ISSUE BRIEF
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HIV, HEALTH AND DEVELOPMENT
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TOBACCO CONTROL FOR HEALTH AND DEVELOPMENT

Tobacco use poses a major health and development challenge, impeding progress on achieving the Millennium Development Goals (MDGs). Tobacco-related disease is the single most preventable cause of death and disability worldwide. Of the one billion people who use tobacco, 5.4 million die each year, in addition to the 600,000 non-smokers, mostly women and children, who die from exposure to second-hand smoke [1, 2]. Tobacco use accounts for one in six deaths due to noncommunicable diseases (NCDs) and is the only risk factor shared by all four of the main NCDs – cancer, diabetes, cardiovascular and chronic respiratory – making it a major contributor to global health and development challenges [1, 3, 11]. If not prevented, it is estimated that tobacco use will cause one billion deaths globally by the year 2100 [11].

Recognizing the need to address tobacco use, in May 2003 the World Health Assembly adopted the Framework Convention on Tobacco Control (FCTC), which came into force in 2005. The FCTC takes a comprehensive approach to addressing the devastating impact of tobacco use, with 176 parties to the Convention as of January 2013.

UNDP's role

As described in UNDP's HIV, Health and Development Strategy (2012-3), UNDP is engaged in the implementation of the FCTC. Within a broader UN partnership and division of labour on tobacco control, agreed in a UN ECOSOC resolution [19], UNDP's roles and accountabilities are specified in Article 5 of the FCTC. Article 5 outlines general obligations of the parties regarding national strategy development, coordination mechanisms, legislative review, resource mobilization and prevention of industry interference. UNDP's role here aligns with its broader mandate on governance, coordination and addressing social determinants of HIV and health. More specifically, UNDP takes a leading role in supporting countries in (a) integrating the FCTC into national development planning processes, (b) UN system coordination and integration of the FCTC into the UNDAF mechanism, (c) research and policy support on tobacco control and (d) NCD prevention and control, including conducting socio-economic analysis of tobacco use and its impacts on health and development priorities. UNDP's HIV, Health and Development Group provides advisory support to UNDP Country Offices in close partnership with other groups and bureaux.

Article 5 of the WHO Framework Convention on Tobacco Control *(summary)*

1) Update and review comprehensive multisectoral national tobacco control strategies, plans and programmes
2) Towards this end, each Party shall:
(a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control; and
(b) develop appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.
3. Protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.
4. Cooperate in the formulation of proposed measures, procedures and guidelines for the implementation of the Convention and the protocols to which they are Parties.
5. Cooperate, with competent international and regional intergovernmental organizations and other bodies, to achieve the objectives of the Convention and the protocols.
6. Raise financial resources for effective implementation of the Convention through bilateral and multilateral funding mechanisms [21].

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Health, development and human rights dimensions of tobacco use

The health, development and human rights dimensions of tobacco use have been recognized at the highest levels. However, a lack of political, financial and technical resources, and interference from the tobacco industry, have led to insufficient implementation of the FCTC [4]. Recent high-level commitments to the prevention of NCDs and tobacco use, including the 2011 UN Political Declaration on NCDs, the 2011 Rio Declaration on Social Determinants of Health, the outcome document of the 2012 Rio+20 UN Summit on Sustainable Development and most recently the BRICS Health Ministers Communique all call for accelerated implementation of the FCTC. The latter stressed the importance of "research into the social and economic determinants of tobacco use and its control" [20].

Tobacco use exacts enormous economic tolls globally. It is expected to cost the world economy trillions of dollars in medical expenses and lost productivity in the 21st century [5]. Globally, a 2012 analysis found that tobacco use results in approximately US$500 billion in annual expenditures related to health care costs, productivity losses, fire damage and other costs [6]. It is estimated that tobacco use costs the world 1-2% of its gross domestic product each year [5]. The pathway to these losses is clear – tobacco use and resultant NCDs: cardiovascular disease, chronic lung disease, diabetes and cancer, that strike people in their prime, especially in lower- and middle-income countries, inhibiting country productivity, burdening already weak health care systems, and consuming scarce national resources [7].

Tobacco consumption also poses a barrier to economic and social development at household level. Households can be driven into poverty by tobacco through multiple means. First, households that spend income on tobacco products can result in depriving families of resources for basic necessities such as food, basic health care, or children's education [11]. Second, health impacts of tobacco use can cause economic hardship through financially debilitating out-of-pocket medical costs and decreased income due to the possible disability or premature death of wage earners [7, 8, 9, 10]. Tobacco use also obstructs access to education, with families instead spending money on tobacco products, children staying home to care for sick family members and children labouring in tobacco production rather than attending school [11].

Not only does tobacco have development impacts, but it also affects development drivers, social and economic policies, norms and inequities. Worldwide, tobacco use is more prevalent among men and within groups of lower socioeconomic status, as 80% of smokers reside in low- and middle-income countries [11, 12]. Recent evidence, however, suggests that the gender gap may be closing, with women taking up smoking at alarming rates [13]. Meanwhile, second-hand smoke will continue to disproportionately burden women, many of whom are powerless to negotiate smoke-free spaces for themselves or their children [13]. Women's vulnerabilities to tobacco are especially critical, considering the fact that, as women's health declines, so does the welfare of their respective households – families can fall deeper into poverty, mortality amongst small children may rise, and children might be withdrawn from school to compensate for their mother's lost wages [13]. Despite these realities, there are few health education and smoking cessation programmes aimed at women particularly among the poor, and women are often invisible from tobacco-related health statistics [14].

In addition to women, youth are also increasingly vulnerable to tobacco use. In Indonesia, for example, male smoking prevalence grew by 18.2% on average between 1994 and 2004. However, the growth rate was much higher among younger men: 139.4% for the 15-19 age bracket, followed by 49.3% for 20-24, and 22% for 25-29 [22].

There is a growing global momentum to mitigate the impact of tobacco use on health and development utilizing human-rights-based approaches. Human rights implications of tobacco include inequities in smoking prevalence and disease burden, with marginalized groups of lower socioeconomic status such as new immigrants, the homeless, those with mental illnesses and members of ethnic minorities being more likely to smoke than individuals of higher socioeconomic status [12]. They also include the right of the individual to enjoy a healthy environment, which is jeopardized by second-hand smoke; the right to have access to information to make informed choices, which is particularly lacking among the poor; the right to sexual and reproductive health; and the rights of the child [15, 16]. The FCTC aims to protect the human rights of all affected by smoking, particularly vulnerable populations such as women, children and those exposed to second-hand smoke. The text of the treaty itself makes explicit links to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

The interrelationships between tobacco use and social and economic development have been the catalyst for high-level global commitments to tobacco control and accelerated efforts are required by UNDP and other development actors in order to scale up FCTC implementation.

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