(2) Failing this, meanwhile there should be:

(a) specified progressive restriction of the sums the tobacco industry is permitted to spend on sponsorship;

(b) limitation of any agreement to a period of not more than two years; after which a fresh agreement should be negotiated; and

(c) regular monitoring of how the agreement is implemented in practice.

(3) In addition, any advertisements at and for events where sponsorship by tobacco interests is permitted to continue for the present should carry a Government health warning, in similar terms to those on standard cigarette advertisements.

We do understand the temptation to accept, for the laudable objective of promoting sport, the large sums of money which can be obtained from tobacco companies through sponsorship. But, as a member of the Government, we feel sure you will recognise your wider responsibility for the welfare of the public.

As the public clearly has a major interest in any agreement on tobacco sports sponsorship which may be made on their behalf, we believe that they are entitled to be made fully aware of the concern of members of the medical profession. We are therefore

sending copies of this letter to Members of Parliament and to the press as well as to the Secretaries of State for Health and Social Security, for England and Wales, for Scotland, and for Northern Ireland.

We would welcome the opportunity for a delegation of the signatories to meet to discuss these issues.

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An antismoking policy for Europe

RICHARD SMITH

What should the European office of the World Health Organisation (WHO) be doing about smoking problems in Europe? Is the WHO capable of taking any effective action in this matter, which has become increasingly political over the last 10 years? For two days last week 15 people from 10 countries ("the top flight of European antismokers," as Sir John Crofton described them) sat round a table in Edinburgh and tried to answer these two questions. Ostensibly they were concerned only with the first question, but several participants wondered whether the WHO, with its need to try and "please all the member states all the time," could achieve anything.

The WHO itself already has a smoking policy (see box)¹ which is in effect to shrink progressively the tobacco market until it disappears. But until now both in the main headquarters in Geneva and in the regional headquarters in Copenhagen smoking has not been seen by the WHO as one of its priorities. A few conferences and workshops have been held, data (much of them of doubtful value) have been gathered, reports and recommendations have been produced, and laboratory services

for analysing cigarettes have been organised, but no coherent or ambitious programmes have been devised. Even in a world context this lack is hard to understand, but within Europe it is a serious deficiency, as smoking is the largest preventable cause of death. A recent change in Copenhagen has meant that all this may be altered, and the Edinburgh meeting was convened to present the European office of WHO with an antismoking programme.

The main recommendation of the meeting was that smoking should be a WHO priority—like malaria or family planning. Within WHO Europe there should be a separate, well-funded, flexible programme. As well as making this primary recommendation the meeting heard reports on current smoking problems and policies within Europe and worked hard to produce a tough and ambitious antismoking programme.

Smoking problems and policies around Europe

When Professor Michael Kunze from Vienna sat down recently to produce a table for an international conference showing how many young people smoked in all the European countries he found that it could not be done. For most countries the information was not available. Indeed, for many countries in Europe—particularly in the east and the south—very little information is available on how many

WHO policy objectives on smoking

- (1) Achievement of lower smoking rates in all age groups of the population. This implies the application of whatever downward pressures on smoking rates that are practical. These might include health warnings on packets, taxation manipulation, restrictions on smoking opportunities, encouragement of the rights of the non-smoker, as well as measures such as are involved in political, publicity and education programmes.
- (2) The encouragement of non-smokers to remain non-smokers. The emphasis of this programme is on youth.
- (3) The cessation of all forms of tobacco promotion.
- (4) Those who have not yet stopped smoking, and therefore remain at high risk, should be encouraged to reduce, as far as possible, their exposure to harmful components of tobacco smoke.
- (5) To maintain liaison with other health organisations and authorities to ensure maximum effectiveness and avoid conflict of activities.
- (6) To achieve public health control of relevant industrial and environmental factors which contribute to lung cancer.

people smoke and how much they smoke. WHO Europe has attempted to gather this information but has failed completely. In 1978-9 it sent to 31 countries a questionnaire that was in eight sections and some 60 pages long. After 18 months only 19 countries had replied, and, as Dr Frank Ledwith from the Scottish Health Education Group explained, most of the information in the questionnaires that were returned was inaccurate and useless. The questions asked were inappropriate in many countries, and some governments must have seen no point in completing such a lengthy document.

The meeting heard reports on various parts of Europe, but first it is worth considering some overall figures. The table shows deaths from smoking-related diseases in Europe. Thus, even excluding Russia and four other countries in WHO Europe, there are about 500 000 deaths each year caused by smoking. Information on tobacco sales in 18 European countries between 1978 and 1980 showed increases in nine, a steady state in eight, and a fall in only one.

SCANDINAVIA

Many of the meeting participants found attractive the idea of WHO Europe producing a league table to show which countries were doing

*Deaths from smoking-related diseases in Europe**

	Year	Deaths from ischaemic heart disease	Deaths from cancer of lung, trachea, and bronchus	Deaths from bronchitis, emphysema, and asthma
Austria	1978	21 302	3 185	1 897
Belgium	1976	17 697	5 415	2 724
Czechoslovakia	1975	40 632	6 898	7 855
Denmark	1978	16 838	2 585	1 549
Finland	1975	12 166	1 729	1 065
France	1976	49 834	15 198	7 241
East Germany	1974	24 788	6 773	10 100
West Germany	1978	141 528	24 726	23 630
Greece	1978	9 551	3 532	2 254
Hungary	1978	29 097	4 924	4 967
Iceland	1978	389	40	21
Ireland	1975	8 626	1 191	1 536
Italy	1975	85 134	18 437	22 010
Luxembourg	1978	502	186	77
Malta	1977	554	60	46
Netherlands	1978	26 226	7 326	4 080
Norway	1978	10 546	947	725
Poland	1978	32 773	10 659	10 157
Portugal	1975	7 960	1 035	2 835
Rumania	1978	23 317	4 714	13 930
Spain	1976	28 618	7 040	10 449
Sweden	1978	32 083	2 402	1 586
Switzerland	1978	8 789	2 349	1 408
Yugoslavia	1977	16 559	4 648	3 422
Bulgaria	1977	21 364	2 504	3 836
United Kingdom:				
Scotland	1978	19 608	4 015	2 344
England and Wales	1977	155 813	33 979	23 210
Northern Ireland	1977	5 017	652	674
Total		847 311	177 149	165 634

*No data were available for Albania, Algeria, Monaco, Turkey, or the USSR, and data were included for the most recent available year.
Source: *World Health Statistics Annuals* 1977-80.

well in reducing smoking problems and which were not. If such a table was available now (and even if WHO Europe did have such a table it would probably be unwilling to publish it) then without a doubt the Scandinavian countries would be at the top.

The Norwegian government began planning an antismoking programme in 1967, and in 1975 the Norwegian Tobacco Act came into force: the Act banned advertising, required all cigarette products to carry a stern health warning, prohibited selling or handing over tobacco to people under 16, and gave the government the right to issue regulations controlling the contents of cigarettes. Since then the proportion of male smokers has dropped considerably, consumption of cigarettes has fallen, and fewer young people are smoking.

The Finns too became concerned about smoking in the 1960s, a Tobacco Act was passed in 1976, and an advertising ban introduced in 1978. Tobacco consumption fell by 11% in 1976 and has remained down, but the government has been timid about using its powers. It has not reduced the tar, nicotine, and carbon monoxide limits—as it has power to do (though this is about to be implemented)—nor has it set aside as much money for antismoking work as the Act required it to do.

Sweden has not banned tobacco advertising but has strict controls, and smoking rates are falling. Denmark is not quite the same shining example as her Scandinavian sisters.

GERMAN-SPEAKING COUNTRIES

West Germany, Austria, Switzerland, and Liechtenstein all have serious smoking problems but compared with the Scandinavian countries have done little about them. Austria recently conducted an intensive mass media campaign, which seemed to reduce smoking rates. (Professor Kunze told the Austrian Government that it cost about one British pound to stop one person smoking.) West Germany, however, has done little, and there is no coherent antismoking campaign—either governmental or non-governmental.

EEC COUNTRIES

Apart from West Germany, Italy, and Greece, the EEC countries would fall in the middle of any league table of antismoking achievement. They have antismoking programmes, but the programmes have little of the vigour of the Scandinavian ones.

EASTERN EUROPE

In most of Eastern Europe the population is smoking heavily and yet there is little activity to counter this. The annual growth rate in cigarette consumption is 2.6% in the Soviet Union, 3.8% in Poland, and 7.6% in Bulgaria. Dr Károly Lapis from Budapest summarised the scanty data available from Eastern Europe. Tobacco consumption has doubled in Hungary in the last 30 years, and now about 40% of the population are habitual smokers. Although the tar yield of cigarettes is decreasing, it is still high—upwards of 20-25 mg per cigarette. In Poland about 48% of the population smoke, and most Poles do not think of smoking as a risk to health. Mortality from lung cancer in the last 20 years has increased from 12.1 to 53.4 per 100 000 in men and from 3.2 to 8.7 in women. Little information is available on East Germany, but in the Rostock region 54% of women were reported to smoke during pregnancy. About 58% of men and 32% of women in Czechoslovakia smoke, and smoking rates are said to be high and growing fast in Bulgaria. No information on Russia was presented.

SOUTHERN EUROPE

Next to no information was available at the conference on Spain, Portugal, Greece, Turkey, Malta, Cyprus, Yugoslavia, Albania, and Morocco and Tunisia (the last two are included in WHO Europe). Yet the feeling was that these were countries with serious smoking problems and next to no antismoking activity.

Forging an antismoking programme

After being presented with all this rather inadequate data the 15 participants split into three groups of five and spent three sessions and several hours generating ideas on what WHO Europe should be doing

about smoking. They reported back to the whole group with about 50 ideas, which were then distilled into a programme. Thirteen themes were identified and lines of action were recommended—some to be begun in 1982-3 and some to fit into the next WHO session, which lasts from 1984 to 1989. To come to pass these recommendations do, of course, have to be accepted by the WHO authorities.

Theme 1: promoting smoking control in countries where there is little activity—Most of the participants thought that WHO Europe could achieve most with this kind of activity. The main areas needing help are Eastern Europe, southern Europe, and the German-speaking countries. The plan is to hold training and information workshops on smoking control in these countries. These will be followed by visits by smoking-control experts to the various countries; they will attempt to "get things going."

Theme 2: producing data on smoking rates in all European countries—This project will be in two parts: one part will be to collect good data and the second to produce mathematical and economic models predicting how consumption and mortality will change. Trying to collect data by sending questionnaires to governments is useless: instead, governments will be asked to organise in their countries a predesigned study. The Finns will then use these and other data to produce the models; in the words of Dr Matti Rimpela from Finland, "Governments will then be able to decide how many people they want to die from lung cancer."

Theme 3: special groups—The meeting was concerned that something should be done for women, children, and people at work and suggested that studies should be commissioned on smoking and women, smoking and pregnancy, and smoking and work. There will be a large international conference on women and health in 1983 and information should be presented there on women and smoking. Information gathered on smoking and work will be presented to international unions, and WHO Europe will hope to work with them. Ideas were less clear on what should be done to combat smoking in children in Europe. One essential is to gather data, and another plan is to work with UNICEF.

Theme 4: an expert report on smoking in Europe—Reports on the "state of the art" should be published every few years; they can be very useful when dealing with uninterested governments.

Theme 5: producing information on "upper limits" and "product modification"—Both scientific and political thinking on setting upper limits on the tar, nicotine, and carbon monoxide content of cigarettes and on ways of modifying the content of cigarettes is confused, and the conference thought that a clear scientific document on this issue would be invaluable. This could be difficult for WHO to produce, and it was felt that a report could be produced more quickly by a non-governmental agency such as the International Union Against Cancer.

Theme 6: passive smoking—Passive smoking is one of the issues that most upsets tobacco companies. The conference suggested that a large conference on the issue should be organised, that WHO Europe should push for more no-smoking zones, and that "a declaration of the rights of the non-smoker" should be produced. Any blaming of smokers, must, however, be avoided.

Theme 7: stimulating individual government action—The conference recommended that WHO Europe should send a letter to all European health ministers asking questions such as: What is the country doing to advance the WHO policy on smoking? If little is being done what are the problems? What are the plans for the future? What is being done about smoking in children? Are the tobacco companies creating

difficulties? The letter might also be sent to the media so that the governments would be encouraged to answer. Recommendations were also made that WHO Europe should contact all non-governmental organisations concerned with smoking.

Theme 8: visible promotion—Changing the smoking behaviour of populations inevitably means lots of publicity about antismoking activities, and also inevitably the WHO is concerned to be seen to be doing something. Slogans are important in this respect, and several were discussed. Another antismoking day was suggested, and Mike Daube from Edinburgh, always an ambitious thinker, suggested an antismoking decade to start in 1990.

Theme 9: studying and stigmatising the tobacco industry—The participants thought that as they sat in Edinburgh discussing ways of reducing smoking another group from the tobacco industry was probably sitting in another European city thinking how to increase tobacco consumption and "neutralise" the antismoking activities of WHO. The tobacco industry studies antismoking activities avidly, and the participants thought that WHO Europe should study the strategies of the tobacco industry in Europe. It should also make great play of the harm that the tobacco industry is doing.

Theme 10: price policy on cigarettes in Europe—In the last analysis putting up the price of tobacco is probably the most effective way of reducing smoking problems, and the group thought that a WHO study on this topic would be important in influencing governments.

Theme 11: doctors and smoking—Although some doctors have been very influential in antismoking movements, in many European countries medical students are taught little about the importance of smoking and many doctors think it unimportant. The participants thought that studies of what is taught in medical schools and of attitudes of doctors combined with a large conference on doctors and smoking might help to counteract this.

Theme 12: smoking cessation—How effective are various smoking-cessation programmes? How can they best be organised and are they cost effective? These are questions that the participants thought could well be addressed by WHO Europe.

Theme 13: incorporating antismoking activities into other WHO programmes—Although the WHO has not been very active with anti-smoking activities, it has many other active campaigns—in mother and child health, for instance. The participants thought it important that antismoking activities should be incorporated into these programmes.

Conclusions

So what will happen now? Fifteen people worked hard and energetically to design an antismoking programme for WHO Europe. Will the upper echelons of WHO Europe accept the programme and will money and resources be made available to carry it out? For the sake of the 10 million Europeans who may die because of smoking between now and the year 2000 we must hope so.

Reference

- 1 Expert Committee. Controlling the smoking epidemic. *WHO Tech Rep Ser* 1979;636.

How often should a patient with a copper intrauterine contraceptive device have a cervical smear performed in the absence of any other clinical indications? Is cervical dysplasia more common in such patients?

Actinomyces have been found in about one-third of smears from patients wearing IUCDs: it has been suggested¹ that intrauterine devices affect only *Actinomyces israelii* and not other species. According to a British report,² actinomyces-like organisms were found in almost one-third of smears from women using plastic IUCDs, but in only 1-2% of smears from women using copper-containing devices. The presence of the organisms was highly significantly correlated³ with pain and clinical evidence of genital infection. These findings suggest that an asymptomatic woman with a copper IUCD should probably have cervical smears no oftener than a patient using any other form of contraception. As to cervical dysplasia, a report³ from India gives a 2.3% incidence of dysplastic lesions among users of various copper IUCDs (compared with a 4.7% incidence among women using the

loop), and a four-year follow-up of 461 women using copper-containing IUCDs failed to show a higher incidence of dysplasia than with plastic ones. A report⁴ from another centre on 815 women using copper devices found that 3.7% had dysplastic lesions when the device was inserted and 5.3% at 36-month follow-up, but all the patients subsequently had normal smears at 48-month follow-up. These results are reassuring, particularly since there is no theoretical reason⁴ to expect the copper to have harmful effects on the cervical epithelium.—J O DRIFE, lecturer in obstetrics and gynaecology, Bristol.

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⁴ Luthra UK, Mitra AB, Prabhakar AK, Bhatnagar P, Agarwal SS. Copper containing intrauterine devices and cervical carcinogenesis—48 months follow up. *Indian J Med Res* 1980;72:659-64.