further believe this should be our target. We are on the point of it in Australia, the Middle East, Egypt and Scandinavia. There is no valid reason for the continued sale of high-tar cigarettes anywhere. How to achieve this?⁵⁴

Gray states that there are three ways to achieve low-tar cigarettes: through legislation, through voluntary agreements with the industry, and through increasing the tax on high-tar cigarettes. The effectiveness of legislation is illustrated by Egypt, where the maximum level for tar was set by law at 20 mg. One year after the legislation was enacted five major brands of cigarettes had reduced their tar content to levels ranging from 15.5 mg to 17.9 mg.⁵⁵

Legislation has the advantage of enabling countries to achieve a progressive reduction in tar levels. In the United Kingdom, however, where an agreement with the industry (announced on 24 March 1986) regulates the promotion of tobacco, differential taxes have been used to promote low-tar cigarettes.

While Gray's well-reasoned analysis supports the need for achieving low-tar cigarettes, a cautionary note should be added. Any small reduction in lung cancer achieved by low-tar cigarettes does not affect mortality and morbidity from cardiovascular and respiratory disease associated with smoking. Light cigarettes may actually be more harmful than strong ones because they encourage smoking by women and children. No opportunity should be given to the tobacco industry to claim that low-tar cigarettes are approved or safe. They are neither.

Experience with control of harmful substances in cigarettes leads to several conclusions:

(1) Although the benefits of low-tar cigarettes do not compare with the benefits of stopping smoking, cigarettes with 5-15 mg of tar may be less harmful than those with 25-45 mg, but only if not smoked in larger numbers.

(2) Legislation to set maximum levels of tar and nicotine is feasible and enforceable. The law should authorize the government to set progressively lower maximum levels of harmful substances.

(3) The technical problems involved in the task of controlling harmful substances are considerably aided by a programme of the World Health Organization for cooperating with developing countries in testing cigarettes.⁵⁶

3.4 Restrictions on sales to adults

Restrictions on places where cigarettes may be sold make a strong statement to the public with respect to a product that has been more widely available than any other product. Such laws thus contribute to the creation of a nonsmoking environment.

Constraints on the sales of cigarettes are of two types. Prohibiting the sale of cigarettes in health institutions and government buildings expresses official policy of the government. Restricting or limiting the use of vending machines reduces the general availability of cigarettes and, most importantly, discourages sales to minors, as discussed below.

Only a few countries have enacted legislation of this type. Before 1982, only four countries had such legislation. Cyprus prohibits the use of cigarette-vending machines entirely. Finland, in order to protect young people, restricts the use of cigarette-vending machines to catering establishments where they are under constant supervision. In 1983, the State of Rio Grande do Sul in Brazil (which is reported to produce 70% of Brazil's tobacco) enacted legislation banning the sale of cigarettes in any establishment subsidized by the government, including the Legislative Assembly.

Experience with legislation restricting sales evokes the following conclusions:

(1) There can be no justification for allowing sales in a hospital or health institution of a product proven to be so harmful to health.

(2) Prohibiting sale of cigarettes in government buildings is feasible and has a strong educational impact.

(3) Where sales to minors are illegal, young people obtain cigarettes from vending machines. Therefore legislation to prohibit cigarette-vending machines is important to prevent smoking by young people.

3.5 Taxation and price policy

Taxation and price policy as part of an overall strategy to control smoking is increasingly recognized as crucial. The 1983 Expert Committee on Smoking Control Strategies

in Developing Countries recommended regular, well-publicized price increases to keep pace with inflation and to serve as a reminder to smokers and particularly to young people of the undesirability of smoking.⁵⁷

Research findings. Thompson and Forbes of the WHO Collaborating Centre for Reference on the Assessment of Smoking Habits, located in Waterloo, Ontario, in Canada, have analysed the uses of taxation in raising revenues, decreasing tobacco consumption, and helping to meet the costs of smoking.⁵⁸ Tobacco taxes are an attractive means of raising revenues because they are easily administered and politically acceptable.

Generally, tax increases have led to decreased consumption of cigarettes because the demand for cigarettes, as for most products, responds to changes in price. Price elasticity of demand for cigarettes is a measure of the responsiveness of cigarette demand to a change in price. Price elasticity is an estimate of the percentage change in consumption that will follow a 1% change in price, e.g. price elasticity of -0.5 means that a price increase of 10% will lead to a 5% decline in consumption.⁵⁹

A comparative analysis by Cox and Smith of the time required for a skilled manual worker to earn the price of 20 local brand cigarettes in 14 countries (1979) suggests, however, that the effectiveness of a pricing strategy is limited. In terms of reducing national consumption, they state, diminishing marginal returns may set in once tobacco becomes generally recognized as a relatively expensive item.⁶⁰ But by contrast, a price increase deters larger numbers of young people from taking up smoking and therefore has a beneficial effect over the long term.⁶¹

Warner's analysis of price elasticity of demand for cigarettes in the United States shows a price elasticity for adults of -0.42, meaning that a 10% increase in price produces a 4.2% decrease in consumption.⁶² For teenagers the price elasticity of demand is -1.4, meaning that a 10% increase in price produces a 14% decrease in consumption.⁶³ Warner calculated that if the 16 cent increase in Federal excise taxes on cigarettes imposed in 1983 had been reduced to eight cents (as had been initially proposed), two million people would have been induced to smoke and one million young people would join the ranks of the smokers.⁶⁴ Warner points out that this is not simply a theory. In 1983, when the Federal excise tax was raised in the United States, the consumption of tobacco decreased by 4%.

Research by Grossman confirms that an increase in the Federal excise tax is a potent policy to decrease smoking for the following reason. Teenagers are more responsive to changes in the price of cigarettes than adults, and price has a greater effect on smoking participation than on quantity of cigarettes smoked by smokers.⁶⁵ These studies present powerful evidence that increasing taxes on tobacco will have both fiscal and health benefits.

Experience in other countries confirms the beneficial effects of raising taxes on tobacco. In the United Kingdom, five successive tax increases from 1974 to 1978 were associated with a 9% reduction in cigarette sales and hastened the move away from high-tar cigarettes.⁶⁶ In 1981 the price of cigarettes was increased (although the increase was less than the rate of inflation) in Brazil, and consumption declined by 6%.⁶⁷

Among the countries that have increased taxes on cigarettes are Zaire, France, and Australia. In 1983, Zaire tripled its taxes on cigarettes (taxes had also been raised significantly in 1981 and 1982).⁶⁸ In 1983 also, France, which has had strong legislation to control smoking since 1977, enacted legislation establishing a levy on tobacco and alcoholic beverages, the proceeds of which accrue to the National Health Insurance Fund because of the health hazards entailed by even moderate use of these products.⁶⁹ In 1978, Venezuela fixed the cigarette tax at 45% of the selling price to the public and the tax on cigars and pipe tobacco at 30% of the selling price to the public.

In addition to general tax increases, differential taxation for cigarettes with different yields of tar discourages consumption of high-tar cigarettes. Between 1978 and 1981, cigarettes yielding more than 19 milligrams of tar were subject to a supplementary tax in the United Kingdom; within three months of its introduction, the market share of such cigarettes dropped from 15% to 3%.⁷⁰

From 1971 to 1975 New York City added a tar and nicotine tax to cigarettes with more than 17 mg of tar and 1.1 mg of nicotine. As a result, the sale of the specially taxed high-tar and nicotine brands declined by 12-13%, as smokers shifted to the exempt brands.⁷¹ The reasons for repeal of the tax are not clear, but they related perhaps to interstate smuggling of cigarettes and problems with vending machines and administration of the tax.⁷²

Still another type of fiscal provision is that pioneered in Finland, which requires that 0.5% of tobacco tax revenue must be allocated in the national budget for health education, research, and evaluation in smoking control.⁷³ Iceland in its 1984 Law provides that of the revenue from tobacco sales, 2% is to be spent on anti-smoking activities.⁷⁴ French Polynesia requires that not less than 1% of the revenue from tobacco taxes must be used for a health education campaign through the press, posters, etc.⁷⁵

One of the objections raised to increasing taxes on cigarettes and consequently their price is that higher taxes are regressive and impinge unfairly on the poor. While an overall tax system should be progressive, individual components may not need to be, particularly if they serve an important health purpose. Warner points out that, in the case of cigarette taxes, higher taxes may encourage more of the poor to quit because smokers who are poor are more responsive to changes in price than higher-income smokers. Moreover, many low-income smokers are teenagers who are only temporarily poor, and they are benefited by not starting to smoke.⁷⁶

Report from Finland. The most penetrating and comprehensive analysis of the effects of increasing the price of tobacco products comes from Finland, a country that pioneered multi-purpose anti-smoking legislation and banned all smoking in public places unless specifically allowed, terming this innovative policy "rule-switching".⁷⁷ A report issued in March 1985 by the Advisory Committee on Health Education, established by the Council of State, evaluates the effects of the tobacco price policy carried out since 1976 in Finland and proposes a new policy.⁷⁸ The report opens as follows:

Every tobacco price decision is also a health policy decision: a decision as to the amount of tobacco-related illness and premature deaths in the future. In making such a decision, the needs of the State Budget, developments in the profitability of the tobacco industry, and inflation control objectives, have all traditionally come before public health objectives, despite the fact that purely economic viewpoints also speak for a reduction in smoking.⁷⁹

Finding that smoking causes annually the premature deaths of at least 4000 Finns and 220 000 days of care in general hospitals, the Committee states that stopping smoking would decrease premature death and illness more quickly and more effectively than any other single preventive measure. The Committee examined production losses and health care costs due to smoking, expenditures on tobacco, income from tobacco production and sales, and employment in the tobacco workforce (more people die prematurely from smoking each year than are provided jobs by the tobacco industry). It concluded that the benefits of a reduction in smoking are clearly greater than the costs.

Price, the Finnish Committee demonstrated, is the most important single determinant of pipe and cigarette tobacco consumption. Reviewing the price policy in Finland from 1960 to 1984 in relation to consumption of tobacco products, the Committee found that unless the real price of tobacco is raised, that is, the price keeps pace with inflation and takes into account increases in real income, there will be no decline in smoking. In fact, it found that consumption of tobacco products decreased in only two years during the period studied — in 1964 by about 17% and in 1976 by about 14.1%. These decreases were attributed to the exceptionally large increases in the real prices of tobacco products combined with exceptionally widespread publicity about the health risks of smoking.⁸⁰

While there was a significant decrease in consumption of tobacco in Finland in these two years, overall the prevalence of smoking among males has stabilized at the level of 35%, after decreases in the 1960s. Among women the prevalence of smoking has increased slowly up to the level of 20%. Adolescent smoking decreased during the period 1973-1979 but has remained unchanged in the last few years.⁸¹ In reviewing these figures, the Finnish Committee states that the objective of reducing tobacco consumption has not been reached since what is commonly described as the Tobacco Act came into force.

After careful analysis of all the economic factors, including revenue to government, earnings by industry, and inflationary effects of tobacco price increases on the economy, the Committee concluded:

A rise in the price of tobacco products which is less than the rate of inflation, occurring simultaneously with an increase in real income, will increase the demand for tobacco products. Since consumer prices in 1985 have been estimated to rise 6%, and household disposable real income to grow by 3%, it can be estimated that the increase in the price of tobacco products by an average 5% implemented at the beginning of this year (1985) will have the effect of increasing total consumption of tobacco products by c 1.3%, unless there is another price rise during the year.⁸²

The goal of the health authorities in Finland is to reduce total consumption of tobacco products by 3% annually. To achieve this goal, taking into account the anticipated growth in purchasing power and the rate of inflation, the Committee recommended that the retail price of tobacco products be raised by an average of 17% in 1985, with similar further increases in 1986 and 1987.

No country seriously desiring to reduce the tragic and unnecessary toll of smoking can afford to ignore the analysis of this candid Finnish report. It is discouraging to learn that the pioneering comprehensive legislation of Finland, coupled with its extensive investment in health education, were not adequate to reduce smoking sufficiently. But the Finnish authorities have had the insight and courage to evaluate a bold strategy to protect the health of their people. In doing so, they have rendered an invaluable service to the rest of the world by showing that if a country wants to reduce tobacco consumption significantly, it must adopt a tobacco taxation and price policy which is based not on the needs of the state budget nor on profits to the tobacco industry, but on the public health needs of the people. If the experience of Finland is generalizable, we may conclude that effective legislation and education can achieve some reduction in smoking, but to achieve the goal of a nonsmoking society, and particularly to deter young people from smoking, the price of a package of cigarettes must be raised substantially and repeatedly.

3.6 Economic strategies

Probably the greatest challenge that lies ahead if the world holocaust wrought by smoking is to be stopped will not be achieved by legislation but by economic strategies to replace the current reliance on tobacco production with other crops. As legislation and education are decreasing consumption of cigarettes in the industrialized countries, the tobacco industry is intensifying its advertising and marketing in the developing countries.⁸³

Tobacco is a cash crop that provides a high return on investment. It is not subject to the fluctuation of world commodity prices, as are cotton, cocoa, coffee, tea, sugar, and groundnuts. It provides income to tobacco farmers, employment to factory workers in tobacco manufacturing, tax revenue to government, and, above all, foreign exchange from export of leaf tobacco and cigarettes — essential to the developing countries for imported tools, machinery, and food.

Acting on repeated resolutions of the World Health Assembly urging the Food and Agriculture Organization of the United Nations (FAO) to study the feasibility of substituting other crops for tobacco, the FAO Commodities and Trade Division issued a report on the subject in 1982. It concluded that tobacco growing has the advantages of giving large-scale rural employment, being one of the most remunerative cash crops, and constituting an important source of foreign exchange for exporting countries. In developing countries where manual methods of producing cigarettes are used, tobacco manufacturing creates jobs with wages that compare favourably with those paid by other industries employing workers with similar skills. Finally, tobacco provides an easily tapped source of tax revenue. The FAO report concluded:

In view of these factors, farmers continue to have strong incentives to produce tobacco, and governments to encourage its cultivation and manufacture.⁸⁴

These factors operate to deter governments from seeking to substitute healthful crops for tobacco, to be sure. At the same time, tobacco production has certain technical and economic disadvantages, not to mention the harm to the health of the people. Tobacco requires a heavy investment in production, handling, and processing.⁸⁵ Tobacco growing requires expensive inputs, such as large amounts of fertilizer. It is a time-consuming crop, demanding attention to detail, experience, and dedication on the part of the grower. In the developing countries large amounts of firewood are necessary to cure the tobacco — firewood that is needed as fuel for cooking and heating. The impact of tobacco production on forests around the tobacco farms has been vividly described:

It has been estimated that around 150 large trees are needed to cure just over one acre of tobacco A quick calculation shows why the horizons are bare: the average size of the tobacco allotment in Rio Grande do Sul is about four acres. Therefore, in one year, the area's 100,000 tobacco farmers need the wood of 60 million trees — or nearly 1.5 million acres of forest. The problem is not unique in Brazil. Huge areas of the Third World where tobacco is grown have been stripped of their forests and woods to provide energy to cure tobacco The effect on the ecological balance, especially in drier areas, can be disastrous. Water tables are lowered, springs dry up, and wells are drained. Deserts may be created where forests once stood.⁸⁶

Some crops may even be more lucrative than tobacco, as has been shown for certain fruit and vegetable crops in the United States.⁸⁷ For the developing countries the task would be to seek to substitute for tobacco a crop that grows in similar climatic conditions and can be converted into a product that will yield government revenue and hard currency.

The task may be difficult, but it is not impossible. Affirmative steps by national governments and agencies in the United Nations system are urgently needed to design and finance a feasibility study of crop substitution for tobacco. A beginning must be made. The cooperation of FAO, the World Bank, the International Labour Organisation, and WHO may assist governments in bringing their agricultural and economic policies into harmony with their public health objectives.

4. THE CONSUMPTION SIDE: INFLUENCES ON SMOKING PRACTICES

Legislation in this category is designed to provide incentives and regulations that encourage changes in practices among smokers. Such legislation operates through restrictions that create social pressures not to smoke and through health education.

4.1 Restrictions on smoking in public places

The claims of nonsmokers to a smoke-free environment were formerly justified on the grounds that smoking creates a public nuisance and is positively harmful to persons sensitive to smoke. New studies in Japan, the United States, Greece, and the Republic of Korea have

presented evidence on the dangers of passive smoking.⁸⁸ In the United States, the nonsmoking wives of smokers were shown to have a 3½-fold increase in the risk of lung cancer as compared with nonsmoking wives of nonsmokers.⁸⁹ Control of smoking in public places is therefore justified not only on aesthetic grounds but also on health grounds.

Before 1982, 31 countries had enacted restrictions on smoking in public places. In the period from 1982 to mid-1986, 17 additional countries and jurisdictions adopted such legislation. Thus, of the 68 countries in the world with legislation to control smoking, 47 restrict smoking in public places. It is the second most common type of legislation in this field, after restrictions on advertising.

The countries and jurisdictions that have adopted restrictions on smoking in public places in the 1982-1986 period are Algeria, Nigeria (Benue State), and Senegal in the African Region; Bolivia, Brazil (Rio Grande do Sul), and Canada in the Region of the Americas; Lebanon, Saudi Arabia, and Sudan in the Eastern Mediterranean Region; Iceland, Israel, Spain, and Sweden in the European Region; and Hong Kong and Macao in the South-East Asia Region. Like this type of legislation enacted in the past, the new laws vary in the range of public places where smoking is prohibited. Some prohibit smoking in a limited number of public places, and some in a wide range of public places. Belgium, Jordan, and Portugal, which formerly prohibited smoking in a few places have amended their laws to increase the number of places where smoking is prohibited. Several countries permit the authorities to specify in regulations the places where smoking is prohibited.

A brief description of the range of public places where smoking is restricted in different countries follows:

Belgium — on premises where pupils are present, in kindergartens and establishments providing primary, special, and artistic schooling, both full-time and of a vocational nature; in health establishments and homes for the elderly; on premises where food is stored, handled, prepared for consumption, or offered for sale (but not premises principally concerned with consumption of food on the premises); in vehicles for collective transport (e.g. school buses) and urban public transport vehicles; and in elevators for collective use.

Bolivia — in schools and health premises, in public transport vehicles, and in indoor public places, where separate smoking areas must be established.

Brazil (Rio Grande do Sul) — in closed areas of public educational establishments, meeting halls, lectures, entertainment, museums, libraries, public health establishments, gymnasia and other closed areas for sports, and inter-city transport vehicles.

Hong Kong — in public elevators and public land vehicles with only one deck or on the lower deck of land vehicles with more than one deck. In cinemas, theatres, concert halls, and public service transport other than those mentioned, not less than 50% of each class of the seating accommodation must be designated as a no-smoking area.

Iceland — in institutions and firms accessible to the public (except restaurants and places of entertainment where nonsmoking tables must be reserved) and specifically prohibited in primary schools, day nurseries, and buildings primarily for social and leisure activities for children and adolescents under the age of 16; in health centres and hospitals (except where it does not inconvenience nonsmokers); and in the passenger section of public transport.

Israel — in closed halls for entertainment or public gatherings, hospitals and clinics (except for a place allotted by the hospital where smoking is allowed), the public section of pharmacies, public library reading rooms, educational institutions, elevators, buses, taxis, and minibuses.

Jordan — in any cinema, theatre, public library, public transport vehicle, or any other place designated as a public place for the purpose of the relevant rules by the Minister of Health, but a special smoking area may be designated in a public place in accordance with conditions laid down by the Minister.

Nigeria (Benue State) — in all health establishments.

Portugal — in health-care premises, places frequented by young people, schools, colleges, universities, and roofed premises devoted to sports or entertainment.

Saudi Arabia — in ministerial offices, government agencies, and public institutions.

Spain — in all urban and inter-urban public transport, entire carriages or compartments of railway vehicles, public rooms on board marine vessels, and health and educational establishments (with areas in which smoking is permitted duly signposted).

Sudan — in enclosed public places, including vehicles, indoor cinemas, and any other places frequented by the public.

United States of America — 35 States have enacted some limitation on smoking in public places, and 24 States have prohibitions against smoking in variety of areas — elevators, health care facilities, mass transit vehicles, schools and public facilities, and in some cases parts of restaurants. These laws generally provide for establishment of smoking areas in which smoking is allowed.⁹⁰ Regulations designed to provide a "reasonably smoke-free environment" for those working in and visiting virtually all Federal buildings were proposed on 17 April 1986.⁹¹

Venezuela — in public transport vehicles and other places open to the public, separate areas are required for smokers and nonsmokers.

In Algeria, Israel, Senegal, and Switzerland (Canton of Vaud), authority is granted to the government to specify the public places where smoking is restricted. In Israel, the Minister of Health has authority to issue and amend regulations specifying the public places where smoking is prohibited. In Senegal, the legislation prohibits smoking in places intended for communal use in which smoking may endanger health. Decrees are to be issued identifying such places, places in which no-smoking areas must be provided, and places and institutions in which health information must be provided. In Switzerland (Canton of Vaud), the State is to encourage measures designed to limit smoking in public buildings and other premises, particularly those accessible to children and young persons. The Conseil d'Etat and the communes are both empowered to prohibit smoking in certain premises.

Legislation prohibiting smoking in a wide range of public places, either by the text of the law or by regulation, contributes to the creation of a nonsmoking environment. One should note once again, however, the approach of Finland, where all smoking in public places is prohibited unless specifically allowed.⁹² In the United States, the Clean Indoor Air Act of Minnesota also forbids smoking everywhere unless specifically allowed.⁹³

In Sweden, a special tobacco committee of the Ministry of Health and Social Affairs presented plans in 1981 for the future development of Swedish efforts to reduce smoking.⁹⁴ The committee recommended a law limiting smoking in public places similar to that in Finland. An alternative approach designed to achieve the same objective was adopted. In April 1983, the National Board of Health and Welfare and the National Board of Occupational Safety and Health issued recommendations on smoking in workplaces and all indoor public places. The Swedish National Smoking and Health Association explains the thrust of these recommendations as follows:

The main rule in the recommendations is the following: "No-one should against his will be subjected to discomfort or to health hazards caused by tobacco smoke in public places and work places". In practice this means that smoking should be permitted only in special smoking rooms. The intention of the recommendations is to accommodate both smoker and non-smokers as far as possible although priority has to be given to the rights of the non-smokers. It is of great importance for a proper functioning of the recommendations that they shall be accepted by everyone, and above all by smokers.⁹⁵

Experience with control of smoking in public places indicates:

(1) Implementation of such laws at the outset may present problems. In Egypt it proved difficult to implement the prohibition on smoking in public places, particularly in crowded buses and certain public offices.⁹⁶ Hong Kong had a similar experience in enforcing its law on buses. The support of the media (television, radio, and newspapers) in explaining the law to the public is helpful, and gradually the public comes to accept nonsmoking in public places as the norm.

(2) It is particularly important, as the WHO Expert Committee on Smoking Control Strategies in Developing Countries pointed out, that hospitals, health care institutions, and official health agencies set an example that smoking be banned in these places.

(3) In drafting and enacting this type of legislation, it is advisable to include as wide a range of public places as possible.

4.2 Restrictions on smoking in the workplace

Laws and policies are increasingly recognizing that the rights of nonsmokers extend to the workplace, where people spend much more time than they do in meeting-rooms and public transportation. Smoking is particularly dangerous where it accentuates the effects of toxic materials. In 1985, a report of the US Surgeon General on cancer and lung disease in the workplace concluded that for the majority of American workers cigarette smoking represents a greater cause of death and disability than their workplace environment.⁹⁷ Smoking alone causes pulmonary impairment, but among people exposed to harmful occupational agents, the interactive effects of smoking may increase the number of individuals developing clinically significant impairment.⁹⁸ There are many such hazardous agents, but asbestos exposure is particularly dangerous both for nonsmokers and smokers. According to the Surgeon General's report, the risk of developing lung cancer in cigarette-smoking asbestos workers is greater than the sum of the risks of the independent exposures and is approximated by multiplying the risks of the separate exposures.⁹⁹ Norway, however, is the only country which, according to available information, prohibits assigning workers who smoke to workplaces where they may be exposed to asbestos dust.¹⁰⁰

Before 1982 only seven countries were known to have legislation restricting smoking in the workplace — Bulgaria, the Federal Republic of Germany, France, Norway, Poland, the USSR, and certain States in the United States of America.¹⁰¹

In the period from 1982 to mid-1986, Austria, Belgium, Iceland, Spain, Sweden, and many local communities in the United States enacted legislation to promote a smoke-free workplace. Additionally, much legislation banning smoking in public places, such as in schools and health establishments, has the effect of restricting smoking by workers in these places.

In Austria, the Employees' Protection Law (as amended on 20 October 1982) requires appropriate technology or organizational measures to be taken to protect non-smoking employees against the effects of tobacco smoke, wherever this is possible.

In Belgium, a 1982 Decree prohibits smoking on premises where food is stored, handled, prepared for consumption, or offered for sale. This prohibition does not apply to premises concerned primarily with consumption of food on the premises.

The Icelandic legislation prohibits smoking in primary schools, day nurseries, buildings primarily intended for social and leisure activities for children and adolescents under 16, and health centres and hospitals, as mentioned. Places of work other than those specified are subject to further regulations to be laid down in cooperation with the Administration of Occupational Safety and Health.

The Spanish legislation provides that smoking areas in indoor public places and large commercial premises are to be established, provided that this is compatible with their dimensions, characteristics, and intended purposes and that smoking is not prohibited. A commission with representatives of the Ministries of Finance, Health and Consumer Affairs, and Economic Affairs and Trade is set up for this purpose.

Sweden's smoking restrictions designed to achieve a smokeless occupational environment, discussed above, contain helpful examples of practical arrangements for various types of premises.

In the United States of America, a noteworthy development is the enactment of city and county ordinances to protect nonsmokers in the workplace. By the end of 1984, 64 communities in the State of California had passed such ordinances covering 7 350 000 workers — more than half the workers in the State.¹⁰² Some of the ordinances apply to all private workplaces, some to those with more than a specified number of employees, some only to office workplaces, some only to county government employees. Many provide that if nonsmokers cannot be otherwise accommodated, smoking will be prohibited entirely.¹⁰³ Enforcement is by administrative action or civil or criminal penalties. In San Francisco violations are punishable by fines up to \$500 a day, but enforcement has proved not to be a problem. In the first 10 months of the operation of the San Francisco ordinance, only 102 complaints were filed, and all were resolved without legal action or fines.¹⁰⁴

Experience with this type of legislation indicates:

(1) There is a need to explore with employers and trade unions the type of legislation that is feasible and appropriate. Special emphasis should be placed on industries where workers are exposed to hazardous materials.

(2) White-collar workers seem more amenable to regulation of smoking in the workplace than blue-collar workers. Increased health education on smoking should be incorporated in occupational health programmes.

(3) The success with control of smoking through local ordinances in the United States suggests the viability of this approach to a smoke-free workplace.

4.3 Preventing young people from smoking

Several kinds of legislation are designed to prevent young people from smoking — prohibiting sales to minors, restricting sales from vending machines, prohibiting children and adolescents from smoking in public, prohibiting smoking in schools and other places frequented by young people, and restricting advertising that might influence young people.

Before 1982 legislation designed to prevent smoking by young people was available to WHO for 13 countries. In the period from 1982 to mid-1986, legislation specifically concerned with preventing smoking by young people has been enacted in at least nine countries and jurisdictions.

Selling or supplying tobacco products to persons under 16 years of age is prohibited in Australia (South Australia), Hong Kong, Iceland, and Spain, and to persons under the age of 18 years in Uruguay. The relevant provisions in the United Kingdom (Section 7 of the Children and Young Persons Act 1933 and Section 18 of the Children and Young Persons (Scotland) Act 1937) were strengthened somewhat by the Protection of Children (Tobacco) Act 1986.

Smoking is prohibited on premises intended for persons under the age of 16 in Portugal. Belgium requires that the dangers of tobacco be clearly publicized on premises principally intended for the collective leisure activities of persons under the age of 16. Bolivia prohibits making use of adolescents in advertisements for tobacco.

The legislation of Hong Kong and Iceland is clear and comprehensive on this subject. Both laws provide that: (1) tobacco may not be sold to persons under 16 years of age; (2) all sales of tobacco from automatic vending machines is prohibited; and (3) tobacco may not be sold in schools or institutions for children and young people.

Experience with legislation to prevent young people from smoking suggests:

- (1) The most important objective is to create a nonsmoking environment — a society in which smoking is not acceptable and not permitted.
- (2) As part of the effort to create a nonsmoking society, legislation designed specifically for the protection of children and young people conveys a strong message from the government.
- (3) Banning sales of cigarettes from vending machines is important because it makes cigarettes less widely available, especially to young people where sales to minors are a criminal offence.

4.4 Mandating health education

The WHO Expert Committee on Smoking Control Strategies in Developing Countries stressed that no legislation may be expected to succeed without educational activity, and it urged making education mandatory before launching legislation.¹⁰⁵ Countries that have achieved a significant reduction in smoking, e.g. Sweden and Norway, have introduced strong education programmes.

There is no gainsaying the importance of eliminating advertising of cigarettes and thus freeing the people from the pressure to smoke. But prohibition of advertising needs to be accompanied by effective anti-smoking messages to the public. In the United States, anti-smoking commercials carried on prime-time television in 1968-1970 reduced smoking prevalence. When Congress prohibited cigarette advertising on radio and television, the media were no longer required to grant "equal time" under the fairness doctrine of the Federal Communications Commission for anti-smoking messages; and cigarette sales increased by 2½% per year.¹⁰⁶

An evaluation of the impact of the anti-smoking legislation in France notes an appreciable fall in the percentage of smokers since 1976 and attributes the decline primarily to "information campaigns in the media which have been decisive in bringing about new attitudes and behaviour in relation to consumption of tobacco".¹⁰⁷

Before 1982, legislation mandating health education was available to WHO for 15 countries. In the period from 1982 to mid-1986 legislation from 10 additional countries and jurisdictions mandating health education on smoking became available. Undoubtedly, many other countries have educational programmes on smoking and health without specific provision in legislation. For example, the 1983 Principles of Medical Ethics of Cuba set forth, with respect to the relations between teachers and students, the obligation to fight against vicious customs that affect health promotion in Cuba, among them the smoking habit.¹⁰⁸

The recent statutes providing for mandatory health education vary in form and may be summarized as follows:

Algeria — the objectives to be attained in the health field are the protection of human life against diseases and hazards and the improvement of living and working conditions by various specified means, including health education.

Belgium — the educational authorities of the French Community are required to organize annually an educational campaign on the dangers of smoking in kindergartens and establishments providing primary, special, and artistic schooling, both full-time and of a vocational nature. The health authorities of the French Community are required to organize annually, in conjunction with the French-speaking radio and television services, an information day on the dangers of tobacco consumption.

Bolivia — the Health Authority is required to draw up mass education programmes to counteract the harmful effects of the use of tobacco.

French Polynesia — not less than 1% of the revenue from tobacco taxes is to be used for a health education campaign through the press, posters, etc.

Iceland — the Ministry of Education, in consultation with the Ministry of Health and Social Security, is required to arrange for regular instruction on the harmful effects of the use of tobacco in the schools of the country. Particular emphasis is to be laid on such instruction in primary schools and in schools preparing people for work in the fields of education, teaching, and health care.

Macao — the Directorate of Health Services is responsible for periodically disseminating reports and information at its disposal on the harmful effects of smoking and for encouraging campaigns and measures against smoking, particularly in establishments for adolescents.

Mexico — the Mexican General Health Law provides that the programme against smoking is to include education on the effects of smoking on health, directed particularly to the family and to children and adolescents by individual, collective, and mass communication methods, including guidance to the population to abstain from smoking in public places.

Spain (Catalonia) — the Executive Council is assigned responsibility for implementing health information and education programmes and activities designed to inform the public of the harmful effects of substances liable to produce dependence, including tobacco. These measures are to be directed in particular towards children and young persons, as well as the social groups concerned.

Sweden — Swedish legislation makes education on smoking and health mandatory in schools.¹⁰⁹ The recommendations issued by the National Board of Health and Welfare and the National Board of Occupational Safety and Health, referred to above, place great emphasis on educational programmes throughout society. In suggesting the future form of Swedish actions to reduce smoking, the tobacco committee of the Ministry of Health and Social Affairs placed overwhelming emphasis on educational activities in the school system, the health services, workplaces, and civic life.¹¹⁰

United States of America — the 1984 amendments to the Federal Cigarette Labeling and Advertising Act provide that the Secretary of Health and Human Services is to coordinate all research and educational programmes and activities within the Department of Health and Human Services concerning smoking and health and coordinate such activities with similar activities of other Federal agencies and private agencies. The Secretary is also required to collect, analyse, and disseminate information, studies, and other data relating to the effect of cigarette smoking on health and to develop standards, criteria, and methodologies for improved information programmes relating to smoking and health.

Experience with mandating health education on smoking suggests:

(1) It is important to mandate strong educational programmes in the schools and in the community, in order to allocate personnel and financing necessary to support these programmes.

(2) Mandating health education on smoking, rather than leaving the task to voluntary initiatives, assures that education will go hand-in-hand with legislation, each strengthening the other.

5. NATIONAL ORGANIZATIONS FOR POLICY DEVELOPMENT AND COORDINATION

In urging those Member States that have not yet done so to implement smoking control strategies, the 1986 resolution of the World Health Assembly urged, among other measures, the establishment of a national focal point to stimulate, support, and coordinate all smoking control activities. Our earlier study of anti-smoking legislation stressed the importance of a national agency on smoking and health to facilitate cooperation of governmental and voluntary agencies, to assure continuity and priority for activities on smoking and health, and to provide official recognition and support for an effective anti-smoking effort.¹¹¹

In Sweden and Norway — countries that have achieved significant decreases in smoking rates — the national organization on smoking and health has played a key role. Sweden was perhaps the first country in the world to establish a specialized agency on smoking and health to serve as a focal point for work in this field.¹¹² The National Smoking and Health Association of Sweden is a private organization that is supported by Government funds and works closely with the National Board of Health and Welfare. In Norway, the National Council on Smoking and Health has been a central force in stimulating activities to lower smoking rates and in monitoring the impact of information and legislation on smoking habits.¹¹³ National agencies on smoking and health may be governmental bodies, organized independently or as committees of national health councils. Or they may be voluntary agencies with substantial governmental support.

In the period from 1982 to mid-1986, a number of countries passed legislation establishing a central body for policy development and coordination of activities to control smoking.

In 1984, Iceland promulgated a law under which the Minister of Health and Social Security is to appoint a three-member Committee for Tobacco Use Prevention, with at least two of its members to be experts on the harmful effects of tobacco or on measures to prevent its use. The charge of the Committee is broad. It is to advise specified governmental agencies on all matters relating to the prevention of use of tobacco, to submit proposals concerning measures to combat the use of tobacco, to encourage other parties to launch anti-smoking campaigns and to endeavour to coordinate such activities, to publish and distribute materials on smoking and health, to keep records of the consumption of tobacco in the country, and to utilize the experience of other countries in the field of anti-smoking activities. The Committee's opinion must be sought on all regulations concerning the use and sale of tobacco. The Ministry of Finance is instructed to consult the Committee on policy regarding the importation and pricing of tobacco. The Committee is to cooperate with various other bodies, such as the National Centre for Hygiene, Food Control and Environmental Protection and the Administration of Occupational Safety and Health.

In 1984, a Resolution of the Ministry of Health and Social Welfare of Venezuela created a Standing Honorary National Council, attached to the Ministry's Division of Chronic Diseases, for the study of health problems associated with smoking, with a view to formulating policies for the prevention of smoking and the smoking-related diseases. The importance of the Council is reflected in its broad interdisciplinary and interagency composition. Its members are to consist of two representatives of the Ministry of Health and Social Welfare (including the head of the Division of Chronic Diseases, who acts as chairman) and one representative from each of the following: the Ministry of Agriculture and Livestock Breeding, the Ministry of Labour, the Ministry of Transport and Communications, the Ministry of Justice, the Ministry of the Environment and Renewable Natural Resources, the Ministry of Information and Tourism, the Ministry of Youth, the Venezuelan Institute of Social Security, the National Academy of Medicine, the Cancer Society, and the Venezuelan Medical Federation. The Resolution also establishes a Technical Support and Coordination Unit, composed of epidemiologists, statisticians, sociologists, teachers, and experts in public relations and social communications, for the development of anti-smoking activities.

The 1983 Portuguese legislation provides for the establishment of a Smoking Prevention Council to develop preventive strategies on smoking and measures to protect nonsmokers, to advise on legislation, action programmes, and expenditures related to smoking prevention, to

promote studies and research, to promote exchange of information with other national and international organizations, and to prepare an annual report on the general situation in this sector and on its activities.

A 1986 Chilean Presidential Decree established an intersectoral National Commission for Smoking Control (chaired by the Minister of Health), its tasks being to study matters related to tobacco and to propose measures designed to control and reduce smoking. It is worth citing Section 2 of the Decree in full:

"2. The specific functions of the Commission shall be as follows:

- to undertake an assessment of the smoking situation and to keep it under continual review, with particular reference to:
 - (a) the place of the tobacco industry in the economy, and as regards employment;
 - (b) coordinating its activities and information with the National Institute of Statistics and other agencies and bodies, with a view to assuring the country-wide monitoring of the prevalence of the smoking habit amongst the population;
 - (c) determining the effects of smoking on mortality and morbidity levels in the population and on absenteeism and unfitness for work;
 - (d) identifying the resources available in the public and private sectors for developing informational, educational, and care activities; and
 - (e) analysing constitutional, legal, and regulatory texts, particularly those related to health, with a view to enacting measures that will form a legal basis for the implementation of anti-smoking activities; and
- to propose a policy for smoking control; and
- to design and evaluate a programme of medium- and long-term smoking control activities based on strategies in the fields of education, information, regulation, and evaluation."

The legislation of other countries also establishes central agencies for policy development and coordination of anti-tobacco activities. For example:

Macao — the Directorate of Health Services is responsible for periodically disseminating reports and information at its disposal on the harmful effects of smoking and for encouraging campaigns and measures against smoking, particularly in establishments intended for adolescents.

Mexico — the Mexican General Health Law provides that the Secretary of Health and Welfare is to coordinate anti-smoking activities, organize smoking-cessation services, and develop activities to prevent smoking by children and adolescents. Coordination in adopting methods within the Federal and local spheres is to be assured by coordination agreements between the Secretary for Health and Welfare and the federated entities (State governments, etc.).

Spain (Catalonia) — the 1985 Law on prevention and care in regard to potentially dependence-producing substances (defined to include tobacco) provides for the establishment of a Coordinating Commission on the Control of Drug Dependence, with its composition and working procedures to be specified in regulations.

United States of America — the 1984 amendments to the Federal Cigarette Labeling and Advertising Act provide for the establishment of an Interagency Committee on Smoking and Health through which the Secretary of Health and Human Services carries out coordination of all research and educational programmes and other activities on smoking and health with similar activities in other Federal government and private agencies.

6. IMPACT OF LEGISLATION TO CONTROL SMOKING

Evaluation of the effects of specific types of legislation is difficult because many factors are involved in the use of tobacco. In a few instances researchers have been successful in demonstrating the decline in smoking associated with specific interventions, such as Warner's finding of a decline in smoking associated with the airing of anti-smoking messages in the United States media and the findings in the United States and the United Kingdom of a decline in smoking associated with price increases, both discussed earlier.

While evidence of the effects of specific legislative interventions is limited at present, the effect of legislative restrictions generally has been clearly demonstrated. A quantitative comparison of the effects of the two main policy approaches — legislation, on the one hand, and control through a voluntary agreement with the industry, on the other — shows the superiority of legislative controls. Analysing data from 15 OECD countries between 1962 and 1980, United Kingdom researchers suggest that countries with legislative programmes have made substantially more progress in containing and reducing smoking levels than those using the approach of a voluntary agreement with the tobacco industry.¹¹⁴

The effect of legislative restrictions generally is demonstrated in the marked decline in smoking that has occurred in countries where anti-smoking legislation has been combined with education. The most powerful evidence comes from Sweden and Norway, where comprehensive anti-smoking programmes have been enacted and implemented. Hong Kong also reflects this experience. Even in countries with more limited legislation and programmes — Canada, France, and the United States — there has been a marked decline in smoking generally or among young people.

In Sweden, where strong health warnings on tobacco were introduced in 1975, the percentage of daily smokers declined steadily from 1976, when 43% of the population were daily smokers, to 1980, when the corresponding figure was 31%. Commenting on the increasing percentages of persons who stopped smoking, the Director-General of the National Smoking and Health Association of Sweden ascribed this to "a snowball effect arising when more and more people find themselves surrounded by more and more friends and companions who have stopped".¹¹⁵ Thus, legislation contributing to the development of a nonsmoking environment is influential.

Most important in Sweden is the decline in smoking among young people. Among 13-year old boys, the percentage who stated that they smoke declined from 14% in 1971 to 5% in 1980; for 13-year old girls the decline was from 16% in 1971 to 6% in 1980. Among 16-year old boys, the percentage who states that they smoked was 41% in 1971 and 21% in 1980; among 16-year old girls the decline was from 47% in 1971 to 33% in 1980.¹¹⁶

In 1983, the Swedish National Smoking and Health Association stated that male smoking rates have declined continuously since 1970 and since that date the rise in female smoking rates has stopped, with a downward trend beginning then for females.¹¹⁷ Even more promising is the downward trend in smoking rates for adolescents, which began in the early 1970s. Since 1978 there has also been a downward trend in male lung cancer rates. The Association concludes that the Swedish experience indicates that a comprehensive, long-term smoking control programme can yield profits in lower smoking rates and thereafter in decreasing rates of smoking-related diseases.

In Norway, the National Council on Smoking and Health has reported trends in tobacco consumption and demonstrated the decline following the decision of the Norwegian Parliament to adopt legislation in 1970 and again in 1973 when what is described as the Tobacco Act entered

into force.¹¹⁸ When the Act became effective, the percentage of male daily smokers was 52%; in three months it dropped to 49%, and by 1982 it had dropped to 40%. The proportion of female daily smokers was 32% in 1973 and increased only to 34% by 1982, showing that the strong increase in smoking by women in previous years had been arrested.

Among school pupils aged 13-15 years, smoking increased for both boys and girls from 1957 to 1975 and has declined since that date. In Norway, among persons aged 16-20 years, 40% of boys and 41% of girls smoked daily in 1974. By 1983, the figures were 21% for boys and 26% for girls. Kjell Bjartveit, the Director of the Norwegian National Council on Smoking and Health has stated, "If this decline continues at the same speed in the future, young people in Norway will be smoke-free by the year 2000. This shows that a government programme works".¹¹⁹ The Council ascribes this positive trend to information activities and education on smoking and health in the schools, to legislation removing advertising which had created pressure on young people to smoke, to the special attention paid to smoking by girls, and to the change in general attitudes towards smoking and smoking behaviour among adults and young people. Smoking is no longer considered normal social behaviour and a sign of maturity in Norway.

One may also view the effect of legislation as part of an anti-smoking programme in another way, that is, in terms of the trend if the legislative intervention had not occurred. According to Bjartveit, if the upward trend in tobacco consumption of the 1950s and 1960s had continued into the 1970s and 1980s, Norway would currently have a per capita consumption 30% higher than it is.¹²⁰ As mentioned earlier, the lung cancer death rate among British males aged 60-69 is more than three times that of the Norwegian, providing a striking comparison between Norway with its strong legislation and the United Kingdom having essentially only a voluntary agreement with the industry.¹²¹

In Hong Kong, the Smoking (Public Health) Ordinance was enacted in July 1982 and introduced compulsory health warnings on cigarette packages and advertising, tar group designations on cigarette packages, and restrictions on smoking in public transport, cinemas, theatres, and concert halls. In 1983 administrative regulations were issued establishing no-smoking areas in schools, hospitals, and clinics, public areas of government offices, and food business premises. In April 1983 a tax increase of 400% was imposed! In July 1984 a poll found general public acceptance of the Government's anti-smoking policy and a 16% drop in daily smokers between 1982 and 1984.¹²²

In other countries where the anti-smoking activities are less pervasive, there has nevertheless been a decline in smoking. In Canada, tobacco consumption for 1983 showed a significant decrease, probably reflecting the substantial price increases for cigarettes in 1981-1982.¹²³

In France, the percentage of smokers declined from 44% in 1976 to 37% in 1982.¹²⁴ The decline among French men was from 60% to 49%; among French women from 31% to 26%.

In the United States, per capita cigarette consumption for individuals 18 years or older decreased at an annual rate of 0.6% from 1963 to 1978, and the proportion of smokers declined at an annual rate of 1.6% from 1965 to 1980 — 42% to 33%.¹²⁵ Of the US population, 67% are now nonsmokers. Among young people the decline in smoking is less marked than in the Scandinavian countries. The percentage of 17-18-year old boys who smoke declined from 30% in 1968 to 20% in 1979; among 17-18-year old girls an initial increase from 18% in 1968 to 25% in 1977-1978 seems to have levelled off by 1979.¹²⁶

In December 1985 the National Cancer Institute in the United States reported that the lung cancer rate for white men had declined 4% from 82.7 new cases of lung cancer per 100 000 men in 1982 to 79.3 in 1983.¹²⁷ But the lung cancer rates of women and black men are discouraging. Lung cancer deaths and new cases of lung cancer among women show no signs of levelling off. The Director of the National Cancer Institute predicted that there would be no decrease for 15 to 20 years because of women's smoking patterns.¹²⁸ The annual lung cancer rate for black men is almost 60% higher than for white men, but there is some indication that it is levelling off.

Authorities generally agree that no single legislative measure can be very effective in reducing smoking rates but that a comprehensive approach, utilizing a combination of measures, will, given enough time, be effective.¹²⁹ The report of the Advisory Committee on Health Education of Finland, discussed earlier, seems to qualify this conclusion, however. The Committee found that in Finland, where comprehensive anti-smoking legislation has been combined with extensive health education since 1976, these measures were not sufficient to achieve satisfactory reductions in smoking rates and smoking-related diseases.¹³⁰ It documented the need for substantial and repeated increases in tobacco taxes and prices if smoking rates are to be decreased by 3% per year — the goal of the health authorities. Although the Finnish Committee recommended a price increase of the order of magnitude of 17% in 1985 if smoking rates are to be decreased by 3%, Finland did in actual fact increase prices by only 3.5%, the amount necessary to keep pace with inflation.¹³¹ If the Finnish experience is not unique to Finland but applies to other countries as well, then we may conclude that the legislative measures necessary to decrease smoking rates significantly and to deter young people from smoking must include substantial increases in tobacco taxes and prices. The remarkable 16% decline in daily smoking rates in a two-year period in Hong Kong following the introduction of restrictive legislation and a 400% tax increase seems to confirm this conclusion.

7. ADMINISTRATIVE AND JUDICIAL ACTIONS

This monograph is concerned with analysis of legislation to control smoking, but legal strategies also include administrative and judicial actions that deal with the problems of smoking. These strategies have thus far been tried in only a limited way.

In the United States, the legal imagination of a lawyer in New York, John F. Banzhaf III, in seeking enforcement of the "fairness doctrine" of the Federal Communications Commission, led to anti-smoking messages on television for the first time in 1968, in response to cigarette commercials. As a result of this initiative, more than \$200 million worth of free broadcast time was made available, cigarette sales fell, and cigarette advertising was finally prohibited on television and radio in the United States.¹³² Banzhaf went on to seek "no-smoking" sections in civil aircraft through action before the Civil Aeronautics Board, and no-smoking sections are now standard requirements on all US airlines. In another innovative administrative proceeding, Action on Smoking and Health (ASH), an organization formed under the direction of John Banzhaf, filed a petition before the Federal Trade Commission which led to exposure of the tobacco industry's deceptive advertising practices. Recommendations of the Federal Trade Commission for strengthened warnings on cigarette packages contributed to the 1984 amendment to the Federal Cigarette Labeling and Advertising Act requiring specific, rotating warnings.¹³³

In the courts of the United States, a number of lawsuits have been won assuring nonsmokers a safe and healthy working environment.¹³⁴ Judicial decisions have also required employers to make reasonable accommodation to a nonsmoker sensitive to tobacco smoke and have awarded sensitive nonsmokers unable to continue working in a smoke-filled room workers' compensation of unemployment compensation benefits.¹³⁵

Pending in the courts are suits that will be of the greatest significance in determining the liability of tobacco companies for damages for premature death and disability caused by cigarettes. As yet, none of these suits has been successful, but the enormous awards against asbestos companies in product liability suits forecast analogous awards in the suits against cigarette companies.¹³⁶ In fact, the asbestos companies have brought in the tobacco companies as co-defendants where records show that the victims were not only exposed to asbestos but were also heavy cigarette smokers.

In Sweden, a court decision on 28 November 1985 held a case of lung cancer due to passive smoking at the workplace to be an occupational injury.¹³⁷ The case involved a 54-year old woman, a life-long nonsmoker, who was diagnosed as having lung cancer in 1980. She had been exposed to tobacco smoke in the room where she worked as a draftsman for 18 years with nine or 10 other people, at least one of whom and often several were smokers, and where the ventilation system was inadequate because the windows could not be opened. The local Social Insurance

Office denied the claim in a preliminary decision and sought a ruling from the National Social Insurance Board, which supported the denial of the award. The patient died in 1982, and her beneficiaries appealed the case to the Regional Insurance Court.

After taking additional expert testimony, the Regional Insurance Court reversed the decision and held that the patient was subjected to an exposure at her workplace that can cause the kind of cancer she had and that no reasons against a relation between the exposure and the injury were stronger than the causal relation found. On appeal, the Insurance Court of Appeal affirmed the Regional Court's decision and held that the patient's case of lung cancer was properly classified as an occupational injury due to passive smoking at the workplace.

Commenting on the significance of this case for the international community, the Director-General of the Swedish National Smoking and Health Association points out that the ruling of the Insurance Court of Appeal will undoubtedly lead to strengthened measures to create smoke-free environments and will further reduce the social acceptability of smoking.

The power of regulatory agencies and the courts to make significant changes in public policy on smoking will probably encourage future innovative actions in administrative and judicial forums. In the words of Banzhaf and Pfeiffer,

Legal action is a powerful weapon when used properly. It should be part of the arsenal of any anti-smoking organization, to be used in conjunction with other more traditional weapons where it is appropriate and effective.¹³⁸

8. APPROACHES TO LEGISLATIVE ACTION

The considerable growth of legislation to control smoking during the period from 1982 to mid-1986 detailed in this paper reflects a heightened determination on the part of governments in both industrialized and developing countries to reduce the use of tobacco — the largest single cause of premature death and disability in the world. No longer is the smoking epidemic the exclusive concern of health experts, health organizations, and health ministries. Other ministries — agriculture, industry, finance, education, and communications — are now becoming involved in the struggle to combat the use of tobacco. The mobilization of parliamentarians, politicians, and policy-makers has begun. One can already see developing a worldwide political strategy that Bjartveit has stated is essential if the smoking epidemic is to be controlled.¹³⁹

This optimistic conclusion does not reduce the urgent need for action in the many countries of the world, particularly developing countries, where the smoking epidemic is spreading. Rather, the enactment of more and stronger legislation by additional countries shows that restrictions are possible and effective.

At this juncture in the development of legislative and other strategies to control smoking, it may be helpful to examine the components necessary for effective programmes. Four components should be emphasized:

- enacting even stronger legislation;
- adopting multifaceted measures;
- expanding the anti-smoking network; and
- strengthening consumer advocacy.

8.1 Enact even stronger legislation

Legislation is the cornerstone of an effective national programme to control smoking and the smoking-related diseases. It expresses the official policy of government, and with the enactment of legislation many different strategies are facilitated.

Not all legislation is equally effective in reducing smoking, however. A consensus is emerging that the first and most important control to be adopted is a curb on advertising and promotion of tobacco products. Such legislation helps to free people, particularly young people, from the social pressure to smoke. New evidence has emerged on the importance of raising taxes and hence prices on cigarettes — a measure which can benefit the health of the people and the revenue of the government.

Legislation need not be static. Once enacted and accepted by the people, laws can be strengthened to make them more effective. In two jurisdictions with comprehensive anti-smoking laws and programmes — Hong Kong and Sweden — future plans include a total ban on all advertising and promotion of cigarettes.¹⁴⁰ In the United States, where restrictions on advertising are weak (advertising on radio and television is banned and health warnings are required on advertising in the press and on billboards), the American Medical Association and the American Public Health Association have called for a ban on all advertising of cigarettes, chewing tobacco, snuff, and other tobacco products.¹⁴¹

8.2 Adopt multifaceted measures

While advocates of smoking control measures have long urged combining legislative and educational strategies, it has become increasingly apparent that these two basic measures need to be complemented by a wide range of other actions. The 1986 resolution of the World Health Assembly recommends numerous actions — specific types of legislation to prevent passive smoking and smoking by young people, strong health warnings (including the warning that tobacco is addictive), education on smoking in schools, public information through use of the media with involvement of health professionals, promotion of healthy lifestyles, smoking cessation programmes, economic alternatives to tobacco production, monitoring trends in smoking and smoking-related diseases, and establishing a national focal point to stimulate and coordinate these activities. In numerous spheres of life opportunities abound for actions that will contribute to a nonsmoking society.

8.3 Expand the anti-smoking network

The struggle against the ravages of smoking requires imaginative intersectoral cooperation at every level of government and society. At the international level, WHO has appropriately taken the lead. Nongovernmental international organizations, particularly the International Union Against Cancer (UICC), have been strong allies. Other agencies within the United Nations system — FAO, the World Bank, the United Nations Conference on Trade and Development (UNCTAD), and the ILO — have made contributions in their respective fields to the fight against the hazards of tobacco. Other international organizations with a concern in this field are the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF), and the United Nations Industrial Development Organization (UNIDO). At the regional level, the European Economic Community is concerned with tobacco production and trade. Listing the wide array of international organizations, with varied expertise and financial resources, concerned in one way or another with tobacco raises a troubling question: why has so little been done to tackle the problem of substitute crops and industries and alternative sources of employment, tax revenues, and foreign exchange when the tragic and unnecessary results of the smoking epidemic can be so clearly forecast?

At the national level in each country, a central body to develop policy and coordinate activities on smoking control is the key to enlisting the support of both governmental entities and nongovernmental agencies. Such a central focal point provides high visibility for anti-smoking efforts.

Within countries, professional and voluntary agencies have an important role to play. While professional associations of health workers and voluntary health organizations have long addressed the problem of smoking, many women's and civic organizations have not yet recognized the importance of combating smoking for their members and the public at large.

In November 1985, 22 consumer organizations from 10 Asian countries met in Penang in a workshop sponsored by the UICC and the International Organization of Consumers Unions (IOCU), which launched a major, long-term campaign for smoking control. The organizations called on governments to ban all tobacco advertising and other forms of tobacco promotion as the key and critical factor to control smoking. They unanimously urged governments to recognize that tobacco products are highly dangerous, to introduce progressive tax increases on tobacco products, and to initiate large-scale and long-term health education programmes.¹⁴²

8.4 Strengthen consumer advocacy

Consumer advocacy in all fields requires a strategy for action, an educational campaign, the organization of consumers, and persuasion of parliamentarians and other policy-makers. Achievement of effective legislation to control smoking requires all these components.

Each country needs to develop a strategy for action. What may be appropriate in one setting may not work in another. In some places, one must begin with a single legislative measure. In others, one can introduce comprehensive legislation dealing with various aspects of smoking control. If possible, priority should be given to prohibiting tobacco advertising and sharply raising prices through taxes of cigarettes. These measures have proved beneficial in reducing smoking rates dramatically.

Once a strategy is developed, an effective educational campaign should be mounted. The evidence is abundant that no legislation succeeds without providing information to and education of the public. Affirmative anti-smoking messages on radio and television are powerful. Education is the basis for consumer action.

Along with educational work goes the organization of consumers. The consumer voice is the only one loud enough to persuade the politicians to act. And the mechanism found most effective in mobilizing consumers is a national smoking and health association. It is crucial in developing strategy, in conducting education, and in assisting the organization of consumers.

* * * * *

Finally, legislators must be informed, educated, and persuaded to enact legislation. The health and social costs of the smoking-related diseases must be brought home to every legislator. The Scottish Committee of Action on Smoking and Health has published a powerful analysis showing the deaths, days of hospitalization, and costs to the National Health Service due to the smoking diseases, by each parliamentary district.¹⁴³ Thus, each Member of Parliament in Scotland now knows the cost, in human and economic terms, of smoking in his constituency.

In conclusion, at the end of 1981 legislation to control smoking was available from 57 countries. In the period from 1982 to mid-1986, the number of such countries has risen to more than 70. In addition, legislation has been enacted at the subnational level by many jurisdictions. More importantly, many countries and jurisdictions, having first adopted moderate controls, have then enacted more restrictive legislation. The trend is clearly towards more and stronger legislation to control smoking.

But progress is slow. There are many countries that have not yet enacted any legislation to control smoking. They have no restrictions on tobacco advertising or on smoking in public places. There are several countries that still rely on an agreement with the tobacco industry, which has been shown to be much less effective than legislation. Yet evidence is mounting that the most effective legislative strategies are (1) a total ban on advertising of all forms of tobacco, (2) control of smoking in public places, and (3) greatly increased taxes on and therefore prices of tobacco products to deter young people in particular from smoking.

Legislation is not an end in itself. It is a means of creating leverage for a comprehensive programme of smoking control. To achieve this leverage scientists and citizens must join forces to convince legislators and other policy-makers of the urgency of legislative action if the worldwide assault of the tobacco industry is to be effectively counteracted.

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- 18a. Warner, supra ref. 12, at pp. 44-46, points out two noteworthy general trends: (1) the consistent substantial growth in real expenditures on advertising and promotion since the mid-1970s, with an increase of more than 18% per year in total real expenditures between 1975 and 1983; and (2) the shift in the relative shares of advertising and promotional expenditures, with the advertising share having fallen steadily and the non-advertising promotional expenditures having increased markedly. Total advertising expenditures rose by 30%, and promotional expenditures doubled, during the period 1980-1983.
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26. See Sir George Godber's "Presentation to the Fifth World Conference on Smoking and Health", supra ref. 13, at pp. 71-75.
27. Legislative action to control the world smoking epidemic, supra ref. 8, at Annex 1.
28. IRELAND. The Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) Regulations 1986 (IDHL,^a 37(1): 48 (1986)).
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31. See ibid. In announcing the Hong Kong Government's plan to ban tobacco advertising on television, Dr Mackay stated, inter alia: "No tobacco issue has been fought so fiercely in Hong Kong as the advertising ban, a good litmus test of the importance of advertising to the tobacco industry".

^a This abbreviation is used throughout for International Digest of Health Legislation.

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57. Ibid., at p. 56.
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59. Smoking control strategies in developing countries, supra ref. 6, at p. 56, and Thompson, M. E. & Forbes, W. F., supra ref. 58, at p. 497.
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113. See Trends in tobacco consumption and smoking habits in Norway. A report from the Norwegian National Council on Smoking and Health. Oslo, 1983.
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115. See "Much less smoking in Sweden" (Statement of the Swedish National Smoking and Health Association, 1980); RAMSTROM, L. M. Population scale evidence that smoking control can prevent lung cancer. Paper presented to the 6th International Symposium on Prevention and Detection of Cancer, Vienna, 26-29 November 1984.
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134. See the leading case of Shimp v. N. J. Bell Telephone Co., 145 N.J. Super. 516, 368 A. 2d 408 (1976).
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141. AMERICAN MEDICAL ASSOCIATION, supra ref. 42; as regards the American Public Health Association, see "Foegen calls for a boycott of a tobacco company's other products". The nation's health, May-June 1985, p. 3; FOEGE, W. H. Tobacco plague may cause 20% to die prematurely. The nation's health, December 1985, p. 2; see also RYNER, T. A. U.S. Supreme Court upholds advertising ban. The citation, 53(9): 102-103 (1986).
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LIST OF LEGISLATION REVIEWED^a

ALGERIA

Law No. 85-05 of 16 February 1985 on health protection and promotion (Sections 63-66) (IDHL, 1985, 36, 916)

ARGENTINA

Law No. 23344 of 31 July 1986 on restrictions on the advertising of tobacco, cigars, cigarettes, and other products intended for smoking, and their packaging^{**}

AUSTRALIA

South Australia

The Tobacco Sales to Children (Prohibition) Act, 1984 (IDHL, 1986, 37, 45) (repealed by the Tobacco Products Control Act, 1986^{**})

AUSTRIA

The Employees' Protection Law of 1972, as amended by the Federal Law of 20 October 1982 (IDHL, 1986, 37, 114)

^a Texts marked with an asterisk were not available at WHO headquarters. Texts marked with two asterisks are due to be published in forthcoming issues of the IDHL.

BELGIUM

Crown Order of 21 January 1982 amending the Crown Order of 5 March 1980 on advertising for tobacco, tobacco products, and similar products (IDHL, 1983, 34, 767)

Decree of 2 December 1982 on the control of smoking and tobacco consumption (IDHL, 1986, 37, 45)

Crown Order of 20 December 1982 on the advertising of tobacco, tobacco products, and similar products (IDHL, 1985, 36, 62)

Crown Order of 20 December 1982 amending the Crown Order of 28 December 1979 on the manufacture and marketing of tobacco, tobacco products, and similar products (IDHL, 1985, 36, 63)

BOLIVIA

Regulations of 15 March 1982 on the use of tobacco (IDHL, 1983, 34, 538)

BRAZIL

Rio Grande de Sul

Law No. 7813 of 21 September 1983 laying down provisions on smoking, and other provisions (IDHL, 1983, 34, 768)

CHILE

Decree No. 01 of 2 January 1986 establishing a National Commission for Smoking Control **

FINLAND

Decree No. 770 of 15 November 1984 of the Council of State on the maximum levels of harmful substances in tobacco products approved for sale and the classification of factory-manufactured cigarettes (IDHL, 1985, 36, 992)

FRANCE

Law No. 83-25 of 19 January 1983 prescribing various measures relating to social security (IDHL, 1983, 34, 767)

Order of 4 March 1983 determining the form to be taken by the distinctive mark to be apposed to the packaging of alcoholic beverages and tobacco (IDHL, 1983, 34, 767)

Order of 16 July 1984 on the additives permitted in the manufacture of tobacco products and their substitutes (IDHL, 1985, 36, 648)

French Polynesia

Deliberation No. 82-11 of 18 February 1982 of the Territorial Assembly of French Polynesia on the organization of the control of tobacco abuse and tobacco dependence in the Territory (IDHL, 1982, 33, 283)

GAMBIA

The Tobacco Products (Control of Advertisements) Act, 1985 (IDHL, 1986, 37, 570)

HONG KONG

The Smoking (Public Health) (Notices) (Amendment) Order 1983 (IDHL, 1983, 34, 768)

The Smoking (Public Health) (Amendment) Ordinance 1984 (IDHL, 1984, 35, 771)

The Smoking (Public Health) (Amendment) Regulations 1984 (IDHL, 1984, 35, 772)

The Smoking (Public Health) (Specification of Newspaper Circulation) Notice 1984 (IDHL, 1984, 35, 772)

ICELAND

Law No. 74 of 28 May 1984 on the prevention of the use of tobacco (IDHL, 1984, 35, 772)

Regulations No. 499 of 28 December 1984 concerning warnings on tobacco products (IDHL, 1986, 37, 47)

IRELAND

The Health (Restricted Article) Order, 1985 (IDHL, 1986, 37, 48)

The Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) Regulations, 1986 (IDHL, 1986, 37, 48)

The Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) (No. 2) Regulations, 1986 (IDHL, 1986, 37, 571)

ISRAEL

The Restriction of Smoking (Public Places) Law, 1983 (IDHL, 1984, 35, 617)

KENYA

The Public Health (Warning on Cigarette Smoking) Rules, 1984 (IDHL, 1985, 36, 993)

LEBANON

Decree-Law No. 101 of 16 September 1983 on the warning of citizens of the harmful effects of tobacco (IDHL, 1985, 36, 63)

MEXICO

The General Law on health. Dated 26 December 1983 (Sections 188-189, 275-277) (IDHL, 1986, 37, 475)

NORWAY

Regulations No. 830 of 25 March 1983 on the labelling of packets of cigarettes, packets of smoking tobacco, and packets of cigarette paper (IDHL, 1984, 35, 344)

Regulations No. 2145 of 14 December 1984 on asbestos (IDHL, 1985, 36, 1060)

PAKISTAN

The Cigarettes (Printing of Warning) Ordinance, 1979 (IDHL, 1984, 35, 74)

The Cigarettes (Printing of Warning) Rules, 1982 (IDHL, 1984, 35, 75)

PORTUGAL

Law No. 22/82 of 17 August 1983 on the control of smoking (IDHL, 1985, 36, 64)

Decree-Law No. 226/83 of 27 May 1983 for the implementation of Law No. 22/82 of 17 August 1982 on the control of smoking, and establishing the Smoking Control Council (CPT) (IDHL, 1985, 36, 64)

Macao

Law No. 3/83/M of 11 June 1983 on the prevention and control of smoking (IDHL, 1985, 36, 648)

SAUDI ARABIA

Circular of 18 October 1983 prohibiting smoking in ministerial offices, Government agencies, and public institutions (IDHL, 1986, 37, 49)

SENEGAL

Law No. 81-58 of 9 November 1981 prohibiting advertising for tobacco and smoking in certain public places (IDHL, 1983, 34, 90)

Ministerial Order No. 8236 M.S.P.-D.PH. of 30 July 1982 prescribing the substances that must be indicated on the packaging units of tobacco or tobacco products and the conditions for determining the presence of such substances (IDHL, 1983, 34, 90)

Law No. 85-23 of 25 February 1985 amending Law No. 81-58 of 9 December 1981 prohibiting the advertising of tobacco and smoking in certain public places**

Decree No. 85-1375 of 28 December 1985 specifying the conditions governing the promotion or advertising of tobacco or tobacco products**

SPAIN

Crown Decree No. 709/1982 of 5 March 1982 regulating the advertising and use of tobacco (IDHL, 1985, 36, 403)

Catalonia

Law No. 20 of 25 July 1985 on prevention and care in regard to potentially dependence-producing substances**

SUDAN

The Control of Smoking Act, 1983 (IDHL, 1983, 34, 769)

Regulations No. 16 of 1983 on the control of smoking (IDHL, 1986, 37, 49)

SWITZERLAND

Canton of Vaud

Law of 29 May 1985 on public health (Sections 52-54) (IDHL, 1985, 36, 942)

UNITED KINGDOM

The Protection of Children (Tobacco) Act 1986**

UNITED STATES OF AMERICA

Part 252 of Title 14 (Aeronautics and Space) of the United States Code of Federal Regulations
(IDHL, 1984, 35, 775)

The Comprehensive Smoking Education Act (IDHL, 1985, 36, 649)

The Comprehensive Smokeless Tobacco Health Education Act of 1986**

URUGUAY

Law No. 15361 of 24 December 1982 adopting provisions on the advertising and marketing of
cigarettes, cigars, and tobacco products (IDHL, 1983, 34, 539)

VENEZUELA

Resolution of 23 October 1984 of the Minister of Health and Social Welfare establishing a
Standing Honorary National Council, attached to the Ministry's Division of Chronic
Diseases, for studying health problems associated with smoking and with a view to
formulating policies for the prevention of smoking and the organic diseases resulting
therefrom (IDHL, 1986, 37, 276)

Resolution of 1985 of the Venezuelan Institute of Social Security prohibiting smoking in
administrative and medical care facilities*

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