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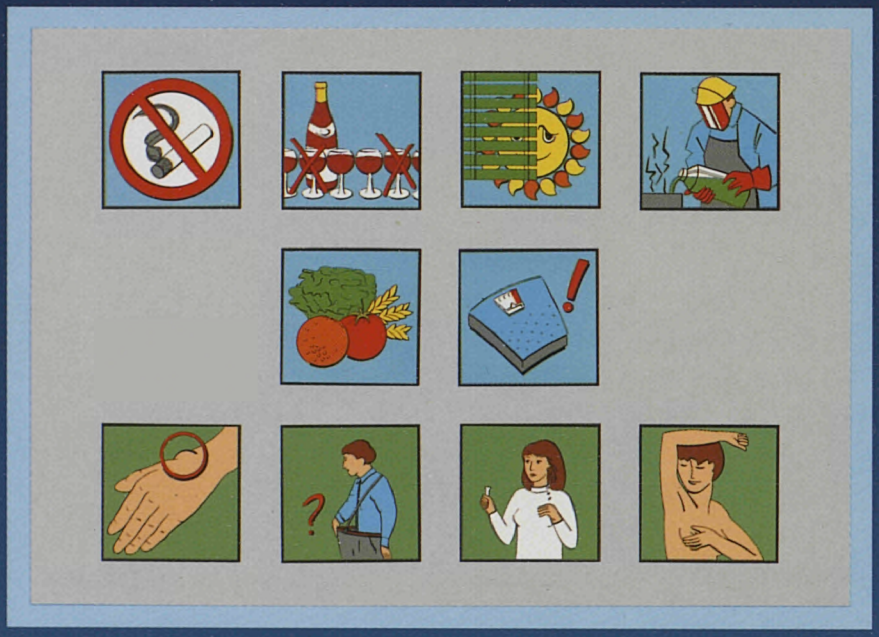

Europe against cancer

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Public health: initiatives and texts adopted in 1990

COMMISSION OF
THE EUROPEAN COMMUNITIES

DIRECTORATE-GENERAL FOR
EMPLOYMENT, INDUSTRIAL RELATIONS
AND SOCIAL AFFAIRS

1/91

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The first part of this edition, on 'Europe against cancer', has been prepared by the unit 'Europe against cancer' in the Directorate-General for Employment, Industrial Relations and Social Affairs of the Commission of the European Communities. Coordination of the text was undertaken within this service by David Sweet and Dr Alain Vanvossel, administrators.

The editors of *Social Europe* would like to thank the cancer experts, and all the partners of the 'Europe against cancer' programme, as well as the members of other Directorates-General of the Commission who have willingly contributed to this edition.

COMMISSION OF THE EUROPEAN COMMUNITIES

DIRECTORATE-GENERAL FOR EMPLOYMENT, INDUSTRIAL RELATIONS AND SOCIAL AFFAIRS

Notice to readers

The information contained in this publication does not necessarily reflect the opinion or the position of the Commission of the European Communities.

The articles were prepared before German unification, so the text and statistics are based on a population of 320 million in the European Community.

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Photo: CEC.

With the 'Europe against cancer' programme the European Community has reinforced its human dimension - a new dimension for the Community in many respects - and drawn closer to the citizens of our 12 countries.

One European in four is stricken by this terrible disease at some stage. However, it is a proven fact that many cancers can be avoided, and many cured if detected sufficiently early. This is the essential message of the 'Europe against Cancer' programme, which aims to reduce the trend of deaths from cancer by 15% between now and the year 2000.

The programme covers four areas: cancer prevention, training of health personnel, information of the public and health education in schools, and medical research.

By pooling their efforts and working more closely together, Europeans can hope to advance further and faster in all these areas. Tangible results have already been achieved, as this special edition of *Social Europe* clearly demonstrates.

Vasso Papandreou

Member of the Commission
of the European Communities

Foreword

Europe against cancer: a new concept

When the Heads of State or Government of the European Community approved the launch of a European programme against cancer at the Milan European Council in June 1985, they were breaking new ground. Up until then actions at Community level in this field had been limited to two tasks:

- ☐ the development of norms for the protection of the population against ionizing radiation and chemical carcinogens;
- ☐ the avoidance of occupational cancers, originally in the iron and steel industries, subsequently in all the other sectors.

But even taken together, these actions confronted the origins of only 10% of the mortality from cancer despite the fact that over 75% of cancers are linked to external factors which can be overcome at individual, national or Community level.

From now on, with the Europe against cancer programme, the European Community can act in new areas such as disease prevention, information of the public, health education (especially in schools) and the training of health personnel. But the innovative character of the programme is not just a question of the areas covered. It also inspires the chosen strategy, which has three key elements:

- ☐ the partnership approach, which enables the programme to bring together all the national actors involved in the campaign against cancer, and to regroup them in European committees and working parties, both scientific and non-scientific;
- ☐ the European Code against cancer, which presents 10 rules for a healthy lifestyle;
- ☐ the importance of maintaining a long-term vision because the objective of the programme is cited for the year 2000 and the campaign is a long-term affair.

This concept is new but fertile. It amounts simply to saying that the European Community can and should be concerned with its citizens, on the one hand by allocating a part of its budget to financing European actions against cancer, and on the other hand by taking account of the 'cancer dimension' in the traditional areas of its competence such as research, protection of the population against ionizing radiation and protection of workers.

The European Commission has succeeded in having a number of proposals adopted by the Council of Ministers of the European Community, not only in the field of cancer but also concerned with other illnesses (cardiovascular diseases, pulmonary diseases, etc.). These texts are included as annexes to this volume.

This edition of *Social Europe* reflects the innovatory character of the Europe against cancer programme. We read the contributions from cancer experts, directors of cancer leagues, general practitioners and educationalists, and from officials and experts at the Commission. All these partners are contributing to the special character of the programme and to bringing the European Community closer to the concerns of its citizens.

Jean Degimbe

Director-General for Employment,
Industrial Relations and Social Affairs
Commission of the European Communities

CHAPTER 1

What is the problem?

Before a problem can be solved, it must be identified. In these articles, the principal causes of cancer are reviewed, with analysis of possible means of prevention. The current epidemiological situation concerning certain cancers in the Community is illustrated by maps of mortality and the apparently mundane but vital task of registering cancers explained.

Prevention of cancer

Prospects for the near future?

An alternative title for the present article could read 'Promotion of a healthy life'. Our global aim is encouraging the development of a general environment conducive to the well-being of populations. Such a goal should be seen in a much wider context, taking into account not only the economic aspects of health and disease, but also the philosophical and moral issues by which the attainment of good health allows human beings to aspire to a better, more equitable and socially fair world.

Cancer: responsible for a quarter of the mortality in the Community

Although we do not live in the land of Utopia, and, consequently, the well-known goal for the world's population set by the World Health Organization (WHO) of 'Health for all by the year 2000' may be unattainable in its entirety, having such an ambitious slogan has undoubtedly allowed considerable progress to be made in a shorter time-scale than it would otherwise have been.

With regard to cancer, more limited goals have been set by various national and international bodies, most of these also aimed at the somewhat mystical figure of the year 2000. The target of the European Regional Office of the World Health Organization is a reduction of at least 15% in cancer mortality in people under 65 in Europe.

At the present time, cancer represents around a quarter of the overall mortality in most EC countries. But this figure, as high as it might be, only alludes to a small proportion of the total amount of human, social and financial costs linked to cancer. This explains the need to try to prevent at least some of these cancers from taking place.

A rational approach to prevention would require knowledge of cause and subsequently removal of that cause. In reality, this is neither sufficient nor even necessary. As the classical historical example of the termination of the cholera epidemic in London in 1854 by removal of the handle of a water pump clearly shows, even years before the agent responsible for cholera had been isolated, prevention was possible. On the other hand, some causal agents, even if known, cannot be removed from our environment. This applies to external factors, such as solar radiation or, even more importantly, internal determinants of disease such as the genetic background of an individual or the hormonal milieu.

With this proviso in mind, prevention is often separated into two components: primary prevention aiming at preventing the occurrence of cancer, mainly through removal of identified risk factors and secondary prevention, the goal of which is to diagnose cancer at a very early stage or preferably to be able to recognize disease at a precancerous phase. This last type of prevention is referred to as screening.

Primary prevention: attainable and desirable goals

Primary prevention requires some knowledge of cause or at least strong indication of risk factors and, in fact, tentative removal of suspicious exposures and subsequent reduction in disease occurrence often helps in identifying causes.

Eliminate tobacco from our environment

In the domain of cancer, the best example of possible and necessary effective primary prevention is the removal of tobacco from our environment. Tobacco is in fact a remarkable product because of the number of diseases to which it can reliably be linked as a causal agent or, at least, as a factor which is partially responsible for the occurrence of disease. In this respect, tobacco is almost unique, perhaps only rivalled by alcohol, which is also responsible for many diseases. As early as the 17th century, those in medicine or in government had seen the need to combat smoking, but unfortunately, economic constraints prevailed, and it was felt more profitable to tax tobacco rather than to ban it. Therefore, we are faced today with a myriad of tobacco-related ailments and their considerable human and financial costs.

Tobacco is the best known and most widely used carcinogen, and its use is responsible for:

- ☐ the vast majority of cancers of the lung, trachea and bronchus;
- ☐ a considerable proportion of cancers of the bladder and of the renal pelvis;
- ☐ a considerable proportion of cancers of the oral cavity, lip, pharynx, larynx and oesophagus, with an added large proportion of risk attributable to alcohol consumption;
- ☐ a considerable proportion of cancers of the pancreas and possibly of renal adenocarcinoma.

The causal link between lung cancer and cigarette smoking was established as early as 1950, based on epidemiological studies of very high quality. Since that time, hundreds of investigations have been carried out in various populations and countries, and they have repeatedly confirmed the earlier findings. It seems almost inconceivable that almost 40 years later governments still accept the sale of sources of deadly smoke and subjects still maintain and initiate the habit of smoking, especially when one considers, on the one hand, the repeated oral assertions of concern for the public's health made by governments and, on the other, the fear of cancer in the general population. The very low survival rate of lung cancer and the suffering experienced by cancer patients should be an additional very valid deterrent against the maintenance and dissemination of the habit, but obviously, this information is somehow removed or ignored in the individual's conscience.

In addition, cancer is not the only disease associated with tobacco use. The increased risk of cardiovascular diseases has also been clearly demonstrated. Smokers have higher rates of coronary heart disease, including myocardial infarction and chronic heart disease, peripheral vascular diseases and cerebrovascular diseases. Special note should be taken of the specific risk of cardiocerebrovascular diseases among women who smoke and use oral contraceptives.

The present action plan also offers help to smokers who want to give up.
Photo: © Tome & Janry / Dupuis, Belgium.

Another group of diseases which have been associated with smoking are chronic obstructive lung diseases, such as emphysema and chronic bronchitis. Still other diseases could be cited: pneumonia, tuberculosis, peptic ulcers.

It would therefore seem reasonable to eliminate tobacco from our world, but no country has yet taken such a drastic decision. At least, every effort should be made to advance in the right direction by trying to make cigarettes and other tobacco products less affordable through taxes, by bringing into force and effectively implementing restrictive legislation such as a complete ban on tobacco advertising, a restriction of sales to minors and of smoking in public places and, most important of all, by promoting effective health education for adolescents and children as well as for the general population.

Alcohol: moderate consumption

Recommendations for a healthy life style should also address the issue of alcohol. Whereas there is no safe level for cigarette smoking and no such thing as a safe tobacco product, arguments can be put forward for alcohol to be consumed in moderation. A dose of approximately one glass of wine per day presents no measurable health risk and may even slightly reduce cardiovascular mortality. But increased amounts of alcohol lead to increased risk of disease. In particular, alcohol is a recognized carcinogen for cancers of the oral cavity, pharynx, larynx, oesophagus and liver. For most of these cancer sites, the combined effects of drinking alcohol and smoking greatly increase risk. If one also takes into account the other diseases linked with excessive drinking as well as the accidents and violence it causes, it is clear that the public health message should stress in no uncertain terms the importance of moderating one's intake and preferably this should be done in quantitative terms.

Eat fresh fruit and vegetables several times a day

This method of presenting quantitative information is even more relevant for diet. Once again, the public message needs to be clear, simple, yet to the point and easy to implement. One cannot and should not give advice which is only concerned with cancer prevention. But in order to avoid obesity and its ensuing diseases and, more specifically, to reduce cardiovascular risk, a diet rich in fresh fruit, vegetables and cereals and poor in fat, particularly of animal origin, is to be recommended. To put it simply, everyone should eat fruit and vegetables several times a day. The problem of tolerable fat intake is more complex given the numerous sources of such compounds and their various types which carry differing risks or benefits. In general, a person's total caloric intake should be such that no excess weight should occur. This caloric intake should of course be adjusted according to one's requirements, which in turn are linked to the usual level of physical exercise. Total intake of fat should be reduced, and preference should be given to vegetable fat. Finally, it is advisable to vary the types of foods consumed.

The importance of personal lifestyle

Personal habits and ways of life account for a large proportion of all cancers. In contrast, only a limited number of cancers may reliably be linked to specific carcinogens present in the general environment. The effects of air pollution or background radiation on health are extremely difficult to quantify precisely. The same can also be said of potential risks linked to the presence of contaminants, such as pesticide residue in food.

Prevent the development of occupational cancers

Of special note is the issue of occupational exposures to known or suspected carcinogens. Although the number of subjects exposed is low and, therefore, the impact of removing these carcinogens from the work environment is small in terms of population cancer incidence, these compounds represent a substantial threat to the workers involved, and every effort should be made to reduce exposure and, if possible, to replace these products by other less dangerous substances. The work force needs to be adequately informed of possible risks and an efficient control should be maintained to prevent the emission of hazardous chemicals in the production chain.

Avoid excessive exposure to the sun

One other factor, the exposure to which can be controlled by the individual, is solar irradiation. Sunlight is necessary for life, but excessive exposure to it, in particular for some fair-skinned individuals, may lead to malignant melanoma of the skin. Avoiding sunburn, especially during childhood, is relatively easy. An important point is to convince women (and men!) that having fair skin is as attractive as having a dark

suntan. Although UV machines are controlled (but certainly not in all instances) for the type of UV rays emitted, it is difficult to justify their use apart from wanting to appear fashionable.

In the future, it may be possible to control some other risk factors for cancer. Already today, immunization against hepatitis B is being carried out and it is expected not only to prevent the occurrence of viral hepatitis, but also to reduce the risk of primary liver cancer. In Europe, the majority of cancers most commonly encountered, with the exception of cervical cancer, are not known to be linked to viruses or parasites. Control of genetic factors is not yet possible, although some screening could be foreseen in the near future to identify individuals at particularly high risk who could benefit from a specific surveillance.

Secondary prevention: screening for cancer can have a positive impact

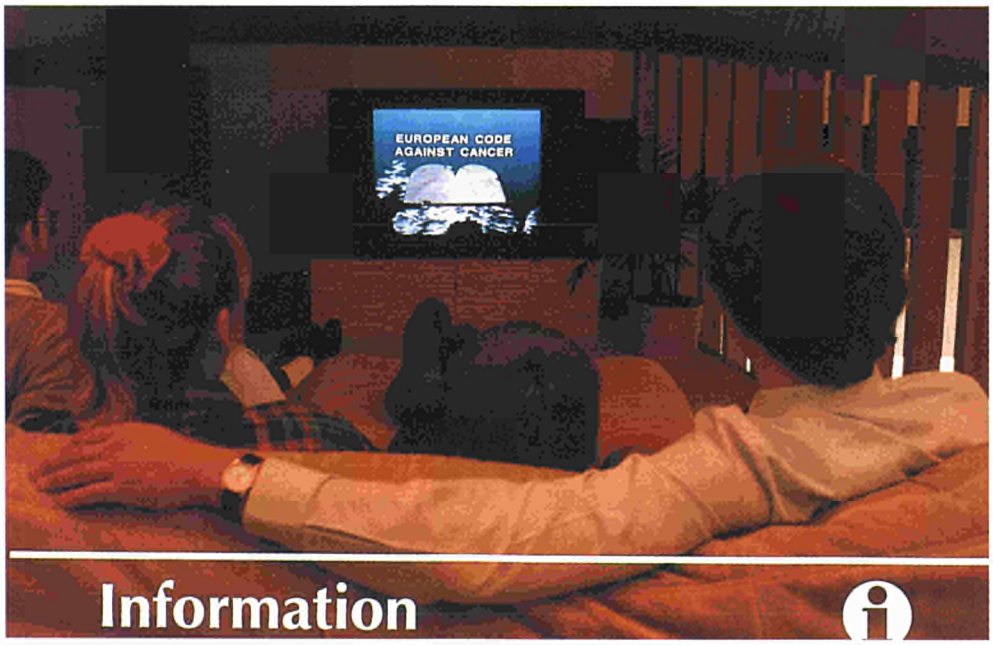
Knowledge of the aetiology of most common cancers is still quite limited. Fortunately, even though the causes of cancer are not fully understood, an impact on cancer occurrence and/or mortality through early detection is possible.

For two cancer sites, cancer of the cervix and breast cancer, there is agreement on the efficacy of screening. The carrying out of cervical smears at regular intervals, starting at a young age, has been consistently linked with a decrease in mortality from cervical cancer as well as with some reduction in incidence through treatment of precancerous lesions and carcinoma *in situ*. Screening for breast cancer by mammography has also been shown to reduce mortality by 20 to 40%, at least among women over 50 years of age.

The case for colon cancer, although less clear, certainly warrants considerable attention, whereas some screening programmes, lung cancer for example, cannot be justified as the savings (if any) in major expense are minimal.

Most identified carcinogens are man-made substances

Of the 59 agents classified as carcinogenic to humans (for which there is sufficient evidence of carcinogenicity, according to the definitions of the International Agency for Research on Cancer – IARC), the large majority are man-made industrial chemicals, industrial exposure and medical drugs. Therefore, among the recognized human carcinogenic agents, only a few (or



Information is an essential element of cancer prevention. *Photo: CEC*

at least exposure to them) go back more than a century and a half: ionizing and non-ionizing radiation, aflatoxins, certain combustion products and possibly certain viruses for instance. As far as we know, the situation would therefore indicate that the industrial exploitation of natural resources, of which asbestos and tobacco are two different and conspicuous examples, and the synthesis of new chemicals have indeed generated new hazards and new carcinogens which have been added to the older ones. Since cancer is a much older disease than the industrial revolution, we must assume that there are causes we have not yet identified which are responsible for a rather consistent fraction of the total cancer cases.

An important challenge for the 21st century

At the dawn of the 21st century, we are facing a considerable challenge. Our knowledge of cancer causation is still limited, particularly with regard to some of the most common cancers (such as breast, ovary, colon, prostate and gastric cancer), and it would therefore appear logical to concentrate our efforts on trying to discover their aetiology. In a logical world, this information could then be used in prevention by the removal from our environment of avoidable causes of disease.

Unfortunately, knowledge is not enough and even when some causes of cancer, particularly tobacco use, have been identified beyond any doubt, experience shows that it may take as long as 20 or 30 years before sufficient energy is devoted to the fight against smoking.

A smoke-free generation by the year 2000 should be our most important goal. Children born today should be the object of all our concerted efforts to provide a smoke-free environment by not being exposed to passive smoking and by not becoming smokers themselves. It is also important to protect the developing world from becoming the next victims of the tobacco industry. Faced with a diminishing market in the Western world, marketing strategies are now being implemented in the Third World, leading to a 1 to 2% increase in annual tobacco sales in developing countries.

In order to succeed, we need to take action in a number of fields: education, information, health, taxation, economics, agriculture, politics and legislation. The issues of education and information are of paramount importance. We need to find the best ways of communicating health information effectively, in order not only to increase awareness of the problem, but also to motivate subjects to modify their behaviour. If advertising succeeds in changing consumers' choices, why has public health information failed to make an impact on people's habits? Part of the answer may be financial constraints, but it may also be that we lack creative imagination and that the exhortation to lead a healthier life must contain not only a physical but also a moral component.

Dr Annie J. Sasco
Dr Lorenzo Tomatis, Director
International Agency for Research on Cancer (IARC)

The role of cancer registration

The incidence of cancer varies between different parts of Europe, suggesting that factors associated with place of residence are important determinants of cancer risk. That is the reason why epidemiology, the scientific study of the distribution and determinants of a disease, is and will be playing a central role in the 'Europe against cancer' programme. Cancer registration as the presupposition of cancer epidemiology is the organized effort to collect, verify and tabulate, employ and disseminate information on the incidence of malignant neoplasms (in a defined geographical area). So, cancer registries are epidemiological institutions which deal with cancer registration and will nearly always conduct research in analytical and descriptive epidemiology.

Cancer registration is an essential component of any rational programme of cancer control. It has proved estimating the size of the public health problem posed by cancer, examining the causes of cancer, evaluating survival of cancer patients and the benefits of cancer treatment, and planning of cancer treatment services. The ultimate goal of any cancer control programme is the reduction of cancer incidence. This comprises primary prevention aspects, and the monitoring of trends in cancer incidence thus becomes an integral part of a cancer control programme. To assess and control the impact of malignant disease on the community with the emphasis on epidemiology and public health, population-based cancer registries are needed. This type of cancer registry records all new cases in a defined population.

Cancer registration reveals the scale of the problem

The enumeration of cancer cases in a defined population serves to assess the dimension of the cancer problem in terms of the number of new cases and the comutation of incidence rates, i.e. the number of new cases per 100 000 population per year. The incidence of cancer varies with age, and differences between the sexes are often apparent (e.g. a 3 to 4 times higher incidence of lung cancer in men). There are wide variations in incidence between populations both among and within countries (e.g. differences between regions, occupational groups, socio-economic classes, and religious groups). Increasing trends are seen for several sites (e.g. lung cancer, skin melanoma), while others are decreasing in many countries (e.g. stomach cancer, cancer of the uterine cervix). Such differences in incidence between populations have led to the recognition that the risk of cancer development is determined by exogenous factors related to lifestyle (smoking, alcohol consumption, diet, exposure to UV radiation), to the occupational environment, and to the general environment. Thus, cancer would be to a large extent avoidable.

Another important role of the cancer registry lies in the possibility to link cancer registry records with other data files. The cancer registry has thus served as an end-point in numerous cohort studies to evaluate risks associated with occupational exposure, drug taking, smoking, diet, etc. Similarly, the cancer registry facilitates the conducting of intervention trials such as the study of the possibly cancer-preventive action of beta-carotene and tocopherol supplementation in heavy smokers. Cancer registries may also serve as a source of cancer cases for investigations — case-control studies for instance — where exposures are compared among patients with cancer and persons without cancer in order to identify characteristics of individuals who have developed a malignant disease.

The cancer registry's data may be used for the planning and establishment of cancer treatment and care facilities directed towards various types of cancer. Geographic differences as well as time trends, including the projection of future incidence roles, may be useful for such purposes.

When the cancer registry follows up individual patients for their remaining life-time, and collects information on the date and cause of death, it may contribute to the evaluation of patient care and health-care planning, by

According to epidemiological data, one in four Europeans is currently affected by cancer and, if the present trend continues, the figure will increase to one European in three by the year 2000.
Photo: CEC.

monitoring population-based survival rates. This supplements the more detailed information that is often available from specialized hospitals. If true differences are found, diagnostic and treatment facilities may be directed to parts of the population with less favourable survival expectancy.

Finally, registries have played a crucial role in demonstrating the effect which cancer screening programmes have had in lowering cancer incidence, by comparing incidence trends between areas where such screening has been practised with different intensity, e.g. Finland versus Norway and different Scandinavian countries. Examination of asymptomatic persons to detect cancer at an early stage is becoming increasingly important in the control of certain malignant diseases.

Cancer registration within the European Community began in 1929

Continuous registration of cancer morbidity in Europe started in 1929 when the first population-based cancer registry was set up in Hamburg, Germany. Its main goal was to collect information on cancer patients in order to facilitate follow-up. The next two registries were opened in the United States in Connecticut in 1936, and in the State of New York (excluding New York City) in 1940. The first registry to cover a whole nation was the Danish Cancer Registry set up in 1942.

Cancer deaths in Europe (1986)

Country	Total deaths	Cancer deaths		
		Total	Lung (men)	Breast (women)
Belgium	112 791	27 220	5 780	2 400
Denmark	57 777	14 946	2 220	1 290
FR of Germany	701 832	163 038	21 310	14 165
Greece	91 783	18 365	3 682	1 193
Spain[1]	299 409	65 810	9 771	4 231
France	546 926	133 008	17 393	9 530
Ireland	33 704	6 886	1 118	571
Italy[2]	547 436	133 770	23 597	9 953
Luxembourg	4 014	938	190	77
Netherlands	125 307	33 966	7 536	3 040
Portugal	95 828	16 241	1 600	1 231
United Kingdom	660 735	156 858	28 627	15 245
European Community	3 277 542	771 046	122 824	62 926

Based on WHO figures.
[1] 1984.
[2] 1985.

Today, population-based cancer registries covering all or part of the national populations exist in all countries of the European Community except Greece and Luxembourg. A recent survey showed that there are 62 cancer registries in the European Community which attempt to record neoplasms in general in their respective territories. An additional 20 registries collect data sets restricted either to children, or to a single site, or to a group of cancer. The only country in the Community where cancer is a reportable disease is Denmark. In all other European countries, cancer registration is based on voluntary agreement.

Not all cancer registries function at the optimal level, and only 27 registries (12 from the United Kingdom) from the Community have reported their data in the monograph *Cancer incidence in five continents* published by the International Agency for Research on Cancer (IARC) in Lyons, France. The IARC, founded in 1968, assembles the results of all important cancer registries from all continents. In Europe, at least two regional or language group associations exist: The Nordic Association of Cancer Registries, and the Group for the Epidemiology and Registration of Cancer in Latin-Language Countries.

In all European countries, apart from the problems of completeness and validity, the issues of confidentiality and professional secrecy have proven the major issue in the registration of cancer. In some countries of the European Community, this is the most important hindrance to making full use of the information contained in population-based cancer registries.

There is no doubt that cancer registries support the principle that all data concerning individuals with cancer should be strictly confidential. On the other hand, full respect for the confidentiality of such data need not prevent the safe, efficient and useful operation of cancer registries, as experience over many years has amply demonstrated in all parts of the world. No breach of confidentiality has ever been reported from any cancer registry. Cancer registries thus have clear definitions of which information must be handled as confidential, what measures must be taken for the security of data within the registry and for the protection of the reporting physician, how the surveillance and periodic review of data security procedures is effected and what is required of a written application for data release and the necessary mechanisms for the protection of any such release.

Most cancer registries operate a code of confidentiality for individual cancer data and have developed appropriate mechanisms for ensuring adherence to it. In this way, data on individuals whose cancer is reported to the registry do not reach unauthorized third parties.

Proportion of European cancer deaths attributable to various factors

These attempted estimates are largely based on the work of Higginson and Muir (1979) for Birmingham in the United Kingdom, of Doll and Peto (1981) for the United States and of Tubiana (1985) for France. They incorporate many uncertain factors and should, in any case, be adapted to differing national situations.

Factors	Best estimate (in %)	Range of estimates (in %)	Estimated annual number of deaths
Tobacco	30	25-35	220 000
Alcohol	4[1]	2-5	30 000
Diet	30?	10-50	220 000?
Occupation	4	2-8	30 000
Infection	3?	1-10	22 000?
Geophysics[2]	3	2-4	22 000

[1] Could be higher, certainly extremely variable by country (e.g. 10 % in France).
[2] Radioactivity and solar rays.

Developing cancer registration in the Member States

The 'Europe against cancer' programme provides a basis for the strengthening of cancer registration in Europe through improvements in ongoing registration schemes, improvement in the comparability of data, and support for the establishment of cancer registration systems in countries or regions where none exist. Following careful consideration of the current state of cancer registration in the EC during the first half of 1989, the 'Europe against cancer' programme supported a proposal to strengthen cancer registration in the Community Member States through the establishment of a network of European cancer registries. The programme will be jointly managed by the Danish Cancer Registry and the IARC. The overall objective is to improve comparability of cancer registry data and extend cancer registration within the European Community with the aim of creating a solid basis for the continuous monitoring of the burden of cancer in the Community, and of enhancing the use of cancer incidence information for research and planning.

Dr Ole Møller Jensen and Prof. E. Grundmann

Members of the Committee of Cancer Experts of the 'Europe against cancer' programme

Maps of mortality for certain cancers

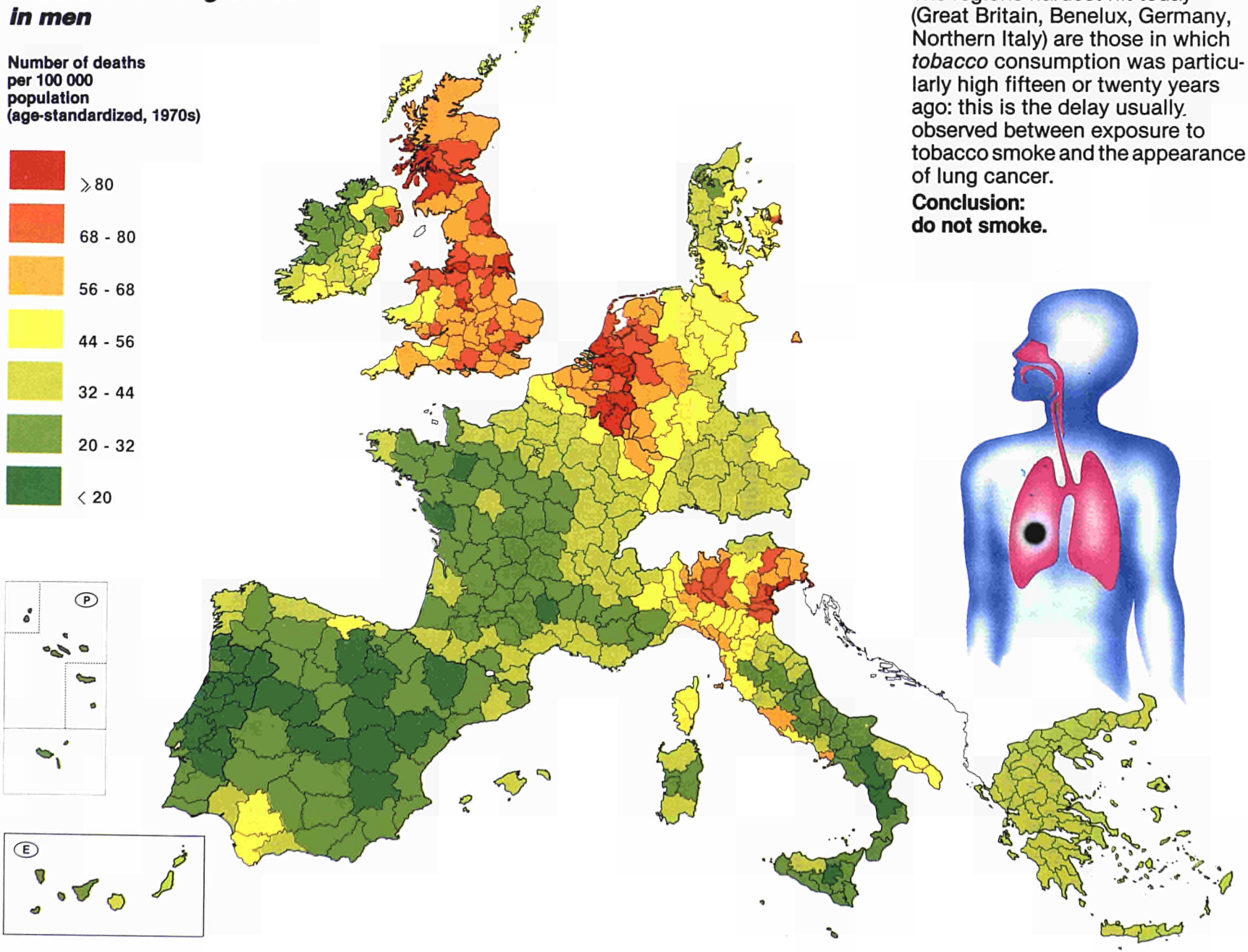
Produced by the IARC for the 'Europe against cancer' programme

- Deaths from lung cancer in men
- Deaths from cancer of the oesophagus in men
- Deaths from stomach cancer in women
- Deaths from malignant melanomas in men
- Deaths from breast cancer in women

Deaths from lung cancer in men

Number of deaths per 100 000 population (age-standardized, 1970s)

- ⩾ 80
- 68 - 80
- 56 - 68
- 44 - 56
- 32 - 44
- 20 - 32
- < 20



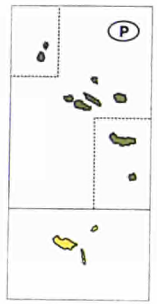
The regions hardest hit today (Great Britain, Benelux, Germany, Northern Italy) are those in which *tobacco* consumption was particularly high fifteen or twenty years ago: this is the delay usually observed between exposure to tobacco smoke and the appearance of lung cancer.

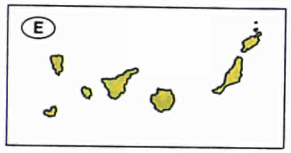
Conclusion: do not smoke.

Deaths from cancer of the oesophagus in men

Number of deaths per 100 000 population (age-standardized, 1970s)

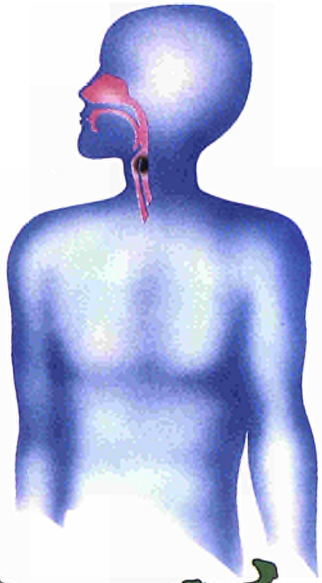
- ⩾18
- 15 - 18
- 12 - 15
- 9 - 12
- 6 - 9
- 3 - 6
- < 3





High *alcohol* consumption, aggravated by smoking, explains the record of mortality in western France.

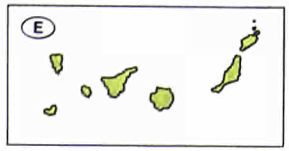
Conclusion: moderate your consumption of alcoholic drinks.



Deaths from stomach cancer in women

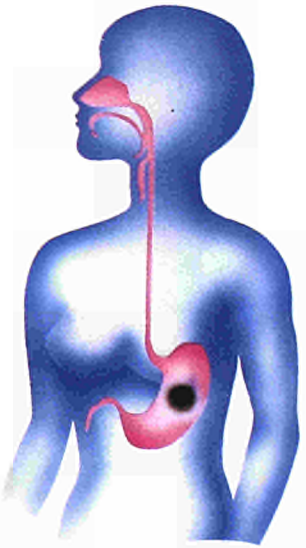
Number of deaths per 100 000 population (age-standardized, 1970s)

- ⩾ 20
- 17 - 20
- 14 - 17
- 11 - 14
- 8 - 11
- 5 - 8
- < 5



Mortality is particularly high in Central-Northern Italy and Portugal. A *diet too low in fresh fruit and vegetables* is probably a risk factor.

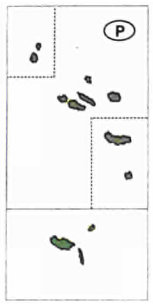
Conclusion:
eat fresh fruit and vegetables often.



Deaths from malignant melanomas in men

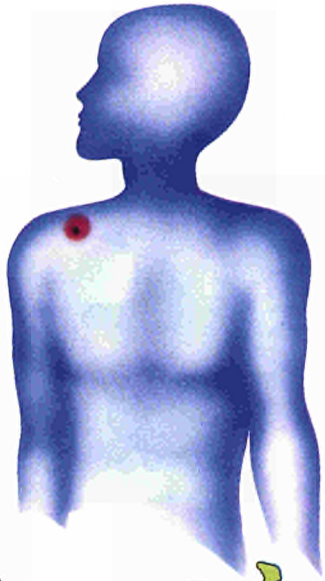
Number of deaths per 100 000 population (age-standardized, 1970s)

- ⩾ 2
- 1,6 - 2
- 1,2 - 1,6
- 0,8 - 1,2
- 0,4 - 0,8
- < 0,4

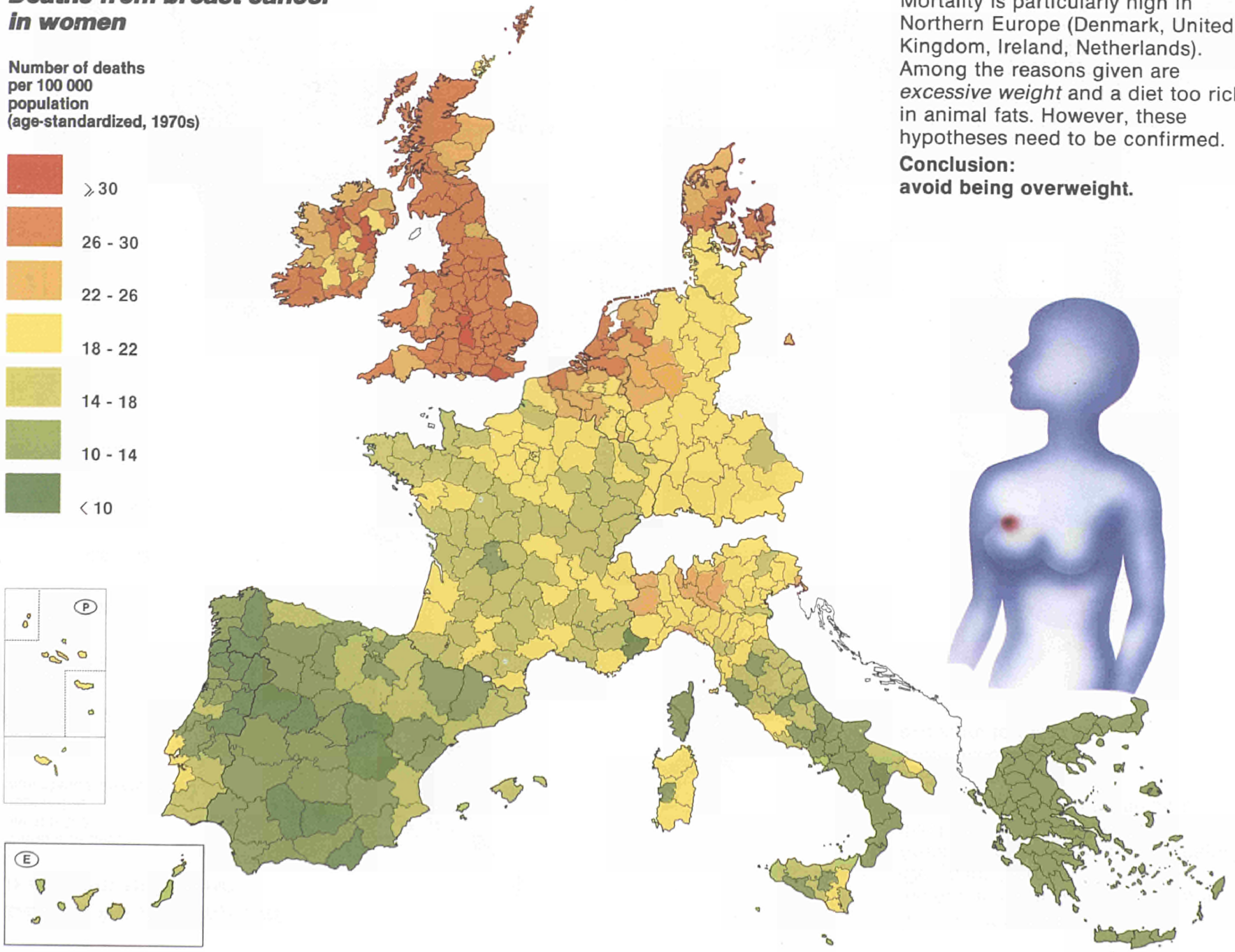


Skin cancers claim most victims in the countries of Northern Europe (Denmark, Germany, England). Among fair-skinned people, a major risk factor is intermittent but *excessive exposure to the sun.*

Conclusion: avoid excessive exposure to the sun.



Deaths from breast cancer in women



Mortality is particularly high in Northern Europe (Denmark, United Kingdom, Ireland, Netherlands). Among the reasons given are *excessive weight* and a diet too rich in animal fats. However, these hypotheses need to be confirmed.

Conclusion:
avoid being overweight.

CHAPTER 2

The European Community's response

These three articles present in a nutshell the essential features of the 'Europe against cancer' programme. Professor Tubiana explains how the predominantly scientific and medically oriented group of cancer experts came to identify the key features of the programme (information, education, training, tobacco control, screening and research) as priorities, and produced the European Code against cancer. This is discussed more fully in the second article. Finally, progress and achievements are evaluated and the future directions of the 'Europe against cancer' programme identified.

The advantages of a European programme from a cancer expert's point of view

When the principle of a European action against cancer was decided in Milan in June 1985 at the meeting of the Heads of State or Government of the 12 countries of the Community, European cancer experts asked themselves at first what useful effect such an action could have, in addition to the national programmes and the major international operations such as those sponsored by the World Health Organization (WHO) and the International Union Against Cancer (UICC). Nevertheless, it quickly became apparent that a European action could have three specific advantages, namely:

- ☐ *to exploit the prestige of a 'European' label to increase the effectiveness of actions which could only be undertaken at a national level;*
- ☐ *to take advantage of the experience and help of experts from all the Community countries. The European dimension considerably increased the ability of each country not only in research but also in applying new methods of diagnosis and treatment;*
- ☐ *to promote legislative or regulatory measures at a time when more and more decisions were being taken at European level for subsequent implementation at national level.*

A few examples quickly illustrate the benefit that Europeans have received from these three aspects of the action against cancer.

The European Code against cancer and its 10 commandments have been promoted in all the European media and distributed widely by all the organizations against cancer in the Twelve. This result was only possible because the cancer experts of the European Community were able to agree on a text which, for this reason, has had a major impact on public opinion.

Moreover, a whole series of actions around the Code have taken place which could not have been implemented without experience gained in one or another of the Member States. One of the most promising is health education in schools: informing children from the age of 5-7 through to the end of their adolescence of the strengths and weaknesses of the human body and what they need to do to maintain a healthy development.

There is no doubt that all these elements are the best way to bring home to everyone what is necessary to achieve and maintain good health and thus to take responsibility for establishing a healthy lifestyle through the years to come. This could have happened independently in each country but the mutual support and cooperation between European countries has played a decisive part in this undertaking; thanks to these contacts those countries less experienced in this field have been able to take advantage of the others.

This positive result of European cooperation has been even more apparent in the case of screening for cancers. An important decision of the Council of Health Ministers was to organize mass screening campaigns for breast and cervical cancer, at the request of the Committee of Cancer Experts. Its implementation was only possible, however, because certain countries which had launched pilot exercises had an experience in the field which enabled the difficulties and rewards of these projects to be assessed. This experience allowed the other countries to move forward to mass screening more rapidly.

Alongside information to the general public, training of health professionals, especially general practitioners, has been an important aim of the programme, much appreciated by European doctors.

In the field of research, Community cooperation is still more fruitful in broadening the national dimension and providing young doctors and scientists with the possibility of training in other European centres. More and more, the cooperation between cancer specialists and hospitals in every country is improving the effectiveness of clinical research and speeding up the evaluation of new methods of treatment. Large programmes can be developed which would be too costly for a single country.

Even the differences between countries have enriched the programme. Research on the role of dietary factors in the development of cancer has benefited from the differences between northern European and Mediterranean countries; we can thus hope to understand why certain cancers are much more frequent in some countries than in others.

Significant progress has been made in the campaigns against tobacco and alcohol abuse, which are the causes

In January 1986, the European Commission created a committee, bringing together the leading cancer experts, which was charged with the development of an action plan against cancer.
Photo: CEC.

of many cancers. On the legal front, Europe plays a crucial role. Important decisions restricting tobacco have already been taken: harmonization of labelling on cigarette packets; the banning of high-tar cigarettes; the banning of tobacco advertising on television; and the banning of smoking in public places. Unquestionably, such measures could not have been taken so quickly without the European impetus.

These examples show the advantages of a European action against cancer — still the second highest cause of death and the principal cause of death in the 35 to 65 age group. Moreover, the more successful the actions against other diseases the more the death toll from cancer mounts. The primary goal of the European action is to reduce the number of deaths from cancer by at least 15% at the beginning of the 21st century, compared with the situation which would have been the case without the action. This highly ambitious objective requires willing and energetic support at all levels.

The campaign against tobacco, screening of certain cancers, better training for health professionals, better public information, coordination of therapeutic research in European hospitals and checks on the quality of treatment are all major elements of such a strategy. Success will need the perseverance of all the partners and increased awareness of all Europeans. Without a European action against cancer this could not possibly be achieved.

Prof. Maurice Tubiana

Chairman of the Committee of Cancer Experts of the 'Europe against cancer' programme

The European Code

A basic tool

Cancer is not a death sentence. Many cancers can be avoided, more can be cured if detected early. Outcome does not depend solely on the doctor, but also, and especially, on the patient. These are the essential messages of the European Code against cancer.

The first objective of the cancer experts, when they met at the invitation of the Heads of State or Government of the European Community, was to prepare a short document explaining how each of us can, on the one hand, reduce the risk of being affected by a cancer in our lives, and on the other, increase the chance of being cured if we do develop one.

A document of this type, to be useful, should be based on a complete awareness of the causes and development of cancers: exhaustive preparation was therefore necessary, involving epidemiologists, statisticians and clinicians.

The document starts with prevention. Taking all cancers concerning men and women of all ages together, one third are due to tobacco. Given that a third of adults smoke, this indicates that the risk of cancer is much greater among smokers than among non-smokers. For example, cancers of the lung and the larynx are, respectively, 20 and 10 times more frequent among smokers than among non-smokers. The first recommendation, and the most important therefore, deals with tobacco: do not smoke and do not smoke in the presence of others because tobacco is poisonous for them, especially for children.

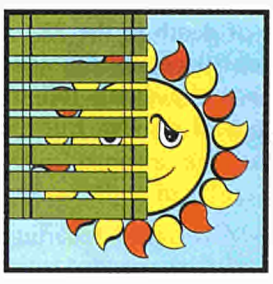
Alcohol, while a less potent carcinogen, is also implicated in a significant number of cancers, especially those of the mouth, throat and oesophagus. None the less, in contrast to tobacco, where even one cigarette per day is already damaging to health, there is no evidence for a toxic effect on men of a consumption of alcohol equivalent to a third of a litre of wine per day. The recommendation is therefore: moderate your consumption of alcohol.

Prolonged sunbathing, especially by fair and red-headed people whose skin is more fragile, can provoke skin cancers, of which certain types, melanomas, are very serious. Excessive exposure to sun should therefore be avoided by fair-skinned people, light clothes worn as protection and sun protection creams used. These recommendations are especially important for children who should not be allowed to play in direct sunshine for long periods without precautions.

Finally, it is difficult to avoid the presence of carcinogens, especially chemical products, in our environment. For example, the combustion of coal, oil and wood releases powerful carcinogens; it is out of the question to ban their use. But risks can be substantially reduced if industries and workers follow the safety procedures which have been developed to achieve the maximum security.

If the first four commandments show how we can protect ourselves against the carcinogens present in our environment, the fifth and sixth show how we can increase the resources of our own organism and so reduce our risk. A number of studies undertaken in Japan, America and Europe have established the role of diet in the prevalence of cancers.

Certain foods have a beneficial effect. In particular, people who eat fresh (including deep-frozen) fruit and vegetables at every meal are less affected by cancer than those of the same age and sex with different diets.



Similarly, but with less certainty, a number of studies show a protective effect from fibre-rich foods such as cereals. The positive effect of fruit and vegetables can easily be accounted for by the number of vitamins, especially A, C and E, they contain. As they probably include other useful elements, they should not be replaced by vitamin pills. The favourable effect of fibres is probably due to the fact that they accelerate the passage of food through the intestinal system.

There is a correlation between a diet rich in fat, especially of animal origin (from meat, whole milk, creamy cheeses), and an increased risk of colo-rectal cancers, cancers of the breast and prostate. The exact mechanisms are still under research and the object of many discussions. Since, in addition, a reduction in animal fat reduces the risk of cardiovascular diseases it seemed legitimate to recommend it. As the standard of living in the Western world has risen and the consumption of meat and dairy products has increased at the expense of cereals, fat has come to supply 45 % or more of the calorific intake. This proportion should be diminished, if possible back to 30 %; this would require a marked change in our habits, for example increasing our consumption of cereals, fish, and low-fat milk products.

Finally, statistics demonstrate that certain cancers, such as of the breast, uterus and prostate, are more frequent among people whose weight is higher than average. The campaign against obesity is therefore part of the campaign against cancer.

A cancer diagnosed and treated at its outset will be managed and cured more easily. Experience shows that an informed public will consult medical help earlier and thus improve the therapeutic outcome. This is true for all cancers, but especially for cancers of the skin, digestive tract, uro-genitary organs, and the respiratory tract. In all these cases swelling or bleeding are warning signs which should not be neglected and which should lead to a medical consultation.

Finally, simple tests exist for two frequent cancers, those of the cervix and breast. Screening can detect precancerous or cancerous lesions at a stage where they can be easily cured. Every three years, all women between 25 and 70 should undergo a cervical smear and those between 50 and 70 a mammography. These two completely painless tests, if carried out under correct conditions on all eligible women, could save the lives of 30 000 women in Europe every year.

All of us need to work together to spread these commandments, to follow them and to encourage others to do so. Through these means we could save more than 100 000 Europeans from dying of cancer each year.

Prof. Maurice Tubiana

Chairman of the Committee of Cancer Experts of the 'Europe against cancer' programme

European Code against cancer

If the 'Ten European Commandments' are followed, there will be a significant reduction in the number of deaths from cancer in the European Community, already predicted to reach 15% by the year 2000.

Committee of Cancer Experts of the European Community

CERTAIN CANCERS MAY BE AVOIDED:

1 **Do not smoke.** Smokers, stop as quickly as possible and do not smoke in the presence of others.

2 **Moderate your consumption of alcoholic drinks, beers, wines or spirits.**

3 **Avoid excessive exposure to the sun.**

4 **Follow health and safety instructions at work** concerning production, handling or use of any substance which may cause cancer.

YOUR GENERAL HEALTH WILL BENEFIT FROM THE FOLLOWING COMMANDMENTS WHICH MAY ALSO REDUCE THE RISKS OF SOME CANCERS

MORE CANCERS WILL BE CURED IF DETECTED:

5 **Frequently eat fresh fruit and vegetables, and cereals with a high fibre content.**

6 **Avoid becoming overweight** and limit your intake of fatty foods.

7 **See a doctor** if you notice a lump, or observe a change in a mole, or abnormal bleeding.

8 **See a doctor if you have persistent problems,** such as a persistent cough, a persistent hoarseness, a change in bowel habits or an unexplained weight loss.

FOR WOMEN

9 **Have a cervical smear regularly.**

10 **Check your breasts regularly,** and, if possible, undergo mammography at regular intervals above the age of 50.

Europe against cancer

Achievements and prospects

The 'Europe against cancer' programme has now been running for four years. The first three constituted the first plan of action 1987-89. The fourth marked the launch of the second plan of action which will run to 1994. It is instructive to draw on the experience gained so as to place the prospects for the next four years in perspective.

1987-89: Highly satisfactory progress

Between 1987 and 1989 significant progress was recorded in each of the programme's areas, namely cancer prevention, health information and education, training of health personnel and cancer research.

Remarkable results in the campaign against tobacco

In the area of prevention remarkable results were obtained, particularly in the campaign against smoking, which is responsible for almost a third of cancer deaths. A number of proposals for Community legislation were drafted by the Commission and discussed by the European Parliament and the Council of Ministers of the European Community. Some proposals were adopted during this first plan of action, namely a resolution on banning smoking in places open to the public (adopted on 16 May 1989), and a Directive on harmonization of the labelling of tobacco products (adopted on 13 November 1989). This Directive obliges Member States to modify their legislation on the labelling of tobacco products by 1 January 1992, so as to inform smokers more clearly of the indisputable risks which smoking entails, by printing unambiguous medical warnings such as 'Smoking causes cancer' or 'Smoking causes heart disease' in large legible letters on one of the two largest surfaces of every cigarette packet. A second Directive which imposes limits on the maximum tar levels in cigarettes (15 mg by the end of 1992, 12 mg by the end of 1997) was adopted by the Council of Ministers on 17 May 1990.

1989: The European Year of Information on Cancer

In the field of information and health education, the main achievement during the first action plan 1987-89 was of course the 'European Year of Information on Cancer' in 1989. This involved the participation of non-governmental organizations (anti-cancer and anti-tobacco associations, general practitioners, cancer experts, producers of medical TV programmes) as well as the Ministries of Health and Education, and was designed to make the general public and schoolchildren more aware of the European Code against cancer. The Year culminated on 9 January 1990 with the first ever Eurovision broadcast on a serious scientific subject.

Training in the best centres of Europe

With regard to the training of health personnel, the representatives of all the parties concerned agreed on a series of recommendations concerning cancer training for doctors, dentists and nurses. In addition, around 100 doctors and nurses were given the opportunity to receive further training in cancer screening and treatment at the best centres in Europe.

Research: a broader European dimension

Finally, cancer research took on a broader European dimension with the promotion of exchanges between research workers (50 grants awarded each year) and the coordination of clinical and basic research. Research was also initiated into promising new radiotherapy techniques involving neutron capture or light ions.

1990-94: The second plan of action: continuation and extension of the programme

Building on the satisfactory results achieved so far, the European Community will extend its campaign over the next five years, on the basis of the decision adopted at the Council of Health Ministers of 17 May 1990.[1] This decision covers the following fields.

[1] OJ L 137, 30.5.1990, p. 31.

Improved knowledge of the links between diet and cancer

The Community will pursue with undiminished vigour its legislative activities in the fight against smoking. Thus certain Directives will seek to reinforce the existing controls. Particular importance will be given to studies and pilot actions concerning the links between nutrition and cancer, given that diet could be responsible for a third of cancer deaths. Prospective studies will allow large population samples across the Community to be monitored for many years. The diversity of diets in the Member States should enable clearer links to be established between certain foods and cancer of the breast or digestive system.

Progress on screening

The 'Europe against cancer' programme will also assist common progress in the field of screening with the establishment of pilot networks for breast and cervical screening. The European Week of 1991 will be focused on screening and early detection, particularly of the 'female' cancers. In addition, completion of the evaluation studies of colo-rectal screening by 1994 will allow conclusions to be drawn by national and regional health authorities on this topic.

Accent on health education in schools

The 'Europe against cancer' programme will continue to promote public awareness of the 10 European commandments for cancer prevention. In particular it will build on the experience of the European Year of Information on Cancer 1989 and on the support offered by the associations and leagues. The second action plan will place special emphasis on health education in schools based on the conclusions of the studies and the European conferences conducted so far. In this context the European Conference held in Dublin in February 1990 allowed the creation of a strategy which should be progressively applied across the Member States.

The success of the 'Europe against cancer' programme, since its launch in 1986, is due both to national actions and the cooperation between the various partners at European level.
Photo: CEC.

Pilot schemes for training

Special efforts will be made to encourage implementation of the recommendations produced during the first action plan, and at the beginning of the second, especially in the so-called 'consensus conferences' for general practitioners, nurses and dentists.

Also, on the basis of the experience acquired from 1988 to 1990, financial support will be forthcoming for further training initiatives for doctors and nurses.

Finally, the first results of the joint medical research actions undertaken since 1987 should find practical applications in the course of the next five years notably in the form of pilot installations for treating patients by improved radiotherapy.

The objective: to reduce mortality by the year 2000

We should first note the conditions which have facilitated this significant success in the campaign against cancer. The importance of a motivating objective — to reduce mortality from cancer by 15% by the year 2000 (i.e. to reduce the number of deaths from the expected 1 million to 850 000) — is fundamental. Secondly, the European Commission has adopted a partnership strategy to ensure the inclusion of all the national bodies involved in the campaign against cancer. These have been brought together at European level and form:

- ☐ the Committee of Cancer Experts (the safeguard of the scientific content of the programme);
- ☐ the senior officials concerned in the Ministries of Health, Education and Research, without whom the programme could not be effective;
- ☐ the organizations against cancer and the anti-tobacco organizations of the European Community, the 'advance battalions' of the programme;
- ☐ the representatives of the general practitioners who play a central role in the early detection and systematic screening of cancer;
- ☐ the producers of medical TV programmes, thanks to whom the messages about cancer prevention have been widely broadcast.

While it is too early to detect a possible modifying of the rising trend of mortality from cancer it is apparent that the partners of the programme are now convinced of the value of a common effort at European level (which was far from being the case at the beginning of the programme). Their wholehearted support is a fact which has allowed the European Community to make significant advances in a field of wide concern to so many citizens.

Michel Richonnier

Head of 'Programme of action against cancer' Unit
Directorate-General for Employment,
Industrial Relations and Social Affairs
Commission of the European Communities

CHAPTER 3

Attacking the causes

The Commission of the European Communities has undertaken many actions which have as their principal or secondary effect the protection of citizens of the Community from cancer. Some of these are presented in this section, beginning with the question of tobacco use.

Tobacco is linked to a third of all deaths from cancer. This stark fact obliges any serious cancer prevention programme to make every effort to reduce smoking prevalence and consumption, and the Committee of Cancer Experts has placed the campaign against tobacco at the head of its priorities and of the Code. The report by Jacques-René Rabier on smoking in the European Community shows that prevalence is beginning to decline. The article by Stylianos Christopoulos shows the range of actions undertaken under the 'Europe against cancer' banner, both by the decision-making bodies of the Community and by the partners in the Member States.

Three other types of action against the causes of cancer are discussed here: the improvement of nutrition practices, which requires collaboration between many services of the Commission as well as across the Community; the protection of workers from industrial carcinogens and the laborious but vital work of classifying chemical substances according to their toxicity, including carcinogenicity.

The campaign against tobacco in Europe

The first priority of the programme

Every year, some 450 000 people are killed by tobacco — 230 000 of them by cancer — in the European Community.[1] That is why the campaign against tobacco was one of the first priorities of the Europe against cancer programme. This involves not just legislative measures but a large-scale campaign of public awareness and also specific measures towards strategic groups such as general practitioners and teachers.

All these actions were preceded and will be followed by sample surveys of the target groups.[2] Some of the principal results are presented below.

One in three Europeans admits to smoking

A little over a third (36%) of Europeans aged 15 and over call themselves smokers.[3] Three countries have more than 40%: Denmark (45%), Greece (43%) and the Netherlands (42%). The country with the lowest prevalence is Portugal with 'only' (28%) smokers.

It might at first sight seem surprising that Denmark, with the highest-priced cigarettes in the Community, should have the highest smoking rate. There is no real contradiction, however, because when the price of a packet of cigarettes is compared with some indicator of the standard of living, such as GDP per head, measured in purchasing power standards, the relative price is 30% less in Denmark than, say, Ireland. In Portugal, on the other hand, the low prevalence rate can be explained by the fact that women, traditionally non-smokers, are still less likely to smoke than men.

In fact any study of smoking habits, or attempt to predict their change, must take account of the sex and age differences observed.[4] In general terms women smoke less than men, but this is becoming less and less true. In Denmark, for example, they have quite caught up, so to speak. For men the highest rates of smoking are in the 25 to 54 age group, while for women they are in the 15 to 39 age group.

When age and sex are considered together, it can be seen that in the countries where women's socio-cultural status has advanced faster or further compared to men (Denmark, Netherlands, Luxembourg) young women (15 to 24) already have higher smoking rates than men of the same age. In countries such as Greece, and even more so Portugal, young women still smoke less than men but it unfortunately would not be surprising if prevalence among women rises sharply with the newer generations and as a side effect of a more modern status.

Giving up

The risks of smoking are well known. Three-quarters of Europeans, when asked, think that the recommendation 'Don't smoke' is 'very important'. This attitude is of course largely shared by general practitioners and teachers. Better still, nearly 60% of smokers in the general public agree that it is 'very important' that they should not smoke.

The smoker's world seems to be riddled with contradictions:

- ☐ one smoker in three says he/she wants to stop, and more than one in four to cut down; these rates are even higher among GPs;[5]
- ☐ six smokers in ten claim to have tried to stop at least once.

Putting these responses together, we can draw the following conclusions about the 94 million smokers (out of 260 million people of 15 and over) in the European Community:

- ☐ 25%, or around 23 million, have tried, and still want, to stop;

[1] According to available epidemiological data and statistics from the WHO.

[2] Four surveys have been conducted of the general public, in spring 1987, spring 1988, autumn 1988 and spring 1989. 12 000 people aged 15 and up were questioned in each survey. GPs were surveyed in early autumn 1989 (N = 2314) and teachers in January/February 1989 (N = 2750). All these surveys were conducted by specialized organizations collaborating under the name of 'European Omnibus Surveys' and coordinated by 'Faits et Opinions' (Paris).

[3] According to the aggregated results of the four surveys of the general public.

[4] The 'normal' trend is considered to be that which would result from the free play of market forces without any attempt to promote a health message.

[5] Teachers were not asked this question.

- 35%, or 33 million, have tried, and half of these would like to cut down, the other half are happy as they are;
- the rest, 40% or around 37 million, can be considered as the hard-core or confirmed nicotine addicts.

Actions against smoking must be coordinated and evaluated with care, whether generalized, for example legal measures, or specific towards the most influential role models, in this case GPs and teachers.

These groups are not yet free of the weed. Across the Community, the proportion of GPs who smoke is much the same as that of the general public (36%). So far as we can tell (the question was not put in quite the same way) teachers have a significantly lower rate (21%).[6] But note the very low rate among doctors (and teachers) in the United Kingdom, the remarkable result of 40 years of consistent campaigning since the publication of the epidemiological research of Doll and Hill.[7]

The surveys into these two professions allow us to identify the most effective types of anti-smoking actions to initiate or develop.

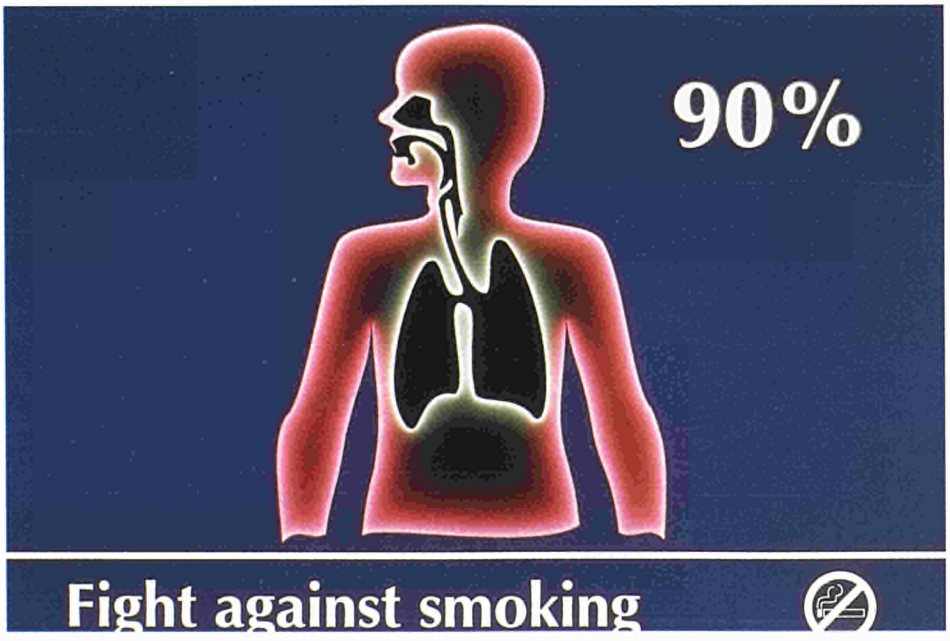
General practitioners warn their patients against smoking

Nearly all doctors questioned agree with the recommendation 'Do not smoke'. But they realize that it is a hard rule for the general public to follow.

How do they present it to their patients? Rather too discreetly, at least in some countries, it would seem. Nearly nine GPs out of ten say that they 'very often' warn their patients of the dangers of smoking if the patient has symptoms linked to smoking. Rather fewer (75%) do so when the patient himself raises the question. It falls to less than half (48%) — and even lower in Denmark and the Netherlands (26% and 20% respectively) — if the patient is a smoker without tobacco-related symptoms who does not bring the subject up.

[6] Strictly speaking, we should take account of the differences in demographic structure between doctors, teachers and the general public.

[7] 'Smoking and carcinoma of the lung', *British Medical Journal*, 1950.



90% of lung cancers are linked to smoking. Moreover, smoking increases the risk of cancer for all tissues in contact with the smoke: lips, mouth, oesophagus, kidneys . . .
Photo: CEC.

Teachers warn their pupils

Teachers are also quite convinced of the importance of the smoking point of the European Code. How is the question dealt with in the classroom? Eight out of ten primary and nine out of ten secondary teachers, across the Community, claim to warn their pupils about tobacco.

Is this positive attitude of teachers supported by school rules such as the prohibition of smoking by pupils in schools? The situation seems to vary greatly from one country to another; prohibition is the rule in Ireland, Greece, Portugal and the United Kingdom; restrictions, such as no smoking in the actual classroom, in Spain and Denmark. In Denmark and the Netherlands the head of school is apparently given the power to permit smoking in specified areas.

This brief review of the surveys which have been conducted under the aegis of the Europe against cancer programme shows that there is still much to be done before one of the most dangerous habits affecting citizens of the European Community — smoking — can be eliminated.

The battle is far from won, but at least it has been engaged.

Jacques-René Rabier

Special Adviser to the Commission of the European Communities

European Community initiatives in tobacco control

A comprehensive and varied approach

In the framework of the first action plan of the 'Europe against cancer' programme, the Commission identified 14 measures to reduce the adverse impact of tobacco on health.

The proposed legislation on tobacco has so far included five proposals for Directives: harmonization of indirect taxation on tobacco products, harmonization of the health warnings on tobacco packaging; limiting the tar yield of cigarettes to 15 mg by 1992 and 12 mg by 1997; restricting tobacco advertising (including a ban on indirect advertising) and the strengthening of the health warnings with the ban of moist snuff. Moreover, in 1989 the Council and the Ministers for Health meeting within the Council adopted a resolution based on a draft recommendation of the European Commission concerning smoking in public places. Last but not least, Eurostat has, since July 1989, published a monthly price index excluding tobacco.

Taxation: a proposal that combines harmonization and flexibility

In respect of the harmonization of taxes, no progress has been noted yet. The wide variety of prices and the wide variety of taxation systems make the harmonization process very difficult.

The Commission has therefore adopted a modified proposal which takes account of these difficulties while preserving the objective of eventual harmonization. According to this proposal:

- on 1 January 1993 each Member State will be required to apply rates higher than, or equal to, the minimum rates set for each product category (in the Member States as a whole, the approach will allow fiscal health to be maintained or increased). This flexibility must under no circumstances jeopardize the fundamental principle of abolition of customs and tax frontiers by 1 January 1993;
- after 1 January 1993, the initial flexibility must gradually give way to a movement towards target rates compatible with essential public health requirements. To this end, the target rates have been significantly increased compared to those proposed in 1987.

A price index excluding tobacco by Eurostat

Since July 1989, a price index excluding tobacco has been published monthly by the Statistical Office of the European Communities.

In general, the difference between including or excluding tobacco from the price index is negligible.

Comparison between index including tobacco and index excluding tobacco
Position 1990 (base 1985 = 100)

	General index	
	including tobacco products	without tobacco products
B	109.4	109.2
DK	119.7	119.9
D	106.2	106.0
GR	201.4	199.9
E	134.0	134.0
F	114.6	114.4
IRL	116.7	116.3
I	129.2	128.8
L	107.6	107.4
NL	102.8	102.3
P	164.4	164.5
UK	127.1	127.2
EUR 12	120.2	120.0

Source: Eurostat.

Smoking in public places: non-smokers have priority

This measure has been adopted as a resolution of the Council and of the Ministers for Health of the Member States meeting within the Council.[1] It identifies a series of public places where smoking should not be allowed. In order to allow enforcement of such a measure, special provision is made for clearly defined areas to be reserved for smokers in those establishments. The measure also asks Member States to ensure that in case of conflict, in areas other than those reserved for

[1] OJ C 189, 26.7.1989, p. 1.

smokers, the right to health for non-smokers prevails over the right of smokers to smoke.

Member States must inform the European Commission every two years of actions taken in response to this resolution.

The labelling Directive

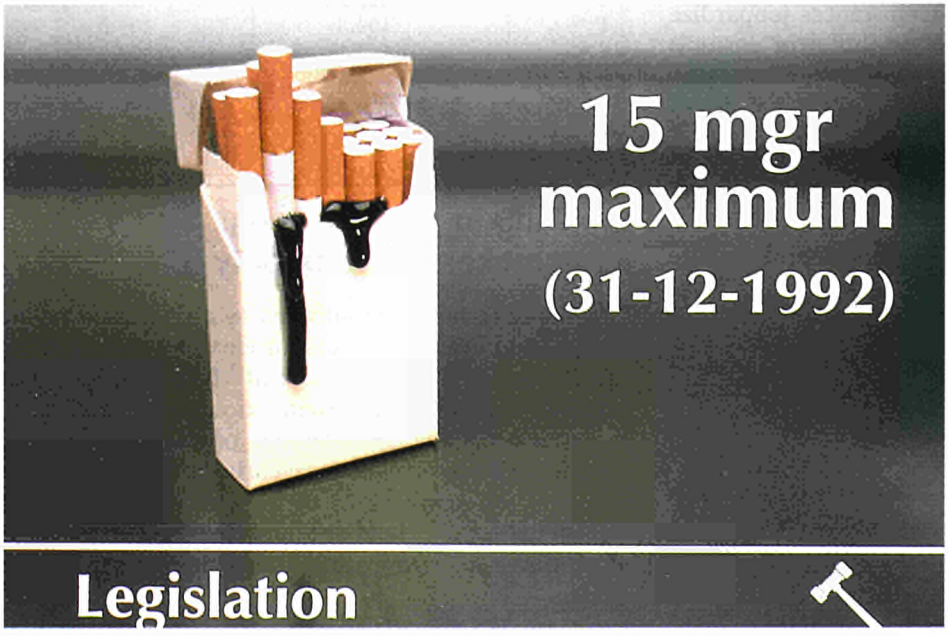
The Council of Ministers of 13 November 1989 adopted the first directive on tobacco prevention: Directive 89/622/EEC on the labelling of tobacco products.[2]

This Directive is aimed at the harmonization of national provisions on the labelling of tobacco products which, at present, are likely to constitute obstacles to trade incompatible with the establishment and functioning of the single internal market. In accordance with Article 100a of the EEC Treaty the Directive takes as a base a high level of protection in the fields of health and consumer protection.

The main lines laid down in the EC Directive are the following:

- ☐ all units of packaging of tobacco products must carry on one of the largest surfaces the following general message 'Smoking seriously damages health';
- ☐ for cigarette packets, the other largest surface must carry specific alternating messages chosen from a list drawn up by each Member State on the basis of the list of health warnings set out in the annex. These national lists must include the following warnings: 'Smoking causes cancer', 'Smoking causes heart disease';
- ☐ the tar and nicotine yield of cigarettes must be indicated on the side of the packet.

[2] OJ L 359, 8.12.1989, p. 1.



The European Community has adopted a Directive limiting the tar content of cigarettes.
Photo: CEC.

Directive limiting the tar yield in cigarettes to a maximum of 15 mg by the end of 1992

As adopted by the Council of Ministers of 17 May 1990,[3] this Directive provides for a maximum tar level of 15 mg per cigarette by the end of 1992 and 12 mg by the end of 1997. Special transitional measures delaying the implementation in Greece were also approved.

While there is no such thing as a 'safe' or 'healthy' cigarette there is convincing evidence that reducing the tar content of cigarettes can help to reduce their poisonous effects.

Proposal for a Directive limiting the advertising of tobacco products

On 30 March 1989, the Commission presented a proposal[4] covering the advertising of tobacco products in the press and by means of bills and posters to the Council of Ministers.

The main items of the proposal were the following:

- ☐ the limitation of the content of the advertising message;
- ☐ incorporation of warnings in tobacco advertising inserts concerning the health risks of the product;
- ☐ ban on indirect advertising;
- ☐ ban of all kinds of advertising in youth publications.

The European Parliament, in its plenary session in March 1990, adopted a more radical position: it called for a total ban of direct and indirect advertising, as is already the case in France, Italy and Portugal. The Commission adopted a modified proposal on 19 April 1990.[5]

The Council of Ministers of 17 May and 3 December 1990 did not manage to reach a common position.

In 1991 the European Commission will examine the possibility of adopting a proposal for a Directive to completely harmonize the various national regulations concerning advertising of tobacco products.

Proposal for an amendment of Directive 89/622/EEC concerning the labelling of tobacco products

When adopting the first labelling Directive 89/622/EEC in November 1989, the Member States asked the Commission to warn consumers more effectively by completing labelling by specific warnings on all tobacco products and not only cigarettes, as soon as technically possible.

Consequently, on 14 November 1990, the Commission presented to the Council a proposal for a Directive[6] amending Directive 89/622/EEC concerning the labelling of tobacco products.

The main amendments:

- ☐ all tobacco products are to carry, in addition to the general ('Tobacco seriously damages health'), a specific health warning;
- ☐ packs of rolling tobacco are now to carry the same health warnings as cigarettes;
- ☐ packs of cigars, cigarillos, pipe tobacco and other smoking tobacco products are to carry the same health warnings as cigarettes except those referring to heart diseases;
- ☐ smokeless tobacco products (mainly traditional chewing tobacco) are to carry the general health warning 'Tobacco seriously damages health' plus the specific warning 'can cause cancer';
- ☐ a new optional warning has been added: 'Smoking causes addiction'.

Oral moist snuff products present a special case which justifies real prevention. Therefore the Commission proposes to ban moist snuff in the EC by 1 July 1992.

Some key elements of the campaign against tobacco

It always takes a combination of the approach chosen, of the means devoted, of time and of human factors to tackle a problem successfully. However, at this stage, some elements which play a central role in the general approach have been identified.

Smoking prevention as part of the 'Europe against cancer' programme

According to the World Health Organization and the Committee of Cancer Experts of the 'Europe against cancer' programme, tobacco is the single most impor-

[3] OJ L 137, 30.5.1990, p. 36.
[4] OJ C 124, 19.5.1990, p. 5.
[5] OJ C 116, 11.5.1990, p. 7.
[6] OJ C 29, 5.2.1991, p. 5.

tant avoidable epidemic in the world. The fact that the smoking prevention policy of the European Community was a part of a major integrated programme, the 'Europe against cancer' programme, contributed to the credibility of the anti-smoking measures proposed. The first commandment of the European Code on cancer prevention is 'Don't smoke'. This way, this message passed to several million European citizens during the European Year of Information on Cancer.

Continuous monitoring of the smoking habits and attitudes of European citizens

From the beginning of the programme, smoking habits of European citizens have been systematically monitored through regular opinion surveys. Five such opinion surveys have been conducted in the framework of the *Eurobarometer* survey between 1987 and 1990.

All those surveys were conducted under similar conditions on the basis of a sample of about 12 000 people. On the basis of those surveys, there are about 90 million smokers in the European Community (35% of the population above 16 years of age).

The same surveys showed that almost three out of four Europeans were in favour of banning tobacco advertising and smoking in public places.

One measure for every tobacco prevention issue

Moreover, the measures proposed by the Commission of the European Communities on the legislation level were individually presented and not concentrated in a sole proposal. This enabled the Commission to identify every possible sphere of specific EC competence when dealing with tobacco prevention issues.

This approach contributed to simplifying the examination of each measure in the Council of Ministers and the European Parliament. Finally, it also helps in maintaining public interest alive when tackling each specific aspect of the tobacco prevention issue.

Smoking prevention and reconversion of tobacco production

Apart from anti-smoking measures, there is a need to assist reconversion of the tobacco-growing sector of the European Community as proposed in action No 9 of the first 'Europe against cancer' programme.

The Directive on maximum tar yield in cigarettes has revealed that certain of the tobacco varieties produced in the EC are particularly damaging to health. Reconversion towards other crops and/or reorientation towards other more marketable and less toxic varieties must therefore be started.

Conversion of tobacco plantations to other crops or less toxic varieties of tobacco must be encouraged.
Photo: CEC.

Public awareness

The 'Europe against cancer' programme also deals with information and public awareness in the fight against tobacco. To this end, the European Commission created a European Bureau for Action on Smoking Prevention (BASP) entrusted with the contact with all European organizations for smoking prevention. It also helps with studies in relation to tobacco prevention and various issues raised at the different stages of examination of the European Commission proposals.

The newsletter issued by BASP has rapidly gained a very good reputation for the quality of its information. Finally, the relationship built up with the major European organizations for smoking prevention which hold regular meetings in different European countries is very important in the promotion of the European Commission proposals. Moreover, the European Commission maintains close contact with the WHO with whom it organized the first European Conference on smoking policies in Madrid in November 1988.

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Actions for a healthy diet

Eating habits, including the consumption of alcoholic drinks, play an important role in the development, and also the prevention, of a number of cancers of the digestive tract and of breast cancer. It is estimated that nutritional factors could be at the origin of more than one third of deaths from cancer. Faced with this evidence, it was clear that proposals for actions in the area of nutrition should be incorporated in the 'Europe against cancer' programme.

Nutritional recommendations for the prevention of cancer adapted to each category of actor concerned

Despite the lack of certainty which characterizes present knowledge on the links between diet and cancer, the Committee of Cancer Experts nevertheless judged it appropriate to formulate two recommendations on diet together with a preceding general warning:

'Your general health will benefit from the following two recommendations which may also reduce the risks of some cancers:

- ☐ frequently eat fresh fruit and vegetables and cereals with a high fibre content;
- ☐ avoid being overweight and limit consumption of fatty foods.'

The dissemination of these two recommendations was undertaken by the governmental and non-governmental partners of the programme in each of the Member States, in the majority of cases, with the financial support of the European Commission.

Euro-Santé opinion polls have evaluated the degree of awareness of the European Code against cancer and its application. The application of the first nutritional recommendation 'Frequently eat fresh fruit and vegetables' appears to be more widely spread among the general public than the awareness of following a very important rule of cancer prevention.

In fact, almost one European in three (28%) claims to eat fresh fruit and vegetables regularly without however being aware that this is an essential element of cancer prevention. As far as differences between countries are concerned, there seems to be a general uniformity in the application of this rule, with the exception of Germany.

The second nutritional recommendation is, however, only considered as 'very important' by a little less than one European in two, on average, and large variations can be observed between countries (67% in Portugal and 39% in France). However, two thirds of Europeans claim to avoid being overweight. Again, the application of the recommendation is more widely spread than the importance attached to it.

Improved public information would permit a better understanding of the link between the avoidance of being overweight and the prevention of cancer.

Avoidance of being overweight is a conscious concern of as many as 77% of Greeks and as few as 54% of Germans.

Numerous studies on 'diet and cancer'

Several studies have been financed within the framework of the first action plan 1987-89 with a view to improving the level of knowledge on the possible links between diet and cancer:

- ☐ feasibility phase of a prospective study on the links between nutrition, health and cancer;
- ☐ prospective study on the anti-promoting role of selenium;
- ☐ feasibility phase of a case-control study on the links between nutrition, lifestyle and the incidence of breast and colon cancer in the European Community;
- ☐ case-control study of patients with adenomatous polyps or cancer of the colon;
- ☐ case-control study of the link between lifestyle, especially diet, and cancers of the pancreas and bile ducts;
- ☐ case-control study on nutrition, alcohol consumption and breast cancer;
- ☐ case-control study of nutrition and precancerous intestinal lesions;
- ☐ intervention study on the anti-promoting role of calcium.

An evaluation of the first results of these studies has been drafted in the form of a scientific report for the programme and is available on request.

It is now accepted that certain eating habits increase the risk of developing certain types of cancer.
Photo: CEC.

Information campaigns on diet launched

All programme partners in the 12 Member States have adapted their existing public information campaigns to take account of the European recommendations on cancer prevention concerning diet and the results of the epidemiological studies available, and new brochures have been published.

During the European Year of Information on Cancer a number of actions involving the free distribution of fresh fruit and vegetables were organized through the intermediary of the non-governmental associations: among others, in Italy during the European Week against Cancer in May 1988 and in Luxembourg and Denmark during the European Week of October 1989. Finally, several colloquia were organized.

The second action plan 1990-94 intends to finance a larger number of quality studies whose results will make it possible to clarify the guiding principles of nutritional recommendations.

In general, we can conclude that the experience of the dissemination of nutritional messages in the framework of a vast information campaign undertaken by the 'Europe against cancer' programme has been conclusive. The dissemination of such messages, contained within the European Code, with the added comment that their application would be beneficial for health in general, constitutes a good model for increasing the primary awareness of the general public.

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Classification and labelling of carcinogens

The first step in chemicals control

The European Community took an early initiative in the field of legislation for chemicals. In 1967 the Council of the European Communities adopted a first Directive[1] in order to approximate the laws, regulations and administrative provisions in the Member States relating to the classification, packaging and labelling of dangerous substances — Directive 67/548/EEC. This Directive has been amended six times over subsequent years. The sixth amendment is the version that is in force today. It was adopted in 1979 (Directive 79/831/EEC).[2] A common position on a seventh amendment has recently been adopted by the Council.

The objectives of this Directive are twofold:

- ☐ *first, the protection of man and the environment, and*
- ☐ *second, the elimination of technical barriers to trade.*

1 500 chemicals classified

The objective of classification is to identify all the physico-chemical and toxicological properties of the substances which may constitute a risk during normal handling or use.

All dangerous substances must be labelled when they are marketed. Annex I of the sixth amendment contains some 1 500 chemicals which have been classified and labelled at Community level. All dangerous substances not yet contained in Annex I must be provisionally labelled by the manufacturer or the importer.

The toxicological properties of the substance that must be considered for classification and labelling include a wide range of effects, including acute and chronic toxicity, corrosivity, irritation, sensitization, carcinogenicity, mutagenicity and teratogenicity.

Criteria for the classification and labelling of chemical substances are shown in Annex VI of the sixth amendment.

Three categories of classification of carcinogenic substances

The criteria in the labelling guide for carcinogenic substances are shown below.

'For the purpose of classification and labelling, and having regard to the current state of knowledge, such substances are divided into three categories:

Category 1

Substances known to be carcinogenic to man. There is sufficient evidence to establish a causal association between human exposure to a substance and the development of cancer.

Category 2

Substances which should be regarded as if they are carcinogenic to man. There is sufficient evidence to provide a strong presumption that human exposure to a substance may result in the development of cancer, generally on the basis of:

- ☐ appropriate long-term animal studies,
- ☐ other relevant information.

Category 3

Substances which cause concern for man owing to possible carcinogenic effects but in respect of which the available information is not adequate for making a satisfactory assessment. There is some evidence from appropriate animal studies, but this is insufficient to place the substance in category 2.

The following symbols and specific risk phrases apply.

Categories 1 and 2

T; R 45 — May cause cancer

However, for substances and preparations which present a carcinogenic risk only when inhaled, for example as dust, vapour or fumes (other routes of exposure, e.g. swallowing or contact with the skin do not present any carcinogenic risk), the following symbol and specific risk phrase should be used:

T; R 49 — May cause cancer by inhalation

[1] OJ 196, 16.8.1967, p. 1
[2] OJ L 259, 15.10.1979, p. 10.

R 45 – May cause cancer.

Toxic

The phrase 'may cause cancer by inhalation' will be introduced into national legislation in 1991 for the first time, to indicate a special subcategory of carcinogens that only cause cancer by inhalation.

Category 3

Xn; R 40 — Possible risk of irreversible effects

The labelling guide also includes comments regarding the categorization of carcinogenic substances:

'The placing of a substance into category 1 is done on the basis of epidemiological data; placing into categories 2 and 3 is based primarily on animal experiments.'

For classification as a category 2 carcinogen, either results in two animal species should be available or clear positive evidence in one species, together with supporting evidence such as genotoxicity data, metabolic or biochemical studies, induction of benign tumours, structural relationship with other known carcinogens, or data from epidemiological studies suggesting an association.

Category 3 actually comprises 2 subcategories:

- ☐ substances which are well investigated but for which the evidence of a tumour-inducing effect is insufficient for classification in category 2. Additional experiments would not be expected to yield further relevant information with respect to classification;
- ☐ substances which are insufficiently investigated. The available data are inadequate, but they raise concern for man. This classification is provisional; further experiments are necessary before a final decision can be made.

For distinction between categories 2 and 3 the arguments listed below which reduce the significance of experimental tumour induction in view of possible human exposure are relevant. These arguments, especially in combination, would lead in most cases to classification in category 3, even though tumours have been induced in animals:

- ☐ carcinogenic effects only at very high dose level exceeding the 'maximal tolerated dose'. The maximal tolerated dose is characterized by toxic effects which, although not yet reducing lifespan, go along with physical changes such as about 10% retardation in weight gain;
- ☐ appearance of tumours, especially at high dose levels, only in particular organs of certain species known to be susceptible to a high spontaneous tumour formation;

- ☐ appearance of tumours, only at the site of application, in very sensitive test systems (e.g. intraperitoneal or subcutaneous application of certain locally active compounds), if the particular target is not relevant to man;
- ☐ lack of genotoxicity in short-term tests *in vivo* and *in vitro;*
- ☐ existence of a secondary mechanism of action with the implication of a practical threshold above a certain dose level (e.g. hormonal effects on target organs or on mechanisms of physiological regulation, chronic stimulation of cell proliferation);
- ☐ existence of a species-specific mechanism of tumour formation (e.g. by specific metabolic pathways) irrelevant for man.

For a distinction between category 3 and no classification arguments are relevant which exclude a concern for man.

- ☐ a substance should not be classified in any of the categories if the mechanism of experimental tumour formation is clearly identified, with good evidence that this process cannot be extrapolated to man;
- ☐ if the only available tumour data are liver tumours in certain sensitive strains of mice, without any other supplementary evidence, the substance may not be classified in any of the categories;
- ☐ particular attention should be paid to cases where the only available tumour data are the occurrence of neoplasms at sites and in strains where they are well known to occur spontaneously with a high incidence.

These criteria and comments have been developed by the Commission's Working Group on Dangerous Substances with the advice of the Commission's Group of Specialized Experts in the field of carcinogenicity.

The criteria and comments are used when the Commission and the Member States are preparing proposals for the classification and labelling of substances for inclusion in Annex I.

At the beginning of 1991, a total of 14 entries in Annex I were category 1 carcinogens, 56 entries category 2 carcinogens and 38 entries category 3 carcinogens — a total of 108 entries.

It should be noted that some of these entries are for groups of substances (e.g. benzidine salts) so the actual number of individual substances in Annex I classified as carcinogens is larger.

Carcinogens not included in Annex I

As with all other dangerous substances carcinogens are required to be classified and labelled even if they are not included specifically in Annex I.

If a manufacturer or his representative has information available which indicates that a substance should be classified and labelled as a carcinogen, he or his representative shall provisionally label the substance in accordance with these criteria.

He shall also submit as soon as possible a document summarizing all relevant information to one Member State in which the substance is placed on the market. This summary document should include a bibliography containing all relevant references, including any relevant unpublished data.

Furthermore, a manufacturer or his representative who has new data which are relevant to the classification and labelling of a substance as a carcinogen shall submit these data as soon as possible to one Member State in which the substance is placed on the market.

Further work on the classification and labelling of carcinogens

The Commission's Working Group is still discussing the classification and labelling of potential carcinogens. Proposals will be put forward in 1991 for Commission directives for the classification of a large number of metals and their salts, pesticides and other industrial chemicals.

The number of new entries in Annex I for carcinogenic substances is expected to be even greater in 1991 than in 1990.

Hazard identification — Risk management

The classification of a dangerous substance is based on its intrinsic properties, independent of the use to which the substance might be put, or of the quantities produced or the patterns of exposure.

This is only the first step in making people aware of the dangerous properties of a particular substance and to warn the user or consumer by means of a label. It is the starting point for downstream legislation and risk management that might follow after undertaking a detailed risk evaluation which has to take into account other parameters such as use, quantities, exposure, etc.

Examples of possible downstream legislation are:

- ☐ ban or restriction of marketing and use of a substance;
- ☐ measures to protect people at work (in particular maximum concentrations in the air of the workplace);
- ☐ measures to protect the different compartments of the environment, i.e. the aquatic environment, air, soil;
- ☐ finally, measures concerning the safe disposal of the substance or products containing the substance.

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Protection of workers from the risks related to exposure to carcinogens

It has for a long time been recognized in the industrialized countries that occupational cancer is a serious problem in the context of worker protection. Estimates vary, but it appears that between 2 and 8% of all deaths due to cancer might have an occupational origin. Because of the need to prevent and monitor the risk, the Member States of the European Community have introduced into their legislation regulations concerning either agents in general or specific agents.

However, while the purpose of the legislation in each country is the same there are considerable differences in scope and in the importance attached to individual aspects.

Most of the regulations take into account data from the cancer registers kept in a number of countries and epidemiological studies carried out throughout the world; other important sources of information are the international organizations such as the International Labour Office, the World Health Organization and the International Agency for Research on Cancer (IARC) in Lyons.

The first Directive adopted in 1959

Because of the differences in legislation the European Community decided to use Council Directives for harmonization purposes and these, once adopted, must be incorporated into national legislation.

The first Directive in this area was adopted in 1959 and covered ionizing radiation; the basic standards ensure the protection of workers and the prevention of radiation-induced diseases. These standards are complemented and updated at regular intervals.

Three European Community action programmes on health and safety at work were adopted between 1978 and 1987. These programmes provide a basis for Community policy and have given rise to a number of major measures to protect workers. Many of the measures introduced cover hazardous substances in general but some relate specifically to carcinogenic substances at work.

A vital part of the first programme was the adoption by the Council on 27 November 1980 of a Directive[1] on the protection of workers from the risks related to exposure to chemical, physical and biological agents at work. This Directive asks Member States to take short- and long-term measures and also provides for the adoption by the Council of individual directives laying down the limit value(s) and other rules governing specific listed agents, some of which are regarded as occupational carcinogens.

By virtue of this Directive, the Council adopted two Directives on carcinogenic agents — asbestos in 1983 and four aromatic amines in 1988.

In fact, before the 1980 Directive, the Commission had reacted quickly to the publication of studies on the links between vinyl chloride monomer and angiosarcomas by adopting the first Directive to cover the monitoring of worker exposure to a carcinogenic chemical substance in 1978.

New impulse from the adoption of the 'Europe against cancer' programme

New impetus came from the resolution of the Council and the representatives of the Governments of the Member States meeting within the Council on the proposed European Community programme of action against cancer and the proposed plan of action for the 1987-89 'Europe against cancer' programme submitted by the Commission to the Council.

. . . and the entry into force of the Single European Act

In the mean time the Single European Act had been signed by the 12 Member States in The Hague and the Treaties thus amended to increase unity within the European Community.

The keystone for development will be the creation in 1992 of the internal market. This is central to the

[1] OJ L 327, 3.12.1980, p. 8 (published in *Social Europe* 2/90).

strategy for relaunching the 'construction of Europe'. However, this process must include a social dimension with the physical and mental well-being of workers as one of the main priorities. A new article in the Treaty, Article 118a, describes the main means of achieving the objectives:

- ☐ Member States shall set as their objective the conditions for protecting workers, while maintaining the improvements made. The Directives must therefore lay down minimum requirements for gradual implementation;
- ☐ the provisions shall not prevent any Member State from maintaining or introducing more stringent measures;
- ☐ the directives shall avoid imposing administrative and financial constraints on small and medium-sized undertakings.

A new Directive adopted in 1990

In order to make rapid progress in the prevention of occupational cancer it is felt that the best policy now is to establish a new kind of general directive rather than directives on individual agents but to use the content of these as a basis, the aim being to harmonize conditions in the Member States while at the same time making progress.

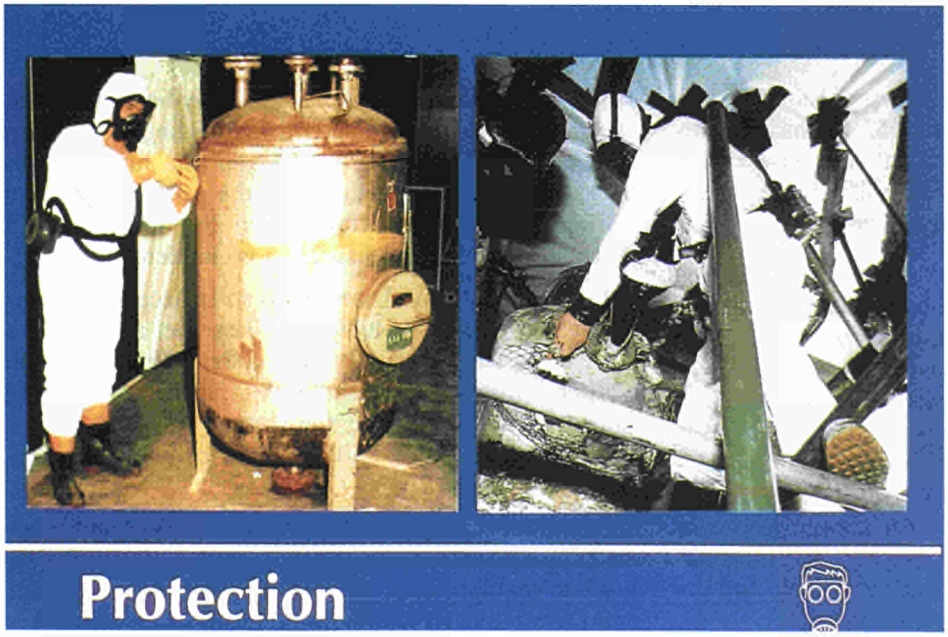
The aim of the new Directive (90/394/EEC) adopted by the Council on 28 June 1990,[1] is therefore to eliminate the differences between the legislations of the Member States and represents a guarantee of better protection for workers by improving working methods, working conditions, information and human behaviour.

Article 1 states that the aim of the Directive is to protect workers against risks to their health arising from exposure to carcinogens at work.

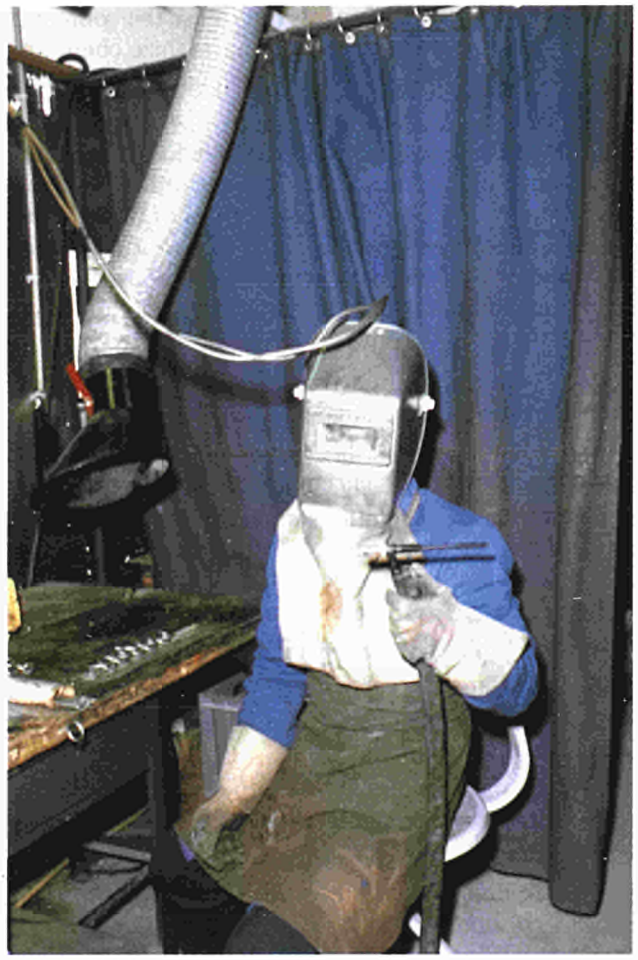
Article 2 defines the term 'carcinogen'. Council Directives 67/548/EEC and 88/379/EEC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the classification, packaging and labelling of dangerous substances and preparations automatically apply with amendments to take account of technical progress.

Once a substance or preparation has been classified by risk phrase 'R 45' ('may cause cancer'), workers

[1] OJ L 196, 26.7.1990, p. 1 (published in *Social Europe* 2/90).



The European Community plays a vital role in the promotion of a better protection of workers from carcinogenic substances. *Photo: CEC.*



The directive specifies that protective clothing and individual equipment must be worn as long as the normal exposure persists.
Photo: INRS.

exposed must be protected by the provisions of this Directive. There are at the moment 52 chemical agents classified in this way. 'Carcinogen' also covers the substances, preparations or processes listed in Annex I, which consists at present of four articles.

Article 3 describes the scope of the Directive. In the case of any activity likely to involve a risk of exposure, the nature, degree and duration of workers' exposure must be determined in order to lay down the measures to be taken. Articles 4 and 5 describe the measures to be taken to avoid or reduce exposure. The employer is required, in the first instance, to replace the carcinogenic agent or at least to use it in a sealed environment; in every case he must apply a series of preventive measures. Article 6 specifies the information which the employer must keep available for the responsible authorities of the Member States.

Abnormal exposure to carcinogens may be unforeseen, accidental or a result of activities involving an increase in exposure. The Directive obliges the employer to take all necessary measures for the protection of the workers involved and lays down the technical and personal protection measures to be implemented.

Other articles in the Directive restrict access to places where activities involving carcinogenic agents take place and describe the measures to be taken to provide workers with washing and toilet facilities, including showers and facilities for the storage of street clothes and working clothes and personal protective equipment.

Workers must receive adequate information and regular training concerning the potential risks to health, hygiene requirements, the use of protective equipment and procedures to follow in the event of an incident.

Article 12 stipulates that measures shall be taken to ensure that workers can check that the Directive is being properly applied and that they receive information on the potential risks to health from abnormal exposure. The employer is obliged to keep a list of the workers exposed, to which the worker has access.

Article 13 establishes that consultation and participation of workers shall take place in accordance with Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work. Article 14 sets out the requirements regarding health surveillance of workers and refers to the practical recommendations given in Annex II. Article 15 requires that the health records and the list of workers exposed be kept for at least 40 years following the end of exposure.

Article 16 allows the Council by means of a Directive on a proposal of the Commission, to specify exposure limit values for all carcinogenic agents where that is possible and, if necessary, other related arrangements; this to be on the basis of the scientific and technical information available. Annex III will contain these values.

Article 17 explains the procedure for amending Annexes I and II.

Article 18 asks the national authorities to provide the Commission with the analyses made of data on notified cases of occupational cancer.

Article 19 sets out the time limits and methods for implementing this Directive in the Member States. The Directive will enter into force on 31 December 1992 at the latest in each Member State.

The Commission hopes that this Directive will be a milestone in the protection of workers from the risk, of which they are often unaware, of contracting cancer as a result of exposure at work.

Clearly the Commission's efforts will not stop here. Epidemiological research and data assessment must be a continuous process if the welfare of all workers is to be maintained. Every effort must be made to achieve this objective.

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and

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CHAPTER 4

The advantages of screening

There is no doubt at all that early detection of cancer saves lives. There are a number of approaches to improving early detection. It is clear that a high level of awareness of symptoms and risks is necessary among medical personnel, and this need is met by the training section of the programme. It is also vitally important that individuals are alerted to the possible significance of certain danger signs, and these are covered in points 7 and 8 of the European Code against cancer. Thirdly, for specific cancers techniques exist that permit identification and diagnosis before any symptoms appear.

Screening consists of the application of this approach: some of the considerations that determine whether it is useful are discussed in the article by Professor De Waard. The two areas where it is considered of proven utility, cervical screening and breast screening, are the subject of points 9 and 10 of the European Code and the development of pilot programmes implementing European networks is described by Alain Vanvossel. The point of view of the 'consumer' is important in this area and the report on a recent 12-country survey provides original and unique data on this.

Screening for cancer

In the fight against cancer several approaches are being followed. In the first place efforts are made to understand the causative factors of this disease by means of basic laboratory research and epidemiological analysis. The rationale will be clear: understanding causation is the key to preventive measures.

The difficulty is, however, that cancer is a group of diseases each of which apparently has its own causes. For example, smoking has to do with a number of cancers, mainly those of the upper respiratory tract, but not with such frequent cancers as cancer of the breast and of the large bowel.

Objective: to detect cancer at the earliest possible stage

For clinical doctors the fight is mainly concerned with diagnosis and treatment of cancers which present themselves through symptoms like persistent cough, loss of blood or abnormal growth in the skin. Experience has taught them that — statistically speaking — chances of cure are better if the cancer is still localized in one organ; dissemination to other organs (metastasis) seriously worsens prognosis.

Naturally, emphasis has been put on the possibility of early detection of cancer by means of systematic investigation of persons with and without symptoms. Empirical knowledge confirms the theoretical notion that cancer found in persons without symptoms is on average in an earlier stage of its development than in persons with symptoms, thereby leading to better prognosis.

Systematic investigation of whole populations irrespective of symptoms is called screening. Screening has to make use of one or more screening tests which will distinguish those who (probably) have the disease from the majority who (again: probably) do not have the disease. The properties of a good screening test are given by its sensitivity (namely, the ability to identify those who have the disease under scrutiny) and specificity (namely, the ability to identify those who do not have the disease). It will be clear that the usefulness of a screening test depends not only on these characteristics but also on its practical applicability and its cost.

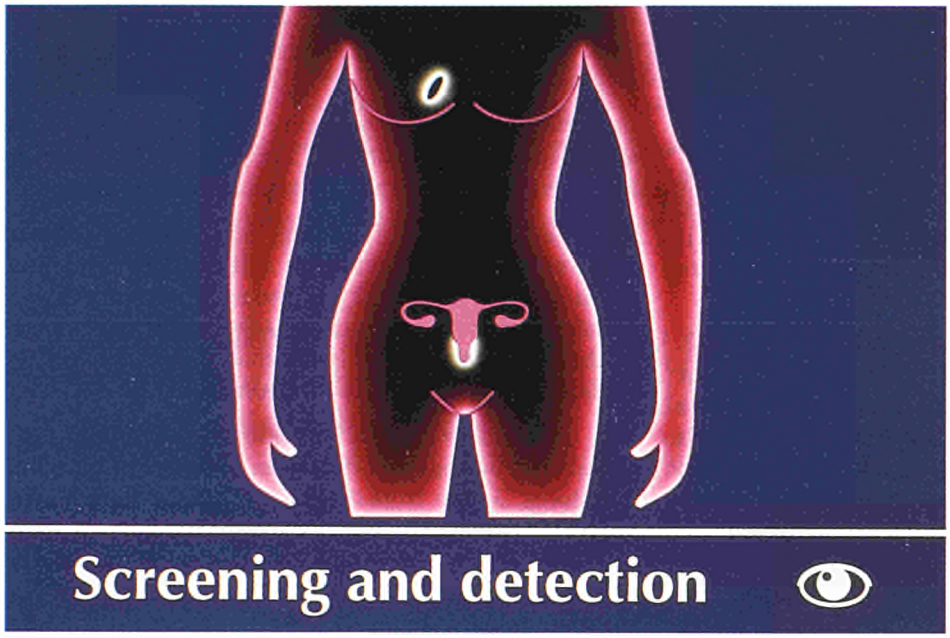
Screening programmes are large undertakings and they should not be started before serious consideration of their pros and cons. Since even the best test is not 100% specific there will always be persons who will turn out 'positive', namely suspected of having the disease at screening but in whom further examination does not reveal the suspected cancer. The 'predictive value' of a positive screening test depends not only on its quality (defined by its sensitivity and specificity) but also on the prevalence of the disease in the screened population. Since the prevalence of any kind of cancer in a free-living population is usually low (in the order of magnitude of a few cases per 1 000 persons) there will always be a substantial proportion of so-called 'positives' who will go through the anxiety of false alarm. The issue is whether the benefits of screening will outweigh the anxiety and the cost brought about by the programme.

Screening programmes for three types of cancer

At present there are three sites of cancer for which screening programmes in Europe are ongoing or in an experimental phase: cancer of the uterine cervix, cancer of the breast and cancer of the large bowel (colo-rectal cancer).

Screening for cancer of the uterine cervix has a history which dates back to 1943 when G. N. Papanicolaou (born in Greece but working in the United States) discovered that loose cells exfoliated from the surface of the 'mouth' of the uterus (an easily accessible site) may reveal the presence of cancer. This was a somewhat revolutionary idea since the doctrine had always been that cancer can be diagnosed only by studying whole tissue blocks. The concept emerged that cyto (= cell) diagnosis can be used as a screening test for the existence of cancer to be confirmed by histo (= tissue) diagnosis.

Europe was not very quick in appreciating the potential of the 'Papanicolaou' test as a tool in the fight against cancer outside the hospital setting. Still, the test fulfills all the criteria for good screening: in qualified hands it has good sensitivity and specificity, and taking a Pap smear is a quick and harmless procedure. Moreover, it is able to detect very early stages of the disease.



The 'Europe against cancer' programme supports projects for the screening of cervical and breast cancer.
Photo: CEC.

In the late 1960s (more than 15 years after such initiatives in North America) systematic campaigns were launched. The Nordic countries excelled in their programmes and it is largely through their efforts that the scientific world has become convinced of the public health merits of this screening tool.

Interestingly, there is no formal proof of its efficacy in bringing down mortality from cervical cancer. Such proof should have come from experimental design called the 'randomized controlled trial'. However, by the time that epidemiologists considered such research the Pap test had gained so much foothold already in clinical practice that it would be impossible to withhold it from the control group in an experimental study. Screening for cervical cancer is not yet commonplace in all EC countries. Sufficient knowledge on the 'state of the art' is available and it is mainly a matter of health education and public health organizations to control this disease. Since this type of cancer is not very frequent in some European countries (unlike the situation in the Third World) health authorities may differ in their priorities of cancer control.

Screening for cancer of the breast

Screening for cancer of the breast differs in many respects from screening for cancer of the uterine cervix. Here again the original research was undertaken in the United States. The screening test is mammography, namely an X-ray picture of the female breast. Cancer can be spotted by looking carefully at small densities and micro-calcifications. The test is neither simple nor cheap; its sensitivity and specificity are reasonably good in experienced hands, but one does not detect cancer in stages as early as is the case in cervical cancer screening. This is probably one of the reasons that proof of the efficacy of screening in terms of better prognosis is limited to cancers detected after age 50 (which seem to grow slower than those occurring before that age).

Although Americans took the lead in breast cancer screening with a randomized controlled trial conducted in New York and published from 1971 onwards, they lost their 'yellow jersey' by a series of mistakes and unhappy events which will not be elaborated upon here. Europe took over with projects in Sweden, the United Kingdom, the Netherlands and Italy. In particular, the Swedes undertook a major research effort in setting up large randomized trials which by the mid-1980s have led to the conclusion that breast cancer mortality could be lowered by about 30%.

Recently doubt has been expressed whether such outcome could be equalled in other regions of Europe. In order to understand the scientific debate it is necessary to explain which kind of evidence is at the core of it. Basically, one can compare the mortality rates due to breast cancer between those who have

been screened and those who have not. This has been done in a relative sense by means of so-called 'case-control' studies in the Netherlands and Italy. The results point to a 50% reduction in mortality among the screened population compared to the unscreened. However, persons who decide not to take part in a screening programme certainly are some self-selected group from those invited (less health-conscious?) and it could be that such 'confounding' characteristics are (partly) responsible for the difference.

In order to avoid wrong conclusions based on selection bias, statisticians prefer to compare those invited for screening with those not invited (depending on the outcome of a lottery, the so-called randomization). It will be clear that the difference between groups so designed will be 'diluted' because of the fate of the non-participants in the group invited to be screened. Thus, the impact of a screening programme depends very much on the percentage of participants after invitation. Moreover, it depends on the level of specific preventive care already provided to the target population as a whole (in this case: mammography). Differences in the outcome of various projects can be partly explained in this way.

Even a 50% reduction in mortality from breast cancer in those aged 50 and over is less than desirable. However, breast cancer is such a prevalent disease (about 60 000 deaths annually) in Europe of the Twelve that even a limited relative decrease amounts to a great many lives saved.

In addition to gains in mortality there is the important aspect of a better quality of life since early diagnosis allows a shift to less radical surgical procedures.

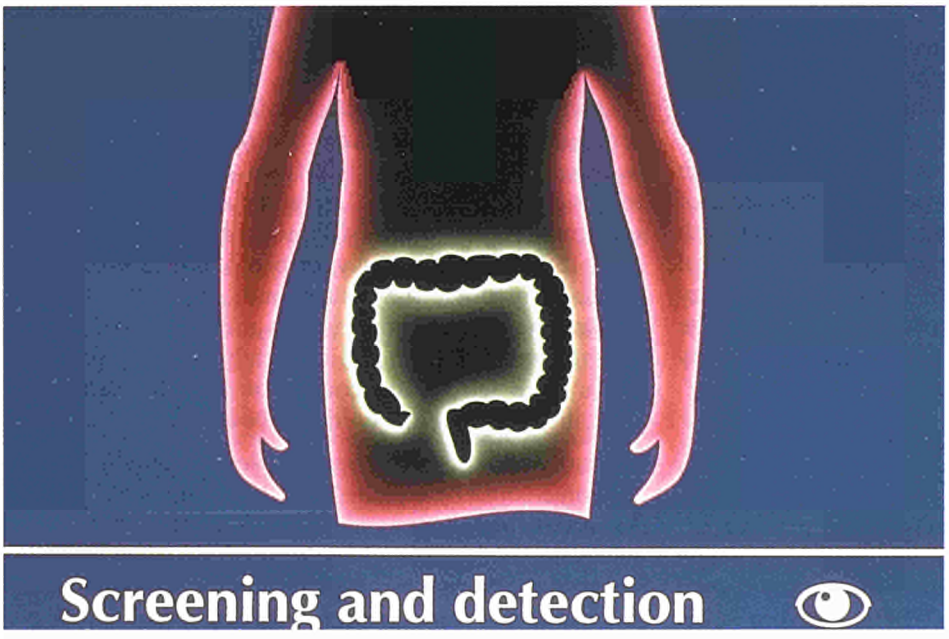
Screening for cancer of the large bowel (which consists of the colon and the rectum) is still in an experimental phase. The prevalence of this disease in both males and females (resulting in about 100 000 deaths per annum in the EC countries) is such that a decision on its applicability would be very welcome.

The problem is that the available screening test, namely the biochemical detection of traces of blood in the stools, is far from specific. Thus, a fairly large proportion of screened persons will have to be investigated further by means of specialized methods (roentgenology, endoscopy) and the predictive value of a 'positive' test will be fairly low.

Those who fear 'medicalization' of health policy have a case here. Further research on the perspective of primary prevention through studies on a probable role of nutrition in the causation of this kind of cancer is without any doubt a priority. If primary prevention were possible there would be no need for expensive screening programmes.

Prof. Frits de Waard

Preventicon, University of Utrecht
The Netherlands



For cancer of the colon and rectum, widespread European studies are presently underway to evaluate the effectiveness of screening through detection of blood in the stool.
Photo: CEC.

Systematic screening for some cancers

Given that it is at present impossible to eliminate all carcinogens, and that primary prevention will always have a limited impact, systematic screening must have a role to play in reducing mortality from cancer. The 'Europe against cancer' programme seeks to promote this screening, and also to alert the public to the importance of early detection. The last two points of the European Code against cancer highlight this:

- *9th recommendation: 'Have a cervical smear regularly'.*
- *10th recommendation: 'Check your breasts regularly and, if possible, undergo mammography at regular intervals above the age of 50'.*

Breast cancer screening: a first European network established in 1989

In order to implement a systematic breast screening programme a pilot network has been established since 1989. Each of the pilot projects is required to follow a large group of women, inviting them to take part by individualized letters with automatic follow-up. These measures to ensure a high participation rate are complemented by other quality criteria to maximize the effectiveness of the programmes.

In four regions, Ilia in Greece, Navarre in Spain, Oporto in Portugal, and Limburg in Belgium, this screening is undertaken by mobile or semi-mobile mammography units. This system allows good coverage of rural and remote areas and encourages participation by relevant local actors (local authorities, general practitioners, socio-cultural organizations, etc.). In Dublin (Ireland) a mixed system combining a mobile unit with a fixed screening centre has been adopted while in Bas-Rhin (France) the screening is performed by independent radiologists with centralized coordination of the results and follow-up. In 1991 Florence (Italy) and Copenhagen (Denmark) joined the network with similar projects.

There are many advantages in collaboration in this kind of network. On the one hand daily improvements in the technique of screening can be made, developing an experience indispensable for establishing a generalized network. On the other hand, comparing the results allows more precise evaluation, from all points of view (medical, epidemiological and economic) and hence a levelling upwards of screening practice.

The first evaluation meeting was held in Coimbra, Portugal, in 1990 when the network had been running for a year. It could already be shown that an adequate participation rate could be achieved when all the local partners were involved. The need to improve quality control became apparent as did the overwhelming importance of social and cultural factors and the need to vary the approach accordingly. The 1991 evaluation exercise on an enlarged network will allow confirmation of factors leading to success.

In addition to action in the field the 'Europe against cancer' programme has supported complementary training in screening. This training leads to a high degree of reliability in the taking and reading of mammograms and improvement in project evaluation. Training sessions have been organized in Utrecht, Florence and Strasbourg.

Finally, an economic evaluation of systematic screening of breast and cervical cancers has been commissioned[1] in order to provide decision-makers at national or regional level with the tools necessary to prepare a medical-economic dossier for cancer screening programmes.

The Commission of the European Communities is convinced that this programme, which integrates public awareness (using the European Code), effective action at the level of the individual citizen by the pilot networks, training of concerned health personnel and ongoing evaluation, will impel the decision-makers to take the steps necessary to implement mass screening.

Towards a comparable network for cervical cancer screening

A comparable network for cervical screening would be very desirable. However, the fact that many projects already exist and that the financial implications would be considerable mean that the programme has had to postpone the launch of such a network. None the less, the criteria for quality control of such a network have been developed and could form the basis for establishing a network in the near future. In the meantime the programme is supporting projects which analyse the factors influencing the participation rate and others testing alternative screening methods such as cervicography.

For other cancers there are many uncertainties restricting the advantages of systematic screening campaigns.

[1] *Report on the economic evaluation of systematic screening of breast and cervical cancers* (Lancry, Fagnani *et al.*, DG XII, Comac-HSR).

The best candidate seems to be colo-rectal cancer, using detection of blood in the faeces, but caution is still necessary. For this reason the 'Europe against cancer' programme has not supported any of the many proposals made in this field.

On the other hand, certain studies which are designed to evaluate the results of the faecal occult test have been supported. These studies on the effectiveness of screening, undertaken by experts of world renown in the United Kingdom, Germany and France should demonstrate whether the test is a reliable screen and also whether an acceptable participation rate can be achieved, the factors influencing this.

The first useful results will arrive at the end of 1991 and a new strategy to promote this technique might perhaps be launched in 1992.

For other cancers such as malignant melanoma and cancer of the prostate the programme has only supported isolated initiatives in order to increase our knowledge in this area, and it would be premature to embark on large-scale campaigns.

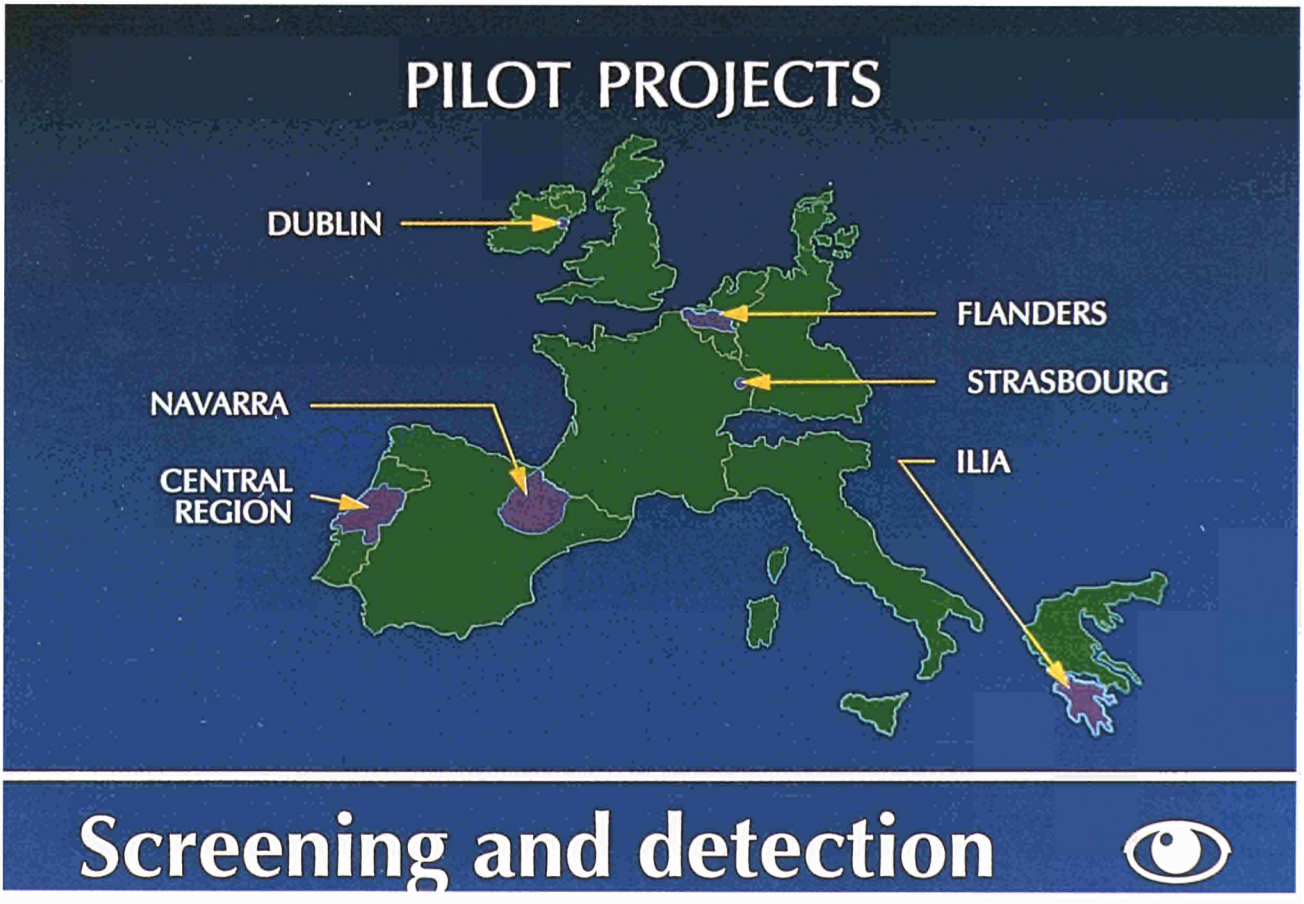
It is clear that the organization of screening campaigns is the responsibility of Member States. However, these actions show that even with a very limited budget the 'Europe against cancer' programme can stimulate the relevant partners to develop effective screening practices. The Commission will therefore continue, during the second action plan, to examine with the Member States how a systematic screening policy can be implemented.

To highlight this, and to keep the public informed, screening and early detection has been adopted as the theme for the European Week against cancer in October 1991. This will ensure that all those concerned, especially the women of Europe, will be motivated to participate in these campaigns which could save so many lives.

Dr Alain Vanvossel

Administrator
'Programme of action against cancer' Unit
Directorate-General for Employment,
Industrial Relations and Social Affairs
Commission of the European Communities

A European network of pilot projects for the screening of breast cancer by mammography is now in place.
Photo: CEC



The European women's point of view

The European Code against cancer contains 10 'commandments', of which eight apply both to men and women and two exclusively to women: 'Have a cervical smear regularly', 'Check your breasts regularly and, if possible, undergo mammography at regular intervals over the age of 50'.

This survey[1] reveals the importance which European women attach to these recommendations, their awareness of them and their compliance with them.

Women agree on the importance of the recommendations for women

Only 4% of European women believe it is not important to have a cervical smear regularly and check their breasts regularly. Seven out of 10 consider it very important. The proportions have remained stable over the years (the same questions were asked in autumn 1988 and spring 1989).

Question:

Here are two recommendations for women. For each of them, please tell me if you think it is very important, fairly important or not important at all in lessening the risks of cancer?

(%)

	Autumn 1988	Spring 1989	Feb.-March 1990
Have a cervical smear regularly			
Very important	71	74	68
Fairly important	19	18	19
Not important	3	3	4
No reply	7	5	9
Total	**100**	**100**	**100**
Check your breasts regularly			
Very important	71	76	70
Fairly important	20	17	20
Not important	3	3	4
No reply	6	4	6
Total	**100**	**100**	**100**

There has been a slight fall in the numbers replying 'very important' in almost all countries compared with 1989. The launching of the anti-cancer campaign at the start of 1989 increased women's awareness of the importance of these two recommendations; in the meantime, this increased awareness has dropped slightly, with fewer replying 'very important' and more replying 'fairly important'. By and large, however, women continue to agree that these two commandments are very important (68% and 70% respectively).

We know that women also attach great importance to the other eight recommendations in the Code, which apply to both sexes. Women rank the 'cervical smear' and 'breast checking' recommendations fourth in order of importance, after the recommendation to see a doctor for a lump, a change in a mole, etc. (86%) or for persistent cough, hoarseness, etc. (82%) and the recommendation not to smoke (77%).

The cervical smear: a considerable difference between generations

The series of questions asked in February-March 1990 was an exact repetition of the questions asked in spring 1988, and the two sets of replies can thus be compared.

Question:

Let us talk about the cervical smear. Do you know what it is, and if so, have you ever had it done?

(%)

	Spring 1988	Feb.-March 1990
Does not know what it is	18	13
Knows, but has never had it done	32	30
Knows, and has had it done	48	56
No reply	2	1
Total	**100**	**100**

The number of women who do not know about the cervical smear has thus fallen, and the number of women who have had one has increased substantially. This trend applies to most Member States, particularly those where cervical smears were relatively uncommon two years ago.

[1] Extracted from a survey conducted for the 'Europe against cancer' programme in early 1990 by European Omnibus Surveys.

In decreasing order of positive replies in 1990	Have had a cervical smear	
	Spring 1988 %	Feb.-March 1990 %
France	70	69
United Kingdom	67	69
Denmark	62	66
Germany	47	62
Luxembourg	63	60
Belgium	43	57
Netherlands	55	56
Ireland	45	55
Italy	40	51
Greece	30	34
Spain	12	26
Portugal	6	20
Community overall	**48**	**56**

The percentage of women having had a cervical smear has increased in all age groups. As could be expected, in all countries it is the women between 25 and 54 who are most likely to have had a cervical smear (see Table 1).

The countries can be divided into three groups, according to the numbers of women between 25 and 54 who have already had a cervical smear:

Table 1
Experience of cervical smear, by age
(February-March 1990)

	% of women who have had a cervical smear, by age				
	Overall	Age 15-24	Age 25-39	Age 40-54	Age 55 or over
Community overall	56	27	70	71	49
Reminder spring 1988	(48)	(25)	(63)	(59)	(41)

- ☐ United Kingdom, France, Denmark, Belgium, Germany, Ireland, Netherlands (seven or more women out of 10);
- ☐ Italy, Greece (five to seven women out of 10);
- ☐ Spain and Portugal (two to three women out of 10).

In the 15-24 age group, almost five women out of 10 have had a cervical smear in the United Kingdom, France, Denmark and Belgium, compared with

Photo: CEE

Screening is often carried out using mobile or semi-mobile units.
Photo: CEC.

approximately two out of 10 in Germany, Ireland and the Netherlands, and even fewer in the countries of southern Europe, i.e. Greece, Italy, Spain and Portugal.

Age at which first cervical smear taken

Question:

At what age did you first have a cervical smear?

	% having had a cervical smear	
	Spring 1988	Feb.-March 1990
Before age 25	33	31
Age 25-34	27	27
Age 35-44	19	20
Age 45 or over	21	22
Total	**100**	**100**

The differences between generations are considerable, as expected. The younger the women, the more likely they are to have started having cervical smears early.

For example, 40% of women aged 25-39 had their first cervical smear by the age of 24 whereas this is true of only 8% of women in the 40-54 age group and a mere 1% of women in the over-55 age group.

Frequency of cervical smears

The same question was put in this survey as was put in 1988.

Question:
How often do you have a cervical smear done?

	% having had a cervical smear	
	Spring 1988	Feb.-March 1990
Every year	35	37
Every 2 or 3 years	25	27
Every 4 or 5 years	10	9
Less often	17	16
No reply	13	11
Total	**100**	**100**

The frequency of smears can be seen to have increased slightly (*at least* every two or three years: 60% in 1988, 64% in 1990).

At the same time as this increase in frequency, however, there has also been an increase in the numbers of women having cervical smears done. Cancer experts recommend that women have their first

cervical smear as soon as they become sexually active, with follow-ups at least every three years.

How does this recommendation tally with the actual situation in each country?

	% of women having a smear at least every three years	
	Women aged 15 or over	Women who have had a smear
Belgium	41	72
Denmark	45	67
Germany	51	78
Greece	19	55
Spain	17	61
France	55	78
Ireland	28	51
Italy	33	64
Luxembourg	58	86
Netherlands	39	63
Portugal	12	59
United Kingdom	39	58
Community overall	**38**	**68**

Breast checks: a quarter of women do it regularly

70% of European women, when shown the list of 10 recommendations in the European Code against cancer, rate regular breast checking as 'very important'. The survey yields additional information on the practice of breast checking and mammography.

Question:

Do you ever feel your breasts to see if there is anything unusual?

	Feb.-March 1990 %
Regularly	27
From time to time	38
Practically never	30
No reply	5
Total	**100**

There is therefore a considerable difference between the numbers of women who say that it is very important to check their breasts regularly (70%) and the numbers who actually do so regularly (27%).

The table below presents the combined results to the two questions, calculated in percentages on the basis of the total number of women interviewed.

(%)

	State that checking breasts regularly is:			
	Very important	Fairly important	Not important or no reply	Total
Check their breasts:				
Regularly	24	2	1	27
From time to time	28	9	1	38
Never, or unknown	16	8	6	30
No reply	2	1	2	5
Total	**70**	**20**	**10**	**100**

The table shows that only a minority of women actually practice what they preach with regard to breast checking: only 24% say that the recommendation 'Check your breasts regularly' is very important and actually do so regularly.

Mammography: awareness is increasing

Question:

Let us talk now about mammography. Do you know what it is, and if yes, have you ever had it done?

	Spring 1988 %	Feb.-March 1990 %
Does not know what it is	23	19
Knows, but has never had it done	56	55
Knows, and has had it done	19	24
No reply	2	2
Total	**100**	**100**

The same phenomenon applies to mammography as applies to the cervical smear: there is progressively less ignorance about it and more women are having it done. The increase is most marked in Spain and Portugal, followed by the countries of northern Europe: the United Kingdom, the Netherlands and Denmark.

In decreasing order of positive replies in 1990	Have had a mammography %	
	Spring 1988	Feb.-March 1990
Germany	29	32
France	24	31
Luxembourg	33	30
Belgium	26	25
Spain	12	23
Italy	21	22
Portugal	9	22
Denmark	17	21
Netherlands	12	18
United Kingdom	8	14
Greece	10	9
Ireland	5	6
Community overall	**19**	**24**

In all countries mammographies are most common in the 40-54 age group (See Table 2).

Table 2
Experience of mammography, by age
(February-March 1990)

	% of women who have had a mammography, by age				
	Overall	Age 15-24	Age 25-39	Age 40-54	Age 55 or over
Community overall	24	8	21	39	24
Reminder spring 1988	(19)	(5)	(18)	(28)	(21)

Slightly more women are ignorant about mammography than about the cervical smear (the European averages are 21% and 13% respectively).

However, the countries where ignorance is highest are by no means the same: the Netherlands leads the field (41% do not know what mammography is), followed by Belgium (40%), the United Kingdom (37%) and Ireland (38%).

Looking more particularly at the age group which should, in principle, be most concerned (55 or over), it is noticeable that in all the abovementioned countries 40% or more of women in this age group do not know what a mammography is. (See Table 3 below).

Table 3
Ignorance concerning mammography, by country and age

	% of women who do not know what it is, by age				
	Overall	Age 15-24	Age 25-39	Age 40-54	Age 55 or over
Belgium	40	39	27	41	54
Denmark	21	41	10	18	21
Germany	16	34	13	13	13
Greece	14	13	1	6	31
Spain	23	20	16	22	31
France	14	27	10	7	15
Ireland	38	55	30	25	44
Italy	8	12	7	5	10
Luxembourg	12	Sample too small			
Netherlands	41	71	34	22	43
Portugal	16	16	5	16	24
United Kingdom	37	53	29	27	41
Community overall	**21**	**32**	**16**	**15**	**24**

Age at which first mammography done

Question:
At what age did you first have a mammography?

	% having had a mammography	
	Spring 1988	Feb.-March 1990
Before age 25	14	18
Age 25-34	20	23
Age 35-44	27	24
Age 45-54	18	18
Age 55 and over	12	11
Don't remember	9	6
Total	**100**	**100**

Over half of all women with experience of mammography have had one done before the age of 45; the 1990 survey confirms the 1988 findings.

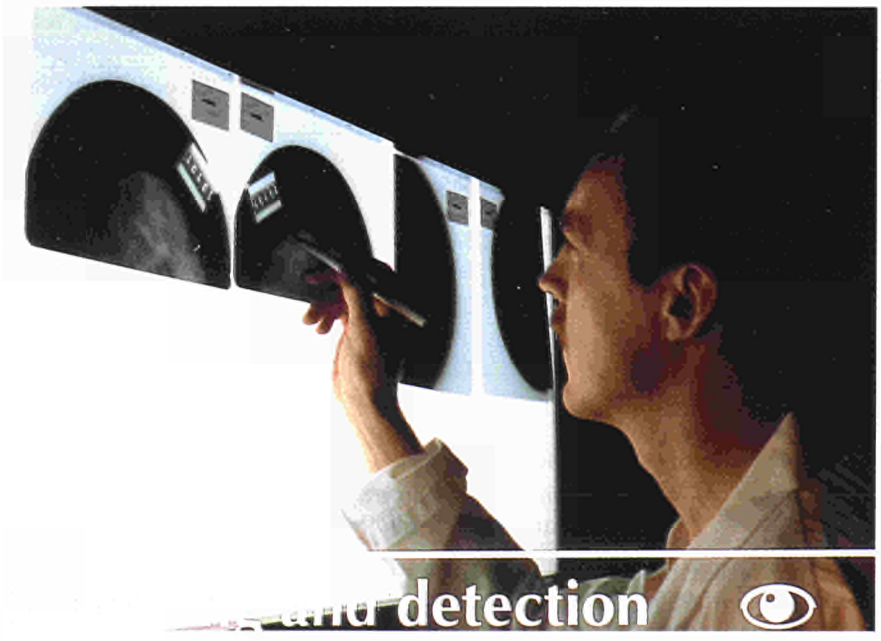
It is particularly important to study the variations in responses according to the ages of the women interviewed.

Table 4
Age at which women had a mammography for the first time (February-March 1990)

First mammography at age	Overall		Based on respondent's present age					
			25-39		40-54		55 or over	
	%	C*	%	C*	%	C*	%	C*
19 or under	1	1	3	3	–	–	–	–
20-24	3	4	6	9	2	2	–	–
25-29	2	6	6	15	3	5	–	–
30-34	3	9	4	19	7	12	1	1
35-39	2	11	1	20	6	18	1	2
40-44	4	15	–	–	10	28	4	6
45-49	2	17	–	–	5	33	3	9
50-54	2	19	–	–	3	36	5	14
55-59	1	20	–	–			4	18
60-64	1	21	–	–	–	–	2	22
65 or over	1	22					2	–
No reply	2	–	1	–	3	–	2	–
Total	**24**	**24**	**21**	**21**	**39**	**39**	**24**	**24**

All figures are calculated on the basis of the total number of women interviewed in the generation indicated at the head of each column.

C* equals cumulative score. The cumulative score is calculated as follows: under 'Overall', for example, 1% of women had their first mammography at age 19 or under, and 3% at age 20-24; the total percentage of women who have had their first mammography by age 24 is therefore 1% + 3%, i.e. 4%.



Cancer can be more easily cured if detected in time.
Photo: CEC.

Most of the women aged 40-54 who have had a mammography (28 out of 36) have had it done before age 45. In contrast, most women of 55 or over who have had one (16 out of 22) did not have their first one until after age 45 (see Table 4).

Frequency of mammographies

Question:
How often do you have a mammography done?

	% having had a mammography	
	Spring 1988	Feb.-March 1990
Every year	20	24
Every 2 or 3 years	20	23
Every 4 or 5 years	9	7
Less often	41	35
No reply	10	10
Total	**100**	**100**

It would appear from the results that the frequency of mammographies is increasing.

CHAPTER 5

Europe against cancer — Examples of action on information, health education and training

The following three sections present an overview of a number of different policies and actions in the context of the 'Europe against cancer' programme.

At the start the accent was very much on the European Year of Information on Cancer and on the various collaborations with television companies and these are fully described in that section. Also of prime importance, however, has been the support given to the programme by the organizations against cancer of the Community, and indeed beyond. Their role is described by the Chairman of the European Cancer Leagues and amplified by the report from a typical league, the Italian one.

Once the first push of information was achieved, the accent shifted to health education, especially in schools, and the programme has been instrumental in developing, in close collaboration with other parts of the Commission and with national authorities, a strategy to achieve an effective form of health education available to all the children in the Community. The cornerstone of this strategy is the set of recommendations established at the first European Conference on Health Education and Cancer Prevention in Schools held in Dublin in February 1990 and reprinted here in full.

Finally, it is apparent that the health professions themselves need to be supported by the best possible initial and in-service training in this field, and the approaches to achieving this are described, with particular attention paid to the key role played by general practitioners.

1989 — European Year of Information on Cancer

An overview

The European Year of Information on Cancer, included in the first plan of action, which took place in 1989, was intended by all concerned with the campaign against cancer to be a high point of the programme and a test bed for future actions. It certainly was the high point so far, both in terms of the scope of themes covered and in terms of the number of actions launched on both European and national scales. However, it was also an important trial for future approaches, in the sense that the efforts to spread the message to the general public exposed the limits of this kind of approach and pointed the way to more effective actions on the future, especially the need to refine selection of the target groups for the messages.

Information directed towards the general public

Among the most important information actions, we should mention those actions aimed at increasing public awareness, those which took place simultaneously in all Member States, those which had a particular impact in one or more countries and finally national initiatives with a European dimension which took place throughout the year.

Among these actions aimed at increasing public awareness figure in particular:

Press conferences:

- ☐ in January 1989 to launch the European Year in each of the 12 capital cities. It should be noted that in the UK the Prime Minister in person launched the European Year;
- ☐ at the beginning of October 1989 to present the programme of activities for the 'European Week against Cancer'.

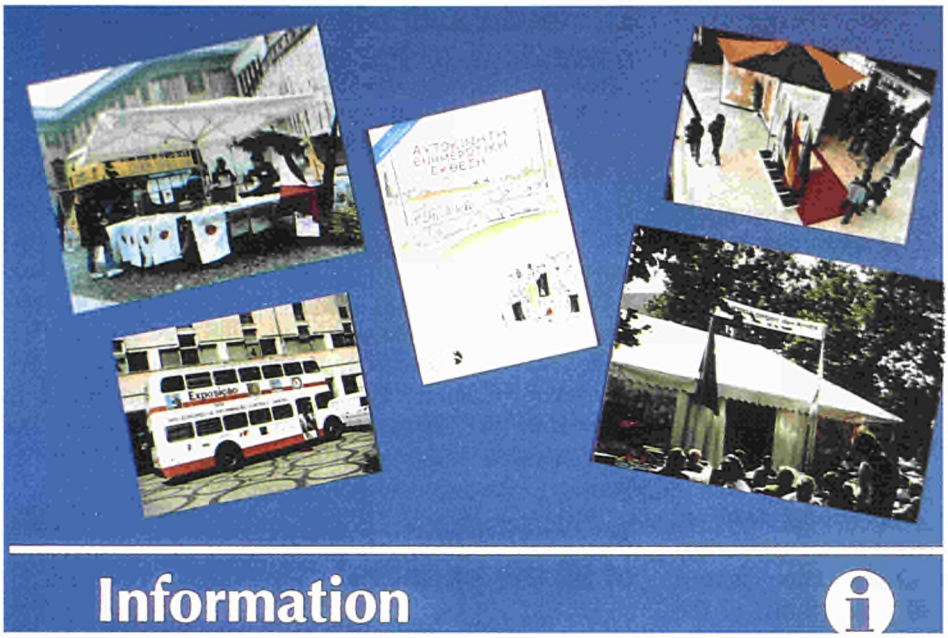
Press releases on the results of the European opinion polls:

- ☐ in January 1989 on Europeans and the European Code against cancer in order to evaluate public awareness of the code and of the programme;
- ☐ in June 1989 on general practitioners and the European Code which made possible an evaluation of the level of awareness and of application of the Code among general practitioners;
- ☐ in September 1989 on teachers and the European Code which gave interesting indications as to the behaviour of teachers concerning cancer.
- ☐ European television programmes which were broadcast between May and December 1989 and a 'Eurovision against cancer' programme broadcast on Tuesday 9 January 1990. These European television programmes (content, target groups, evaluation of results) are discussed in more detail in the article 'TV Europe against cancer'. They have, moreover, been complemented by other TV and radio programmes and spots produced on the initiative of national actors;
- ☐ European mobile exhibitions which were organized during the month of October, in trains (France, Spain) in buses (Belgium, Italy, Portugal), in stations or in tents (Belgium, Denmark, Germany);
- ☐ a European week against cancer from 9 to 15 October took place in all member countries and included a programme of actions and events (open door days, sporting events, exhibitions, distribution of the European Code and brochures);
- ☐ the distribution, by the leagues and associations, of the European Code, January and October 1989;
- ☐ the organization of sporting events open to the general public (marathons, athletic events, cycling rallies, etc.) to promote the European Code and its principal messages (May 1989).

Events with a European dimension

Among these events, the following should be mentioned in particular:

- ☐ the European colloquium on spreading the message of cancer prevention held in Lisbon from 24 to 27 February 1989;
- ☐ the European conference on health education and cancer prevention in schools (from the point of view of the leagues and associations) which was held in Viterbo, Italy, from 5 to 7 April 1989;



A large number of information campaigns and exhibitions were organized across Europe in order to make millions of Europeans more aware of how cancers can be avoided.
Photo: CEC.

- the European conference on the treatment and prevention of cancer. Aimed at 100 medical journalists from the 12 countries of the European Community, it was held in Venice from 11 to 12 May 1989;
- the presentation of the programme of activities of the European Year to the President and Members of the European Parliament, Strasbourg, 24 May 1989;
- the ninth meeting in London (25 and 26 May 1989) of the Committee of Cancer Experts who were received by the Prime Minister;
- participation of two 'Europe against cancer' cars, with European staff, in the 'Tour de France' (with stages in Belgium and in Luxembourg).
- the tenth meeting in Copenhagen (10 and 11 October 1989) of the Committee of Cancer Experts who were received by the Prime Minister.

Numerous national activities having a European dimension were organized throughout the year.

Important actions in the field of health education in schools

Although the emphasis was put on information and prevention during the European Year, several important actions were carried out in the field of health education.

European level conferences to establish a coherent approach

A European conference was held (in April) in Viterbo, Italy with the aim of laying the foundations for a coherent approach by leagues and associations to health education. This action was followed up and developed with those responsible for health education during the European conference on health education and cancer prevention in schools which was held in Dublin (7-9 February 1990). This latter conference, prepared in collaboration with the Ministers for Health and for Education, has identified a number of positive conclusions with a view to the development of a health education policy for schools.

National initiatives supported by the Commission

The year 1989 has also been the occasion for a certain number of national initiatives supported by the European Commission: the elaboration of education packs for teachers, conferences and colloquia aimed at teachers, the distribution of brochures in schools, the presentation of health education films.

Among the most important actions which received the support of the European Commission in 1989, the following should be particularly noted:

- ☐ the training of teachers in Portugal, started in 1988 and continued in 1989, to increase awareness of the European Code against cancer and to familiarize them with the UICC training manual, specially adapted for use in Portugal (Portuguese League against Cancer);
- ☐ development, in 1989, of a manual for teachers in the UK 'Cancer in perspective: an awareness course for educators' (Cancer Education Coordinating Group) complementing the manual of the UICC;
- ☐ distribution, in 1989, of educational material in primary schools in Denmark (Danish Association against Cancer), in France (French Committee for Health Education), in Luxembourg (League against Cancer in Luxembourg and Ministry of Health);
- ☐ distribution, during 1989, of educational material and packs for teachers and students of secondary schools in Belgium (Belgian Organization against Cancer), in Spain (Ministry of Education), in the Netherlands (Dutch Association against Cancer), in Denmark (Danish Association against Cancer);
- ☐ organization of special awareness sessions among secondary school children in Portugal (Ministry of Health in collaboration with the Ministry of Education);
- ☐ organization of poster competitions on some of the European commandments for a healthy way of life in different primary schools in Spain (Spanish Association against Cancer in collaboration with the Ministries of Health and Education), in Luxembourg (League against Cancer in Luxembourg), in Greece (Greek Association against Cancer) and in different secondary schools in Portugal (Portuguese League against Cancer and Ministry of Education).

European audiovisual material — more than 30 000 videocassettes

In addition, in 1989 the European Commission financed 3 600 000 brochures, some 6 000 000 copies of the European Code and the printing of approximately 100 000 sets of 6 posters representing maps of cancer mortality in Europe and the European Code against cancer; it also circulated approximately 30 000 videos with health education programmes that had already been broadcast to the public in 1988 (see Annex IV). These materials, available in the nine languages of the European Community, were widely distributed in schools by the Associations against Cancer or by the Ministries of Health and Education of the 12 Member States.

Increased participation of all the partners

The European Year has been characterized by an active participation of the leagues and associations of the various countries, although the situation is different from country to country and depending on the association. Without them the dissemination of the messages of the European Code would not have had the same impact. Moreover, the collaboration started in 1988 between associations on both national and European level was continued and reinforced, as is shown by the large number of actions carried out by several associations working together.

The financial support of the European Community made possible the financing of numerous programmes presented by national actors and the contribution of considerable support material (brochures, video films, various promotional 'gadgets').

Régis Malbois

Adviser

David Sweet

Administrator
Commission of the European Communities
Europe against cancer programme
Directorate-General for Employment, Industrial Relations and Social Affairs

The role of the cancer leagues

The first action plan 1987-89 of the 'Europe against cancer' programme has not only had the effect that the EC Commission has made the Member States adopt this important common action plan against cancer, but it has also contributed to increasing the efforts among the European leagues in the fight against cancer. On this background I warmly support the continuation of the programme in the years 1990-94.

As president of the Association of European Cancer Leagues whose members also include cancer leagues from countries which are not members of the European Communities, I am particularly pleased to see that also the cancer leagues of these countries have been inspired by the action plan — it is for example worth noting that several countries outside the EC are now working on the basis of the European Code against cancer.

However, it is important to emphasize the fact that the fight against cancer is not only a personal matter but also a public matter.

Education and information of the citizens are of course of utmost importance — but if we are to attain the goal set in the action plan — that is to reduce the number of deaths from cancer by 15% by the year 2000, directives must be adopted and implemented in the fields mentioned in the action plan at a much faster rate than has so far been the case.

In the tobacco field, it is of a vital importance to adopt directives on, for instance, a total ban on the advertising of tobacco products, on the tar content of cigarettes and on the introduction of smoke-free areas.

Furthermore, it is highly important that the Commission takes initiatives in the nutrition field, especially with a view to protecting the consumers against substances in food which may cause cancer.

It is equally important to stress the necessity of the Commission giving higher priority to the labelling of chemical substances which are suspected of causing cancer.

Moreover, the Commission must take the necessary steps to ensure that all women in the individual Member States are offered screening for cervical cancer and breast cancer based on the existing recommendations.

The 'Europe against cancer' programme has provided a welcome opportunity for the European Cancer Leagues to deal with their responsibility to influence the public authorities to convert results of cancer research into practical policy. Accordingly, the Association of the Cancer Leagues (ECL) consisting of 27 European cancer leagues has decided to play a more active political role in questions of importance in the fight against cancer.

The ECL has reached a consensus on how to deal with three major problems i.e. screening for cervical cancer and breast cancer and the labelling of carcinogenic substances.

- in relation to cervix cancer the leagues recognized the need for nationwide organized screening for cervix cancer as a proven method to reduce cancer morbidity and mortality.

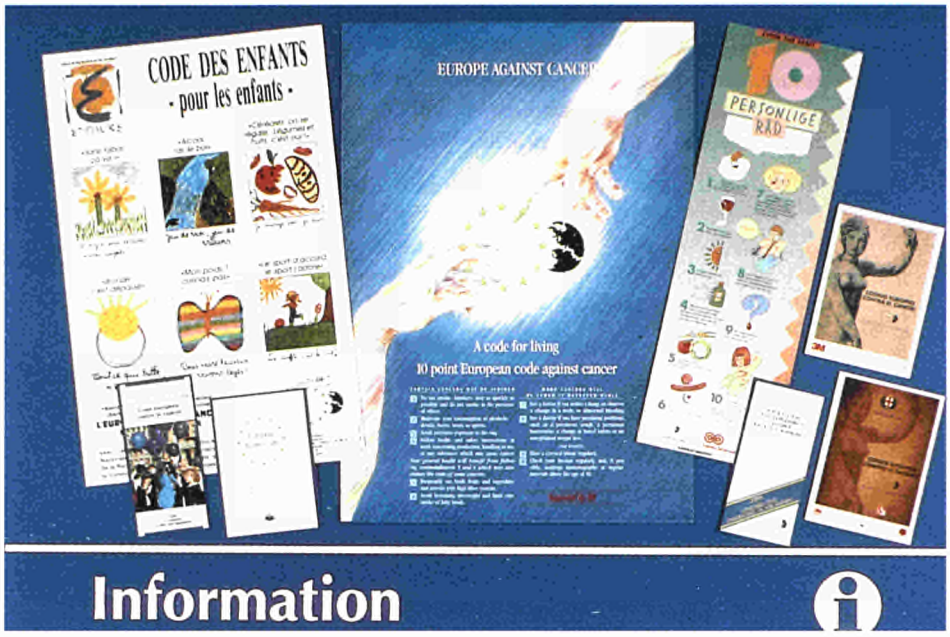
  Conditions for the implementation are well-trained screening health professionals, quality control of their performance, especially of the Pap smear, agreement on intervals and ages of women to be screened. Continuous scientific evaluation of the programme is needed;

- nationwide mammographic screening was wholeheartedly supported by all leagues. Studies made in many countries in the last decade have shown that the potential reduction in mortality and in morbidity due to breast cancer is considerable in screening programmes using mammography among women over 50 years of age.

  The ECL supports the continuation of the existing Community programme and recommends that well-organized screening programmes are implemented as fast as possible in all countries.

  Requirements for the achievements of this goal are well-trained personnel and facilities. Continuous scientific evaluation of the programme is needed. Moreover, in both programmes quality public information is needed to motivate the target population to participate, including personal invitations;

- the presence of carcinogenic substances in the environment was recognized by the leagues as an important worldwide problem. Their contribution



All partners of the 'Europe against cancer' programme participate in the European-wide information campaign. *Photo: CEC.*

to cancer mortality is not clearly identified in all cases at the moment. The growing problem forces the leagues to take action. More research is needed and the existing knowledge must be converted into a practical policy for cancer leagues enabling them to act as governmental policy influencing organizations.

In the case of well-identified problems they have to increase the awareness of the general public on carcinogenic substances and should cooperate with relevant bodies to put pressure on public authorities on local, national and international level.

The cancer diseases and accordingly the fight against cancer know no frontiers. A condition for success is international cooperation, and the establishment of the 'Europe against cancer' programme is a vital contribution in this respect.

As for the national cancer leagues the 'Europe against cancer' programme has so far led to intensified efforts on the national level. These efforts in the fight against cancer will no doubt be strengthened considerably during the second action plan with even closer cooperation, on the basis of the programme, between the cancer leagues of Europe.

Ole Bang

Managing Director, Danish Cancer Society
President, Association of European Cancer Leagues

The point of view of the Italian league against cancer

As the 'Europe against cancer' programme commences its second action plan, I believe that there is a need to emphasize the positive aspects of the initiatives taken by the European leagues and associations against cancer and the considerable results obtained.

The work which has been developed in common, and this is one of the most important results, has enabled us to develop within ourselves a genuine European awareness, not in an abstract sense but in full consciousness of the fact that via the convergence of the activities and the experiences of the different Community countries it is possible to establish with greater conviction and greater prospects of victory our struggle against such a grave disease.

As a result, we do not feel that we are involved in sectoral interests or problems, but rather that we are participating directly and consciously in a programme and playing an active part in Community life.

The leagues and associations against cancer are established in and operate in all the Community countries. They probably represent more than 10 million European citizens. Each of them has its own national characteristics and style, but all of them have been campaigning against cancer for many years in the area of public information, research and assistance to victims.

In the course of the implementation of the 'Europe against cancer' programme the leagues and associations have played a particularly important role in relation to a wide range of measures:

- ☐ the anti-smoking campaign;
- ☐ information on appropriate nutrition;
- ☐ promotion of early screening and diagnosis;
- ☐ health education;
- ☐ the training of health care staff.

We should particularly like to emphasize the measures developed in relation to the anti-smoking campaign. Smoking today is a major social problem.

The number of dead as a result of smoking in the countries of the European Communities amounts to about half a million people per year, 30% of them dying of cancer, 25% of heart disease and 45% as a result of respiratory disease. The role of tar as a cause of lung cancer has been known for many years and has been publicized by the World Health Organization and the International Agency for Cancer Research. The incidence of lung cancer has been increasing steadily in all the Community countries and in recent years it has also begun affecting women aged under 40. As a consequence of these developments and in order to face up to this serious problem the 'Europe against cancer' programme has launched measures to combat smoking.

A delegation of the leagues and associations involved met a number of members of the European Parliament responsible for reporting on the Community Directives concerning the requirement to label tobacco products and indicate the maximum tar yield in cigarettes.

It is with great satisfaction that the representatives of the European leagues and associations against cancer and the committees concerned with the campaign against smoking learned that the Council of Health Ministers of the 12 Member States which met in Brussels on 13 November 1989 approved the Directives on labelling tobacco products and on maximum tar yields as presented by the Commission and approved by the European Parliament.

We all know that the European Community institutions, from the Council through the Commission to the European Parliament are strongly committed to implementing the Single Act and realizing the economic and social integration of Europe.

In the face of such an important subject as the struggle against cancer which is one of the most widespread diseases of the European population we have to continue stressing the urgency of health care as an essential component of the process of constructing a united Europe.

One of the priority aims of such a union is the improvement in the quality of life of all the citizens of Europe.

I should also like to thank the President of the European Parliament Lord Plumb, who in May 1989 was kind enough to grant an audience to the representatives of the leagues and associations against cancer. On the occasion of this meeting we reaffirmed our commitment to the European programme by supporting and developing our activities.

The Italian league against cancer is one of the first to have used mobile exhibitions to reach the general public directly.

The leagues and associations have placed at the disposal of the Community efforts in this area their information and action systems by offering their active collaboration in all measures to combat cancer.

We were also very pleased to note that the Council has adopted the new action programme for 1990-94 presented by the Commission.

The new plan will devote particular attention to staff training and also to prevention and improved nutrition.

Where smoking is concerned, the programme sets out to define specific priorities and underscores in particular the need to cut smoking among young people and women.

In brief, the new plan will improve awareness of the causes of cancer and the possibilities of prevention and treatment. The Italian League against Cancer will participate in the programme by developing its own measures, on the one hand by highlighting the risks run by those people who do not organize their lives in an appropriate way and on the other by calling for specific legal measures to safeguard public health.

If practical prevention measures against cancer are to be realized there is a need to guarantee:

- ☐ the effective participation of the public in the various initiatives realized in this connection via health education programmes;
- ☐ the appropriate training and continuing training of medical and non-medical staff;
- ☐ the availability of structures suitable for providing appropriate prevention;
- ☐ the provision of legislative standards in relation to specific forms of action.

The Italian League against Cancer offers all its support for the advancement of the European programme in the conviction that the necessary final objective is the preservation and improvement of human health above and beyond all technical and economic considerations.

Maria Grazia Lanfranco

Lega Italiana per la Lotta contro i Tumori

TV 'Europe against cancer'

A successful collaboration

No information policy can afford to neglect the audiovisual medium, a fact which was not lost on the 'Europe against cancer' programme which clearly perceived from the word go the need to base its 'information' platform on the production of films and videos for mass communication aimed at the general public. It was therefore decided at the outset to secure whenever possible the cooperation of the television channels of the Member States of the European Community.

A European group of TV producers

The approach was sound but fraught with obstacles, witness the socio-cultural and economic diversity of these countries and particularly the traditional 'journalistic' independence encountered in the world of television. As we shall see, however, even deep-rooted attitudes can be overcome and a seemingly daunting task turned into a wonderful example of solidarity and sense of collective responsibility.

The first step was to set up the Group of Producers of Medical and Scientific Programmes of European Television Channels. Most of the major EEC television companies were told in 1987 of the launching of the 'Europe against cancer' programme and were invited to take part in the work of this group by appointing a representative to it, either the person responsible for scientific and medical programmes or, alternatively, the person responsible for documentaries or current affairs. This group has since then held around a dozen meetings in Brussels and has been the catalyst at European level for a vast audiovisual campaign to get the relevant messages through to a very broad public.

The first European Week against Cancer (May 1988)

A number of invitations to tender were sent out in mid-1987 for the production of programmes to be shown by the European TV network during the European Week against Cancer (1-7 May 1988).

The following programmes were produced as a result:

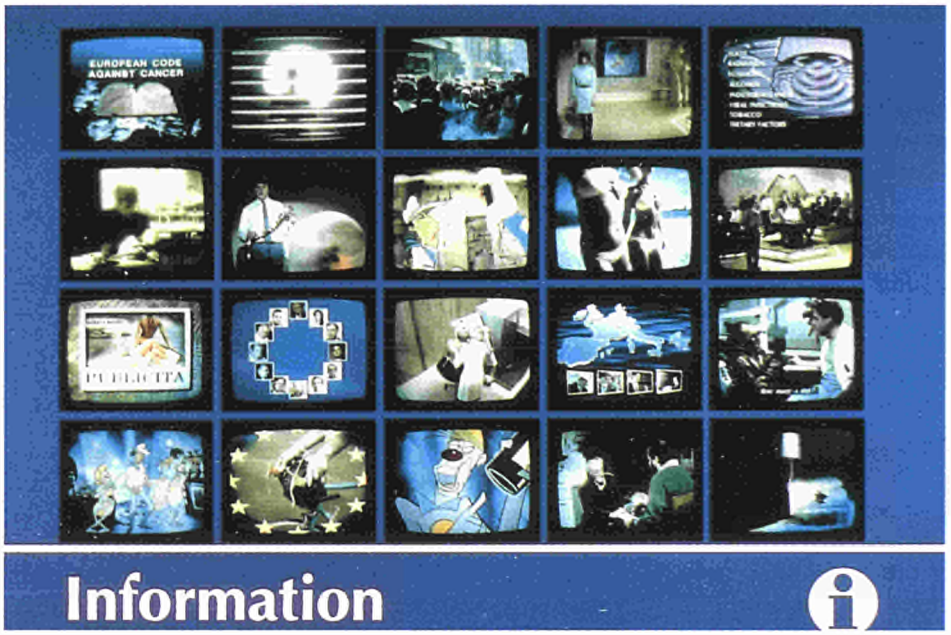
- 'Lifestyles and cancer in Europe'. This 40-minute programme was entrusted to the BBC and directed by John Groom. The aim of the film was to make the public aware of the relationship between lifestyle (smoking habits, eating patterns, excessive exposure to the sun, etc.) and the prevention of cancer;
- 'Man and cancer'. Based on an original script by David Filkin (BBC), this 30-minute programme was produced jointly in London by the BBC (UK), the RTBF (B), the BRT (B), the TVE (E) and the NOS (NL). Filmed in front of the public, this production uses large-scale models of cells, graphics and animation techniques to explain what cancer is, how it is triggered and how it can be avoided. The programme sets out the 10 'commandments' of the European Code against cancer;
- 'Euro-Jim against crab-cancer'. This is a four-minute cartoon intended to make children aware of the five cancer prevention rules connected with lifestyle ('Don't smoke', 'Beware of alcohol!', 'Avoid being overweight', 'Sun, yes but ...', 'Eat fresh fruit and vegetables'), was produced by AAA (Paris) and Final Cut (Brussels).

These three programmes were made available free of charge by the Commission to all the EEC television channels for showing during the European Week.

The results were on the whole very encouraging both as regards the number of broadcasts and as regards viewing figures and reception. 'Lifestyles and cancer in Europe', for instance, was shown by 11 channels and, in particular, was watched by around six million viewers in Germany (see annex for summary table).

The audiovisual approach: A significant feature of the European Year of Information on Cancer (1989)

In order to give a 'general public' slant to the launch of the 'European Cancer Information Year' (1989), preparation of a 12-minute film on the content of the 'Europe against cancer' programme was started at the end of 1988.



European television channels have contributed to informing the general public and promoting a healthier way of life.
Photo: CEC.

As a follow-up to the TV showing, the four programmes produced in 1987 and 1988 ('Lifestyles and cancer in Europe', 'Man and cancer', 'Euro-Jim against crab-cancer' and 'Europe against cancer') were adapted into the nine Community languages, reproduced on 30 000 'general public' cassettes and distributed throughout the 12 EEC countries by the Community press and information offices, public relations agencies and governmental and non-governmental organizations involved in the fight against cancer.

In order to build up the corpus of audiovisual material for the European Year of Information on Cancer (1989); the 'Europe against cancer' programme sent out a fresh invitation to tender in June 1988 for the production of television programmes.

In October 1988 it was decided to produce the following programmes:

- ☐ 'Vom Krebs geheilt' (Production: Dr H. Mohl — ZDF);
- ☐ 'Cancers professionnels en Europe' (Production: Marie-Anne Mengeot and Salvatore Nay — RTBF);
- ☐ 'Free generation' (Production: Stratecom SA);
- ☐ 'Bronzer sans griller' (Production: Stratecom SA);
- ☐ 'Can you treat cancer?' (Production: Yorkshire TV);
- ☐ 'A very European cancer' (Production: Yorkshire TV);
- ☐ 'Living with cancer' (Production: Yorkshire TV);
- ☐ 'Eurovision against cancer' (Production: RTBF in association with other TV channels).

With the exception of 'Eurovision against cancer', which will be dealt with separately, these programmes were all produced in the first half of 1989 and widely shown via the EEC television networks.

The 52-minute 'Vom Krebs geheilt' programme, aimed at convincing the general public of the success of early detection drives, is based on accounts by cancer sufferers from different Member States of how they were cured.

'Occupational cancer in Europe' goes back over the discovery of the first cases of occupational cancer, describes the present situation and reports on the efforts being made internationally, particularly by the European Community, to protect workers effectively.

'Bronzer sans griller' ('Tan, don't burn') is a 26-minute programme on skin cancers, with special emphasis on malignant melanoma. This film goes into the somewhat chequered relationship between man and the sun and stresses the dangers of excessive exposure.

'Free generation': this 26-minute programme is aimed at warning the 12-18 year-old group of the dangers of tobacco smoking. The film is presented by Ray Cokes (the MTV star presenter) against a backdrop familiar to this generation, i.e. rock music, cinema, advertising, adventure, etc. It exposes the tobacco industry's adver-

tising strategy: sponsoring sporting or cultural events, fashion, rock concerts, etc.

It features interviews with celebrities who do not or no longer smoke, the message being in the programme's slogan: 'Smoking is out!'

'Can you treat cancer?' is a programme based on three subjects:

- ☐ the state-of-the-art techniques used in radiotherapy;
- ☐ the most recent methods of cancer treatment: bone marrow transplants, monoclonal antibodies, interferon and interleukine;
- ☐ early detection techniques.

'A very European cancer' is devoted to breast cancer in women. It is tackled in three parts: an interview with Daniela, an Italian lady cured of breast cancer, detection methods and the difficulties encountered in this context, and the causes of breast cancer.

'Living with cancer' hinges on the socio-psychological aspects of cancer and offers three reports:

- ☐ an interview with Jessie Hunt, a 74-year old English lady who has suffered from cancer for the last 23 years and who thinks that cancer ought to be considered in the same way as any other illness;
- ☐ the work carried out in a clinic in the Black Forest in Germany where children suffering from cancer are treated in the company of their families with a view to their reintegration into normal life;
- ☐ Michel, from France, tells of how he was turned down for a job with the French PTT because he had suffered from cancer as a child.

  This kind of discrimination is now prohibited by law in France.

In parallel with these other programmes, 'Europe against cancer' asked the Leicestershire Health Education Video Unit headed by Professor Ralph Rosenthal to produce a video on 'Prevention and early detection of cancer'.

A brief introduction on the actual nature of the illness starts this programme which then goes into the methods of prevention and early detection of the following types of cancers: lung cancer, cancer of the colon, skin cancer, breast cancer, cervical cancer and cancer of the testes. It ends with a reminder of the 10 commandments of the European Code against cancer.

This film won the first prize for cancer films at the Parma International Scientific and Medical Film Festival (Italy — 1989). Following this award, the programme has been distributed on video in all the Member States of the Community and also in the USA, Canada and Australia. In addition, the USSR's No 1 television channel has acquired the broadcasting rights for this film.

'Eurovision against cancer' — January 1990: bringing the European Year to an end

The European Cancer Information Year closed with an ambitious media event: 'Eurovision against cancer', which also marked the start of the 1990-2000 decade of fight against cancer.

This programme, prepared over a two-year period and coordinated by the RTBF, the instigator of the project represented by Mrs Françoise Wolff and Mr Jean-Michel Briou, is a unique technical achievement and reflects a tremendous solidarity between the members of the group of European TV channels. It brought together 11 channels from nine Community countries: RTBF/Télé21 and BRT 2 (Belgium), Antenne 2 (France), ET2 (Greece), TV2 (Denmark), TVE (Spain), ZDF/3SAT (RFA), RAI UNO (Italy), RTP (Portugal), RTE (Ireland) and TV5.

On 9 January 1990, these channels, with the exception of the Irish television channel which withdrew at the last minute, showed an information programme produced jointly with the support of the Commission of the European Communities on four major cancer prevention themes: tobacco, alcohol, eating habits and systematic detection.

The principle of the programme was simple enough. Each participating TV channel undertook to produce a 4-5 minute spot on one of the four major themes mentioned above. These spots were then pooled, adapted into the nine Community languages and made available to each participant. On the evening the programme was shown, each participant organized a studio set around guests who were then given the possibility of duplex linkups for live discussion with foreign panels. We thus had the Greek putting live questions to the Belgian panels on the tobacco theme, the Belgian panels putting questions directly to the Danish panels on detection, etc.

Italy and Germany, however, opted for national panels involving no exchanges with foreign sets.

This programme can be considered a major success. On a country-by-country basis the results recorded are eloquent:

- ☐ Denmark: Shown at 9 p.m. on 9 January.
  Viewing audience of 12% with peaks of 16%
  Appreciation: 4.07 on a scale of 0 to 5.

- ☐ France: Shown at 10 p.m. on 9 January.
  Viewing audience of 6% (i.e. 1 171 600 households), a remarkable score in a country where there is fierce competition.
  France-Soir rating: 9/10
- ☐ Spain: Shown at 3 p.m. on 9 January.
  Viewing audience: 3.1%
- ☐ Portugal: Shown at 9 p.m. on 9 January.
  Viewing audience: 35%
- ☐ Belgium: BRT2 shown at 9 p.m. on 9 January.
  Viewing audience: 3%
  RTBF shown at 9 p.m. on 9 January.
  Viewing audience: 2.8%
- ☐ Greece: Shown at 9 p.m. on 9 January.
  Viewing audience: 15%
- ☐ Germany: Shown at 8.30 p.m. on 9 January on 3SAT.
  Audience viewing figures unavailable.
- ☐ Italy: Shown at 11.40 p.m. on 9 January.
  Viewing audience: 13.58%.

It should be added that the RTBF French version of 'Eurovision against cancer' was shown by TV5-Europe on 9 January 1990 and by TV5-Canada on 12 February 1990.

In the context of this report, it should be stressed that the European Committee of Cancer Experts chaired by Professor Maurice Tubiana was closely involved in the scientific scrutiny of the various audiovisual productions of the 'Europe against cancer' programme.

Audiovisual productions in 1990

1. In December 1990 a second edition of videocassettes was made available for health education purposes to all those involved in the nine-language programme of the Community. This new cassette contains four films ('Europe against cancer' in an updated version, 'Euro-Jim against crab-cancer', 'Free generation' and 'Prevention and early detection of cancer'.
2. The 'Europe against cancer' programme co-financed with the various associations and leagues against cancer in the Member States of the Community (plus Finland, Sweden and Norway) a major documentary entitled 'Smoking'. It was produced by the Danish company 'Angel Film Aps' and directed by the Swede Dan Säll.

   This documentary was made available to all TV channels throughout the European Community for showing during the 'European Week against Cancer' in October 1990.

An abridged 20-minute version of this film was produced at the end of 1990 and made available to all those involved in the 'Europe against cancer' programme.

A positive response from the critics

There was some reason to suppose that an audiovisual campaign on cancer might well fall flat in view of the somewhat forbidding nature of the subject and the natural propensity of the public to shy away from such deep and potentially disturbing issues.

The results prove otherwise and show that, indeed, there is a public demand for reliable information on health education in general and particularly on cancer.

So let us leave the last word to the journalists in their role as commentators and critics.

France-Soir's report (11 January 1990) on 'Eurovision against cancer' stated: 'At last! How incredible, if not simply ridiculous, it has been to see Eurovision, ever since it started up, putting everything into futile ventures of the song contest type. The serious, adult Europe came of age on Tuesday ...', while the *'La Croix'* issued on the same day carried an article by Jacques-Yves Bellay, who wrote: 'I always shudder at the thought of big medical shows, in cases illness itself becomes (...) the means to an end which is merely to entertain or to provide an opportunity for the advertisers to cash in. Fortunately Eurovision against cancer (...) will not have been debased in this way. Tactfully steered by Jean-Daniel Flaysakier, the programme succeeded in involving 10 European television channels (...). This was television carrying out real journalism'.

Lastly, Jacques Poncin had this to say in the 5 May 1988 edition of *Le Soir*, 'There is no doubt that information is important to health, but it is an instrument whose effectiveness can be very variable and its effects not particularly incisive in the short-term. Take tobacco for example: (...) the repeated campaigns of the last few years have undoubtedly created a psychological climate in which smokers no longer feel comfortable. And in the developed countries (i.e. where there is a *consistent flow of information)* consumption of tobacco is falling 2% every year...'.

His article is entitled 'There is some considerable sense of achievement at the Commission of the European Communities: TV for Europe is here. Thanks to cancer...'.

Jean-Pol Ferbus

TV producer and consultant to the 'Europe against cancer' programme Directorate-General for Employment, Industrial Relations and Social Affairs Commission of the European Communities

School health education in the European Community

Health education is now acknowledged to be a vitally important element in the central fight against ill health and disease. Through education we can provide young people with the means of overcoming many dangers to health, enabling them to acquire knowledge, positive attitudes and decision-making skills essential for the adoption of healthy lifestyles in a modern society. There is ample experience and much research evidence to show that the seeds of our health-related behaviour (our lifestyles) are sown in our early years. It is evident therefore that both primary and secondary schools can provide major opportunities for systematic and directly influential health education, ideally in partnership with families and community initiatives. It is not surprising therefore that there has been renewed interest in the development of effective programmes of school health education and promotion throughout Europe, an interest accelerated by anxieties over drug abuse, the spread of AIDS and the increasing carnage caused by cancer and heart disease.

While this modern movement in European school health education goes well beyond the confines of the European Communities itself it is none the less true to say that the EC is playing a major role in its development. Other international organizations such as the European Office of the World Health Organization and the Council of Europe have also played prominent roles and, over the past six years, there have been several joint initiatives by these three organizations. Coordination between them is important because of the opportunity to conserve and rationalize scarce resources and, as important, to agree upon and pursue a joint policy for school health education in Europe.

The purpose of school health education: to promote a healthy lifestyle

We have come to understand, through a mixture of research evidence and experience, that the health of an individual is dependent upon a complex interaction between at least four important factors:

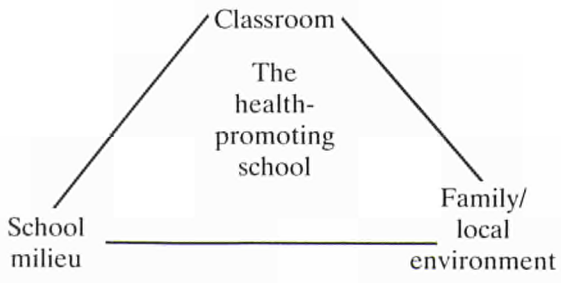
- ☐ genetic inheritance;
- ☐ the physical and social environments in which we live;
- ☐ health-related behaviour (lifestyle);
- ☐ the quality of the available health services.

While there is little that we can presently do to alter the genetic predisposition of individuals there is however a great deal we can do to improve positively the other three factors.

The main objective of school health education in Europe has become the promotion of healthy lifestyles amongst children and young people, but we have learned how difficult this can be in the absence of a supportive physical and social milieu. We now know that, to be effective, classroom teaching and learning must also be reflected by what pupils learn implicitly from the school milieu and, as far as possible, by what they observe and learn at home and in the surrounding community.

This knowledge has helped us to construct the concept of 'the health-promoting school' as the main objective of our work. In its simplest sense the health-promoting school can be represented as the dynamic interaction between three main strands of learning and support.

- What children learn in the classroom — through the health education curriculum.
- What children learn from being in a school community — through its ethos, its culture and traditions, its regard for human relationships and dignity — all of which should support and expand what is taught in the classroom.



Children have also contributed to the 'Europe against cancer' campaign by designing posters.
Photo: CEC.

Health education

• What children learn from local environment — through living in families and exchanges with other influential individuals and groups; through the activities of health-related services such as doctors, nurses and hospitals and through public health campaigns.

The successful health-promoting school is one which is able to coordinate all these learning opportunities to the best possible advantage, to focus all these influences towards promoting the health of both pupils and teachers. Each of us can reflect upon how schools that are well known to us could improve their capacity for promoting health by small changes to their policies and management or by better liaison and coordination without of school agencies.

In many instances where there is excellent learning and teaching in the classroom related to, for example tobacco or nutrition, the messages and influences are undone by bad experiences in school canteens or by lack of coherent smoking policies. Children learn from example and good role models, not from rhetoric.

Promoting health — the challenges

School health education in Europe faces many challenges such as:

☐ where is it to be placed in the school programme? Most European countries have rejected it as a separate subject and insist that it is best integrated with other subjects.

☐ how best is it to be coordinated across the curriculum? If health education is to be integrated with other subjects (science, language, civics, etc.), how can we avoid boring repetition and how can we decide upon priorities?

☐ what kind of teaching methods are most successful? Health education must be concerned to help pupils make decisions about their own lifestyles and this involves a participative process within which the key elements are the acquisition of knowledge and the skills through which the knowledge may be implemented into their day-to-day lives.

Without doubt however, the most significant challenge facing school health education in Europe is that of teacher training. The pre- and in-service training of teachers in health education has been identified consistently as a key issue by conferences, symposia and working parties on European school health education over the past six or seven years. Few countries provide room for health education in the pre-service training of teachers and there is need for good models to be developed and shared. If, during their routine training, health education is neglected, then it is difficult later to convince teachers (or schools) that it is an important part of the school programme. While many countries do provide some in-service education for teachers most agree that this is inadequate to provide a firm foundation for the development of school health education

programmes. Without teachers who understand the importance of the major health issues and how they might be managed within schools, school health education will continue to be viewed with suspicion and the health-promoting school will remain a dream. It is good to see therefore, that positive actions have recently taken place or are planned for the near future under the auspices of one or other of the three main organizations with an interest in promoting school health education.

Planning for the future: promoting school health education

One of the most important events ever held to promote the interest of school health education in Europe was the conference 'Health education and cancer prevention in schools' organized for the Commission of the European Communities by Europe against cancer in Dublin in February 1990.

Out of the work of three major working groups arose recommendations which will help to stimulate and revitalize school health education in the 12 Member States of the EC and will no doubt provide a lead for the rest of Europe.

The recommendations will be implemented through three working groups comprised of representatives from each of the Member States, representing the interests of primary schools, secondary schools and teacher training respectively. The proposed work of the groups is outlined briefly here.

Primary schools

- ☐ To produce a teachers' school guide 'Promoting healthy lifestyles amongst primary schools in Europe' by the end of 1991;
- ☐ to produce a training module to accompany the guide by the end of 1991.

Secondary schools

- ☐ To produce a teachers' coordinators' guide 'Promoting healthy lifestyles of young people in secondary schools' by the end of 1991;
- ☐ to produce a training module to accompany the guide by the end of 1991.

Teacher training

- ☐ To plan and organize two five-day training workshops for teachers and teacher trainers in each of the next five years.

Because training has been given such a high priority, a Summer School in School Health Education was held at the University of Southampton, United Kingdom, from 9 to 21 July 1990, which was financed jointly by the European Office of the World Health Organization and the Commission of the European Communities. Twenty-five countries were represented, including two participants from each of the Member States of the EC and two from most Eastern European countries. As a result of the Summer School, it will now be possible to call upon a reservoir of potential trainers from across Europe to help staff future training events.

The Summer School has also helped to create an even stronger network of European colleagues which will no doubt be enlarged further over the next few years. The Southampton event proved to be such an unqualified success that there are plans to repeat the Summer School in 1991. An additional training workshop is also planned on nutrition education for August 1991 which will be held in Schleswig-Holstein, Germany, accommodating up to three participants from each of the 12 Member States of the European Community.

In addition to the training and other events outlined above, the 'Europe against cancer' programme of the European Community intends to stimulate school health education activities even further by offering sponsorship for selected school-based projects in the 12 Member States. The projects accepted for sponsorship will need to be based upon the promotion of healthy lifestyles amongst pupils in both primary and secondary schools and must include those aspects related to the prevention of cancers such as tobacco and nutrition education. Submissions of projects have already been made by most countries and it is expected that go-ahead for those selected will be made early in 1991.

An Association for European School Health Education?

European school health education is, relatively speaking, in its infancy and recent comparative studies show how uneven its development is. Most experienced school health educators voice the opinion that its interests could be best served by the creation of a School Health Education Association for Europe (SHEAE).

At present there is no one single organization devoted specifically and totally to the development of school health education in Europe. There are organizations set up to consider single issues such as tobacco smoking or nutrition or community health education. There is as yet, however, no forum for the discussion and development specifically of school health education in its entirety.

While school health education shares basic principles and ideas with community health education, it has nevertheless developed guiding principles of its own which are uniquely related to schools — for example the health-promoting school, the spiral curriculum, starting from where children are, integration, coordination, etc.

Where countries have introduced a school health education association, school health education has prospered and developed — such as in the United States of America, Canada and Australia. Associations typically encourage research and development and the exchange of ideas in school health education in three ways:

By stimulating activities in the regions which in the case of Europe would be in each of the European countries.

By stimulating international exchanges through international conferences — which could be held annually or every two years in different countries on a rotating basis — south, north, east and west.

By producing a six-monthly or quarterly newsletter or magazine *School health education in Europe* containing recent research and/or developments from across Europe and other continents.

No other association or organization would be in any way threatened or intimidated by the creation of a European Association of School Health Education, the membership could be a new clientele — the 200 000 primary and 60 000 secondary schools of the European Communities together with those from all the other European States. The task of such an Association would be to ensure that every one of its schools was as health-promoting of its staff and pupils as it possibly can be. A goal which I am sure every parent, teacher, pupil or citizen would share.

Trevor Williams

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Directorate-General for Employment,
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The contribution of the European Community to health education

Deprived of direct competence in the field of public health or general education, the European Community has nevertheless succeeded, with the 'Europe against cancer' programme, in promoting significant actions in the field of health education.

The importance of the European Code as a guide to a healthy life

One of the first tasks the Committee of Cancer Experts took on, in 1987 and 1988, was the devising of a 'European Code against cancer'. These 10 recommendations which result from the latest research are based on two statements: on the one hand, a healthy way of life (tobacco, alcohol, nutrition, etc.) is beneficial to health in general and allows us to avoid certain cancers as well as other diseases; on the other hand, awareness of one's body enables us to detect certain cancers early, therefore making it possible to cure them.

These 10 commandments are aimed at adults and adolescents. For primary school children and young adolescents at secondary school level, only those commandments concerning a healthy way of life are appropriate.

This 'European Code against cancer' was approved during the second half of 1987 by the non-governmental organizations against cancer and by the Ministers for Health. It was formally transmitted to Heads of States and/or Governments, during the European Council of Copenhagen in December 1987, in order to achieve maximum publicity in 1989, the 'European Year of Information on Cancer'.

On the basis of the recommendations of the European group of senior officials for health education which met six times from 1987 to 1989 the 'Europe against cancer' programme pursued the following strategy: to directly emphasize the healthy way of life (by adding the 'awareness of one's body' dimension for adolescents) and to indirectly promote positive benefits for cancer prevention. As for the opportunity to approach the disease as such, this was left to the appreciation of the different partners of the programme in the Member States. So, in southern Europe, the word 'cancer' very often remains taboo, which is not the case any more in northern Europe.

Since the launch of the first action plan a number of actions in the field of health education have taken place at both European and national level. These include conferences, training seminars and working groups.

With the second action plan 1990-94 of the 'Europe against cancer' programme, these awareness campaigns for children and adults promoting a healthier way of life and an awareness of one's body will increase during the next five years.

The programme contributes to the improvement of the daily environment of children

In order to attain its principal goal of promoting the adoption of a healthy lifestyle among children, health education cannot limit itself to classrooms or school programmes. What is the use of a message denouncing the bad effects of tobacco if teachers freely smoke in schools, if bills around schools show advertisement in favour of tobacco, or if periodicals for youngsters contain advertisements for tobacco?

Unfortunately, this type of advertising is still very common in newspapers, periodicals and billboards of several Member States. This situation is particularly prejudicial for young people who are, in fact, the main target of tobacco dealers. In some cases, advertisements filter into periodicals for young people. Fortunately, some Member States forbid such practices. However, young people of these Member States are not totally protected from such harmful influences. Indeed, newspapers, periodicals and magazines circulate more and more in the European Community. Moreover, in different countries, learning a new language is not done any more with the help of works from Goethe, Victor Hugo or Shakespeare, but with magazines for the general public. That is why, in June 1989, the European Commission took on the harmonization of the existing dispositions in the Member States concerning advertisements in favour of tobacco products by means of bills and posters.

This European legislation can only facilitate the task of teachers by avoiding that messages spread in classrooms be contradicted in the children's daily environment. Moreover, this European action in favour of a

Teachers play an important role in this long-term action. The European Community helps them through the organization of training seminars and the translation and distribution of teaching materials.
Photo: CEC.

healthier way of life is also reinforced by the 'information of the general public' section of the 'Europe against cancer' programme.

With the 'Europe against cancer' programme, the European Community, under the banner of the 'Citizens' Europe', succeeded for the first time in its history, in making a significant contribution to health education in schools. In some respects, this intervention is decisive, notably in the domain of the fight against tobacco. This breakthrough, launched in 1987, is being enlarged and built on during the second plan of action 1990-94 of the 'Europe against cancer' programme.

Michel Richonnier

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From Viterbo to Dublin

A strategy unfolds

Health education in schools was not born in Viterbo during the Conference which was organized by the Italian League against Cancer from 5 to 7 April 1989 under the auspices of the Commission and the 'Europe against cancer' programme. Several conferences on the subject had already been held beforehand organized by the Commission or other international organizations such as the World Health Organization or the Council of Europe. Certain countries had already begun to implement certain principles of health education in schools. But for the most part this entailed conferences and seminars aimed at specialists or initiatives taken by officials in Ministries either inside or outside of the direction defined by the public authorities.

The main accomplishment of the Viterbo conference, whose theme was the role of health education in the prevention of cancer, was undoubtedly that it assembled for the first time representatives from a variety of backgrounds: associations and leagues against cancer, teachers, people and organizations working in the field of health education as well as doctors, dentists, nurses and those working in the fight against tobacco. Together they tried to make an inventory of current experience and methodologies and to sketch an outline of how associations and leagues could contribute to the process of health education.

With the distance necessary to judge the significance of such an event, it can be seen today that the final recommendations made by the group of associations and leagues of the Community at the end of this conference, served as a starting point to a strategy which would later be defined on Dublin.

The Dublin conference: the beginning of a real strategy

The European conference, held in Dublin from 7 to 9 February 1990 was on the same theme as that of Viterbo and in the framework of the 'Europe against cancer' programme. It gathered together individuals, organizations, institutions and associations working in health education including those with experience in particular areas essential to health education – healthy lifestyle, tobacco, nutrition teacher training.

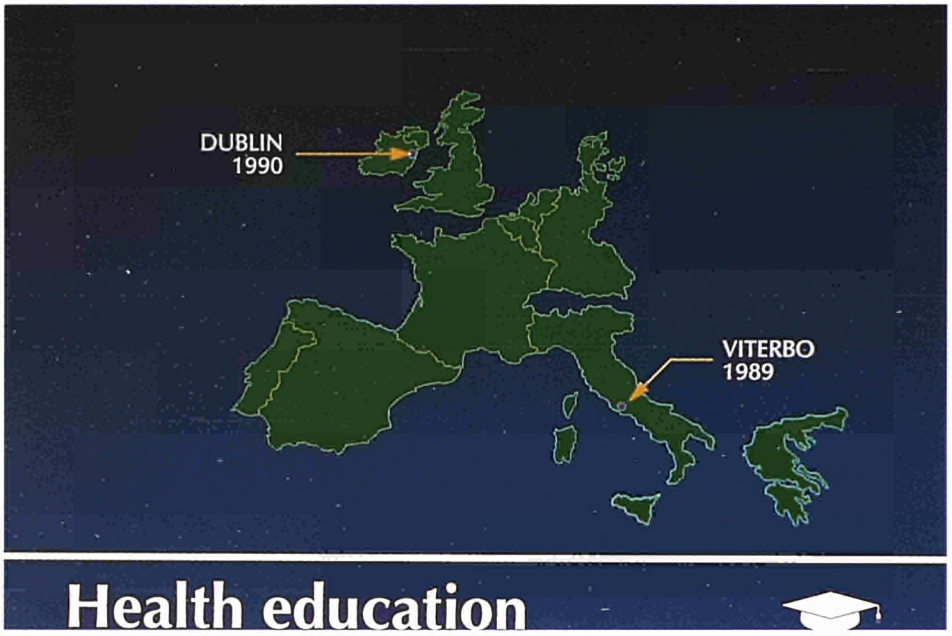
The objectives of the conference were essentially to promote a positive and dynamic approach to health education in every country. Three particular objectives had been specified:

- ☐ an exchange of information on national experiences which would allow an objective assessment of successes and failures in each country;
- ☐ the establishment of a database on what is available on health education in each country from information to teacher training in health education. There is a wealth of such documentation but it is often scattered and deserves to be better known;
- ☐ the development of precise concrete and practical recommendations for those responsible for health education in the Member States.

The outcome of the conference corresponded closely with its proposed objectives and justified the hopes of the Commission and the national ministries. The actual recommendations approved by the national Ministers for Education accepted:

- ☐ the extent and content of a policy on health education;
- ☐ the essential role of the primary teacher in awareness and respect for the human body and its protection from nuisance;
- ☐ the role of second-level teachers in teaching about healthy lifestyle through studying particular diseases especially cancer;
- ☐ the definition of methodology for teacher training in health education.

The proposition regarding the content and the methodology of health education as well as the training of teachers were sent to those responsible for health education policy. Working groups were established at the European level to study each of these three propositions.



In February 1990, the Community took the initiative of organizing, in Dublin, a European conference on health education in schools. This was a follow-up to the meeting of European organizations against cancer in Viterbo, in 1989.
Photo: CEC.

Moreover to assure the success of the conference it was decided that its final conclusions would be discussed at national conferences which would be attended by those responsible for health education nationally. Such conferences have already been held in some countries and are being planned in others.

To conclude, while the Viterbo conference was the start of a common reflection on health education, that in Dublin defined and implemented a real strategy on which in the future those working a health education at either European or national level can build.

Régis Malbois

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Oncology in the medical curriculum

The fight against cancer is a fight against a complex phenomenon the causes of which are still largely unknown. For this reason, research is one of the essential elements of oncology, that branch of medicine which deals with the diagnosis and treatment of tumours.

Another and fundamental pillar in the fight against cancer is the training of health professionals. The need for training has become permanent and pressing in recent years for three main reasons:

- the first is that, according to the latest estimates, up to 20% of cancer deaths are due to late diagnosis or inadequate treatment. In fact, in Europe it has been shown that approximately 45% of cancer patients are curable, signifying that 35% of our defeats can be imputed to the intrinsic biological aggressiveness of the disease. Therefore, to achieve a reduction in this figure, our means of attack lies in experimental research in the laboratories, where scientists are constantly trying to understand the mechanism of cellular transformation into malignancy. Furthermore, in view of the need of improving the majority of European health systems, a reduction in the number of cancer deaths will require us to invest increasingly in education and training;
- the second reason lies in the fact that the teaching of oncology is a difficult task owing to the need for so-called interdisciplinarity, meaning integration of diverse specialities and backgrounds, whereas in the past there was a rigid separation of the roles of medical disciplines (in so far as gastric cancer simply had to undergo surgery and leukaemia was cured exclusively by drugs). One of the major achievements of modern oncology is, in fact, this multidisciplinary approach to the cancer patient: mutilation of limbs for sarcomas has been drastically reduced by combining less extensive surgery with more chemotherapy; the breast preserving treatment of breast cancer has been made possible by a synergistic combination of limited surgery with radiotherapy;
- the third reason which makes training so important in oncology is the rapid development of technology in this field. New methodologies, such as the use of laser in cancer treatment or nuclear magnetic resonance in tumour diagnosis, are not yet included in the curricula of most medical faculties. Nevertheless the oncologist finds himself obliged to employ these new techniques, imposed on him by the reality of technological development, immediately.

Unfortunately, a standardized system of control of training and updating for health professionals is sadly lacking in Europe.

In the United States, medical training is both checked periodically by the American Medical Association and encouraged by the government by way of fiscal benefits for the doctors who attend selected congresses and educational meetings with the purpose of bringing themselves up-to-date (credit hours of training). There are no rules of a similar kind in most of the member countries in Europe. A solution should be found, because it is not possible to rely exclusively on the good will and the humanist tradition and culture of our doctors.

At undergraduate level, there is a need for a curriculum which will include oncology for all European medical students; a proposal was prepared by the European Commission at a Consensus Conference in Bonn in 1988 and some of the member countries have already implemented it. It guarantees at least 75 hours of coordinated teaching of oncology for all medical students including a compulsory examination at the end. At postgraduate level, a crucial role in the fight against cancer is played by the general practitioner who must then be well trained in educating his patient (anti-smoking campaigns, etc.), in being a skilled early detector of tumours, in assisting his patients with cancer during treatment and in the cases where pain control and terminal care are needed.

Specialists who are not oncologists can also contribute enormously and, consequently, need to be continually updated at least in their specific fields of action (dentists for oral cavity tumours, gynaecologists, haematologists, etc.). Oncologists, too, need to make an effort in this direction: it has been estimated, for example, that three relevant papers on breast cancer are published every week in medical journals. All this concerns cancer nurses as well, and it is more and more frequently being suggested that a specialization be recognized in order to encourage these crucial professionals, both economically and in terms of their status within the medical community.

As in other important fields of our social life, the European Community can play an extremely important

European School of Oncology, Venice.
Photo: CEC.

role in improving cancer education and training by recommending an advance curriculum in oncology to all medical schools, by harmonizing oncological specializations among the member countries, by suggesting incentives for the permanent education of doctors and nurses and by activating mechanisms of 'training the trainers' to spread the knowledge of cancer prevention and management.

Dr Alberto Costa

Director, European School of Oncology

Using advisory committees to promote cancer training

Training as a whole for certain health professions is regulated within the European Community by directives: there are separate ones for each profession concerned.[1]

Their basic purpose is to facilitate the free movement for purposes of employment of Community citizens holding the qualifications referred to in the directives. They do this by listing the professional diplomas recognized at Community level and by setting the criteria to be met in the training leading up to the award of those diplomas within Member States.

When the directives were under discussion, it was recognized by the Council and the Commission that ongoing advice would be needed on the effective implementation of the directives and on any changes needed to them to reflect developments in professional training, both basic and post-basic. At the same time that it adopted the successive directives the Council therefore also adopted decisions setting up training advisory committees, responsible for helping the Commission to ensure comparably high standards of training throughout the Community. Each committee has 72 members, nominated by the Member States and drawn from the professions at large. There are three groups of members — the practising profession, the teachers and the competent authorities. The advisory committees are the authoritative sources of advice to the Commission on training for the health professions. The Commission provides the secretariat for the committees.

With the launch of the 'Europe against cancer' programme's plan of action, it was natural that the Commission should request the advisory committees for doctors, nurses and dentists for their views on the present state of the art in training in cancer and for their recommendations as to improvements that were desirable and feasible in such training.

The committees had at their disposal the general advice given in this field by the committee of national cancer experts, but the Commission looked to the three advisory committees for a much more detailed assessment, one upon which specific future action in training could be built. The advisory committees were asked to report on all levels and forms of training – basic, specialist, continuing professional education, and teaching technology.

All three advisory committees had to work within a tight timetable, but they finished their task by the end of 1988 and the reports and recommendations on training in cancer for their respective professions are now public.[2]

In addition, as part of this work there was a conference held in Bonn in May 1988 upon undergraduate training in cancer and the Royal Marsden Hospital, London, did a review of the training of nurses in cancer. There is insufficient space here to present in detail the recommendations of the committees, but copies of their full reports can be obtained on request from the Commission (Directorate-General for the Internal Market and Industrial Affairs). There were certain key conclusions common to all reports, however, and these merit attention.

One was the emphasis placed on prevention and early detection in the fight against cancer, and the consequential need to improve the skills of health personnel in these areas of their professional training. Prevention on the one hand, and early detection and treatment on the other, help to avoid the need for more extensive and distressing late treatment of cancer. They are also the most cost-effective approach to patient care.

Improving the capabilities of GPs and dentists

Allied with this conclusion in all three reports was the emphasis placed upon the role in prevention and early detection of the front-line professionals, those in routine frequent contact with patients. The committees felt that the training in cancer of such health personnel justified particular attention in the future. Especially in mind here were general medical practitioners and general dental practitioners. In short, the family doctor and family dentist.

The committees felt that, in general, there was need for better coordination in the teaching of cancer within and between training institutions.

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[1] Doctors, nurses, midwives, dentists, pharmacists and veterinarians.

[2] Doctors: Doc III/D/890/3/88; nurses: Doc III/D/248/3/88; dentists: Doc III/D/886/3/88.

Given the speed of development in knowledge and technology, the skills of health professionals in cancer can rapidly become out of date. This is especially true of practitioners who work mainly by themselves, away from health institutions. The three advisory committees therefore stressed the importance of well-constructed schemes of continuing professional education, readily available to health personnel working in all types of settings. The committees found that, on the whole, the arrangements at present made for continuing professional training in cancer were deficient in a number of ways.

Lastly, all three committees considered that the Community could play a valuable role in cross-fertilization of ideas and experience in the field of teaching technology in cancer.

As regards the future, the Commission made it clear to the committees from the beginning that it was not looking for a single one-off exercise but that it was seeking recommendations for continued action in the field of training. The Commission's proposals for such further action are to be found in its action programme for 1990-94. The new programme proposes that the budget provision for action on training should be considerably increased from the figure in the 1987-89 programme.

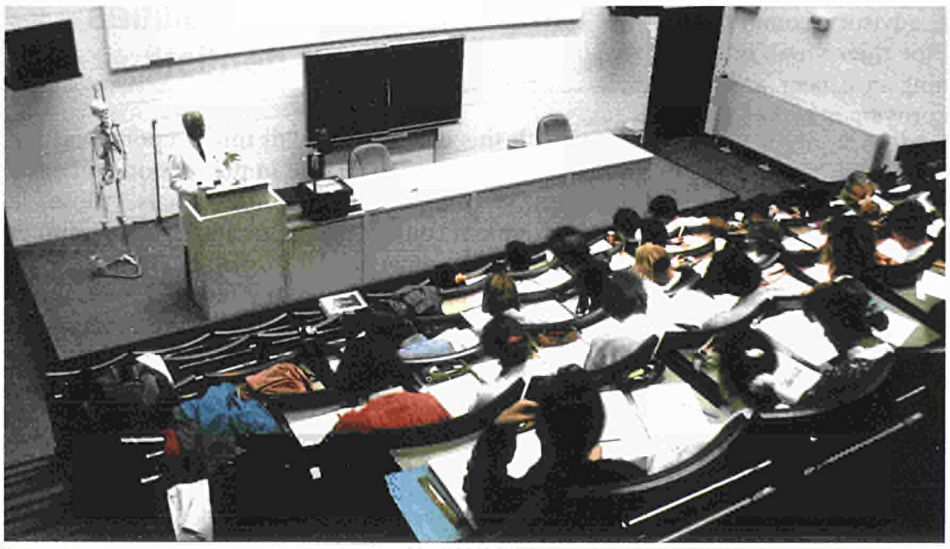
A double approach: the Commission and national authorities

The approach to be taken over the next four years falls into two broad areas. There are the initiatives that the Commission proposes to take under its own responsibility and direct funding.

Some of these initiatives are already well under way, such as those on the curriculum and teaching material for general practitioner training in cancer. Work is also in hand on developing agreed core curricula for training in cancer for nurses and dentists.

The other broad area is the initiatives that could and should be taken directly by national authorities, governmental or professional, to give a practical follow-up to the recommendations of the three advisory committees; with a view to trying to stimulate such initiatives the Commission took the unusual step of making the work of the three advisory committees the subject of a formal recommendation of its own.[3] Recommendation 89/601/EEC of 8 November 1989 is addressed to the

[3] OJ L 346, 27.11.1989.



Thanks to the programme, students of the health professions should have a minimum training in oncology.
Photo: CEC.

Member States, and it requests that they, their competent authorities and their establishments responsible for professional training should ensure that the recommendations of the committees are widely distributed, discussed and implemented. The recommendation also forewarns that the Commission will in due course review the practical outcome of the committees' recommendations in the Member States.

The work of the advisory committees in cancer is, of course, by no means at an end. They are not constituted in such a way as to enable them to undertake the detailed activity which is already in hand or which will begin as the 1990-94 programme gathers speed, although individual members of the committees will be drawn into this detailed work by virtue of the particular expertise that they can provide. The committees as a whole will be kept informed about the implementation of the 1990-94 programme, and they will be free to offer their advice about it. They will have a particular interest in the relationship between specific ideas for training in cancer and the curricula as a whole for the professions for which they are responsible. All curricula are already overcrowded: increasing the emphasis given to one area of study — in this case cancer — runs the risk of creating imbalances elsewhere in a curriculum.

Involvement in cancer has been, and will remain, an unusual experience for the advisory committees. The directives under which they function state the criteria for training in fairly broad terms only. Moreover, where indiviudal areas of study are mentioned it is in terms of disciplines and not of diseases. In the case of cancer, the committees were requested for the first time to study in depth the training for a specific disease and, in doing so, to consider the prevention and treatment of that disease. Cancer was also a new venture for the committees in that their involvement was not directed towards issues affecting freedom of movement but towards the intrinsic nature of training in cancer and its appropriateness in equipping health-care personnel to meet the needs of patients.

Sidney Allman

Principal Administrator
Unit for freedom of establishment
and freedom to provide services
Directorate-General for the Internal Market
and Industrial Affairs
Commission of the European Communities

The role of the general practitioner

'In the campaign against cancer, general practitioners are in the front line. The spontaneous trust which is placed in them and their continuous contacts with their patients make family doctors a cornerstone of any policy of prevention, of systematic check-ups and of early detection of cancer'. With these words the committee of leading cancer experts introduced their comments on the training needs of general practitioners to fully engage them in the 'Europe against cancer' programme.

A key role for the general practitioner

The role of the general practitioner involves him in the health care of the population from birth until death. In consequence, he is in contact with his patients on average at least three times a year. Thus he is in a unique position to advise his patients, not only about the life-style issues in relation to cancer but also concerning appropriate screening examinations, some of which he can carry out himself. Furthermore, because of his continuing contact with his patients over long periods of their lives he is aware of their personal and family history and is in a position to identify those individuals who are particularly 'at risk' of developing a cancer and who merit special screening counselling.

As the physician responsible for the care of the patient at home he is involved not only in the early diagnosis of cancer but also the care of the patient with cancer when he is at home. If the patient is living at home during treatment the general practitioner will be involved in the management of the side-effects of treatment and, increasingly, will be involved in the treatment itself (chemotherapy, immunotherapy or hormone therapy). Certainly he has an essential role in caring for the patient after treatment, in rehabilitation as well as during periods of remission. The family physician has always played an essential role in terminal care of his patients and this role is particularly important in the case of patients with cancer. Not only does this require his particular skills in terminal care but also the use of measures available to alleviate the symptoms associated with an incurable cancer.

In order to fulfil all of these functions the general practitioner requires specific postgraduate training, analogous to that of specialists. This has been recognized by the European Community in the Directive on specific training of general practitioners (Directive 86/457/EEC). This Directive, whose first provisions became operative on 1 January 1990, requires Member States to set up specific postgraduate training programmes for those intending to become general practitioners and offers the opportunity to incorporate in these programmes appropriate training in prevention, early detection and treatment of cancers. This training is theoretical and practical, incorporating not only information about the frequency of cancers and their early detection but also the real possibilities available for treatment. Because of his special relationship with patients on a continuing basis over many years, the general practitioner is the best person to break down the taboo which inhibits frank and open discussion of cancer, still commonly regarded as a dreaded disease.

The fact that certain cancers can now be cured, can be treated and by adjustment of life-styles avoided or the risk substantially reduced, is a message which the family physician can convey on an opportunistic basis during consultations.

In certain areas the family doctor has quite specific contributions to make.

Smoking

As tobacco plays such an important part in the development of many diseases, not only cancers, the general practitioner is best placed to influence smoking habits in the population. He not only has the opportunity to enquire about smoking practices in the context of many consultations, but also to influence his patients by his own example.

Alcohol

The important role of alcohol in certain diseases presents a possibility for the general practitioner to advise his patients concerning their use of alcohol. This is particularly relevant to the development of cancer when it is combined with smoking.

Diet

This aspect of the individual life-style is one frequently discussed in the context of many diseases. The general practitioner with his special knowledge of the patient and of his family is able to advise his individual patients concerning dietary factors relevant to certain cancers.

Early diagnosis

This is a particularly important part of the role of the general practitioner as he is likely to be the first person to be presented with any abnormal symptom or anxiety of a patient concerning his health.

Whether these symptoms are related to a cancer or not, the consultation presents either the opportunity to diagnose a cancer at the time of consultation or to advise and, if the patient is willing, carry out or arrange appropriate screening procedures, e.g. cervical screening, or instruction in breast self-examination.

Actions by the European Community

The advisory committees on medical, dental and nursing training considered the training of health personnel in the matter of cancer and the Commission has commended their recommendations to Member States.[1] In the recommendations on medical training the vital role of general practitioners was recognized and specific training in screening methods, counselling, appropriate methods of treatment, rehabilitation and terminal care called for. The importance of teaching of these subjects in continuing medical education was also stressed.

In order to seek the best method of implementing this and to engage general practitioners as actors in the 'Europe against cancer' programme, a group of representatives of general practitioners was established.

As a result general practitioners have been involved in various ways during the European Weeks against Cancer. The group is examining the appropriate cancer core-content of specific training programmes for intending general practitioners and will be making recommendations on continuing medical education programmes.

Unfortunately in some Member States the number of family doctors smoking remains high whereas in others huge reductions in the number of doctors smoking have been achieved. The representatives of general practitioners are promoting 'no smoking' practices in all their organizations and are examining the best ways in which they can use the successful methods of reducing smoking amongst doctors in the UK.

There is wide variation between Member States in the degrees to which general practitioners carry out cervical screening or are trained to carry out this procedure. Recommendations for pilot projects in those Members States where there is no training have been made.

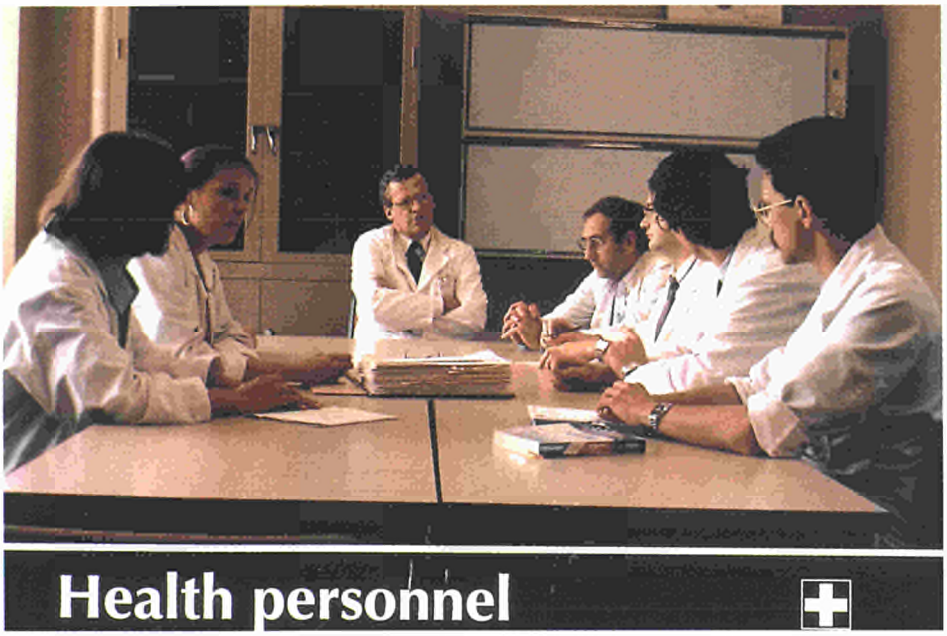
Following the extension of the training programmes to include treatment, palliative medicine will constitute a particularly important sector to be included in both specific and continuing education programmes.

In the course of the action plan 1990-94 firm foundations will be established to ensure that general practitioners as key actors in the programme have the opportunity to be adequately trained to carry out their essential role in education, prevention, early diagnosis and the treatment of cancer.

Dr Alan Rowe

Consultant to the
'Europe against cancer' programme
Directorate-General for Employment,
Industrial Relations and Social Affairs
Commission of the European Communities

[1] OJ L 346, 27.11.1989.



General practitioners, key actors in the programme, must receive adequate training.
Photo: CEC.

CHAPTER 6

Research

One of the earliest actions of the 'Europe against cancer' programme was to include a cancer chapter in the programme for scientific research of the European Community. Professor Bleehen here describes the range of actions undertaken or coordinated at Community level while Dr Vermorken concentrates on the major projects in radiation treatment led and largely financed at Community level. Finally, demonstrating that European cooperation can take many forms, Professor Veronesi describes the development and achievements of the European Organization for Research and Treatment of Cancer (EORTC).

The EC effort for improving cancer research in Europe

During the first action plan 1987-89, the 'Europe against cancer' programme had its highest public visibility in the areas of prevention and education. This is, of course, as it should be. However, we should not assume that it is being slow to implement activity in aspects of research.

During the early meetings of the cancer experts, decisions were very clearly made as to the research priorities. The four categories of endeavour that were identified were those of fellowships, clinical orientated research, epidemiological research and basic laboratory research.

It was unanimously agreed that there should be a priority order established as it was not possible, within the available funding, to implement large-scale programmes in all areas. Indeed, in terms of scientific feasibility, it clearly is not desirable to attempt to do too many things at once in this new venture. We therefore allocated certain defined priorities which have been implemented over the period.

In addition, of course, many actions relating to cancer research were already being implemented from previous programmes at the time when the 'Europe against cancer' programme was commenced.

Some of these will be continuing in terms of concerted actions and new ones will also be initiated as a result of further applications following an advertisement inviting more requests.

Fellowship programme widely appreciated

The fellowship programme was allocated the equivalent of 50 man-years of fellowships. It was decided that these should be allocated in two ways. They could be fellowships awarded to one individual for a whole year, with the possibility of renewal for a second year. These would permit good collaborative research by the fellow in the centre visited. Alternatively, the fellowships might be used for shorter periods of time, of one to three months, for visits between laboratories and hospitals to exchange information and techniques and to set up collaboration between the two centres. Several such short-term fellowships could then collectively represent one man-year.

These fellowships are available to scientists, clinicians and epidemiologists from the 12 Member States to work in another Community State. In addition, Sweden and Switzerland with their associate status are also eligible. Emphasis has been placed on the importance of encouraging young applicants as part of a programme of career development. There is a real need to bring good scientists and clinicians into cancer research and it is hoped that this programme within the Community will facilitate this.

It is pleasing to report that many good applications have been received for these fellowships. Their award has been carried out critically by peer assessment. The short award of term fellowships may be carried out rapidly by a selected panel of experts using post and telephone. The one-year fellowships are reviewed twice a year by a committee of experts. Applications have been received and awards made over a very wide range of disciplines.

This programme is particularly appreciated by the young scientists and clinicians. For example, from my own laboratories a pharmacologist who was recently successful in obtaining her PhD whilst working on mechanisms of tumour drug resistance, has gone to work in a department in Italy to gain new experience in another related area.

We have also received in our laboratories three recently graduated medical scientists who have come from Spain, Portugal and Germany to work on programmes relating to hyperthermia, drug resistance and the molecular biology of lung cancer. Each one of these fellows is now gaining further experience and opportunities which would not have necessarily been available in their own country. When they return home, we have little doubt that they will be able to communicate their training and experience to the benefit of their parent countries and institutions.

Treatment research: encouragement at a supranational level

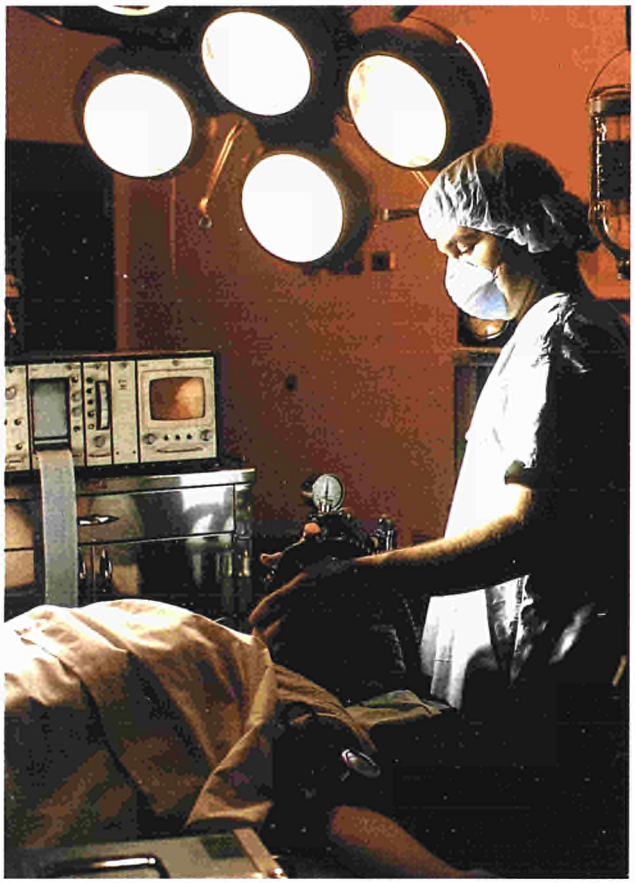
The second priority is related to treatment research. This is an extremely important area of work as most new treatments need to be tested and validated in clinical trials. It is very easy to gain a clinical impression that a treatment works, which, as a result of undue optimism, is spurious. Well-structured and organized studies are needed before unequivocal assessment is possible. Many such clinical studies are carried out by large oncology centres and national organizations. However, the European Community is fortunate in having a supranational collaborative organization, the European Organization for Research and Treatment of Cancer (EORTC), which has for many years now been running numerous cooperative clinical trials. These investigate new drugs, other new and old modalities of treatment, such as radiotherapy, hyperthermia and combinations of these, both in early clinical trials and formal randomized studies. The funding of the EORTC has until recently been from a variety of sources which lacked an element of continuity.

Early in the discussions of the Experts' Committee relating to the goals of the European cancer initiative, it seemed appropriate that a high priority should also be given to providing at least part of the funding of the EORTC. Currently the European Community funds ECU 750 000 per year towards this work. This money is earmarked for several different aspects, largely related to trial management. The data centre, currently situated in Brussels, employs many statisticians and data managers.

One interesting aspect of the funding is that a specified sum of ECU 100 000 per year has been allocated to the EuroCode project. This project is designed to provide a computer link-up between key trial centres so that patient details, randomizations, treatment protocols, etc. can be exchanged rapidly, without the need for involving post and all the consequent delays. This EuroCode project is now in its third year of operation. Centres in many of the Community's countries are now participating and more are hoping to join in, provided enough money is available. The seed money of ECU 20 000 available to individual centres can be extremely productive. Thus the designated centre in England, the MRC Cancer Trials Office in Cambridge has, as a result of this seed money, subsequently been given a VAX computer to ensure that the EuroCode project is implemented optimally in the UK.

Between 40 to 50% of all patients with cancer survive five years, most of whom we may then regard as cured. There are many methods used for the treatment of cancer. The commonest and best known is that of surgery which is probably responsible for about half of all the cures. Thus around 22% of all patients with cancer will be cured by surgery alone.

Each year, 50 grants are awarded to European scientists wanting to specialize in cancer research. *Photo: CEC.*



Research makes a significant contribution to improving the effectiveness of cancer treatment.
Photo: Colothèque.

Support for research to improve results from chemotherapy and radiotherapy

The next most important treatment modality is radiotherapy, with 12% cured by radiotherapy alone. That is, a quarter of the total of those who are cured. Chemotherapy alone, unfortunately, is only curative in a relatively small percentage of patients, probably less than 2% of all cancers. It is very effective in some of the uncommon ones such as children's malignancies, some leukaemias, testicular tumours and lymphomas. Various combinations of surgery, radiotherapy and chemotherapy provide the remaining cures.

Much emphasis has therefore been placed on the funding of clinical research in trying to improve the results of chemotherapy treatment by identifying new and more effective agents. There is also the need to improve the results of radiotherapy by the investigation of newer modalities of treatment. Some research is also being carried out on surgical managements but these are usually combined with other treatment modalities.

Encouragement of concertation in other research

The other support within the Community for cancer research is very varied and is largely mediated by a number of concerted actions. These do not provide large sums of money for funding individual research projects but assist collaborative groups to meet together. They may then define research programmes, allocate amongst themselves various projects within the main one, exchange information about techniques and finally jointly assess the results. This is a well-defined path for coordination within the Community.

Recently, following an advertisement for further concerted action applications, a very large number of excellent collaborative projects were suggested by brief declarations of intent. After further exploration by requesting more detailed specifications, the successful ones will be funded individually in their own right or combined together in group actions.

It is not possible to give extensive details of these projects, but a few illustrate the broad range of this work. They include projects such as studies of cytokines in the treatment of haematogical malignancies, gene expression and growth factors in leukaemias, preclinical diagnosis and prevention of colo-rectal cancer in familial polyposis. Other studies are on various aspects of bone marrow transplantation, drug targeting, malignant melanomas, thyroid cancer, the genetics of solid tumours, cellular properties relating to invasion and metastasis, oncogene growth factors and their receptors, and papilloma virus.

This list does illustrate that the European Community is very active in supporting basic clinical and laboratory research not only by funding large projects and fellowships, but assisting in the coordination of groups of workers to make the maximum use of their own resources.

There is little question that the sums of money that the Community can put into such research is inadequate if considered on its own. However, it must be remembered that each of the Member States finances its own internal research programmes. One should, therefore, regard the Community's research effort as being one of bringing our supranational groups together. There is every indication that the 'Europe against cancer' programme has started to do this very successfully. Provided that funding continues to be available, hopefully at an increased amount, this goal will continue to be achieved.

Prof. Norman Bleehen

Member of the Committee of Cancer Experts
of the European Community
'Europe against cancer' programme

European strategy for research on cancer therapy

Future cancer management will continue to involve surgery, radiotherapy, chemotherapy and immunotherapy working together in a more important fashion than ever before. Local approaches such as surgery and radiotherapy will be needed to get rid of as much as possible of the macroscopically visible tumour tissue so as to leave a minimal tumour burden. In this way the effect of the systematic treatments available can be maximized. As a consequence, more effective methods of local control and of systematic treatments are required in order to achieve rapid improvement in overall survival. It is estimated that selectivity of radiotherapy can be further improved using light ion therapy and boron neutron capture therapy, with direct consequences for the survival rate of cancer patients in the immediate future.

The European cancer experts have defined their strategy for research on cancer therapy up to the year 2000 in the context of the 'Europe against cancer' programme.

There are at present various approaches to cancer treatment:

- ☐ surgical removal of the tumour tissue;
- ☐ radiotherapy;
- ☐ chemotherapy;
- ☐ immunotherapy.

It is the lack of specificity which limits most existing therapeutic approaches, and research in most fields is therefore directed towards increasing this specificity.

Surgery generally produces the best results

Surgery, usually applied to relatively limited tumours, is at present the most general successful mode of cancer treatment. About half of all cancer patients have a survival exceeding five years. Half of these may be attributed to surgery alone, and half either to a combination of surgery and radiotherapy or chemotherapy or either of these latter treatment modalities alone.

Surgery is quite specific since it removes mainly diseased tissues; its applicability is, however, normally limited to tumours which have not yet metastasized. For that reason, research in the field of early diagnosis is important and it therefore forms the strategic approach I: Research on early detection and diagnosis. The techniques of surgery have already reached a very high level and they can be combined with other treatment modalities. Progress in this field could result in further improvement in functional and cosmetic outcome. Improvement of surgery is therefore part of strategic approach II: Research in improvement of local treatment.

Radiotherapy: given to two patients in three

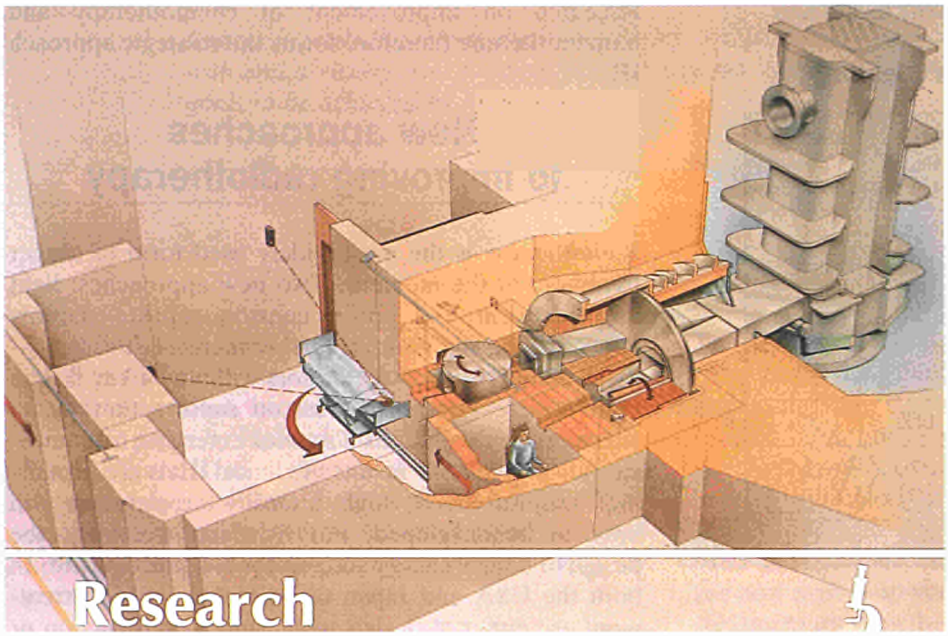
Radiotherapy is the most widely used form of cancer treatment, being given to two out of every three patients. Approximately one quarter of cured cancer patients owe their five-year survival to radiotherapy alone, and another eighth are cured by combined treatment with surgery and/or chemotherapy. Radiotherapy is therefore involved in almost half of curative cancer treatment. Moreover, radiotherapy is involved in the palliative treatment of many other patients.

Although in principle radiation is not selective for a cancer cell, the selective destruction of a tumour is achieved to some extent by the fact that considerable efforts are made to concentrate the dose in the tumour tissue and so spare the surrounding normal tissue as much as possible.

There are now new approaches which appear promising for further increases in selectivity of radiotherapy.

Radiotherapy with ions of light atoms (light ions)

Beams of light ions such as those of carbon, oxygen and neon travel in virtually straight lines with negligible sideways spreading and they deposit a large fraction of their energy at the end of their range. This allows a well-defined distribution of the dose in depth better even than that of protons. In addition, because of their intense local ionization, light ions could be effective against radioresistant tumours.



Light ion beam therapy has given excellent results for certain types of cancer.
Photo: CEC.

Boron neutron capture therapy

For various reasons, some boron compounds may accumulate in some tumours, and particularly in brain tumours where a reduction in the tumour blood-brain barrier encourages their selectivity.

Upon irradiation with neutrons the boron atoms capture the neutrons and give rise to alpha and lithium particles. These have a high energy and their track is less than a fraction of a millimetre in tissue, so that they do not leave the tumour. It is estimated that in this way, with the same dose to surrounding normal tissue, the dose to the tumour can be increased by about one third.

The first clinical trials in Japan indicate that this treatment could be beneficial for treatment of certain brain tumours such as gliomas, and trials for other tumour types are being initiated.

Chemotherapy: palliative in most cases

Chemotherapy has been employed mostly when tumour metastases are already present. Up to now, however, noteworthy successes have been limited predominantly to haematopoietic malignancies, malignancies of embryonal origin (e.g. testicular tumours) and paediatric malignancies. At the present time, unfortunately these only make up approximately 4% of total tumour incidence, although in about two-thirds of these cases cure is indeed achieved. The early adjuvant use of chemotherapy with surgery and/or radiotherapy in the more common cancers (e.g. breast carcinoma) is encouraging, but in all other situations chemotherapy serves mainly as palliation.

Immunotherapy: used in conjunction with other treatments

Active immunotherapy by vaccination with tumour cell extracts has been successful in experimental systems and recently some success has been reported in humans. There are now some preliminary indications, that progress along these same lines is to be expected in the future. As an example, the histo-compatibility antigens hold a key position in cellular interactions with the immune system. In animal models reintroduction of missing histo-compatibility antigens (neo-antigens) into tumour cells renders these cells more sensitive to immune rejection processes. It has also been shown that introduction of new transplantation antigens by *in vitro* mutagenesis induces a response against the tumour cells. Both approaches may become extremely useful in cancer treatment; they will however only be effective against relatively small numbers of cells and they will thus need to be used in conjunction with other anti-cancer modalities such as surgery, radiotherapy and chemotherapy.

Current status of treatment techniques

Situation now at moment of diagnosis

Treatment used	Primary tumour (58% of cases)	Metastasized tumour (42% of cases)	
Surgery alone Radiotherapy alone Both combined All other treatments and combinations including chemotherapy	22% 12% 6%	 5%	
Patients curable now	40%	5%	45%
Strategic approach (see table below)	II	I III	
No cure available	18%	37%	55%

Strategy

Problem	Remedy
I Late diagnosis	Screening
II (a) Poor treatment	Quality control
(b) Tumours with difficult localization	Light ions and BNCT / Improved local treatments
(c) Tumours currently radioresistant	Light ions and BNCT
III Conventional treatments not effective	Improved local treatments combined with improved systemic treatments

Research on improvement of chemotherapy and immunotherapy therefore forms the strategic approach III.

New approaches to improving radiotherapy

Radiotherapy is the most widely used form of cancer treatment at the moment. Two new approaches: light ion treatment and boron neutron capture therapy appear promising *vis-à-vis* further increases in selectivity in radiotherapy. Accelerators will play a key role in their design. For boron neutron capture therapy an alternative exists: neutron sources emerging from nuclear power plants. If results of clinical trials are promising, hospital-based, high intensity accelerators will have to be developed. For light ion treatment the design of a high-energy accelerator is a prerequisite. In both the USA and Japan facilities for light ion treatment are either at design stage, under construction or in part-time use.

Fons Vermorken

Administrator,
Medical research Unit
Directorate-General for Science,
Research and Development
Commission of the European Communities

EORTC

European Organization for Research and Treatment of Cancer

Cancer is probably one of the most complex problems that medicine has had to deal with and a victory over it represents, without any doubt, one of the most challenging goals to be achieved by human beings.

Whilst for a long time the first answer of modern medicine to cancer was surgery (the first radical mastectomy for a breast cancer was described in a scientific paper by Halsted almost 100 years ago), after World War II new successes were obtained by chemotherapy, i.e. treatment of tumours with chemicals which were discovered for use in war time and, subsequently, found to be active in impeding the growth of malignant cells.

In the late 1970s and during the 1980s, the main effort of oncology has been to correlate our increasing biological knowledge of cancer with the treatment of our patients, thus progressively approaching the goal of optimum knowledge of every single human tumour. For example, when a breast cancer was removed in a surgical theatre 10 years ago, it was simply sent to the pathology department for histological diagnosis and classification: today, in every cancer research centre it will also be sent to the laboratory of molecular biology for testing oncogenes, to the laboratory of endocrinology to test its hormonal receptors, to the cell kinetics department to evaluate its growth rate and chemosensitivity, etc.

One of the protagonists of these developments has been the EORTC, the European Organization for Research and Treatment of Cancer with its more than 25-year contribution to the fight against cancer. The idea of a European organization for the fight against cancer was born in 1962 when the Groupe européen de chimiothérapie anticancereuse (GECA) was founded; in 1963 the *European Journal of Cancer and Clinical Oncology* became the official organ of the Organization which changed its name to the EORTC; in 1972 the National Cancer Institute (USA) set up a liaison office in Brussels to collaborate with the EORTC in the new anti-cancer drug research; in 1984 the EORTC New Drug Development Office was set up in Amsterdam.

Due to the rapid development of the EORTC and in order to meet the many requirements of research and education the following four branches were instituted: Epidemiology and Prevention; Research; Treatment; Education.

The Epidemiology and Prevention branch has, apart from establishing contacts with EORTC clinical groups such as the Lymphoma, the Genito-Urinary, the Breast Cancer and the Melanoma Cooperative Groups, developed studies in two main areas. They are: aetiology of childhood leukaemia and late effects of anti-cancer therapies. The latter is crucial and now possible since children successfully treated 15 or 20 years ago are now grown-up youths and the effects of anti-cancer treatment on growth, fertility, blood cell count etc. can be evaluated.

The basic aim of the Research branch is to provide every year all clinical groups with a highly specialized, updated report on developing areas of experimental research. It is of extreme importance that conceptual and methodological innovations in the basic sciences which are potentially applicable to clinical oncology be exploited without needless delay. The New Drug Development Office (NDDO) aims at reducing the time-lag between drug synthesis and early clinical studies and develops guidelines for the conduct of preclinical and early clinical studies.

The Treatment branch deals with the research in patient management and encompasses the assessment of new drugs, combinations of drugs and biological response modifiers, as well as the investigation of new radiotherapeutic and surgical techniques and the development of new combined treatment strategies. The basic work is done by 30 groups which centre their work either on specific tumour types or on a particular discipline. The groups are setting up controlled clinical trials (phase II or phase III) and are publishing results. The EORTC data centre provides the necessary know-how in data-processing and statistical analysis and has also developed a system called EuroCode (The European Computerized Oncology Data Exchange) to speed up communication among European oncologists.

The main concern of the Education branch is to address the issue of cancer education in Europe and to attempt to set up several projects. As a result of meetings in Venice and Bonn in 1988 agreement was reached on

the major components of an undergraduate curriculum in oncology and its implementation is a part of the EC action programme for 1990-94. A list of courses suitable for international participation in Europe is published annually within the quarterly journal *Review in Oncology* providing updated information on key topics in experimental and clinical cancer research. Other educational activities of the Education branch are the *European Journal of Cancer and Clinical Oncology*, the programmes for fellowships and personnel exchange.

The EORTC and the European School of Oncology common initiatives are also coordinated by the Education branch.

The EORTC is today one of the most established models of international integration in cancer medicine and as such it offers a guarantee for a brighter future. Thanks to a donation of the Belgian Government, the EORTC Central Office is now based in new headquarters in Woluwe, 83 Avenue E. Mounier, B-1200 Brussels.

Prof. Umberto Veronesi

Past President EORTC
Vice-President of the EC
Committee of Cancer Experts
of the 'Europe against cancer' programme

Europe against cancer

Only the beginning

Building on the satisfactory results achieved so far, especially in the context of the first action plan of the 'Europe against cancer' programme, the European Community will extend its campaign from 1990 to 1994, on the basis of the decision adopted by the Council and representatives of the Member States meeting in the Council on 17 May 1990.

This decision covers the following fields:

- With regard to prevention, the Community will pursue its legislative activities in the fight against smoking (restrictions on the tar content of cigarettes, strict controls on advertising, etc.).

  Particular importance will be given to studies and pilot actions concerning the links between nutrition and cancer, given that diet could be responsible for a third of cancer deaths. Prospective studies will allow large population samples across the Community to be monitored for many years. The diversity of diets in the Member States should enable clearer links to be established between certain foods and cancer of the breast or digestive system.

- As regards screening, further progress is expected to be made at European level with the setting up of European networks of breast and cervical cancer pilot screening programmes. In addition, evaluation studies on the effectiveness of screening programmes for colo-rectal cancer will be completed and should enable national and regional health authorities to reach precise conclusions by the end of 1994.

- On the question of information and health education, the 'Europe against cancer' programme will continue the work of promoting public awareness of the 10 European commandments for cancer prevention. The second action plan will place special emphasis on health education in schools, based on the conclusions of the studies and the European conferences conducted between 1987 and 1989.

- With regard to training of health personnel, special efforts will be made to encourage implementation of the recommendations produced during the first action plan. Also, on the basis of the experience acquired in 1988 and 1989, financial support will be forthcoming for numerous further training initiatives for doctors and nurses.

- Additionally, the first results of the joint medical research actions undertaken since 1987 should find practical applications, notably in the form of pilot installations for treating patients by improved radiotherapy. Naturally, endeavours to coordinate medical research will be continued and strengthened.

Finally, I cannot conclude this review of the positive results already achieved, or expected to be achieved between now and 1994, without mentioning the crucial role played in each of the 12 Member States by the public and private bodies involved in the fight against cancer. In particular, the cancer associations and leagues, which have more than 10 million families in their ranks, have given wholehearted and enthusiastic support to the 'Europe against cancer' programme. Without these partners the European Community would never have been able to progress so far in a field which concerns so many of its citizens.

Steffen Smidt

Deputy Director-General
Directorate-General for Employment,
Industrial Relations and Social Affairs
Commission of the European Communities

Annex

Principal texts regarding the 'Europe against cancer' programme

'Europe against cancer' programme

Tobacco products

Other fields

COMMUNICATION
from the Commission to the Council
of 13 December 1985
regarding the action against cancer

Introductory statement

1. The European Council in Milan (28 and 29 June 1985) expressed interest in a French memorandum calling for, and emphasizing the value of, a coordinated European action against cancer, making full use of existing structures.

   A letter was subsequently sent on the same subject by the President of the Council of Ministers of Italy to the Heads of State or Government and to the President of the Commission of the European Communities.

   The European Council in Luxembourg (2 and 3 December 1985) took note of a French-Italian communication on this subject and asked that the Ministers for Foreign Affairs should examine at their next meeting the best way of giving a rapid and effective follow-up to this initiative.

   The Commission welcomes these initiatives and fully shares the views expressed in the abovementioned documents.

Community actions

2. The Commission has so far undertaken a series of actions which, in various ways, contribute to the fight against cancer.

3. As regards prevention, Directives have been adopted by the Council which have a direct bearing on cancer induction by physical and chemical agents. The 'Basic safety standards for the health protection of the general public and workers against the dangers of ionizing radiation' and the 'Protection of workers from risks relating to exposure to chemical, physical and biological agents', including protection from asbestos and vinyl chloride, are examples of such Directives.

4. In the light of the conclusions of the European Council in Milan, the Commission has submitted to the Council a proposal for a resolution on a programme of action of the European Communities on cancer prevention. This programme aims at improving the health and quality of life of the citizens within the Community and at providing a setting in which existing actions and future initiatives in the field of prevention can be made more coherent. The objectives of the programme are to halt the increase of cancer, to establish health strategies for those factors to which cancer is attributed, to facilitate development of population screening and treatment, to improve the monitoring of the health and specific groups of the population in order to identify risk factors for cancer, and to collaborate with international and national organizations to these ends and to the application of the results of cancer research.

   Prevention and therapy of cancer must undoubtedly contain an important element of public and professional information and education. The draft resolution therefore proposes that due attention be given to these. The Commission will seek to act jointly with national authorities.

   This proposal is currently under discussion in the Council.

5. In the field of research, a series of actions in the areas of cancerogenesis and cancer therapy have been supported in Community research programmes, mainly the environmental protection, radiation protection and medical research programmes of the EEC and the ECSC. In this context, the coordinating and data centre of the European Organization for Research on Treatment of Cancer (EORTC) has been given financial support.

6. The Commission has announced to the Council that 'a coordination action on cancer, in agreement with the conclusions of the Milan Summit'[1] will be embodied into the proposal for a renewal of its medical research programme, to be presented to the Council in early 1986. This clearly identifies a 'cancer' action which will focus on three areas: early detection and diagnosis, multi-modality treatment (including the development and improvement of clinical trials in organ-oriented projects) and transfer of research results. In conducting this programme, the Commission will seek to make an optimal use of existing structures.

Conclusions

7. Important national and international efforts are under way at present. Community actions have been described above. New initiatives have been proposed at the recent European Councils. Given the desirability, therefore, of appropriate consultation and coordination between all the parties concerned, it appears that the Community framework offers a possibility for the development of a coherent 'Europe against cancer' action which would optimize the benefits of the various efforts already being undertaken, without interfering in their efficient functioning or duplicating existing work.

[1] COM(85) 530 final.

As a first step, the Commission intends to host an *ad hoc* expert committee, composed of high-level scientists and cancer specialists, in order to make recommendations on the ways and means of implementing a European action against cancer.

The Council is therefore requested:

(i) to decide on the launching of an action to be known as 'Europe against cancer', aimed at ensuring the optimum coordination of all initiatives currently being taken in Europe as well as the study of new initiatives in the fields of prevention and research (including therapy);

(ii) to take note of the Commission's intention to convene the abovementioned *ad hoc* expert committee and to report back to the Council with specific proposals based on the recommendations of the Committee within a period of three months;

(iii) to undertake to examine as a matter of priority the existing Commission proposals on prevention as well as the forthcoming proposals on research with a view to their rapid adoption.

RESOLUTION

of the Council and the representatives of the Governments of the Member States, meeting within the Council,

of 7 July 1986

on a programme of action of the European Communities against cancer

(86/C 184/05)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL,

Having regard to the Treaties establishing the European Communities,

Having regard to the draft resolution submitted by the Commission,

Having regard to the opinion of the European Parliament (1),

Having regard to the opinion of the Economic and Social Committee (2),

Whereas, pursuant to the Treaty establishing the European Economic Community, the Community has *inter alia* as its task, by establishing a common market and progressively approximating the economic policies of Member States, to promote throughout the Community a harmonious development of economic activities, a continuous and balanced expansion and an accelerated raising of the standard of living;

Whereas the European Council in Milan on 28 and 29 June 1985 emphasized the importance of launching a European programme of action against cancer;

Whereas that European Council also approved the proposals of the *ad hoc* Committee on a People's Europe calling for an appropriate follow-up to the Commission communication on cooperation at Community level on health problems;

Whereas various Community actions to prevent cancers arising from exposure to ionizing radiation or exposure to chemical carcinogens are already being carried out under the Treaties establishing the European Economic Community and the European Atomic Energy Community;

Whereas actions to reduce the risk of cancer from exposure to carcinogenic substances are included in a number of existing Community programmes on the environment, worker protection, consumer protection, nutrition, agriculture and the internal market;

Whereas the present programme would increase knowledge about the causes of the cancer and the possible means of preventing and treating it;

Whereas by ensuring a wider dissemination of knowledge of the causes, prevention and treatment of cancer, and an improvement in the comparability of information about those matters, in particular concerning the nature and degree of risk of cancer arising from exposure to given substances or processes, the programme will contribute to the achievement of Community objectives, in particular the removal of non-tariff barriers to trade, while contributing to the overall reduction of risks of cancer;

Whereas research into cancer and carcinogenic effects of physical and chemical agents is being undertaken in a number of Community research programmes;

Whereas the coordination of national research activities relating to the early detection and treatment of cancer is not the specific purpose of this resolution; whereas research should take place in the context of the promotion of research organized by the Commission and of the relevant medical and public health research programmes; whereas it is desirable to provide the necessary coordination and liaison between those activities and the activities undertaken pursuant to this resolution;

Whereas cooperation with international and national organizations carrying out work in this field will ensure a wider dissemination of knowledge of cancer and help to avoid duplication of effort,

1. *take note of* the conclusions of the *ad hoc* Committee of cancer experts (which met in Paris on 19 and 20 February 1986), forwarded to the Council by the Commission in its report of 10 March 1986;

2. *express* the political will to implement a five-year action programme of the European Communities against cancer;

3. *set* for this programme the objective of contributing to an improvement of the health and quality of life of citizens within the Community by:

   — reducing the number of illnesses due to cancer and the related mortality and

   — decreasing the potential years of life lost because of cancer;

(1) Opinion delivered on 12 May 1986 (not yet published in the Official Journal).

(2) OJ No C 101, 28. 4. 1986, p. 22.

4. *call on* the Commission to examine systematically whether and to what extent, Community legislation, measures and other activities are likely to constitute a hindrance to cancer prevention;

5. *take note of* the action programme proposed by the Commission and consider the following priority actions to be necessary:

(a) **Tobacco**

As a first priority, development of measures to limit and reduce the use of tobacco.

These measures should be based on the practical experience gained in the various Member States and should contribute to increasing the effectiveness of national programmes and actions.

Systematic examination of the various ways and means of limiting and reducing the use of tobacco, such as rules on advertising, rules on labelling, tax legislation, sponsorship, enforcement of no-smoking rules, extension of no-smoking areas and, if appropriate, the drafting of proposals for actions at Community level.

(b) **Chemical substances**

Development of harmonized criteria and procedures for evaluating the carcinogenic nature of chemical substances.

Identification and quantification of the carcinogens to which workers and/or the population are exposed and, if appropriate, drafting of new legislation and amendment of existing legislation in order to reduce exposure of workers and/or the population to carcinogens.

(c) **Nutrition and alcohol**

Assessment of the results of research and, where appropriate, preparation of measures, taking account of differing circumstances and habits in the Member States.

Attention should also be paid to abuses in the consumption of alcohol.

(d) **Prevention/early diagnosis**

Exchange of information and experience, particularly on Member States' preventive and early diagnosis programmes (type of examination, numbers participating, effectiveness, cost/benefit analysis excluding resources directly allocated to research) and, on this basis, the preparation of any appropriate measures.

(e) **Epidemiological data**

Exchange of information on Member States' structures and procedures for cancer epidemiology (*inter alia* through exchanges of experts) and evaluation of those structures and procedures with a view to improving them.

Improvement in the collection, availability and comparability of epidemiological data on cancer and factors causing cancer and, if appropriate, preparation of measures in this field taking particular account of the problems of data protection to assist in and help increase the effectiveness of epidemiological research.

(f) **Health education**

Exchange of information and experience, particularly on Member States' health education and information programmes and, on this basis, the preparation of any appropriate measures.

(g) **International collaboration**

Collaboration with international and national organizations active in the field covered by these actions to achieve maximum possible effectiveness;

6. *consider* that a high degree of cohesion between current and future actions at national and Community level would help achieve the objective referred to in point 3 and therefore advocate the strengthening of cancer prevention measures already initiated at Community level and the coordination of such actions with those referred to in point 5;

7. *call on* the Commission to submit within 12 months of the adoption of this resolution, and thereafter annually, in close collaboration with the Member States, a work programme detailing the work it intends to carry out in order to implement this resolution and, if necessary, to submit proposals to the Council to this effect.

The annual work programmes, together with a report on results achieved and activities carried out, will be forwarded to the European Parliament, the Council and the Economic and Social Committee;

8. *take note of* the Commission's intention to:

— submit proposals on research and on a European Cancer Information Campaign and

— intensify work relating to cancer in all other Community programmes with a view to submitting appropriate proposals.

26. 2. 87 Official Journal of the European Communities No C 50/1

II

(Preparatory Acts)

COMMISSION

'EUROPE AGAINST CANCER' PROGRAMME

Proposal for a plan of action, 1987 to 1989

including a proposal for a Council Decision on informing the general public and the training of members of the health professions

COM(86) 717 final

(Submitted by the Commission to the Council on 17 December 1986)

(87/C 50/01)

PRELIMINARY REMARKS

In June 1985, in Milan, and in December 1985, in Luxembourg, the Heads of State and of Government of the 12 Member States of the European Community stressed the importance of launching a European programme in the fight against cancer, so that the construction of Europe could make the necessary contribution to combatting this scourge, but also take on a new dimension, closer to the concerns of citizens.

In order to implement that conclusion of the European Council and prepare a proposal for a 'Europe against cancer' programme, a committee of leading cancer experts (1) was set up in January 1986 under the auspices of the Commission of the European Communities. The following proposals cover the first three years of implementation of the programme. They are based to a large extent on the conclusions of that committee, whose readiness and commitment, and the high calibre of its work should be stressed.

In addition, this work has benefited significantly by the studies and research carried out or underway in the World Health Organization, and in its International Agency for Research on Cancer.

Four areas are covered by this proposal for a plan of action for the period 1987 to 1989:

— cancer prevention: On 7 July 1986, a resolution was adopted by the Council and the representatives of the Governments of the Member States meeting within the Council which lays down the main lines for the preventive part of the European programme of action against cancer (2). The present communication completes this programme by identifying about 30 Community actions,

— information and health education of the general population and training of health care workers in cancer, for which a proposed Council Decision is attached to the present communication,

(1) The committee consists of the following figures: Prof. C. de Duve, substitute, Prof. Boon (Belgium), Prof. C. Schmidt (Federal Republic of Germany), Prof. E. Grundmann (Federal Republic of Germany), Dr O. Moeller Jensen (Denmark), Prof. J. Estape (Spain), Prof. M. Tubiana (France), Dr S. Vassilaros (Greece), Dr M. Moriarty (Ireland), Prof. U. Veronesi (Italy), Prof. M. Dicato (Luxembourg), Dr R. Kroes (Netherlands), Prof. J. Conde (Portugal) and Prof. N. Bleehen (United Kingdom). From January 1987 Sweden will be represented by Prof. J. Einhorn, as an observer.

(2) OJ No C 184, 23. 7. 1986, p. 19.

— cancer research: In November 1986 the Commission forwarded to the Council of Ministers of the European Communities a proposed Regulation (1) on a fourth programme for coordination in medical research (1987 to 1989). The present communication clarifies and details the cancer research dimension.

Some of the actions which are foreseen come directly under the Commission's management powers. They will be carried out as such in that manner, beginning in 1987 for the majority of them. This communication also contains many proposed actions which the Commission intends to send, in 1987 to 1989 to the European Parliament, for consultation, and the Council of Ministers of the European Communities, for approval. They are therefore liable to be amended at a later stage.

(1) Doc. COM(86) 549 final, 29. 10. 1986.

TABLE OF CONTENTS AND SUMMARY

(1) These proposed actions will be prepared by the Commission of the European Communities and submitted from 1987 to 1989 to the European Parliament, for consultation, and to the Council of Ministers of the European Communities, for adoption.

(2) The actions as stated will be put into effect by the Commission of the European Communities using its management powers, mostly from 1987.

GENERAL INTRODUCTION

Going back probably to the origins of man (the Kanam jawbone, which is some 500 000 years old, already shows signs of the disease (1)), varied in its manifestations (several hundred different types are observed today), extremely widespread in our developed societies (one European in four today has been, is being or will be affected), cancer is still considered as a mysterious disease characterized by the disorganization of certain cells and their anarchical proliferation, for reasons about which more and more is being learned but that have not so far been totally elucidated. Moreover, if the increase observed in recent years were to continue, by the year 2000 one European in three would be stricken by cancer at some time in his life.

Although worrying, the picture is not, however, altogether sombre. Clearly, the rise in the number of cancer cases can be accounted for by the increase in the average lifespan, since the incidence of cancer increases rapidly with age. Moreover, cancer is only the second largest cause of death in man, after cardiovascular diseases.

All the same, like the infectious diseases in previous centuries, cancers are the most feared form of illness today, probably because treatment is still too often at the cost of surgical mutilation or undesirable side effects, and probably also because, until the recent invention of effective pain-suppressant drugs, cancer frequently caused prolonged and unbearable suffering.

Nevertheless, we no longer have to accept that cancer is a fatal disease. It is a fact that the frequency of cancer should be reduced by prevention, and treatment improved through therapeutic research. The current state of our resources renders long-term survival, if not complete cure, possible in nearly half the cases, whereas scarcely one-quarter of patients were cured in 1950 (2). Above all, cancer is often avoidable, as can be seen from the considerable successes registered in certain countries in combating three common types of cancer.

The spectacular reduction in the number of stomach cancers in the developed countries can thus probably be ascribed to more wholesome food, free from microbial proliferation (thanks to refrigerators and probably also thanks to antioxidant food additives). The fall in the frequency of cervical cancer, a disease that is increasingly thought to be sexually transmitted can, for its part, probably be attributed to more regular gynaecological screening and improved standards of hygiene in both sexes. Lastly, in countries such as the United States and the United Kingdom, a drop in the frequency of lung cancer is being observed today, such countries having begun anti-smoking campaigns earlier than others.

Through better prevention and through more effective treatment, improved by research, Europeans can in future hope to achieve a further big reduction in the death rate due to cancer and the number of persons afflicted. The struggle against cancer concerns everyone at all levels. For its part, European agriculture and industry can harmonize its regulations and techniques so that the day-to-day environment in which Europeans live is improved and rid of cancer-inducing factors. As regards European research and technology, it can boost the effectiveness of private and public research efforts through a more efficient coordination of its human and financial resources.

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(1) *Origine et l'évolution de l'homme,* National Museum of Natural History, Paris, 1984.
(2) M. Tubiana, *Le cancer,* Presses Universitaires de France, Paris, 1985.

No L 160/52 Official Journal of the European Communities 28. 6. 88

DECISION OF THE COUNCIL AND OF REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL

of 21 June 1988

adopting a 1988 to 1989 plan of action for an information and public awareness campaign in the context of the 'Europe against cancer' programme

(88/351/EEC)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL,

Having regard to the Treaty establishing the European Economic Community,

Having regard to the proposal from the Commission,

Having regard to the opinion of the European Parliament (1),

Having regard to the opinion of the Economic and Social Committee (2),

Whereas in June 1985 in Milan and in December 1985 in Luxembourg the European Council underlined the advantages of launching a European programme against cancer;

Whereas in December 1986 in London the European Council decided that 1989 should be designated 'European Cancer Information Year' and specified that the aim would be to develop a sustained and concerted information campaign in all the Member States on the prevention, early screening and treatment of cancer;

Whereas the prevention and reserach measures already undertaken in the context of the 'Europe against cancer' programme should be supplemented by measures to increase awareness among members of the health professions and by an information campaign;

Whereas this campaign should be especially designed to increase the awareness of the public, teachers and members of the health professions regarding the fight against cancer, which includes in particular the fight against tobacco, protection against carcinogenic agents and, for the purposes of health promotion in general, improvement in nutrition;

Whereas information campaigns against cancer are a matter for the competent private organizations and public authorities of the Member States, but Community action may give a major boost towards success in the fight against cancer;

Whereas duplication of effort should be avoided by developing common basic material for the information of the public and for the training of members of the health professions, as well as by promoting exchanges of experience,

HAVE DECIDED AS FOLLOWS:

Article 1

1. The Commission and the Member States shall implement, in the period 1988 to 1989, the measures set out in the Annex.

2. The estimated amount of the Community distribution necessary for these measures is 10 million ECU.

Article 2

1. At intervals, and at least once a year, the Commission shall consult the competent authorities of the Member States during the various stages of implementation of the measures provided for in this Decision.

2. The Commission shall keep the European Parliament and the Council informed of progress.

Done at Luxembourg, 21 June 1988.

For the Council

The President

J. WARNKE

(1) OJ No C 68, 14. 3. 1988, p. 84.
(2) OJ No C 105, 21. 4. 1987, p. 18.

COMMUNICATION

from the European Commission to the Council, the European Parliament and the Economic and Social Committee

of 8 May 1990

regarding the 'Europe against cancer' programme: Report on the implementation of the first plan of action 1987-89

The 'Europe against cancer' programme was launched on the initiative of the Heads of State or Government of the European Community meeting in Milan in June 1985. Acting on proposals from the European Commission, and following favourable opinions from the European Parliament, the Council adopted three basic texts defining the overall framework and financial provisions for the programme:

(a) Resolution of 7 July 1986 (OJ C 184, 23. 7. 1986), which concentrated on prevention and health education;

(b) Decision of 7 November 1987 (OJ L 334, 24. 11. 1987) on medical research;

(c) Decision of 17 May 1988 (OJ L 160, 28. 6. 1988) on informing the public and training medical personnel.

Also in 1986, the Commission prepared a detailed plan of action for the period 1987-89. This 75-point plan was published in the Official Journal (C 50, 26. 2. 1987, pp. 1-55). It constitutes the first stage of the programme, the objective of which is to reduce the expected number of deaths due to cancer by 15% (from 1 000 000 to 850 000) by the year 2000. To achieve this ambitious goal, the European Commission adopted a 'partnership approach' aimed at involving everyone concerned with the fight against cancer at national level:

(i) the Committee of Cancer Experts, the scientific soul of the programme;

(ii) the cancer associations and leagues and anti-smoking organizations in the European Community, the spearheads of the programme;

(iii) the producers of television medical programmes, who have helped to spread the message of cancer prevention;

(iv) the representatives of general practitioners, who play a central role in early detection and systematic screening for cancer;

(v) senior officials in the health, education and research ministries.

Of course, it is much too early to identify any possible fall-off in the growing number of cancer deaths in the European Community. It is, however, no problem at all to take stock of achievements under each of the 75 actions announced at the beginning of 1987. An overall assessment is contained in the conclusion on page 135.

Chapter 1: Cancer prevention

I — CAMPAIGN AGAINST TOBACCO

Action 1: Upward alignment of taxation on tobacco manufactured in the European Community

(a) On 7 August 1987, as part of the process towards completing the internal market, the Commission presented two proposals for Directives (COM(87) 325 and COM(87) 326) on the approximation of taxes on cigarettes and on manufactured tobacco other than cigarettes.

The proposal on cigarettes required the tax burden in the European Community to be increased by more than 30% before 1 January 1993. In at least nine of the 12 Member States, this meant very sharp increases in taxes and prices (more than 150% in some cases), but in three countries prices would have fallen.

The price and tax increases for manufactured tobacco other than cigarettes (cigars, cigarillos, pipe tobacco, snuff and chewing tobacco) would, generally speaking, have affected the countries with the highest consumption.

The 1987 proposals, which required the unanimous approval of the Member States if they were to become law, gave rise to fervent discussions within the Council and European Parliament, but were not adopted. The Member States and the European Parliament took the view that the introduction of an element of flexibility in the rates proposed was the only way of progressing towards harmonization.

(b) Consequently, on 19 December 1989, the Commission officially presented its amended proposal for a Council Directive on the approximation of taxes on cigarettes and manufactured tobacco other than cigarettes (COM(89) 525 final). According to the amended proposal:

(i) on 1 January 1993, each Member State will be required to apply rates higher than, or equal to, minimum rates set for each product category (in the Member States as a whole, this approach will allow the maintenance or the increase of the fiscal burden to a level more compatible with the requirements of public health). This flexibility must under no circumstances jeopardize the fundamental principle of abolition of customs and tax frontiers by 1 January 1993;

(ii) after 1 January 1993, this initial flexibility must gradually give way to a movement towards target rates

compatible with essential public health requirements. To this end, the target rates have been significantly increased compared to those proposed in 1987.

Action 2: Financing of preventive actions at national level by the use of increased fiscal measures on tobacco

No action of this type was taken by the Member States under the first plan of action 1987-89. However, discussions have started in some countries, e.g. France, between the authorities and both sides of industry, with a view to removing tobacco from the price index (see action 3) in return for an increased effort by the authorities in the field of cancer screening. Exemplary measures have been taken in certain non-Community countries such as Australia, where the state of South Australia increased tax on tobacco products to finance health promotion publicity – thus helping to compensate for the loss to advertising agencies caused by the total ban on tobacco advertising.

Action 3: Publication of indices excluding tobacco by the Statistical Office of the European Communities

Since July 1989 a price index excluding tobacco has been published monthly by the Statistical Office of the European Communities. Comparing price index trends with and without tobacco reveals that the price of tobacco in real terms – calculated on the general consumption price index – fell during the period covered by the first plan of action (December 1989 compared with December 1986) in four countries, namely the United Kingdom (-9.4%), Denmark (-8.9%), Spain (-5.2%) and the Netherlands (-0.2%). This contrasts with an increase in real terms in the other eight countries: Federal Republic of Germany (+0.6%), Ireland (+1.3%), Luxembourg (+2.6%), Portugal (+4%), France (+6.9%), Italy (+7.5%), Belgium (+10.3%) and Greece (+27.1%).

Action 4: Harmonization of cigarette labelling in the European Communities

On 4 February 1988, the Commission submitted a proposal for a Council Directive, on the basis of Article 100a of the EEC Treaty (qualified majority), concerning harmonization of the labelling of tobacco products (OJ C 48, 20. 2. 1988). The opinion of the Economic and Social Committee was delivered on 7 July 1988 (OJ C 237, 12. 9. 1988), followed by the first reading of the European Parliament on 14 December 1988 (OJ C 12, 16. 1. 1989). The Commission generally took account of both institutions' opinions in its amended proposal (OJ C 62, 11. 3. 1989), which served as a basis for the Council's common position of 16 May 1989. Following a favourable vote at the second reading by the European Parliament, the Council adopted this Directive on 13 November 1989 (OJ L 359, 8. 12. 1989). Article 4 states that:

(i) all unit packets of tobacco products shall carry, on the most visible surface, the following general warning in the official language or languages of the country of final marketing: 'Tobacco seriously damages health' (Article 4 (1));

(ii) with regard to cigarette packets (Article 4 (2), (3) and (4) and Annex), the other large surface shall carry alternating specific warnings. For this purpose each Member State shall draw up a list of warnings taken exclusively from those listed in the Annex to the Directive.

The following warnings must be included in each Member State's list:

'Smoking causes cancer';
'Smoking causes heart disease';

(iii) the tar and nicotine contents of cigarettes must also be printed on the side of packets (Article 2).

The Member States must bring into force the laws, regulations and administrative provisions needed to comply with this Directive before 31 December 1991.

Action 5: Prohibition of cigarettes with a high tar content

On 1 February 1988, the Commission presented a proposal for a Council Directive (OJ C 48, 20. 2. 1988), on the basis of Article 100a of the EEC Treaty, to limit the maximum tar content of cigarettes to 15 mg by 31 December 1992 and 12 mg by 31 December 1995. On 7 July 1988, the Economic and Social Committee adopted a favourable opinion (OJ C 237, 12. 9. 1988). The European Parliament expressed its opinion on 25 May 1989 (OJ C 158, 26. 6. 1989), diverging considerably from the Commission's proposal by recommending an initial limit of 20 mg tar by 31 December 1989, with the possibility of a further reduction to 15 mg by a second, unspecified date, after approval of a report on the socio-economic repercussions of these limits. The Commission did not see fit to amend its initial timetable in its amended proposal (OJ C 228, 5. 9. 1989, and OJ C 237, 15. 9. 1989 – corrigendum).

On 13 November 1989, the Council of Health Ministers adopted a common position maintaining the date of 31 December 1992 for the 15 mg limit and differing the date of application for the 12 mg limit until 31 December 1997. A special temporary exemption was granted to Greece (20 mg by 31 December 1992, 18 mg by 31 December 1998, 15 mg by 31 December 2000 and 12 mg by 31 December 2006).

On 14 March 1990, the European Parliament adopted the common position of the Council at its second reading, which meant that the Directive should be adopted finally by the Council of Health Ministers on 17 May 1990.

Action 6: Harmonization of the standards for measuring the components of tobacco smoke

The Council Directives on the labelling of tobacco products and the maximum tar content of cigarettes require the nicotine and tar contents of cigarettes to be measured on the basis of standards ISO 4387 and ISO 3400 and verified in accordance with ISO 8243.

The national and European standardization institutes are currently working on ISO standards for measuring the tar

and nicotine yields of tobacco products other than cigarettes (rolling tobacco, cigars, etc).

Action 7: Prohibition of tax-free sales of tobacco in the European Community

Proposals will be drawn up under the second plan of action, 1990-94.

Action 8: Protection of children from tobacco sales

After consulting experts, the European Commission decided not to draw up a proposal for a Directive prohibiting the selling of tobacco products to minors. In several countries, particularly in southern Europe, such a ban could encourage young people to smoke for the sheer thrill of breaking the law.

The European Commission felt that is was better to increase protection of young people through a campaign against tobacco. Its proposal on limiting advertising for tobacco products in youth magazines therefore provides for a total ban on tobacco advertising (see action 12).

Action 9: Reorientation of tobacco production towards less toxic varieties and study of the possibilities of reconversion

The common agricultural policy has taken account of concern about public health by encouraging the reorientation of tobacco production towards less toxic varieties (which are also the most popular) and promoting conversion to other products. The following measures have been implemented:

(a) The prices and premiums paid in 1987-89 for the most toxic varieties were reduced by 8 to 18%. The maximum quantities for which the guaranteed prices and premiums were payable, introduced in 1988, has been reduced by 25% for the period 1988-90.

(b) The structural Funds set up in connection with the CAP have been used to finance investments, e.g. irrigation, necessary for conversion to less toxic varieties or other crops. The technological research and development programme for agriculture has also financed research into the creation of tobacco varieties which are less toxic as a result of a lower tar content or, by way of diversification, tobacco plants containing proteins which can be used for pharmaceutical purposes. The integrated Mediterranean programmes budget has also been used, to the amount of ECU 2.33 million over the period 1986-92, to finance changes to less toxic varieties and for conversion of 4 030 ha of land used for tobacco growing in Greece.

Action 10: Information and public awareness campaign in the struggle against tobacco

The Commission has subsidized a large number of activities in the campaign against tobacco, most of them carried out by anti-cancer associations and leagues and anti-smoking organizations in the 12 Member States. A special effort was made during the European Cancer Information Year to promote the first commandment of the European Code against cancer: 'Do not smoke. Smokers, stop as quickly as possible and do not smoke in the presence of others' (see report, published separately, on the European Cancer Information Year).

The graph on the next page shows that encouraging results have been achieved during the first action plan in seven of the 12 Member States.

The 'Europe against cancer' programme also financed an assessment of the effectiveness of legislation and the anti-smoking campaigns in the European Community over the past 40 years. The results of this study were published in 1990 in the journal *Scandinavian oncology*.

Action 11: Study of national provisions, and development of proposed Community regulations on tobacco smoking in public places

On 16 May 1989, the Council and the Health Ministers of the Member States adopted a resolution based on a proposal from the Commission (OJ C 32, 8. 2. 1989), to ban smoking in places open to the public (OJ C 189, 26. 7. 1989). The Member States have to inform the European Commission every two years of action taken in response to this resolution.

Action 12: Study of national provisions, and development of proposed Community regulations on the limitation of tobacco publicity

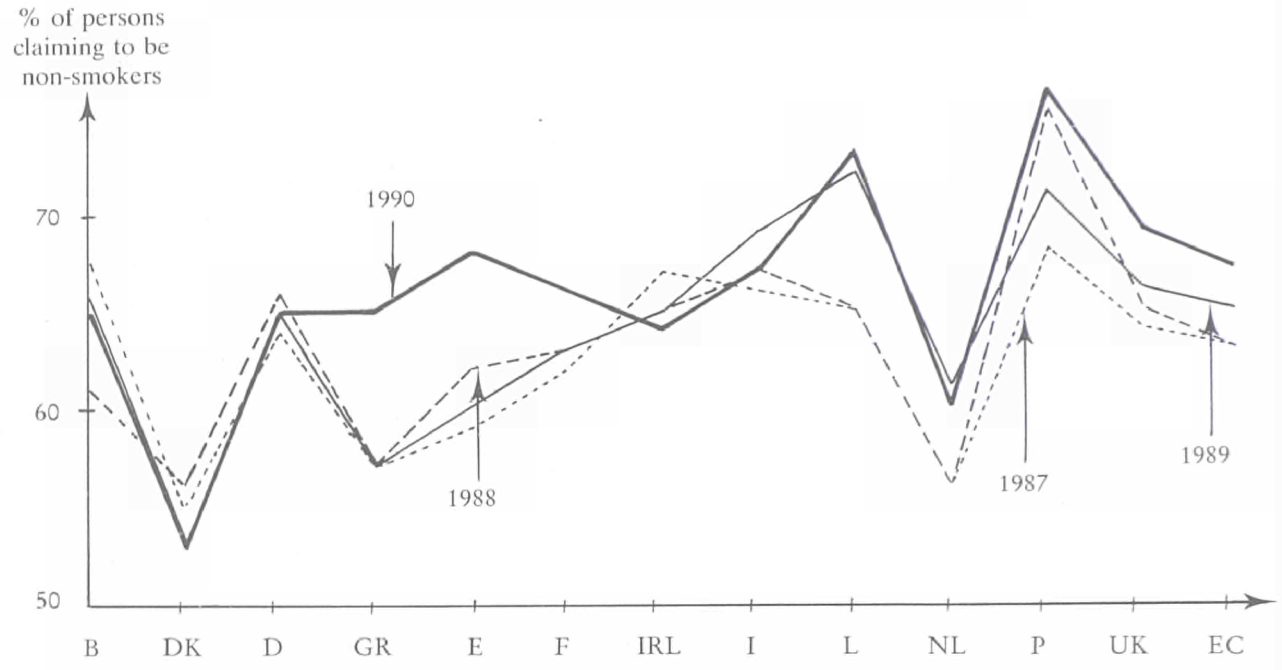
In September 1989, the Council (Internal Market Ministers) adopted the proposal for a Directive on the pursuit of television broadcasting activities (OJ L 298, 17. 10. 1989). Article 13 of this Directive states that 'All forms of television advertising for cigarettes and other tobacco products shall be prohibited'. This ban must be effective by 3 October 1991 at the latest and covers both direct and indirect advertising, the latter being defined in the 29th recital as 'forms of advertising which, whilst not directly mentioning the tobacco product, seek to circumvent the ban on advertising by using brand names, symbols or other distinctive features of tobacco products or of undertakings whose known or main activities include the production or sale of such products'.

On 30 March 1989, the European Commission presented a proposal for a Council Directive on the advertising of tobacco products in the press and by means of bills and posters (OJ C 124, 18. 5. 1989). This proposal places strict controls on direct advertising, for example by imposing compulsory health warnings identical to those annexed to the Directive on labelling. Indirect advertising is totally banned, and both direct and indirect advertising are prohibited in publications mainly intended for young people. Finally, the proposal does not prevent the Member States from placing a total ban on the advertising of tobacco products, should they so wish.

Action 13: Comparative analysis of anti-smoking campaigns

In cooperation with the World Health Organization and the British Medical Association, the European Commission has helped to finance a report on helping smokers to give up smoking (available in French, English and Spanish).

Changes in the percentage of non-smokers during the action plan 1987-89



Significant changes (4% or more) have been recorded in seven of the 12 Member States

Action 14: Information exchange in the struggle against smoking

In the course of the first plan of action 1987-89, the European Commission set up the following three information exchange structures:

(i) a European group of non-governmental organizations against tobacco, which met four times between 1987 and 1989;

(ii) a group of senior officials responsible for the campaign against tobacco, which also met four times;

(iii) the European Bureau for Action on Smoking Prevention (BASP), which was established in 1988 and published six information brochures in 1988 and 1989.

Finally, the European Commission joined forces with the World Health Organization and the Spanish Health Ministry to organize the first European conference on anti-tobacco policy, held in Madrid from 7 to 11 November 1988 and marked by the publication in French, English and Spanish of a set of 10 brochures which were then widely distributed in 1989, in particular to the 300 participants in the 'Europe against cancer' programme in the 12 Member States.

II — IMPROVEMENT IN NUTRITION

Action 15: Analysis of existing information on 'Nutrition and cancer'

Several studies aimed at improving knowledge on the possible links between nutrition and cancer were subsidized under the first plan of action 1987-89:

(a) Feasibility phase of prospective studies of the links between nutrition, health and cancer. Seven studies were launched in the Federal Republic of Germany, United Kingdom, Netherlands, France, Italy, Spain and Greece in order to explore the possibility of undertaking a very wide study of these links in the seven countries mentioned as from 1990. This would involve monitoring a group of around 350 000 persons over a period of several years, through nutrition surveys carried out every two or three years and correlated with the subjects' state of health. The European Commission and the WHO's International Agency for Research on Cancer are jointly responsible for overall coordination.

(b) Prospective study of the anti-promoting role of selenium. Conducted by the University of Limburg between 1986 and 1989, this study monitored 120 000 subjects aged between 55 and 69 to assess the possible protective role of selenium, a mineral salt present in foodstuffs. The results will be published in October 1990.

(c) Feasibility phase of a case control study relating to the links between nutrition, lifestyle and the incidence of breast and colon cancer in the European Community. The separate studies carried out in nine Member States, namely the United Kingdom, Netherlands, Federal Republic of Germany, Ireland, Belgium, Luxembourg, Greece, Italy and Spain, were coordinated by the IARC, and the results should be available in mid-1990.

(d) Case control study of patients with adenomatous polyps or cancer of the colon. 450 persons from Belgium, France, the United Kingdom, Federal Repu-

blic of Germany, Italy and Portugal were monitored for three years to evaluate the possible role of diet on the development of the polyps and their degeneration into cancer of the colon. The study was coordinated by the European Organization for Cooperation in Cancer Prevention Studies (ECP), and the results will be published towards the end of 1990.

(e) Case control study of the link between lifestyle, especially diet, and cancers of the pancreas and bile ducts. This study was undertaken in the Netherlands, between 1984 and 1989, by the Institute for Health, and involved a group comprising 189 persons with cancer of the pancreas, 127 persons with cancer of the bile ducts and 487 persons not suffering from either. All subjects were interviewed twice to establish their lifestyles and dietary habits. The results will be published in 1990.

(f) Case control study of nutrition, alcohol consumption and breast cancer. Carried out under the auspices of the Nutrition Department at the Athens School of Public Health, this study, which began in 1988, is monitoring 600 women with breast cancer and a 1 200-strong control group. It will be completed by the end of 1990.

(g) Case control study of nutrition and precancerous intestinal lesions. This was carried out in five Member States, covering 180 persons with precancerous intestinal lesions and a control group of 500 persons. The aim was to identify possible links between dietary habits and the appearance of precancerous lesions. The work was coordinated by the ECP, and the preliminary results will be published towards the end of 1990.

(h) Intervention study of the anti-promoting role of calcium. Launched in 1989 by the University of Nottingham (United Kingdom), this study will monitor a group of 200 persons with colorectal adenomas and a 200-strong control group for a period of five years. Each group is divided into two subgroups, one of which receives a daily supplement of 1.5 g of calcium, whilst the other does not. The results will be available in 1994.

Action 16: Development of nutritional recommendations against cancer adapted to each of the categories of participants concerned

Despite the numerous uncertainties affecting current knowledge of the links between nutrition and cancer, the European Committee of Cancer Experts has formulated two recommendations on nutrition, introduced by a general warning:

'Your general health will benefit from the following two commandments which may also reduce the risks of some cancers:

Frequently eat fresh fruit and vegetables and cereals with a high fibre content.

Avoid becoming overweight and limit your intake of fatty foods.'

These two rules have been publicized by the governmental and non-governmental programme participants in each Member State, in most cases with financial support from the European Commission.

Action 17: Harmonization of nutritional labelling of foodstuffs in the European Community

The European Commission's proposal dated 5 October 1988 (COM(88) 489 final) was revised following consultation of the European Parliament (COM(89) 420 final), resulting in a common position dated 21 December 1989. Article 2 of this common position states that 'Nutrition labelling shall be compulsory when a nutrition claim is made in labelling or advertising. Nutrition labelling is optional in all other cases.' (OJ C 66, 16. 3. 1990).

Action 18: Consumer protection against certain agents in foodstuffs

In 1988, the European Commission drew up a new proposal for a Directive on pesticide residues in fruit and vegetables (OJ C 46, 25. 2. 1989), on the basis of Article 43 of the EEC Treaty. This consolidates existing legislation and in addition makes it compulsory to provide clear information for the consumer. The Council will reach a decision on this proposal once the European Parliament has delivered its opinion at the May 1990 part-session.

Action 19: Improvement of existing information campaigns concerning nutrition

All the participants in the 'Europe against cancer' programme in the 12 Member States realigned their information campaigns aimed at the general public to take account of the two European cancer prevention rules on nutrition and the results of epidemiological studies which had become available. New brochures were published with financial assistance from the European Commission, including 'Diet and cancer' from the UK Health Education Authority, 'Eet wijzer' from the Nederlandse Kanker Bestrijding, and '100 recettes santé' from the Association contre le Cancer (Belgium).

Action 20: Initiation of information campaigns for recommended foodstuffs

Numerous campaigns were conducted, particularly during European Cancer Information Year, including the free distribution of fresh fruit and vegetables through non-governmental associations – in Italy during the European Cancer Prevention Week in May 1988, and in Luxembourg and Denmark during the European Week in October 1989.

Action 21: Promotion of appropriate foodstuffs and techniques

Community-level activities of this nature may be included in the second plan of action, 1990-94.

Action 22: Evaluation of pilot experiments in nutrition

An assessment of the strategies used to provide the general public with nutrition information and education was started in 1989, and the results will be published in 1990.

Action 23: Exchange of information on 'nutrition and cancer'

In 1988 and 1989 several symposia were organized, with the financial support of the 'Europe against cancer' programme.

(a) European seminar on 'Fighting cancer with prevention, education and research' for 60 scientific journalists. (Organized by the European School of Oncology, Venice, 11 and 12 May 1989.)

Two of the papers dealt with nutrition, namely 'Ingestion of fats and the risk of cancer' and 'Vegetable fibres and the risk of cancer'. All the papers presented are available in a booklet, and the most important ones will be published in French and English by Springer Verlag in mid-1990.

(b) EEC workshop on the important components of food and nutrition policy in the EEC. (Organized by the Athens School of Public Health, Corfu, 6 to 8 October 1988.)

This workshop looked at current knowledge of links between nutrition and health and examined existing legislation on foodstuffs, especially nutritional labelling. The proceedings have been summarized in a brochure (in English), several thousand of which have been distributed.

(c) EEC workshop on recommended dietary intakes. (Organized by the Athens School of Public Health, 23 to 25 November 1989.)

This workshop examined the similarities and differences between the dietary intakes recommended in the European Community Member States and Scandinavia. The objective was to study the possibility of harmonizing the nutritional standards recommended in Europe. The proceedings have been summarized in a brochure and will be published as a supplement to the *European journal of clinical nutrition* in 1990.

III — PROTECTION AGAINST CARCINOGENIC AGENTS

Action 24: Protection against ionizing radiation and follow-up to Chernobyl

On 14 December 1987, the Council adopted Regulation No 87/3954/Euratom laying down maximum permitted levels of radioactive contamination of foodstuffs and of feedingstuffs following a nuclear accident or any other case of radiological emergency (OJ L 371, 30. 12. 1987). In 1989, the Council adopted Regulation (EEC) No 2219/89 on the conditions governing exports of foodstuffs and of feedingstuffs following a nuclear accident or any other case of radiological emergency (OJ L 371, 30. 12. 1987), and Directive (Euratom) No 618/89 on informing the population of health protection measures and behaviour in the case of a radiological emergency (OJ L 357, 7. 12. 1989, p. 31).

Action 25: Creation of an observation antenna and establishment of a list of chemical substances suspected of being carcinogenic

Owing to a shortage of staff, it was not possible to create such an antenna within the European Commission. However, the following studies habe been financed under the 'Europe against cancer' programme:

(a) Study of occupational cancers among workers involved in the manufacture of certain types of herbicides. The purpose of this study, by the National Institute for Public Health and Protection of the Environment in the Netherlands, is to compare the frequency of deaths caused by the various types of cancer among persons exposed and persons not exposed to the suspected substances (phenoxy acids and chlorophenols). The results should be available towards the end of 1990.

(b) Study of the carcinogenic risks of certain pesticides used in agriculture. The objective of this case-control study is to identify the possible links between cancers observed among certain farmers and chemicals used in farming. This study was launched in 1989 by the Italian Health Institute.

(c) Preliminary study of the cancer risk among biology laboratory workers in Europe. The need for such a study became apparent in 1986 when several cases of rare cancers occurred at the Institut Pasteur in Paris. The feasibility study, carried out in 1988 and 1989 by the International Agency for Research on Cancer, recommends a large-scale European study.

(d) Preliminary study of the prevention of secondary cancers caused by chemotherapy. This study is currently being carried out by the International Agency for Research on Cancer and aims to identify the possibilities of improving certain types of chemotherapy treatment in order to reduce the long-term risks of secondary cancer.

(e) Study of the role played in lung cancer by exposure to radon in houses and flats. This study is currently being carried out by the Department of Hygiene and Medicine at the University of Ghent. It may be extended to France and the Federal Republic of Germany.

Action 26: Speeding up of the work at Community level, and creation of a special group on classification and labelling of carcinogenic substances

In 1987 a working party on carcinogenic substances was created within the 'Classification and labelling of carcinogenic substances' group created by Directive 67/548/EEC. Several suspected substances have been examined during the past three years. Eighty carcinogenic substances or

groups of substances have already been classified, and at the beginning of 1990 a further 150 substances were being examined.

Action 27: Adoption of Directives currently being discussed by the Council for the protection of workers

On 9 June 1988, the Council adopted Directive 88/364/EEC on the protection of workers by the banning of certain specified agents (OJ L 179, 9. 7. 1988). Apart from a number of exemptions which may be granted by the Member States for clearly specified purposes under clearly established conditions, the production and use of the following substances, responsible for cancers of the bladder, are banned: 2-naphthylamine and its salts, 4-aminobiphenyl and its salts, benzidine and its salts, and 4-nitrodiphenyl. The Directive also states that the Council, acting by a qualified majority on a proposal from the Commission, in cooperation with the European Parliament and after consulting the Economic and Social Committee, may amend the Annex, in particular to include further agents or activities.

Action 28: New Directives for the protection of workers against carcinogenic substances

On 21 December 1987, the Commission, acting on the basis of Article 118a of the EEC Treaty, presented a proposal for a Council Directive on the protection of workers from the risks related to exposure to carcinogens at work (OJ C 34, 8. 2. 1988). Where exposure of workers is inevitable, the proposal calls on employers to take various supplementary measures, including the design of work processes, early detection of abnormal exposures, information for workers, surveillance of workers' health, emergency measures, and arrangements for safe storage of substances and safe disposal of waste. The Economic and Social Committee delivered its opinion on 2 June 1988 (OJ C 208, 8. 8. 1988), followed on 24 May 1989 by the European Parliament (OJ C 158, 26. 6. 1989). On 31 July 1989, the European Commission transmitted to the Council a revised proposal taking account of most of the European Parliament's amendments (OJ C 229, 6. 9. 1989).

On 30 November 1989, the Council on Social Affairs adopted a common position including most of the amendments contained in this latter proposal. The proposal covers 52 chemical agents already classified as carcinogenic and will automatically be extended to cover any substances classified as such in the future (see action 26). The Directive should be adopted finally in 1990, after the European Parliament has given its opinion on the Council's common position at the part-session in May 1990.

Action 29: Prevention of occupational cancers by improving the practical organization in undertakings, including information to employers and workers

On 18 March 1988, the Commission presented a proposal for a Council Directive on the introduction of measures to encourage improvements in the safety and health of workers at work (COM(87) 73 final). It requires employers to assess the health risks to their workers, decide on the protective measures to be taken, and make information accessible to workers and their representatives. The Directive (EEC/89/391) was adopted in June 1989 (OJ L 183, 29. 6. 1989).

Action 30: New measures for public protection against carcinogenic substances

On 28 January 1988, the European Commission, acting on the basis of Article 100a of the EEC Treaty, presented to the Council a proposal for a Directive amending Directive 76/769/EEC relating to restrictions on the marketing and use of certain dangerous substances and preparations. The substances covered include the four product families mentioned under Action 27, plus benzene. The Directive was adopted by the Council on 21 December 1989 (OJ L 398, 30. 12. 1989).

IV — SYSTEMATIC SCREENING AND EARLY DIAGNOSIS

Action 31: Promotion of a policy for systematic screening and early diagnosis of cancer of the uterine cervix and cancer of the breast

In 1988, the Committee of Cancer Experts set up under the 'Europe against cancer' programme created two subcommittees on screening for breast cancer and cervical cancer respectively. Each of these subcommittees drew up a strict protocol to be respected by all projects to be taken under the wing of and receive financial support from the 'Europe against cancer' programme. For example, systematic screening for breast cancer is recommended between the ages of 50 and 65 (every 2 to 3 years) and for cervical cancer every 3 to 5 years from the age of 25.

A European network of pilot projects for breast cancer screening was established in 1989. Every project must monitor a group of at least 10 000 women, each of whom must be invited by a personal letter, with an automatic reminder if necessary, in order to achieve high rates of participation. In four regions — Pirgos (Greece), Navarra (Spain), Porto (Portugal) and Limburg (Belgium) — mobile units are used for screening. In the Dublin area, screening takes place in a mobile unit and at a permanent centre (Mater Hospital). In the department of Bas-Rhin (France), it is done by approved radiologists. In 1990, the network will be extended to the Florence region and to Luxembourg. The staff involved in pilot operations are being invited for further training at one of the most advanced screening centres, that in Utrecht (Netherlands).

Finally, the 'Europe against cancer' programme budget permitting, a start could be made in 1991 on setting up a European network of pilot projects for cervical cancer screening.

Action 32: Evaluation and improvement of the policy for the systematic screening and early diagnosis of other common cancers

There are still many uncertainties about the usefulness of policies for systematic screening for colo-rectal cancers by detection of blood in the faeces, which is why the 'Europe against cancer' programme has not given financial support to the many projects submitted. On the other

hand, three studies on the subject have been financed under the first plan of action 1987-89:

(a) A report on the efficiency of haemoculture for early detection of colo-rectal cancers. Carried out by experts of international standing under Professor Hardcastle (United Kingdom), this study was described at the European Conference in Venice on 11 and 12 May 1989. Publication in French and English by Springer Verlag will follow in 1990 (see action 23).

(b) A study to assess the efficiency of colo-rectal cancer screening in the Federal Republic of Germany. Conducted in the Saarland by the University of Heidelberg, it will provide an assessment of the effectiveness of colo-rectal cancer screening, which was introduced on a large scale in 1977. The results should be available early in 1991.

(c) A controlled experiment on the efficiency of colo-rectal cancer screening in the Dijon region (France). This experiment, comparable in principle with those carried out in the United Kingdom and Denmark, covers 45 000 persons aged between 47 and 55. Initial results should be available as from 1991.

V — EUROPEAN CODE AGAINST CANCER

Action 33: Transformation into layman's language of the European Code against cancer

The European Code against cancer was adopted by the Committee of Cancer Experts set up under the 'Europe against cancer' programme in May 1987 following wide consultation of the health ministries and non-governmental organizations involved in the fight against cancer.

Chapter 2: Information and health education

I — INFORMING THE GENERAL PUBLIC

Action 34: Establishment of a directory of the private organizations against cancer in Europe

This directory was prepared in 1987 and is available in French, English and German. It will be updated in 1990.

Action 35: Comparative survey of private and public cancer prevention information campaigns

At the start of the plan of action 1987-89, a general study was undertaken to establish what had been accomplished in the various Member States. The creation of the group of organizations against cancer led to a broad exchange of experience and permitted continuous assessment of actions (dissemination of the European Code through various channels, organization of open days, travelling exhibitions, etc.). On 25 January 1990, a symposium was held in Athens to assess the efficiency of actions (see special report on the European Cancer Information Year).

Action 36: Bringing cancer prevention and the 'Europe against cancer' programme to the attention of the media

Following an invitation to tender, a public relations agency network was set up at the beginning of 1987, and as from 1989 a 'Europe against cancer' programme correspondent was assigned to each of the European Commission's offices in the Member States. Every year, two press conferences are organized simultaneously in the 12 Member States, and three or four press releases are sent out. In some countries (e.g. Denmark), the press releases have, since 1989, been backed up by a bi-monthly newsletter. This will be practised in all countries as from 1990.

Action 37: Eurobarometer survey of Europeans' attitudes to cancer and its prevention

Between 1987 and 1989 several surveys were carried out simultaneously in the 12 Member States of the European Community to assess the extent of knowledge and application of the European Code against cancer by the general public, doctors and teachers. The survey reports are available in French and English, and a book containing the full results will be published in French, English and German towards the end of 1990.

Action 38: Financial contribution to television cancer prevention broadcasts for the general public

Ten television programmes on cancer prevention and treatment were financed in 1988 and 1989 by the 'Europe against cancer' programme. Two of them received international awards. The European Cancer Information Year ended on 9 January 1990 with a major Eurovision broadcast (see special report on the European Year).

Action 39: Dissemination of the European Code against cancer at sports and cultural events sponsored by the European Community

Two of these events deserve special mention. First of all, the special concerts given in 1987 to mark the 30th anniversary of the Treaty of Rome, when around ECU 100 000 was collected and donated to the European Organization for Research on Treatment of Cancer, and secondly, the 1989 Tour de France across Luxembourg, Belgium and France, when the 'Europe against cancer' programme was represented in the accompanying convoy by two vehicles in the programme colours, which distributed information in several languages on the European Code against cancer. This action was coordinated by a Netherlands anti-cancer association, the LOK.

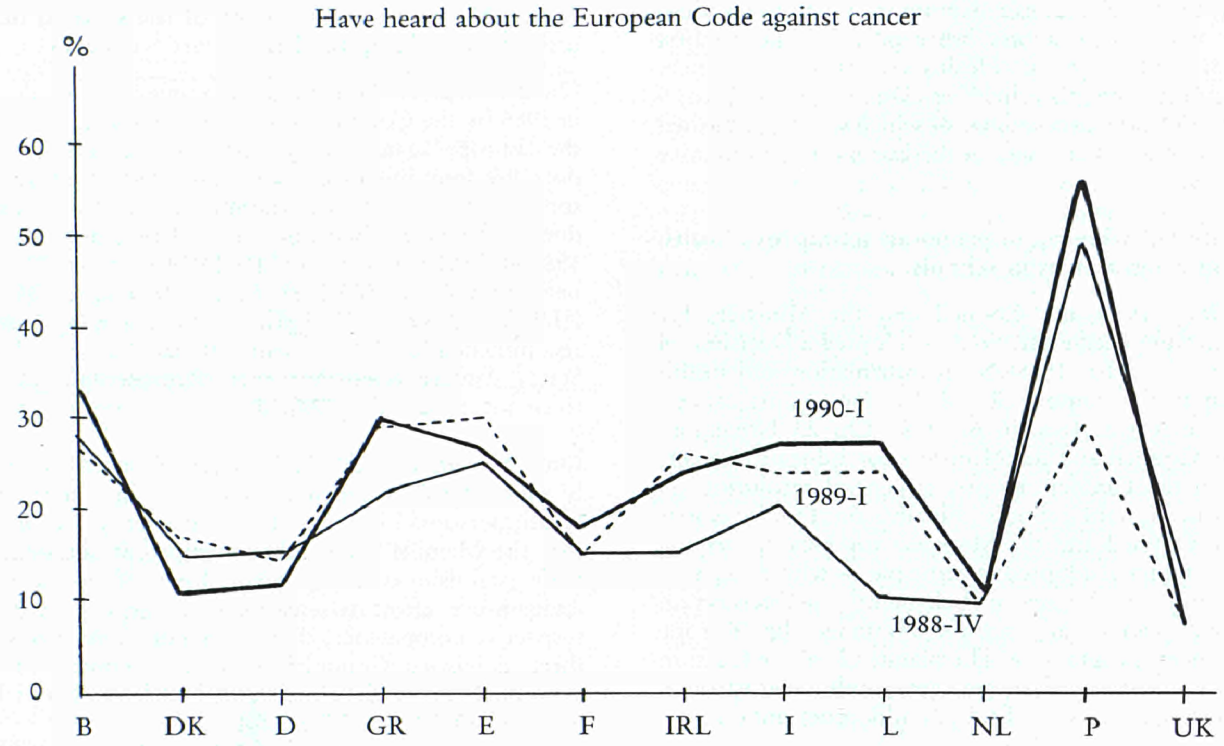
Action 40: Public meeting to mark the end of the first year of the 'Europe against cancer' programme

During the European Council in Copenhagen on 5 December 1987, a brief official ceremony was held, and a prestige version of the European Code against cancer was presented to the Danish Prime Minister, the President-in-Office of the Council. Each Head of State or Government received a similar copy in his or her own language.

Action 41: Preparation of the actions to be carried out in 1989, European Cancer Information Year

This involved the various networks of partners set up since the end of 1986: cancer prevention, anti-smoking and general practitioners' organizations; producers of medical programmes for the European television stations; public relations agencies; senior health and education ministry officials. A total of nearly 100 non-governmental organizations took part.

Evolution of the notoriety of the European Code during the European Year of Information on Cancer



The objective of the European Year of Information on Cancer was to increase the notoriety of the European Code against cancer. This objective was attained in 9 of the 12 countries, and most spectacularly in Portugal (from 29% to 56%). On the contrary, in the Netherlands and the United Kingdom the level of notoriety remained stationary and fell slightly in Germany (from 15% to 12%) and in Denmark (from 15% to 11%).

Action 42: Organization of a European week against cancer as a test for the 1989 campaign (European Cancer Information Year)

The purpose of this week (1 to 8 May 1988) was to prepare for the European Cancer Information Year. Three European television broadcasts were produced by the European Commission, and numerous activities were organized by the programme participants.

Action 43: Increase in 1988 of the campaigns carried out in 1987 to inform the public and increase public awareness of the campaign against cancer

The objective was achieved despite a very limited budget, thanks above all to the non-governmental organizations, which invested substantial human and financial resources in the dissemination of the European Code against cancer. Polls in the 12 Member States measured changes in the degree of awareness of this Code, and the excellent results recorded in certain southern European countries show that it is possible to increase Europeans' awareness on matters of such paramount importance as their health.

Action 44: Interesting teachers and the health professions in dissemination of the European cancer prevention commandments

The European Commission was able to involve these vital groups despite a lack of financial resources, thanks to the representatives of general practitioners and senior health education officials whom it met twice a year in Brussels. In many countries, the European Code against cancer was displayed in general practitioners' waiting-rooms, and there were numerous campaigns aimed at schools (see special report on the European Year).

Action 45: Organization in 1989 of a media campaign aimed at the general public: '12 nations, 12 days of action against cancer'

This action was not carried out owing to a lack of funds.

Action 46: Intensification in 1989 of the campaigns carried out in 1987 and 1988 to inform the public and increase public awareness of the fight against cancer

See special report on the European Cancer Information Year. The graph illustrates the encouraging results reached in most of the Member States.

II — HEALTH EDUCATION

Action 47: Establishment of a comparative survey of health education programmes in European schools

Two comparative studies of health education in the 12 Member States of the European Community were carried out in 1988 and 1989. The first, by Professor Trevor Williams (Head of the Health Education Department at the University of Southampton and consultant to the

'Europe against cancer' programme) looked at the existing situation. The second took the form of a survey of 2 750 teachers in the European Community. Both studies, together with other reports, were presented at the first European conference on 'Health education and cancer prevention in schools', held in Dublin from 7 to 9 February 1990, the proceedings of which will be published in the nine official languages of the European Community in mid-1990.

Action 48: Drawing-up of proposals to improve health education programmes in schools

On 31 May 1988, the Council and the Ministers for Health meeting within the Council adopted a Decision on a plan of action for 1988-89 on information and health education in the context of the 'Europe against cancer' programme (OJ L 160, 26. 6. 1988). On 23 November 1988, the Council and the Ministers for Education meeting within the Council adopted a general resolution on health education in schools. Finally, on 13 November 1989, the Council and the Ministers for Health meeting within the Council adopted in principle — whilst awaiting the opinion of the European Parliament — a Decision on the second plan of action 1990-94 under the 'Europe against cancer' programme. The planned health education campaigns aimed at preventing cancer will benefit from a budget averaging close to ECU 2 million per annum.

Action 49: Provision of teaching material relating to health education

Three types of European audiovisual material were produced by the European Commission in the nine official languages of the European Community and distributed free of charge via the governmental and non-governmental programme participants:

(i) a booklet aimed at the general public about the 'Europe against cancer' programme;

(ii) a set of six posters containing the European Code against cancer and five maps showing cancer deaths in Europe (lung-tobacco; oesophagus-alcohol; melanomas-sun; stomach-fruit and vegetables; breast-fats);

(iii) a cartoon video for children *(Euro-Jim against Crab Cancer)*, illustrating the European commandments relating to tobacco, alcohol, sun, fruit and vegetables, and fats) and two films for older teenagers and adults *(Man and cancer* and *Lifestyle and cancer in Europe).*

Action 50: Contribution to the financing of television health education broadcasts on the prevention and treatment of cancer

In addition to the television programmes aimed at the general public and mentioned under Action 38, the European Commission produced a special health education film entitled *Prevention and early detection of cancer,* which was awarded the first prize for films on cancer at the international medical film festival in Parma (Italy) in 1989. This film is particularly suitable for health education teachers and will be available on video to programme participants free of charge as from mid-1990.

Chapter 3: Training of the health professions

Action 51: Comparative study of the systems of university training for health-care workers

On the basis of the general recommendations drawn up in 1986 by the Committee of Cancer Experts set up under the 'Europe against cancer' programme and specific reports by four European experts in 1987, the three Advisory Committees on the training of nurses, dentists and doctors delivered their opinions and recommendations in 1988 and 1989 (Documents III/D/248/3/88 of 20 December 1988, III/D/886/3/88 of 22 November 1988 and III/D/890/3/89 of 20 April 1989). These opinions and recommendations were sent officially to the Member States' Ambassadors (Permanent Representatives) in 1989 to ensure maximum publicity.

On 8 November 1989, the European Commission formally adopted a Recommendation concerning the training of health personnel in the matter of cancer. It 'recommends that the Member States, their competent authorities and their establishments responsible for professional training make every effort to ensure, in accordance with their respective competence, that [the recommendations of the three Advisory Committees on the training of health personnel] are widely distributed, discussed and implemented' (OJ L 346, 27. 11. 1989).

Action 52: Formulation of proposals for improving the organization of studies in the cancer field

In May 1988, a first European conference on cancer training as part of basic medical studies was held in Bonn. Organized jointly by the European Commission and the European Organization for Research on Treatment of Cancer, it was attended by around 40 faculty of medicine deans and cancer experts. Consensus was reached on the minimum amount of cancer training in basic medical studies and on the procedures for implementation. Three further 'consensus' conferences of this type were prepared in 1989, covering cancer training for dentists, nurses and general practitioners.

Action 53: Stimulation of mobility of medical and nursing students

Fifty grants were awarded in 1989 to doctors and nurses wishing to undergo further training in cancer at the European School of Oncology in Venice. Another 20 grants were awarded in 1989 to persons involved in the European network of pilot projects for breast cancer screening to allow them to receive further training at the Prevention Centre in Utrecht. Grants were also awarded to medical students and student nurses under the Erasmus programme.

Action 54: Joint preparation and exchange of teaching materials and testing of this during the European Cancer Information Year

Teams of international experts prepared handbooks for the European School of Oncology on lung cancer (1988) and breast cancer (1989) to be used for initial or further training of general practitioners. These were distributed to a sample of general practitioners for trial use and will

be published as from September 1990 in the nine official languages of the European Community, by Springer Verlag.

Action 55: Exchange of experience on continuous training

The European Commission has limited its activity in this field to further training for general practitioners, given their central role in a policy of cancer prevention and screening. Apart from the handbooks mentioned above, an *ad hoc* working party was set up to prepare the consensus conference on the training of general practitioners, which should take place early in 1991.

Action 56: Development of common computer programs for expert medical systems for cancer

This action was not carried out owing to lack of funds.

Chapter 4: Cancer research

Action 57: European grants to encourage mobility of cancer research workers

The cancer research training scheme became fully operational in 1988. More than 100 fellowships were allocated to young scientists wanting to spend up to two years in another Member State, or in Switzerland or Austria (countries participating in the cancer target). In 1988, 25 post-doctoral and 21 post-graduate long-term fellowships were allocated (for one year and, in exceptional cases, two years). Moreover, 10 short-term fellowships were allocated (up to four months). In 1989, 21 post-doctoral and 17 post-graduate long-term fellowships as well as 18 short-term fellowships were allocated.

Action 58: Comparison of existing cancer registers and recommendation for their minimum contents and conditions of access to them

During the first action plan, a study was carried out by the International Agency for Research on Cancer (IARC) in Lyons on the existing cancer registries in Europe. This study shows several different approaches towards data collection and data management.

In 1989, the first phase of a feasibility study for setting up a European network of cancer registries was carried out, coordinated by the IARC and the Danish Cancer Registry. The aim of the study is to fix a minimum of data collection in order to enhance comparability. During the second action plan 1990-94, this network will be set up and gradually be extended to permit the implementation of a monitoring system on cancer incidence in the EC.

Action 59: Launching European coordination of medical research on food and cancer

This action, which is partially under way within the framework of the joint Euronut-ECP (European Organization for Cooperation in Cancer Prevention Studies) project, has seen the launching of a pilot study on the role of dietary factors in the development of type B atrophic gastritis, a pre-cancerous stomach lesion. Data are collected in seven countries, and in a few months, the centres will stop collecting cases and controls. The next step is the data set analysis. The total number of cases and controls will be around 450 instead of the planned 600.

A collaborative research project on the geographic correlation between biological risk factors for gastritis and gastric cancer has been financed by the Commission from January 1989 for a period of two years. A first meeting, organized in collaboration with the International Agency for Research on Cancer (IARC) in Lyons, permitted the finalization of the study protocol.

Action 60: Stepping-up of European research on occupational cancers

Following up a seminar held in Paris in December 1987 on methodologies for evaluating the links between occupational exposure and the risk of developing cancer, a workshop was organized in 1988 to prepare a joint action on this subject within the framework of the fourth medical and health research programme (1987-91). A proposal for a concerted action was approved in June 1989 and will be financed by the Commission from January 1990 onwards for a duration of 2½ years.

The objectives of the concerted action are:

(i) to improve the ways of measuring occupational exposures in epidemiological investigation of cancer;

(ii) to compare the performance of different methods on a large number of epidemiological surveys in a standardized way, to make conclusions and recommendations.

Action 61: Continuation of the co-financing by the European Community of research on the prevention of radiation-induced cancers

The current (1985-89) and future (1990-91) radiation protection research programmes support, on a cost-shared basis, projects designed to improve the understanding of how radiation induces cancer and the dependence on dose and exposure conditions.

(1) Cell transformation and molecular biology studies investigate the mechanisms by which radiation converts a normal cell to malignancy.

(2) Animal studies investigate the effect of dose, dose rate and radiation quality on the induction of cancer.

(3) Epidemiological studies on human populations exposed to radium and thorotrast in previous medical treatments and to radon in homes attempt to determine the risk of cancer induction from these sources of radiation.

A meeting on 'Cell transformation systems relevant to radiation-induced cancer in man' was jointly organized by the Commission, the US Department of Energy and the Nuclear Energy Board of Ireland, and the proceedings of the meeting have been published. A report 'Feasibility of studies on health effects in Western Europe due to the

reactor accident at Chernobyl and recommendations for research' has been finalized. The report concludes that it will be virtually impossible to detect the relatively few cancers resulting from the accident but recommends that an epidemiological study of childhood leukaemia incidence be made using existing cancer registries.

Action 62: Continuation of co-financing by the European Community of research on environmental factors and cancer

The coordinated projects in this area are intended to provide a scientific basis for early identification and assessment of cancer risks to the general population from environmental factors. There are a number of substantial projects currently under way:

(1) Genetic effects of environmental chemicals, which include the following research topics:

Mechanisms of mutagenesis;

Quantitative mutagenesis (molecular dosimetry);

Development and validation of predictive tests for chromosome non-disjunction;

Development and validation of tests for detection of epigenetic (promoter) substances.

(2) Biomonitoring of human populations exposed to genotoxic environmental chemicals: the aim of this project is to develop monitoring techniques for the determination of chemically-induced DNA damage in man.

(3) The EC environmental R&D programme has been requested by the OECD to prepare a review of the OECD guidelines for genetic toxicity tests.

Action 63: Continuation of European coordination of medical research on cancer and reproduction

In 1988, two studies were carried out as a part of the Eurocat project for birth surveillance in order to assess the mutagenic and teratogenic consequences of the Chernobyl accident. The preliminary results do not suggest an increase in frequency of chromosomal syndromes or of central nervous system anomalies among conceptuses in women exposed to radiation in May to August 1986. The results have been published (De Wals P. *et al.*, Int. J. Epidemio. 17: 230-231, 1988; Eurocat Working Group, Paed. Perinat. Epidemio. 45: 369-382, 1988). A re-analysis of the data collected in 1988 and 1989 is foreseen.

Other studies are needed to assess the long-term carcinogenic effect of the contamination.

Action 64: Launching of European coordination of medical research on passive smoking

A seminar on 'Passive smoking and health' was held from 30 November to 1 December 1987. On the basis of the participants' recommendations, a proposal for a project on the effects of passive smoking on health was submitted to the Commission for examination.

The objectives of the concerted action are:

(i) to estimate the overall impact of passive smoking on the EC population;

(ii) to substantiate and quantify the effects of exposure to environmental tobacco smoke on the occurrence of lung cancer.

This proposal has been approved, and has been financed from January 1989 by the EC for a duration of 2½ years.

Action 65: Continuation of European coordination of medical research of automated tissue analysis

1. The first project relates to clinically-applied analytical cytometry. A new proposal has been approved in November 1988, with two main lines. The first one is the further development, adaptation to the users, and clinical and technical evaluation of devices for automated, quantitative and analytical cytology and histology; the second one is directly relevant to cancer, in particular breast cancer, with multicentre clinical studies on the use of cytometric analysis of cytological and histological specimens for early detection, diagnosis, prognosis, and treatment management.

Several instruments have been developed by industries, in collaboration with participants in the previous concerted action; they are in the phase of prototype development for clinical testing. It is now planned to participate, in particular, in screening programmes for cervical cancer using automated pre-screening systems.

2. The second project relates to automation of cytogenetics. The progress achieved so far is presented in a publication entitled *Automation of cytogenetics — Advances in systems and techniques* (Springer, 1989). This includes the evaluation of complete image-based chromosome analysis, the development of new image techniques and of systems for chromosome aberration scoring, automatic specimen preparation, and the use of flow systems for chromosome measurement and analysis.

Action 66: Continued European coordination of research on imaging in medicine

A new project on tissue characterization by magnetic resonance spectroscopy (MRS) and imaging (MRI) was approved in June 1988. Its main objectives are, on the one hand, to extend the scope and usage of standardized methods in the fields of MRS tissue characterization by nuclear magnetic resonance (NMR) and of performance assessment of MRS and MRI; and, on the other hand, to gather more complete and reliable data on magnetic resonance properties of tissues.

It follows a project on identification and characterization of biological tissues by NMR which included works on NMR standardization, methodology for *in vitro* measurement of relaxation times, test substances for calibration, test procedures and test objects, etc. The activities and results are reported in a series of six papers in *Magnetic resonance imaging*, Vol. 6, No. 2, 1988, pp. 173-222. List of the activities held in 1989:

Workshop on 'The uses of an *in-vivo* NMR relaxation time data bank — Acquisition and accumulation', Dundee, 13 to 15 March 1989;

Workshop on 'Quantification in NMR spectroscopy and its medical implications', Rome, 16 and 17 June 1988.

Another project was approved in November 1988 on positron emission tomography (PET) in investigation of cellular regeneration and degeneration. Its main objective is to improve the understanding of major diseases and the follow-up of treatment, PET being the only method allowing non-traumatic estimation of cell degeneration, regeneration and proliferation, and special attention is envisaged to be given to pharmacology since PET allows pharmacokinetic studies, estimation of interaction of drugs with their specific receptors, and consequently improvement in drug design and administration. List of activities in 1989:

First modelling expert panel meeting, London, 13 and 14 April 1989;

First radiochemistry workshop, Jülich, 11 and 12 May 1989;

First cardiology workshop, Pisa, 22 and 23 May 1989;

Oncology symposium and workshop, London, 6 and 7 July 1989.

Action 67: Strengthening of European coordination of research on clinical treatment and of control of multicentre therapeutic trials

1. Under the fourth medical and health research programme, support for the EORTC, as well as for its data centre, has been reinforced. Moreover, the improvement of the Eurocode informatics network, which facilitates direct communication between oncologists and their participation in the EORTC's clinical trials, has been achieved by installing peripheral nodes in Britain, France and the Netherlands.

2. It was agreed to make use of the high flux reactor at Petten (EC Joint Research Centre, Netherlands) to establish a centre for the treatment of malignant brain tumours by boron neutron capture therapy. For reasons not yet fully understood, boron compounds are selectively accumulated in tumour cells. Subsequent irradiation with neutrons results in the capture of neutrons by the boron atoms, giving rise to alpha-particles. These have a high cell-destructing capacity and do not leave the tumour since they move only 5 micrometres in tissue. The results obtained in Japan with this treatment are promising. A concerted action was approved and started in July 1989. About 30 institutes will assure the scientific backing of the treatment facility under construction at Petten. It is expected that the first patients can be treated in early 1992.

3. There are both biological as well as physical reasons to assume a potential value of light ion beam therapy for cancer. Light ion beam treatment allows a more accurate irradiation of the tumours, thereby preserving the surrounding healthy tissue. The clinical trials performed in the USA so far indicate that there is a clear value for this type of treatment for certain tumour types. A feasibility study to investigate the possibility of installing a light ion medical accelerator in Europe started in 1988. A final report is expected at the end of 1991.

4. A concerted action on the role of cell surface properties and tumour specific antigens in metastasis and host immune response was approved and started in July 1989.

The general aim is to improve knowledge of the tumour cell properties that influence the specific immune response of the host and the ability of tumour cells to invade surrounding tissues and to metastasize, in order to develop new forms of cancer treatment by increasing the specific host immune response and by inhibiting the invasive potential of tumour cells.

5. A concerted action on treatment of haematological malignancies by bone marrow transplantation from volunteer donors was approved in 1989 and will start in early 1990.

The general aim of the project is to create in the respective areas of donor pool and search coordination, the necessary conditions to increase the number of patients with haematological malignancies who can be treated by unrelated volunteer bone marrow transplantation and therefore be cured of their cancer of the bone marrow.

If successful, unrelated bone marrow transplantation will have a major impact. Until now, the vast majority of patients who could be cured by bone marrow transplantation lack a donor. Bone marrow transplantation would then become a possibility available for all patients with haematological diseases which cannot be cured by means other than transplantation of healthy normal bone marrow. It is estimated that this would quadruple the number of leukaemic patients being cured within the next decade.

6. A concerted action on the pathogenesis, diagnosis and therapy of tumour progression in human melanomas and precursor lesions was approved in 1989 and will start in early 1990.

The objectives are:

(i) to identify the organization and function of the genes coding for progression antigens and their products, and to prepare (monoclonal) antibodies recognizing these progression antigens;

(ii) to identify antigens that predict the susceptibility and effect of immunotherapy in melanoma patients and to study the mechanisms of escape from immune response as a manifestation of tumour progression in melanoma patients;

(iii) to prepare vaccines, useful for immunotherapy;

(iv) to perform dose-response studies on the induction of cutaneous melanoma in the opossum *(Monodelphis domestica)* by UV radiation.

7. A concerted action on the molecular and cellular strategies for immunotherapy of cancer was approved in 1989 and will start in early 1990. The purpose of the project is to elucidate the complex immunologic interrelationship between the host and the tumour, and to manipulate this relationship for the purpose of diagnosis, prevention and treatment of cancer.

8. A concerted action on the molecular genetics of human thyroid cancer was approved in 1989 and will start in early 1990.

The objectives are:

(i) to increase our understanding of the causes of cancer through a cooperative project on an uncommon group of tumours with well-defined inherited and environmental causative factors;

(ii) to identify the somatic and hereditary genetic abnormalities which occur at each stage in the development of sporadic (follicular cell) and familial (C cell) thyroid cancer;

(iii) to use results on thyroid as a simple model for understanding the basic mechanisms of tumourigenesis in human epithelia in general, and hence to provide insight into cancers of more complex epithelia such as breast.

9. A concerted action on genetics in cancer families with primary regard to familial adenomatous polyposis (FAP) was approved in 1989 and will start in early 1990.

The aim of this concerted action is to optimize the possibilities of prevention and management of the disease (or diseases) in the EC. This requires efficient identification and registration of FAP-cases.

For those families who choose to make use of efficient diagnostic methods under further development in this programme, such cases could be prevented if this were in accordance with the wishes and norms of the families involved. A successful implementation of such measures for polyposis could eventually serve as a model for other hereditary cancers.

10. A concerted action on the relation between DNA repair and cancer was approved in 1989 and will start in early 1990.

It aims at a better understanding of mechanisms of DNA repair and their relationship to cancer, in particular (i) mechanisms of action of carcinogens, (ii) variation in response to carcinogens in the population, (iii) basis of cancer-prone DNA repair disorders, (iv) interaction of carcinogens with DNA and short-term tests, (v) mechanisms of chemotherapeutic drugs.

11. A concerted action on molecular cytogenetics of solid tumours was approved in 1989 and will start in early 1990. It aims at: development of totally new diagnostic protocols and reagents to type reliably and easily the major forms of solid tumours. The diagnostic protocols will be based upon molecular cytogenetics.

12. A concerted action on optimization of hyperthermia technology and the assessment of its clinical efficacy was approved in 1989 and it will start in early 1990.

The objectives are:

(i) to improve hyperthermia technologies and determine guidelines for improving the quality of treatment;

(ii) to assess the efficacy of hyperthermia in combination with radiotherapy in cancer treatment.

13. The Commission finances a concerted action on development of medical laser applications. The aims are to improve and to standardize the knowledge and practice of the use of lasers in medicine and surgery. It concentrates on safety and tumour therapy.

Action 68: Co-financing of a European network of data banks for hybridomas (cells producing monoclonal antibodies)

The Community has co-financed, from November 1985 to date, the development of the European centre of the hybridoma and immunoclone data bank of Codata (the International Council of Scientific Unions' Committee on Data for Science and Technology). Codata relies on three centres, located in Europe (Centre for R&D in Immunoclones in the Faculty of Medicine in Nice), the United States (American Type Culture Collection, Rockville, Md) and Japan (Tokyo). The data collected by each centre are made available to all three.

The present European centre is extending its dissemination/collection/publication activities through other forms of European collaboration, in particular electronic networks, starting with an experiment using France's Minitel network. The database is also now mounted on DIMDI, Cologne, the German Institute for Medical Documentation and Information. For further details, contact Dr Louis Réchaussat, Cerdic, Nice (Tel. 33/93.20.01.80).

Action 69: Co-financing by the European Community of research into genetic engineering and protein engineering, techniques potentially useful for the development of anti-cancer drugs

A number of projects under the biotechnology action programme (1985-89) are aimed at achieving a better understanding of the relationship between structure and function of cellular proteins. This fundamental approach will eventually allow the study of proteins specific for tumour cells (such as mutated receptors for growth hormones) and their function in the oncogenic process. In one particular project, the elongation factor Tu (EF-Tu) was studied, a protein closely related to oncogene products such as p21. The work done by the three laboratories involved has given much more insight into the structure/function relationship of EF-Tu. The biotechnology action programme will be followed by the Brigde programme (1990-93), in which these areas of research will continue to be covered.

Action 70: Co-financing by the European Community of research on the targeting of cancer-killing drugs

The project on cancer treatment by drug targeting with neocarzinostatin, which was started in 1988, has now developed into a concerted action entitled 'Drug targeting: immunoconjugates for cancer therapy'. It is the intention to develop monoclonal antibody-neocarzinostatin conjugates and to test them for their tumour specificity both *in vitro* and *in vivo*.

A second concerted action on drug targeting was also started in 1989: 'Targeting systems in cancer chemotherapy: Drug carrier systems'.

During the period of funding, it is expected that candidate carrier systems containing mitomycin C or biological response modifiers for each of three target areas (liver, lymph nodes and bone marrow) will have been evaluated in animal models. Limited clinical studies with promising systems will either have been planned or even conducted before the end of 1992.

Action 71: Co-financing by the European Community of research on the pharmacology of anti-tumour substances

The biotechnology action programme (1985-89) has included a pharmacotoxicology research project in the area of cancer. Many of the results are already published (a list of publications is available from DG XII/F/2); furthermore, some of the newly developed systems are already used for pharmacotoxicological studies by industry.

Action 72: Harmonization of testing standards for anti-cancer drugs

The EEC Committee for Proprietary Medicinal Products (CPMP) has, in accordance with the concerted procedure for the authorization before marketing of a medicinal product foreseen in Directive 87/22/EEC, given a favourable opinion for interleukin-2, indicated in treatment of renal cancer. The CPMP has also pursued its work in the field of harmonization by elaborating explanatory notes for applicants for marketing authorization. These explanatory notes deal in particular with good clinical practice for trials with medicinal products, with clinical trials for anti-cancer drugs, and with radiolabelled monoclonal antibodies. The drafts of these explanatory notes were circulated for consultation and will be finalized in 1990.

Proposed action 73: Co-financing by the European Community of research into the human genome

This project may be carried out under the human genome analysis programme proposal. Final discussions of this proposal will take place in 1990 in the European Parliament and in the Council of Ministers.

Proposed action 74: Co-financing by the European Community of research on nuclear acid probes

This project may be carried out under the human genome analysis programme proposal. Final discussions of this proposal will take place in 1990 in the European Parliament and in the Council of Ministers.

Action 75: Co-financing by the European Community of research on cancer in developing countries

In tropical areas, there is a relatively high incidence of cancers for which viral infections are suspected of playing a role in their aetiology.

Liver cancer is frequent in tropical areas, probably due to the high prevalence of hepatitis. The Commission currently finances four research projects on liver cancer. The aim of two of these projects is to study the role at the molecular level of the hepatitis B virus on hepatic oncogenesis. The goals of the third project are: (a) to detect and characterize hepatitis B virus variants and to analyse their role in primary liver cancer in Senegal; (b) to identify and analyse chromosomal deletions in liver cancer, as well as genetic predisposition to this type of cancer.

The basic objective of the fourth project is to develop the analysis of the control mechanisms of the alpha-foetoprotein gene expression, so as to understand how and why this gene is only expressed in hepatoma cells. The applied objective of this study is to create the basis of a new approach to hepatoma therapy.

Other studies indicate a high percentage of spumaretrovirus (HSRV) infections among nasopharyngeal carcinoma patients from East Africa. The Commission finances a study which plans to develop a reliable, rapid HSRV-specific test system (Elisa), in order to screen for the presence of HSRV in African patients suffering from degenerative or lymphoproliferative diseases such as nasopharyngeal carcinoma. The results of this study are expected to make it possible to correlate and study the prevalence of an HSRV infection in certain human diseases.

The Commission is also financing a project whose aim is to identify putative tumour viruses in AIDS-associated malignancies such as Kaposi's sarcoma and non-Hodgkin lymphoma, and to analyse an association of further specific tumours with human immunodeficiency virus (HIV) infection.

Conclusion

Over the past three years, the European Community has demonstrated its ability to make its own major contribution to the fight against cancer, by no longer restricting itself to its conventional activities — measures to combat carcinogenic chemicals (ECSC and EEC Treaties) or ionizing radiation (Euratom Treaty) — but by extending its sphere of action to new areas such as discouraging the use of tobacco, improving nutrition, cancer screening, training of medical personnel, health information and education, and medical research. On the whole, the results have been most satisfactory.

(a) *Legislation:* Several pieces of Community legislation were announced, concerning the discouragement of tobacco use, improvement of nutrition, and measures to combat carcinogenic chemicals and ionizing radiation. Out of 13 proposals, only one (on the prohibition of tax-free tobac-

co sales) was not drawn up on schedule. Seven out of the other twelve have already been adopted by the Council (labelling of tobacco products, ban on smoking in public places, protection against ionizing radiation, protection against carcinogenic chemicals). The Council has adopted common positions on three others (prohibition of cigarettes with a high tar content, nutritional labelling, protection of workers). The other two are still being discussed by the Council (tax burden on tobacco, limitation of advertising of tobacco products in the press and by means of bills and posters).

(b) *Actions financed by the Community budget:* An average of around ECU 9 million was available from 1987 to 1989 to help finance actions in the fields of research, prevention, training, information and health education. Although on the low side, this budget still enabled progress to be made in each of the four sections of the programme. However, as far as information is concerned, the European Year would not have been possible without the much larger amounts invested by the non-governmental cancer organizations and the active cooperation of major television stations in most Member States of the European Community.

This European-scale action will be continued and extended under the second plan of action 1990-94, which the Council will adopt on 17 May 1990. A complete assessment of the programme, particularly its scientific components, will be made public early in 1992.

30. 5. 90 Official Journal of the European Communities No L 137/31

II

(Acts whose publication is not obligatory)

COUNCIL

DECISION OF THE COUNCIL AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES MEETING WITHIN THE COUNCIL,

on 17 May 1990

adopting a 1990 to 1994 action plan in the context of the 'Europe against Cancer' programme

(90/238/Euratom, ECSC, EEC)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL,

Having regard to the Treaties establishing the European Communities,

Having regard to the draft resolution submitted by the Commission,

Having regard to the opinion of the European Parliament (1),

Having regard to the opinion of the Economic and Social Committee (2),

Whereas, at its meetings in June 1985 in Milan and in December 1985 in Luxembourg, the European Council underlined the advantages of launching a European programme against cancer;

Whereas, at its meeting in December 1986 in London, the European Council decided that 1989 should be designated 'European Cancer Information Year' and specified that the aim would be to develop a sustained and concerted information campaign in all the Member States on the prevention, early screening and treatment of cancer;

Whereas the Council and the representatives of the Governments of the Member States, meeting within the Council, adopted on 7 July 1986 a resolution on a programme of action of the European Communities against cancer (3) which is concerned principally with cancer prevention;

Whereas the Council and the representatives of the Governments of the Member States, meeting within the Council, adopted on 21 June 1988 Decision 88/351/EEC on a 1988 to 1989 action plan for an information and public awareness campaign in the context of the 'Europe against Cancer' programme (4);

Whereas various Community measures to prevent cancers arising from exposure to ionizing radiation or to chemical carcinogens are already being implemented under the Treaties establishing the European Economic Community and the European Atomic Energy Community;

Whereas measures to reduce the risk of cancer from exposure to carcinogens are included in a number of existing Community programmes on the environment, worker protection, consumer protection, nutrition, agriculture and the internal market;

Whereas the right to health is a natural right and every European citizen has the right to the most appropriate treatment, regardless of social position;

Whereas the purpose of this action plan is to increase knowledge of the causes of cancer and the possible means of preventing and treating it;

Whereas occupational cancers account for 4 % of all cancers and cause 30 000 deaths per year;

(1) OJ No C 96, 17. 4. 1990.
(2) OJ No C 329, 30. 12. 1989, p. 60.
(3) OJ No C 184, 23. 7. 1986, p. 19.
(4) OJ No L 160, 28. 6. 1988, p. 52.

Whereas, by ensuring wider dissemination of knowledge of the causes, prevention, screening and treatment of cancer, as well as an improvement in the comparability of information about those matters, in particular concerning the nature and degree of risk of cancer arising from exposure to given substances or processes, the programme will contribute to the achievement of Community objectives while contributing to the overall reduction of risks of cancer;

Whereas it is advisable to promote the dissemination and the implementation of recommendations on the oncology content of training programmes which were approved in 1988 by the three advisory committees on the training of members of the health professions;

Whereas recognition must be given to the crucial role of members of the health professions and whereas theoretical and practical training for all professions and individuals involved in the prevention of cancer and the treatment of cancer sufferers must be encouraged in accordance with the conclusions of the European Organization for Research on Treatment of Cancer;

Whereas it is the view of the World Health Organization that palliative care can provide extremely valuable support both for patients for whom all treatment has failed and for their families; whereas such care should therefore be given recognition and assistance;

Whereas it is advisable to support training actions in respect of cancer for members of the health professions of one Member State in centres of excellence in another Member State;

Whereas encouragement should be given to information campaigns, in schools as well as elsewhere, on cancer and its prevention;

Whereas duplication of effort should be avoided by the promotion of exchanges of experience and by the joint development of basic information modules for the public, for health education and for training members of the health professions;

Whereas efforts should be made to achieve advances in treatment through controlled clinical tests;

Whereas public health policy as such, except in cases where the Treaties provide otherwise, is the responsibility of Member States but whereas promoting cooperation and the coordination of national activities as well as the stimulation of Community activities in this field makes a valuable contribution to the fight against cancer;

Whereas it is advisable to continue and strengthen, from 1990 to 1994, the action undertaken between 1987 and 1989 in the fields of prevention, information and health education, and training of members of the health professions,

HAVE DECIDED AS FOLLOWS:

Article 1

1. The Commission shall implement the 1990 to 1994 action plan set out in the Annex in close coordination with the competent authorities of the Member States.

2. The Commission shall be assisted by an advisory committee consisting of representatives of the Member States and chaired by the Commission representative.

The duties of the committee shall be:

— to examine projects and measures involving cofinancing from public funds,

— to coordinate at national level projects partly financed by non-governmental organizations.

3. The Commission representative shall submit to the committee a draft of the measures to be taken. The committee shall deliver its opinion on the draft, within a time limit which the chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its position recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the committee. It shall inform the committee of the manner in which its opinion has been taken into account.

4. Furthermore, the Commission will involve the high-level Committee of Cancer Experts and the private bodies active in the fight against cancer closely in implementing the action plan. It will cooperate with both the World Health Organization and the International Agency for Research on Cancer.

5. The Commission will regularly publish technical information on the progress of the action plan and on potential Community financing in the various fields of action.

Article 2

1. The Community contribution estimated necessary for implementing the 1990 to 1994 action plan is ECU 50 million.

2. The Council and the Ministers for Health, meeting within the Council, will review this total amount in the light of the evaluation report referred to in Article 3 (2), with the possibility of increasing it to a total amount of ECU 55 million, if necessary, from 1 January 1993.

Article 3

1. The Commission will continously assess the action undertaken.

2. The Council and the Ministers of Health will carry out a scientific evaluation of the effectiveness of the action undertaken. To this end the Commission will submit a report on the subject during the second half of 1992.

3. The Commission will keep the European Parliament, the Council and the Economic and Social Committee regularly informed of progress.

4. The Commission is also requested to encourage every kind of exchange with third countries in connection with the activities set out in the Annex.

Done at Brussels, 17 May 1990.

For the Council

The President

R. O'HANLON

ANNEX

MEASURES TO BE IMPLEMENTED IN THE PERIOD 1990 TO 1994

I. CANCER PREVENTION (including screening)

In addition to the legislative action under way:

A. **Prevention of tobacco consumption**

— Stimulation of projects of European interest concerning the prevention of nicotine addiction, especially amongst such target groups as young people, women, teachers and members of the health professions.

— Stimulation of pilot projects to teach methods of breaking nicotine addiction to members of the health professions and to teachers.

— Stimulation of innovative information campaigns to prevent the use of tobacco among the general public and in the workplace.

— Financing of a study on the possibilities for putting tobacco-growing areas to other uses.

B. **Diet and cancer** (including alcohol)

— Stimulation of studies into eating habits and cancer in close conjunction with the Community medical research programme (meta-analyses, case studies, prospective studies, intervention studies on 'anti-promoting' agents).

— Drafting and publication of guidelines on nutrition aimed at improving cancer prevention.

C. **Campaign against carcinogenic agents**

— Continuation of all Community action concerning protection against ionizing radiation.

— Support for comparative studies of European interest aimed at improving protection against ultra-violet radiation.

— Support for European studies on the possible carcinogenic risks of certain chemicals.

— Continuation of the classification and labelling, at European level, of carcinogens and continuation of the information campaign by means of specialized annual publications.

D. **Systematic screening and early diagnosis**

— Continuation of comparative studies to improve the organization of cancer screening programmes.

— Extension and monitoring of the European network of breast cancer screening pilot programmes to help the Member States determine a general screening policy.

— Evaluation of existing cervical cancer screening programmes and setting up of a European network of regional or local pilot programmes.

— Continuation of evaluation studies on screening programmes for colorectal cancer and possible setting up of a European network.

— Promotion of studies of European interest on the effectiveness and feasibility of early screening for other cancers.

— Promotion of, and support for, screening programmes where the results of exploratory studies have proved positive, in close coordination with the AIM and RACE programmes.

E. **Cancer registers and similar measures**

— Support for exchanges of experience in establishing cancer registers in the Community and for setting up a European network in cooperation with the International Agency for Research on Cancer and in close coordination with the AIM and RACE programmes.

F. **Other aspects**

1. Evaluation of the operation of the various bone marrow banks.
2. Feasibility study on cooperation between such banks and, if appropriate, support for existing European cooperation.
3. Exchanging experience regarding the quality control of care given.
4. Establishing an up-to-date list of treatments recognized as worthwhile by the international scientific community.

II. HEALTH INFORMATION AND EDUCATION

A. **Information of the public**

— Possible updating of the European Code against Cancer.

— Repeat of European compaigns of cancer information, if possible during the second week of October. Encouraging, within this context, private and public television stations to run spots free of charge on the subject of the fight against cancer.

— Production of European information modules on the prevention, screening and treatment of cancers, adaptable to national requirements

— Publicizing of the European Code among the general public by the partners in the action plan.

— Support for innovative information compaigns on cancer prevention among targeted groups.

— Informing workers, and migrant workers in particular, under existing Community Directives, of the fight against job-related cancers.

B. **Health education and cancer**

— Support for efforts to inform and increase the awareness of schoolteachers of the European Code against Cancer.

— Dissemination of European teaching material for health education.

— Promotion of pilot projects to promote awareness of the European Code among young people.

— Encouragement at school of a change in dietary habits and, in particular, encouragement of the consumption of fruit and vegetables during break and at mealtimes.

III. TRAINING OF THE HEALTH PROFESSIONS

— Support for the organization of national or regional meetings to promote the 1989 European recommendations on the cancerology content of basic training programmes for members of the health professions.

— Support for setting up three European pilot networks of medical schools, nursing colleges and dental schools implementing the recommendations on training in cancer formulated in 1988 by the three European advisory committees on the training of the health professions.

— Promotion of cancerology training projects.

— Support for the mobility of the health professions between Member States in order to improve their specialized training in cancerology.

— Collection and exchange of teaching material of European interest for the training of members of the health professions.

— Exchange of experience and support for the organization of European seminars on the continuing education of members of the health professions.

— Exchange of experience between Member States in the area of pain-relieving treatments, palliative and continuing care and the role of the health professions.

IV. RESEARCH AND CANCER

— Contribution towards the preparation of a Fifth European Medical and Health Research Coordination Programme and a Sixth ECSC Medical Research Programme.

26. 7. 89 Official Journal of the European Communities No C 189/1

I

(Information)

COUNCIL

RESOLUTION OF THE COUNCIL AND THE MINISTERS FOR HEALTH OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL

of 18 July 1989

on banning smoking in places open to the public

(89/C 189/01)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE MINISTERS FOR HEALTH OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL,

Having regard to the Treaty establishing the European Economic Community,

Having regard to the draft recommendation from the Commission,

Having regard to the opinion of the Economic and Social Committee (1),

Whereas the European Council held in Milan on 28 and 29 June 1985 stressed the importance of launching a European action programme against cancer;

Whereas the Council and the Representatives of the Governments of the Member States, meeting within the Council, in their resolution of 7 July 1986 on a programme of action of the European Communities against cancer, set the objective of contributing to an improvement in the health and quality of life of citizens within the Community by reducing the number of cases of cancer and under this heading gave priority to measures against smoking;

Whereas, in addition to the potential encouragement to smoke and the unpleasant physical effects and the nuisance which smoke causes for non-smokers, there is an increased risk of respiratory illnesses for non-smokers involuntarily exposed to the smoke of tobacco products; whereas consequently, it is appropriate to protect the right to health of non-smokers against involuntary smoking;

Whereas, to ensure respect for the right to health of non-smokers, it is essential to ban smoking in public places in certain establishments and in forms of transport;

Whereas, however, in view of the extent of tobacco addiction affecting part of the population, it is appropriate to make provision to permit smoking in part of these establishments and forms of transport;

Whereas it is necessary to extend to the citizens of all Member States the protection they are afforded in some Member States against the damage caused by involuntary smoking;

Whereas, finally, the initiative set out in this resolution will have an even more beneficial effect on public health, particularly for the workers directly concerned, when coupled with health education programmes during the years of compulsory education and with information and public awareness campaigns,

INVITES THE MEMBER STATES:

to take the following measures by introducing legislation or by other methods in accordance with national practices and conditions:

1. Ban smoking in enclosed premises open to the public which form part of the public or private establishments listed in the Annex. Member States may add to the said list;
2. Extend the ban on smoking to all forms of public transport;
3. Provide, where necessary, for clearly defined areas to be reserved for smokers in the above establishments and, if possible, in public transport, particularly for long journeys;
4. Ensure that in the event of a conflict, in areas other than those reserved for smokers, the right to health of non-smokers prevails over the right of smokers to smoke;

to inform the Commission every two years of action taken in response to this resolution.

(1) Opinion delivered on 26 April 1989 (not yet published in the Official Journal).

Public and private establishments referred to in point 1 of the resolution

(non-exhaustive list)

1. Establishments where services are provided to the public, whether for a charge or free, including the sale of goods;
2. Hospitals, establishments where health care is given and all other medical establishments;
3. Establishments where elderly persons are received;
4. Schools and other premises where children or young people are received or housed;
5. Establishments where higher education and vocational training are given;
6. Enclosed establishments used for entertainment (cinemas, theatres, etc.); radio and television studios open to the public;
7. Enclosed establishments where exhibitions are held;
8. Establishments and enclosed places where sports are practised;
9. Enclosed premises of underground and railway stations, ports and airports.

8. 12. 89 Official Journal of the European Communities No L 359/1

II

(Acts whose publication is not obligatory)

COUNCIL

COUNCIL DIRECTIVE

of 13 November 1989

on the approximation of the laws, regulations and administrative provisions of the Member States concerning the labelling of tobacco products

(89/622/EEC)

THE COUNCIL OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Economic Community, and in particular Article 100a thereof,

Having regard to the proposal from the Commission [1],

In cooperation with the European Parliament [2],

Having regard to the opinion of the Economic and Social Committee [3],

Whereas there are differences between the laws, regulations and administrative provisions of the Member States on the labelling of tobacco products; whereas these differences are likely to constitute barriers to trade and to impede the establishment and operation of the internal market;

Whereas these possible barriers should be eliminated and whereas, to that end, the marketing and free movement of tobacco products should be made subject to common rules concerning labelling;

Whereas such common rules must take due account of public health protection;

Whereas the European Council meeting held in Milan on 28 and 29 June 1985 stressed the importance of launching a European action programme against cancer;

Whereas the Council and the representatives of the Governments of the Member States, meeting within the Council, in their resolution of 7 July 1986 on a programme of action of the European Communities against cancer [4] set for this programme the objective of contributing to an improvement of the health and quality of life of citizens within the Community by reducing the number of cancers and whereas they have for this purpose identified a fight against the use of tobacco products as their prime objective;

Whereas the printing of health warnings on the unit packaging of all tobacco products concerning the risks of use of such products is a vital factor in the protection of public health;

Whereas, for the purpose of improving public health protection, the indication of the tar and nicotine yield on cigarette packets is essential for the health information and education of the general public;

Whereas this Directive contains provisions which will be reviewed on the basis of experience gained and the development of medical knowledge in this area, the objective being to achieve greater protection of individuals;

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(1) OJ No C 48, 20. 2. 1988, p. 8, and OJ No C 62, 11. 3. 1989, p. 12.
(2) OJ No C 12, 16. 1. 1989, p. 106 and OJ No C 291, 20. 11. 1989.
(3) OJ No C 237, 12. 9. 1980, p. 43.

(4) OJ No C 184, 23. 7. 1986, p. 19.

Whereas, finally, the initiatives set in this Directive will have an even more beneficial effect on public health if they are coupled with health education programmes during the years of compulsory education and with information and public awareness campaigns,

HAS ADOPTED THIS DIRECTIVE:

Article 1

The objective of this Directive is the harmonization of the laws, regulations and administrative provisions of the Member States concerning the warnings regarding health to appear on the unit packet of tobacco products and the indication of the tar and nicotine yield to appear on cigarette packets, taking as a base a high level of health protection by reducing the harm done to health by tobacco addiction.

Article 2

For the purposes of this Directive:

(1) 'tobacco products' means products for the purpose of smoking, sniffing, sucking or chewing, inasmuch as they are, even partly, made of tobacco;

(2) 'tar' means the raw anhydrous nicotine-free condensate of smoke;

(3) 'nicotine' means nicotinic alkaloids.

Article 3

1. The tar and nicotine yields that must be indicated on cigarette packets shall be measured on the basis of the ISO 4387 and ISO 3400 methods.

2. The accuracy of the indications on packets shall be verified in accordance with ISO standard 8243.

3. The indications concerned shall be printed on the side of cigarette packets, in the official language or languages of the country of final marketing in clearly legible print on a contrasting background so that at least 4 % of the corresponding surface is covered. This percentage shall be raised to 6 % for countries with two official languages and to 8 % for countries with three official languages.

4. In January each year the Member States shall forward to the Commission lists of the tar and nicotine contents of the cigarettes sold on their markets. The Commission shall publish this information in the *Official Journal of the European Communities*.

Article 4

1. All unit packets of tobacco products shall carry, on the most visible surface, the following general warning in the official language or languages of the country of final marketing: 'Tobacco seriously damages health'.

2. With regard to cigarette packets, the other large surface of the packet shall carry, in the official language or languages of the country of final marketing, specific warnings alternating in accordance with the following rule:

— each Member State shall draw up a list of warnings taken exclusively from those listed in the Annex,

— the specific warnings selected shall be printed on the unit packets so as to guarantee the appearance of each warning on an equal quantity of unit packets, with a tolerance of around 5 %.

3. Member States may stipulate that the warnings referred to in paragraphs 1 and 2 be combined with the indication of the authority that is their author.

4. On cigarette packets the warnings provided for in paragraphs 1 and 2 shall cover at least 4 % of each large surface of the unit packet, excluding the indication of the authority provided for in paragraph 3. This percentage shall be increased to 6 % for countries with two official languages and to 8 % for countries with three official languages.

The required warnings on the two largest surfaces of each cigarette packet:

(a) shall be clear and legible;

(b) shall be printed in bold letters;

(c) shall be printed on a contrasting background;

(d) shall not be printed in a place where they may be damaged when the package is opened;

(e) shall not be printed on the transparent wrapper or any other external wrapping.

5. In the case of tobacco products other than cigarettes, the general warning laid down in paragraph 1 shall be printed in, or irremoveably affixed to, a conspicuous place on a contrasting background and in such a way as to be easilyvisible, clearly legible and indelible. It shall not in any way be hidden, obscured or interrupted by other written or pictorial matter.

Article 5

Adaptation to technical progress of the provisions of this Directive shall be limited to the measurement and verification methods referred to in Article 3 (1) and (2).

Article 6

With a view to the adaptation to technical progress referred to in Article 5, the Commission shall be assisted by an advisory Committee, composed of representatives of the Member States and chaired by the Commission representative.

Article 7

The Commission representative shall submit to the Committee a draft of the measures to be taken. The Committee shall deliver its opinion on the draft, within a time limit which the chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State may ask to have its position recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the Committee. It shall inform the Committee of the manner in which its opinion has been taken into account.

Article 8

1. Member States may not, for reasons of labelling, prohibit or restrict the sale of products which comply with this Directive.

2. The provisions of this Directive do not affect the right of the Member States to lay down, in compliance with the Treaty, requirements concerning the import, sale and consumption of tobacco products which they deem necessary in order to protect public health, provided such requirements do not imply any changes to labelling as laid down in this Directive.

Article 9

1. Member States shall adopt the laws, regulations and administrative provisions necessary to comply with this Directive before 1 July 1990.

They shall forthwith inform the Commission thereof and communicate to it the provisions of national law which they adopt in the field governed by this Directive.

The Commission shall publish in the *Official Journal of the European Communities* the national warning lists drawn up in accordance with the first indent of Article 4 (2).

2. Member States shall bring into force the above laws, regulations and adminsitrative provisions before 31 December 1991.

However,

— until 31 December 1992 cigarettes, and

— until 31 December 1993 other tobacco products

existing on 31 December 1991 which do not comply with this Directive may still be put on sale.

3. Member States which, after 31 December 1991, amend their warning lists drawn up in accordance with the first indent of Article 4 (2) shall notify the Commission of that amendment eighteen months before its application. The Commission shall publish it in the *Official Journal of the European Communities*.

Article 10

This Directive is addressed to the Member States.

Done at Brussels, 13 November 1989.

For the Council

The President

C. EVIN

No C 359/4 Official Journal of the European Communities 8. 12. 89

ANNEX

List of health warnings referred to in the first indent of Article 4 (2)

A. *Warnings which must be included on the national lists*

1. Smoking causes cancer.
2. Smoking causes heart disease.

B. *Warnings from amongst which Member States may choose*

1. Smoking causes fatal diseases.
2. Smoking kills.
3. Smoking can kill.
4. Smoking when pregnant harms your baby.
5. Protect children: don't make them breathe your smoke.
6. Smoking damages the health of those around you.
7. Stopping smoking reduces the risk of serious disease.
8. Smoking causes cancer, chronic bronchitis and other chest diseases.
9. More than (. . . .) people die each year in . . . . . (name of the country) from lung cancer.
10. Every year, . . . people are killed in road accidents in (name of the country) — . . . times more die from their addiction to smoking.
11. Every year, addiction to smoking claims more victims than road accidents.
12. Smokers die younger.
13. Don't smoke if you want to stay healthy.
14. Save money: stop smoking.

No L 137/36 Official Journal of the European Communities 30. 5. 90

COUNCIL DIRECTIVE

of 17 May 1990

on the approximation of the laws, regulations and administrative provisions of the Member States concerning the maximum tar yield of cigarettes

(90/239/EEC)

THE COUNCIL OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Economic Community, and in particular Article 100a thereof,

Having regard to the proposal from the Commission (1),

In cooperation with the European Parliament (2),

Having regard to the opinion of the Economic and Social Committee (3),

Whereas there are differences between the laws, regulations and administrative provisions of the Member States on the limitation of the maximum tar yield of cigarettes ; whereas such differences are liable to constitute barriers to trade and to impede the establishment and operation of the internal market ;

Whereas those obstacles should accordingly be eliminated and whereas to that end the marketing and free movement of cigarettes must be made subject to common rules concerning maximum tar yields ;

Whereas such common rules must take due account of public health protection ;

Whereas the higher the tar content of smoked tobacco, the greater the risk of lung cancer and whereas the European Council held in Milan on 28 and 29 June 1985 stressed the importance of launching a European action programme against cancer ;

Whereas, in their resolution of 7 July 1986 (4), the Council and the representatives of the Governments of the Member States meeting within the Council considered that measures to combat smoking were a priority ;

Whereas in applying this Directive provision should be made for establishing deadlines which allow, on the one hand, completion to a minimum degree of efficiency of the process of conversion to other varieties which has already begun, and, on the other, consumers and manufacturers to adapt to products with a lower tar yield ;

Whereas this Directive contains provisions, which will be reviewed on the basis of experience gained, the development of techniques and medical knowledge in this area, the objective being to achieve greater protection of individuals ;

Whereas smokers must always be aware that all cigarettes are harmful to health ; whereas it is much more desirable for them to stop smoking rather than to switch to low-tar cigarettes ;

Whereas the initiative set out in this Directive will have an even more beneficial effect on public health if it is coupled with health education programmes during the years of compulsory education and with information and public awareness campaigns ;

Whereas the introduction of maximum tar yields would result in particular socioeconomic difficulties for the Hellenic Republic ; whereas that Member State should be granted, exceptionally, a derogation with regard to the implementation dates laid down for the other Member States,

HAS ADOPTED THIS DIRECTIVE :

Article 1

The objective of this Directive is the harmonization of the laws, regulations and administrative provisions of the Member States concerning the maximum tar yield of cigarettes, taking as a basis a high level of public health protection by the reduction of the health damage caused by tar.

Article 2

1. For the purposes of this Directive, 'tar' means the raw anhydrous nicotine-free condensate of smoke.

2. The tar yield of cigarettes marketed in the Member States shall not be greater than :

— 15 mg per cigarette as from 31 December 1992, and

— 12 mg per cigarette as from 31 December 1997.

3. For the Hellenic Republic, as a temporary derogation, the limit values and dates of implementation shall be as follows :

— 20 mg until 31 December 1992,

— 18 mg until 31 December 1998,

— 15 mg until 31 December 2000,

— 12 mg until 31 December 2006.

However, this derogation may not be used to justify controls at the Community's internal frontiers.

(1) OJ No C 48, 20. 2. 1988, p. 10.
(2) OJ No C 158, 26. 6. 1989, p. 229 and OJ No C 96, 17. 4. 1990.
(3) OJ No C 237, 12. 9. 1988, p. 49.
(4) OJ No C 184, 23. 7. 1986, p. 19.

Article 3

The tar yield of cigarettes shall be measured according to ISO standards 4387 and 3400. Verification must be carried out according to ISO standard 8243.

Article 4

Adaptation of this Directive to technical progress shall be limited to the method of measuring tar yields and the method of verification referred to in Article 3.

Article 5

With a view to the adaptation to technical progress referred to in Article 4, the Commission shall be assisted by a committee of an advisory nature composed of representatives of the Member States and chaired by the Commission representative.

Article 6

The representative of the Commission shall submit to the committee a draft of the measures to be taken. The committee shall deliver its opinion on the draft within a time limit which the chairman may lay down according to the urgency of the matter, if necessary by taking a vote.

The opinion shall be recorded in the minutes; in addition, each Member State may ask to have its position recorded in the minutes.

The Commission shall take the utmost account of the opinion delivered by the committee. It shall inform the committee of the manner in which its opinion has been taken into account.

Article 7

1. The Member States may not, for considerations of limitation of the tar yield of cigarettes, prohibit or restrict the sale of products which comply with this Directive.

2. This Directive shall not otherwise affect the right of the Member States to adopt, in accordance with the Treaty, rules concerning the import, sale and consumption of tobacco products which they deem necessary in order to protect public health, provided such rules do not imply any changes to limits on the tar yield of cigarettes as laid down in this Directive.

Article 8

1. Member States shall bring into force the laws, regulations and administrative provisions necessary to comply with this Directive within 18 months of its notification (1). They shall forthwith inform the Commission thereof.

2. Products existing at the dates referred to in Article 2 (2) which do not comply with this Directive may continue to be marketed for two years thereafter.

3. Member States shall communicate to the Commission provisions of national law which they adopt in the field governed by this Directive.

Article 9

This Directive is addressed to the Member States.

Done at Brussels, 17 May 1990.

For the Council

The President

R. O'HANLON

(1) This Directive was notified to the Member Stattes on 18 May 1990.

11. 5. 90 Official Journal of the European Communities No C 116/7

II

(Preparatory Acts)

COMMISSION

Amended proposal for a Council Directive on the authorized advertising of tobacco products in the press and by means of bills and posters (1)

COM(90) 147 final — SYN 194

(Submitted by the Commission pursuant to Article 149 (3) of the EEC Treaty on 19 April 1990)

(90/C 116/05)

(1) OJ No C 124, 19. 5. 1989, p. 5 (COM(89) 163 final 12 — SYN 194).

ORIGINAL TEXT	AMENDED PROPOSAL
Proposal for a Council Directive on the advertising of tobacco products in the press and by means of bills and posters	**Amended proposal for a Council Directive on the authorized advertising of tobacco products in the press and by means of bills and posters**
THE COUNCIL OF THE EUROPEAN COMMUNITIES,	THE COUNCIL OF THE EUROPEAN COMMUNITIES,
Having regard to the Treaty establishing the European Economic Community, and in particular Article 100a thereof,	Unchanged
Having regard to the proposal from the Commission (1),	Unchanged
In cooperation with the European Parliament (2),	Unchanged
Having regard to the opinion of the Economic and Social Committee (3),	Unchanged
Whereas there are differences between the laws, regulations and administrative provisions of the Member States on tobacco advertising in the press and by means of bills and posters; whereas advertising by these means transcends the borders of the Member States and whereas such differences are likely to constitute barriers to trade, distort competition and thus impede the establishment and operation of the internal market;	Whereas there are differences between the laws, regulations and administrative provisions of the Member States on authorized tobacco advertising in the press and by means of bills and posters; whereas authorized advertising by these means transcends the barriers of the Member States and whereas such differences are likely to constitute barriers to trade, distort competition and thus impede the establishment and operation of the internal market;
Whereas obstacles should be eliminated and, to this end, the rules relating to tobacco advertising by the above means should be harmonized, leaving Member States the possibility of introducing, under certain conditions, the measures they consider necessary to guarantee the health protection of their citizens;	Whereas obstacles should be eliminated and, to this end, the rules relating to authorized tobacco advertising by the above means should be harmonized, leaving Member States the possibility of introducing, under certain conditions, the measures they consider necessary to guarantee the health protection of their citizens.

(1) OJ No C 124, 19. 5. 1989.
(2) Sitting of 14. 3. 1990.
(3) OJ No C 62, 12. 3. 1990.

ORIGINAL TEXT	AMENDED PROPOSAL
	Whereas one of the main objectives of the Member States of the European Commission is to bring about steady improvements in the living and working conditions of their citizens;
	Whereas Article 100a (3) of the EEC Treaty stipulates that the Commission, in its proposals concerning health, safety, environmental protection and consumer protection, should take as a base a high level of protection;
Whereas these rules must take due account of public health protection, in particular in relation to young people;	Whereas it is advisable to ensure that authorized advertising in the press and by means of bills and posters provides information on the main features of the products which meets the essential requirements concerning the health protection of consumers and the fairness of commercial transactions;
Whereas the European Council held on 28 and 29 June in Milan stressed the importance of launching a European action programme against cancer;	Unchanged
Whereas the Council and the representatives of the Governments of the Member States, meeting within the Council, in their resolution of 7 July 1986 on a programme of action of the European Communities against cancer (1) set for this programme the objective of contributing to an improvement in the health and quality of life of citizens within the Community by reducing the number of illnesses due to cancer and, accordingly, regarded measures to counter the use of tobacco as their prime objective;	Unchanged
Whereas the incorporation in tobacco advertising inserts in the press and by means of bills and posters of a warning of the health risks entailed in the use of these products is important for health protection;	Unchanged
Whereas it is necessary to prohibit all indirect forms of advertising which, whilst not directly mentioning tobacco products, seek to promote, tobacco products by using trade marks, emblems, symbols or other distinctive features associated with tobacco products;	Unchanged
	Whereas it has been shown that young people are ready-made victims of advertising and that dependency on tobacco begins at a young age;
Whereas special provisions should ensure the protection of young people against the advertising of tobacco products;	Unchanged
	Whereas these common rules relating only to authorized tobacco advertising in the press and by means of bills and posters shall not apply in the event of a complete ban;
	Whereas this Directive represents the first stage in a harmonization which should guarantee the free circulation of goods aimed at for 31 December 1992,

(1) OJ No C 184, 23. 7. 1986, p. 19.

ORIGINAL TEXT	AMENDED PROPOSAL
HAS ADOPTED THIS DIRECTIVE:	HAS ADOPTED THIS DIRECTIVE:
Article 1	*Article 1*
	This Directive concerns the harmonization of the laws, regulations and administrative provisions of the Member States on authorized tobacco advertising in the press and by means of bills and posters.
For the purposes of this Directive, 'tobacco products' means products intended to be smoked, sniffed, sucked or chewed, in as much as they are, even partly, made of tobacco.	Unchanged
Article 2	*Article 2*
1. Advertisements for cigarettes in the press and by means of bills and posters shall carry specific warnings alternating according to the following rules:	1. Advertisements for cigarettes in the press and by means of bills and posters shall carry specific warnings alternating according to the following rules:
— each Member State shall draw up a list of warnings based on those listed in the Annex,	— each Member State shall draw up a list of warnings based solely on those listed in the Annex,
— the specific warnings so adopted shall be printed against a contrasting background on inserts and in such a way as to guarantee an equal frequency of display for each warning, allowing for a 5 % margin.	— the specific warnings so adopted shall be printed horizontally against a contrasting background on inserts and in such a way as to guarantee an equal frequency of display for each warning, allowing for a 5 % margin.
2. Advertising in the press and by means of bills and posters of tobacco products other than cigarettes shall carry the general warning: 'Tobacco seriously damages your health'.	2. Advertising in the press and by means of bills and posters of tobacco products other than cigarettes shall carry the general warning 'Tobacco seriously damages your health', printed horizontally against a contrasting background.
	3. The warnings referred to in paragraphs 1 and 2 shall, when appearing in the press, be in the same language as that used in the publication and, in the case of bills and posters, shall be in the language or languages of the country in which such bills and posters are shown.
3. Member States may stipulate that the warnings referred to in paragraphs 1 and 2 shall bear the name of the issuing authority.	4. Member States may stipulate that the warnings referred to in paragraphs 1 and 2 shall bear the name of the issuing authority.
4. The text of the warnings mentioned in paragraphs 1 and 2 shall cover a minimum of 10 % of the total advertising insert, excluding the name of any authority as referred to in paragraph 3. The percentage shall be raised to at least 15 % where the warning is in two languages and to at least 20 % where it is in three or more languages.	5. The text of the warnings mentioned in paragraphs 1 and 2 shall cover a minimum of 10 % of the total advertising insert, excluding the name of any authority as referred to in paragraph 3. The percentage shall be raised to at least 15 % where the warning is in two languages and to at least 20 % where it is in three or more languages.
Article 3	*Article 3*
1. The content of advertisements in the press and on bills and posters shall be restricted solely to the presentation of the packaging of the tobacco products, possibly with the addition of information on the features of the product.	Unchanged

ORIGINAL TEXT	AMENDED PROPOSAL
2. Advertising in the press and by means of bills and posters which, whilst not directly mentioning the tobacco product, refers to a trade mark, emblem, symbol or other distinctive feature mainly used in connection with tobacco products shall be prohibited.	2. To prevent the provision in paragraph 1 of this Article from being circumvented, advertising in the press and by means of bills and posters which, whilst not directly mentioning the tobacco product, refers to a trade mark, emblem, symbol or other distinctive feature mainly used in connection with tobacco products shall be prohibited. 3. The preceding paragraph shall not apply when the identity of a tobacco trade mark with the trade mark of a product other than tobacco which is marketed by undertakings that are legally and financially distinct from one another is purely fortuitous.
Article 4	*Article 4*
Member States shall prohibit all advertising for tobacco products in publications mainly intended for people under 18.	Unchanged
Article 5	*Article 5*
1. The Member States may not cite tobacco advertising as the reason for prohibiting or restricting the sale of newspapers, magazines and publications of a similar kind or the display of bills and posters which comply with this Directive.	Unchanged
2. The provisions of this Directive shall not affect the right of Member States to introduce measures concerning tobacco advertising, in accordance with the Treaty, which they deem necessary to guarantee the health protection of their citizens provided that such measures do not imply modifications of the content or of the form of advertisements as provided by this Directive.	2. The Commission will report to the Council, before 31 December 1991, on the evolution of the situation in the Member States, notably following the implementation of this Directive, and at the same time will propose the necessary measures to guarantee the free circulation of goods aimed at for 31 December 1992.
Article 6	*Article 6*
1. Member States shall adopt the laws, regulations and administrative provisions necessary to comply with this Directive by 31 December 1991. They shall forthwith inform the Commission thereof. The provisions adopted pursuant to the first paragraph shall make express reference to this Directive. 2. Member States shall communicate to the Commission the text of the main provisions of national law which they adopt in the fields governed by this Directive.	Unchanged
Article 7	*Article 7*
This Directive is addressed to the Member States.	Unchanged

ANNEX

LIST OF HEALTH WARNINGS, AS REFERRED TO IN ARTICLE 2 (1)

(a) Warnings which must appear in the national lists:

1. Smoking causes cancer
2. Smoking causes heart disease

(b) Warnings from which the Member States may choose:

1. Smoking causes fatal diseases
2. Smoking kills
3. Pregnant women: smoking harms your baby
4. Protect children from tobacco smoke
5. Smoking damages the health of those around you
6. Stopping smoking reduces the risk of serious diseases
7. Smoking causes lung cancer, chronic bronchitis and other chest diseases
8. More than . . . people die each year in . . . (name of the country) from lung cancer
9. Every year . . . (name of nationals of a country) die in road accidents: . . . times more die from smoking
10. Smokers die before their time
11. Don't smoke if you want to stay healthy
12. Save money: stop smoking

5. 2. 91 Official Journal of the European Communities No C 29/5

Proposal for a Council Directive amending Directive 89/622/EEC on the approximation of the laws, regulations and administrative provisions of the Member States concerning the labelling of tobacco products

COM(90) 538 final — SYN 314

(Submitted by the Commission on 16 November 1990)

(91/C 29/06)

THE COUNCIL OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Economic Community, and in particular Article 100a thereof,

Having regard to the proposal from the Commission,

In cooperation with the European Parliament,

Having regard to the opinion of the Economic and Social Committee,

Whereas there are differences between the laws, regulations and administrative provisions of the Member States on the labelling of tobacco products; whereas these differences are likely to constitute barriers to trade and to impede the establishment and operation of the internal market;

Whereas these possible barriers should be eliminated; whereas, to that end, the marketing and free movement of tobacco products should be made subject to common rules concerning labelling;

Whereas such common rules must take due account of public health protection, and of the protection of young persons in particular, taking as a base a high level of protection, according to Article 100a (3) of the Treaty;

Whereas the Council and the representatives of the Governments of the Member States, meeting within the Council, in their resolution of 7 July 1986 on a programme of action of the European Communities against cancer [1], set for this programme the objective of contributing to an improvement of the health and quality of life of citizens within the Community by reducing the number of cancers; whereas they have for this purpose identified a fight against the use of tobacco products as their prime objective;

Whereas, for the purposes of providing objective information on the risks entailed in tobacco consumption, Council Directive 89/622/EEC [2] established a general warning to be carried on the unit packaging of all tobacco products, together with additional warnings exclusively for cigarettes;

Whereas the Commission, at the request of the Council, undertook to propose an amendment to Directive 89/622/EEC so as to establish additional warnings to be carried on the unit packaging of tobacco products other than cigarettes;

Whereas scientific experts are of the opinion that all tobacco products carry health risks;

Whereas, in relation to their effects on health and for the purposes of their labelling, a distinction needs to be made between smoking tobacco products and smokeless tobacco products;

Whereas rolling tobaccos carry the same health risks as cigarettes and it is therefore appropriate that the specific warnings selected for cigarettes should also apply to rolling tobaccos;

Whereas other smoking tobacco products carry similar health risks to those carried by cigarettes, but there are still reservations concerning their contribution to heart disease; whereas these products should therefore be required to carry the specific warnings selected for cigarettes and rolling tobacco, with the exception of the warning concerning heart disease;

Whereas it has been proved that smokeless tobacco products can provoke cancer and that, consequently, they must be subject to a specific warning on tobacco products;

Whereas scientific experts are of the opinion that the addiction caused by tobacco consumption constitutes a danger meriting a specific warning on every tobacco product;

Whereas, moreover, new smokeless tobacco products — moist snuff — designed for oral use, which have appeared recently on the market in certain Member States, exercise a particular attraction for young persons; whereas the Member States most exposed to this problem have already placed total bans on these new tobacco products or are about to do so;

[1] OJ No C 184, 23. 7. 1986, p. 19.
[2] OJ No L 359, 8. 12. 1989, p. 1.

Whereas there are differences between the laws, regulations and administrative provisions of the Member States in respect of oral moist snuff tobaccos; whereas these products therefore need to be made subject to common rules;

Whereas there is a real risk that oral moist snuff tobaccos could be used, particularly by young persons, as substitutes for smoking tobacco products, causing nicotine addiction, if restrictive measures are not taken in time;

Whereas, in accordance with the conclusions of the studies conducted by the International Agency for Research on Cancer, oral moist snuff tobaccos contain particularly large quantities of carcinogenic substances; whereas these new products cause cancer of the mouth in particular;

Whereas, the sales bans for moist oral snuff already adopted by two Member States have a direct impact on the establishment and operation of the internal market, hence the necessity to approximate the laws of Member States in this subject taking as a base a high level of protection, the only appropriate measure being a total ban,

HAS ADOPTED THIS DIRECTIVE:

Article 1

Directive 89/622/EEC is hereby amended as follows:

1. Article 2 is amended as follows:

   (a) point 1 is replaced by the following:

   '1. "tobacco products" means products for the purpose of smoking, sniffing, sucking or chewing, with the exception of oral moist snuff tobaccos, inasmuch as they are, even partly, made of tobacco;'

   (b) the following point 4 is added:

   '4. "oral moist snuff tobaccos" means all products made wholly or partly of moistened tobaccos, in fine-cut, ground or particulate form or in any combination of these forms, which are for oral use other than smoking;'

2. Article 4 is amended as follows:

   (a) paragraph 2 is replaced by the following:

   '2. Apart from the general warning referred to in paragraph 1, tobacco product packaging shall carry specific warnings as follows:

   (a) with regard to cigarette packets and rolling tobacco, the other large surface of the packet shall carry specific warnings. To this end, each Member State shall draw up a list of warnings taken exclusively from those listed in the Annex;

   (b) the unit packets of cigars, cigarillos, pipe tobacco or other smoking tobacco products with the exception of cigarettes and rolling tobacco shall carry, in addition to the general warning provided for in paragraph 1, a specific warning. To this end, each Member State shall draw up a list of warnings taken exclusively from those listed in the Annex, with the exception of warning No 2 in part A of the Annex;

   (c) unit packets of smokeless tobacco products shall carry, in addition to the warning provided for in paragraph 1, the following specific warning: "Can cause cancer".

   The specific warnings provided for in this paragraph shall be printed or irremovably affixed on the unit packets in the official language or languages of the country of final marketing, in such a way as to guarantee, in the cases referred to in points (a) and (b), the appearance in rotation of each warning on an equal quantity of unit packets, with a tolerance of 5 %';

   (b) paragraph 5 is replaced by the following:

   '5. Without prejudice to paragraph 4, the general warning provided for in paragraph 1 and the specific warning provided for in paragraph 2 shall be printed in, or irremovably affixed to, a conspicuous place on a contrasting background and in such a way as to be easily visible, clearly legible and indelible. The warnings shall not in any way be hidden, obscured or interrupted by other written or pictorial matter.';

3. Article 5 is replaced by the following:

   '*Article 5*

   The Commission shall adopt the measurement and verification methods referred to in Article 3 (1) and (2) in accordance with the procedure provided for in Articles 6 and 7.';

4. the following Article 8a is inserted:

   '*Article 8a*

   Member States shall prohibit the release on the market of moist snuff tobacco products for oral use.'

5. the Annex is amended as set out in the Annex to this Directive.

Article 2

1. The prohibition of moist snuff tobacco products shall enter into force before 1 July 1992.

2. For the other amendments made by this Directive to Directive 89/622/EEC, Member States shall take the necessary steps to comply before 1 July 1992. They shall

immediately inform the Commission thereof and shall send to it the provisions they have adopted.

When Member States adopt these provisions, they shall contain a reference to this Directive or shall be accompanied by such reference at the time of their official publication. The procedure for such reference shall be adopted by Member States.

3. Member States shall bring into force the provisions referred to in paragraph 2 before 31 December 1992. Nevertheless, products existing at that date which do not comply with Article 1 (2) (a) may still be marketed until 31 December 1993.

Article 3

1. The Commission shall publish the national lists of warnings provided for in Article 4 (2), point (a) for rolling tobaccos and point (b) for other smoking tobaccos in the *Official Journal of the European Communities.*

2. Member States which, after 31 December 1992, modify their lists of warnings as provided for in Article 4 (2) (a) and (b) shall notify this modification 18 months before its application to the Commission, which shall publish it in the *Official Journal of the European Communities.*

Article 4

This Directive is addressed to the Member States.

ANNEX

1. The title of the Annex to the Directive shall be worded as follows:

'List of health warnings referred to in points (a) and (b) of Article 4 (2)'.

2. In part B of the Annex, the following new warning, No 15, shall be added after warning No 14:

'15. Smoking causes addiction.'

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27. 11. 89 Official Journal of the European Communities No L 346/1

II

(Acts whose publication is not obligatory)

COMMISSION

COMMISSION RECOMMENDATION
of 8 November 1989
concerning the training of health personnel in the matter of cancer

(89/601/EEC)

I. Cancer is a disease on which there has been a great deal of action, both public and private, for many years. This action has covered many aspects, including research, prevention, screening, treatment, and the counselling of patients and their families. Our knowledge about the disease and its management has advanced considerably, but cancer remains one of the biggest causes of death in modern society.

The initiative taken at the European Councils of June 1985 in Milan and December 1985 in Luxembourg was innovative in that it was the first time that a specific disease had been singled out for a broad attack at European Community level. The results already obtained in pursuit of the 'Europe against cancer' programme have confirmed that the initiative was justified, in particular in the field of the training of health personnel.

II. In order to facilitate the mutual recognition of diplomas, certificates and other qualifications between Member States, as provided for in Article 57 of the EEC Treaty, the Council, by successive Decisions, set up the Advisory Committee on Medical Training (1), the Advisory Committee on Training in Nursing (2) and the Advisory Committee on the Training of Dental Practitioners (3). The Advisory Committees are the authoritative sources of advice on professional training of health personnel to the Commission and to the Member States at Community level.

At the request of the Commission and on the basis of the recommendations of the committee of cancer experts, their contribution to the 'Europe against cancer" programme has been to review how the subject of cancer is taught to members of their professions, at all levels in their training, and to make recommendations for improving such training. The Advisory Committees carried out their reviews during 1987/88, and have now adopted the enclosed recommendations which constitute the practical application of the first action programme (1987 to 1989) on the training of health personnel (measures 51 and 52) (4).

III. The Commission attaches considerable importance to the recommendations of the three Advisory Committees, which have underlined the value of looking at training collectively at Community level, and of generating ideas for bringing about improvements while respecting national competences and academic freedom.

All the specific recommendations by these advisory committees should be the subject of wide-ranging debate among those responsible at national and regional level in each Member State.

For its part, within the framework of its responsibilities and the available funds, the Commission intends to propose as part of the second 'Europe against cancer' programme (1990 to 1994) measures which can contribute at Community level to improving training in cancer of those belonging to the health professions.

In particular, measures should be undertaken to encourage the mobility between the Member States of such persons, the exchange of experience in the area of prevention, treatment and terminal care, the collection and exchange of teaching materials of interest at Community level and the establishment of pilot European networks of medical, nursing and dentistry schools.

(1) Decision 75/364/EEC (OJ No L 167, 30. 6. 1975, p. 17).
(2) Decision 77/454/EEC (OJ No L 176, 15. 7. 1977, p. 11).
(3) Decision 78/688/EEC (OJ No L 233, 24. 8. 1978, p. 15).

(4) OJ No C 50, 26. 2. 1987, p. 1.

IV. The Commission intends to work together with the responsible authorities and training establishments in the Member States in the future development of ideas and recommendations relating to the training of health personnel in matters concerning cancer. In this context, the Commission will encourage from 1990 an examination of progress recorded in the Member States as regards the practical implementation of the recommendations.

The Commission, believing that the attached recommendations on training in cancer adopted by the Advisory Committee on Medical Training, the Advisory Committee on Training in Nursing, and the Advisory Committee on the Training of Dental Practitioners, constitute a good basis for the widest possible discussion in the Member States, makes the following recommendation pursuant to the EEC Treaty, and in particular the second indent of Article 155 thereof :

The Commission recommends that the Member States, their competent authorities and their establishments responsible for professional training make every effort to ensure, in accordance with their respective competence, that these recommendations are widely distributed, discussed and implemented.

This recommendation is addressed to the Member States.

Done at Brussels, 8 November 1989.

For the Commission
Vasso PAPANDREOU
Member of the Commission

ANNEX I

RECOMMENDATIONS

of the Advisory Committee on Medical Training

1. The training of doctors in cancer should be vigorously advanced by both teaching and research in the subject.
2. Each medical school should have an undergraduate teaching programme in cancer. Coordination of this programme is of critical importance, and should be implemented.
3. The vital role of the general practitioner both in the prevention and early diagnosis of cancer should be recognized and developed in all possible ways.
4. General practitioners should receive specific training in those aspects of the care of cancer patients particularly relevant to general practice, such as screening methods, counselling, appropriate methods of treatment, rehabilitation and terminal care.
5. Trainees in all relevant disciplines should receive appropriate teaching in the biology of neoplastic disease and in the scientific and clinical basis of treatment.
6. In those countries where oncologists are recognized, agreement should be reached on minimal objectives and requirements for the training of such specialists.
7. The principles of epidemiology should be taught at all levels of training.
8. All postgraduate trainees should have opportunities for gaining experience in both basic and clinical research.
9. The importance of inter-disciplinary cooperation in the care of patients with cancer should be recognized and encouraged in all relevant disciplines.
10. Efforts should be made to coordinate the activities of cancer institutes, specialist and scientific societies, universities and all types of hospital both in regard to clinical training and cancer research.
11. Modern teaching techniques should be used whenever appropriate at all levels of training.
12. More advantage should be taken of existing opportunities for promoting the interchange within the European Community of teachers, undergraduate students, postgraduate students and research workers.
13. All those responsible for planning programmes of continuing medical education should ensure that the subject of oncology receives appropriate emphasis. Particular attention should be given to the needs of doctors who, by nature of their isolated practice, do not have easy access to institutions providing continuing education programmes.

ANNEX II

RECOMMENDATIONS

of the Advisory Committee on Training in Nursing

I. BASIC TRAINING

1. Basic training of nurses should include in a systematic and global way the prevention of cancer, participation in detection and diagnosis, identification of the problems of cancer patients and responding to their specific needs, the administration of anti-cancer therapy programmes, participation in rehabilitation as well as the care of patients in the terminal stage of their illness, and the care of the family of cancer patients.

2. The training of nurses in the care of cancer patients should be based upon a nursing model adapted to the situation of such patients. It should serve as a framework for organising the actual training in accordance with clearly established teaching objectives. The objectives of nursing care are identifying and interpretating the needs of the individual, and responding to them in an appropriate and personalized manner. Nurse training should react to these objectives and should prepare the nurse to practice his or her profession in a responsible manner. Nurses should therefore have the capacity to take decisions, resolve problems, assess their actions and to adapt themselves to the particular situations of patients and to the evolution of knowledge.

3. Together with the other professionals concerned, nurses should participate actively in action programmes against cancer, collaborate in informing and educating the general public about the positive benefits of prevention, screening and detection, and the early treatment of cancerous conditions. To fulfill this task nurses through their own training must acquire a positive attitude towards this very real social problem and should equip themselves, with a sound base of knowledge which they can use in their clinical training.

4. Given the speed of developments and discoveries, as much in the level of understanding of physiopathological processes and mechanisms as in diagnostic and therapeutic techniques, basic training must provide nurses with the substantial tools to enable them to make use of their knowledge and practical skills, and to reinforce their ability. It is a question of a dynamic process, in a constant state of evolution.

5. The teaching materials that cover the prevention, screening and treatment of cancer, the fruit of work carried out in teaching establishments and cancer research and treatment centres, must be developed and a European Community network set up for the exchange of information so as to make the best possible use of human, material and financial resources.

6. The basic training must prepare nurses for interdisciplinary tasks, for team work is essential in patient care and even more so in the case of cancer patients.

II. POST BASIC TRAINING

A. Continuing education

1. Continuing training courses that deal with cancer care should be made available to as many nurses as possible by setting up organizational procedures that can adjust to personal and professional constraints. The organization of these activities should be encouraged and the resources necessary for their realization should be found.

2. Continuing education in the field of cancer care must not be developed as a way of making up for gaps in basic training ; it must be an extension of basic training, taking account of prerequisites and exploiting acquired experience. The courses must comply with adult education principles.

3. In the context of cancer care the objectives of the continuing training programmes are to update acquired knowledge, reinforce it on specific aspects and stimulate and promote reflection on nurses' actual professional experience with cancer patients. The course content must not therefore be limited to passing on theoretical information on pathology and diagnostic and therapeutic methods, but must also cover relationships and personal and ethical question which nurses have to face in their daily work with cancer patients.

4. Both the conditions of access to continuing training courses and the structures used must be very flexible. Distance learning should be promoted, and the Committee recommend that the exchange of knowledge, experience and teaching materials be encouraged at Community level. It is in fact complementary to group sessions and leads to a more effective use of the knowledge acquired.

5. The requirements and expectations of the nurses concerned must be carefully analysed before any continuing education programme is set up. Common training courses drawn up by nurses having special experience of caring for cancer patients and fighting cancer in cooperation with other professionals could be developed and distributed in the various Member States. Such programmes would not constitute sets of rules, but serve as scientific references for the national authorities wishing to introduce such training. Such training courses should make the maximum use of modern teaching technology.

B. Advanced training

1. Improving the quality of the care provided for cancer patients is a priority. It is therefore essential that nurses who have completed high level training in cancer care should take part in the research carried out in this field, fulfilling an advisory role in the departments concerned and providing special training for nursing staff.

2. This advanced training in cancer care should be at the highest appropriate level. The general and specific objectives of such a training programme and its contents should be drawn up by a group of expert nurses in cooperation with other professionals and form a common core for the Member States. Specialized centres should be associated in the implementation of these high level programmes.

3. The content of the training should not concentrate only on the acquiring of theoretical medical knowledge ; it must also incorporate human relations and the acquiring of skills in managing teams of nurses responsible for cancer patients. The theoretical teaching must be supplemented by suitable clinical teaching, preferably in hospital departments or other centres specialized in cancer care.

4. In the course of the advanced training the student should take part in research work in the field of cancer nursing. Publication of work in this area should be promoted and stimulated.

ANNEX III

RECOMMENDATIONS

of the Advisory Committee on the Training of Dental Practitioners

1. Objectives and guidelines should be drawn up at European Community level on the content of a core curriculum upon oral precancer and cancer for undergraduate dental students (1).

2. Consideration should be given to the use (in whole or part) of these objectives and guidelines for the teaching of these same subjects to undergraduate medical students.

3. The basic dental curriculum must equip the general dental practitioner to play a major role in prevention, and in the early detection and diagnosis of oral malignancies so that treatment may be initiated at as early a stage as possible.

4. Emphasis should be placed upon clinical experience during basic training. To this end, where necessary, dental faculties should collaborate closely with medical services to ensure that dental students obtain access to a wide range of patients with malignant disease. At all major centres for the treatment of cancer there should be a dentally qualified specialist with particular knowledge of oral oncology.

5. There should be developed urgently at European Community level continuing dental education courses on oral precancer and cancer.

6. Similarly, consideration should be given to developing at Community level common teaching material in oral precancer and cancer, possibly in association with the medical profession.

7. The three action programmes set out in the Appendix should be implemented as early as possible in all Member States.

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(1) The Advisory Committee has made explicit proposals for such objectives and guidelines (Doc. III/D/886/3/88).

Appendix

Action Programme No 1

National dental associations in all Member States should give consideration to the desirability and feasibility that on one day or more in 1989 citizens in accepted risk groups for oral precancer and oral cancer should be offered a free examination of the oral cavity and associated regions by general dental practitioners.

Action Programme No 2

The national bodies in the individual Member States responsible for continuing dental education should in 1989/90 arrange a national meeting upon oral precancer and oral cancer with emphasis on early diagnosis and prevention as the main theme of the meeting. The meeting should be open to all dental practitioners.

National dental journals should be fully involved in propulgating to the profession current knowledge on oral precancer and cancer.

Action Programme No 3

The national dental associations of the different Member States in cooperation with national cancer organizations and dental school's should prepare informative material for the general public with emphasis on early signs of oral precancer and oral cancer and prevention of oral precancer and oral cancer.

PART TWO

Events and documents

Public health: initiatives and texts adopted in 1990

Detailed summary

Public health: initiatives and texts adopted in 1990[1]

AIDS

Conclusions of the Council and of the Ministers for Health meeting within the Council of 3 December 1990 on AIDS (90/C/329/07) 168

Proposal for a decision of the Council and the Ministers for Health of the Member States meeting within the Council adopting a plan of action in the framework of the 1991 to 1993 'Europe against AIDS' programme, submitted by the Commission on 11 December 1990 (91/C 13/06) . 169

Nutrition

Resolution of the Council and of the representatives of the Governments of the Member States meeting within the Council of 3 December 1990 concerning an action programme on nutrition and health (90/C 329/01) 175

Conclusions of the Council and the Ministers for Health meeting within the Council of 3 December 1990 on the safety of food and drink and water intended for human consumption (90/C 329/05) 178

Fight against cardiovascular diseases

Conclusion of the Council and of the Ministers for Health meeting within the Council of 3 December 1990 concerning cardiovascular disease in the Community (90/C 329/04) 179

Fight against the use of drugs

Resolution of the Council and of the representatives of the Governments of the Member States meeting within the Council of 3 December 1990 on Community action to combat the use of drugs, including the abuse of medicinal products, particularly in sport (90/C 329/02) 180

Acute poisoning

Resolution of the Council and of the representatives of the Governments of the Member States meeting within the Council of 3 December 1990 on improving the prevention and treatment of acute human poisoning (90/C 329/03) 182

Amendment to the draft Council resolution on improving the prevention and treatment of acute human poisoning, submitted by the Commission on 14 December 1990 (91/C 5/03) 195

Fight against drugs

Communication from the Commission to the Council of 8 November 1990 regarding the report on national programmes for drug demand reduction in the European Community . . . 199

Conclusions of the Council and the Ministers for Health meeting within the Council of 3 December 1990 on reducing the demand for narcotic and psychotropic substances (90/C 329/06) . . . 215

Occupational diseases

Commission recommendation of 22 May 1990 concerning the adoption of a European schedule of occupational diseases (90/326/EEC)

OJ L 160, 26.6.1990 – see Social Europe *No 2/90*

[1] Apart from the texts regarding the 'Europe against cancer' programme which can be found in the Annex to Part One of this issue.

31. 12. 90 Official Journal of the European Communities No C 329/21

CONCLUSIONS OF THE COUNCIL AND OF THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL

of 3 December 1990

on AIDS

(90/C 329/07)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL,

Having considered the epidemiological development and the medical and social consequences of the spread of HIV infection in Europe,

Having considered in particular the growing link between drug addiction, infection from HIV (Human Immunodeficiency Virus) and the development of HIV-related diseases in many of the European countries,

Having regard to the conclusions of the Council and the Ministers for Health, meeting within the Council, on 16 May 1989 regarding the prevention of AIDS in parenteral drug users (1), in particular the section on pregnant women drug users, and to the increase in the number of children born sero-positive,

Having regard to the intermediate report and the guidelines for a European plan to combat drugs approved by the European Council in Dublin on 25 and 26 June 1990 and to the draft European plan to combat drugs to be submitted by the European Committee for the fight against drugs (Celad) to the next European Council on 13 and 14 December 1990, and in particular the paragraph on drug addiction and AIDS,

INVITE THE MEMBER STATES:

1. to promote, in drug addiction services and reception centres, access to early intervention and, where appropriate to treatment for sero-positive drug addicts and for those with clinical signs of HIV infection;

2. to foster within these structures, respecting confidentiality, a psychological and social climate which is sensitive to the needs of the individuals concerned,

INVITE THE COMMISSION:

1. to step up exchanges of information, experience and experts:

   (a) on medical and social assistance to sero-positive pregnant women and newborn babies;

   (b) on the organization of home care for people suffering from HIV/AIDS and other forms of health care for HIV-infected persons;

   (c) for assessing the measures implemented in the Member States to supply safer injecting materials; this assessment with also cover new types of disposable syringes and needles;

2. to inform the Council of the results of the exchange of experience referred to in point 1 and to submit an appropriate assessment and, if necessary, proposals for action;

In addition, repeat the call made to the Member States in the conclusions of the Council and the Ministers for Health, meeting within the Council, on 17 May 1990 to continue with active policies to avoid any discrimination against sero-positive persons and people suffering from HIV/AIDS and to encourage the social acceptance of such persons;

Finally invite the Member States to extend the commitment to non-discrimination and social acceptance to those living with sero-positive persons and people suffering from HIV/AIDS or to those who have contact with such persons.

(1) OJ No C 185, 22. 7. 1989, p. 3.

Proposal for a decision of the Council and the Ministers for Health of the Member States meeting within the Council adopting a plan of action in the framework of the 1991 to 1993 'Europe against AIDS' programme

COM(90) 601 final

(Submitted by the Commission on 11 December 1990)

(91/C 13/06)

THE COUNCIL AND THE MINISTERS FOR HEALTH OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL,

Having regard to the Treaty establishing the European Economic Community,

Having regard to the proposed decision submitted by the Commission,

Having regard to the opinion of the European Parliament,

Having regard to the opinion of the Economic and Social Committee,

Whereas, the increase in the AIDS epidemic is of major concern to Member States and the Community;

Whereas the resolution of the European Parliament of 30 March 1989 on the fight against AIDS called on the Commission for action in particular in the fields of information and training of health professionals;

Whereas the resolution of the representatives of the governments of the Member States, meeting within the Council, of 29 May 1986, on AIDS, requested the Commission to organize an exchange of information and experience;

Whereas the resolution of the Council and of the Ministers of Education meeting within the Council of 23 November 1988, concerning health education in schools, expressed concern about the high incidence of AIDS, and invited the Commission to undertake a series of actions at Community level;

Whereas the conclusions of the Council and Ministers for Health of the Member States, meeting within the Council of 16 May 1989, regarding the prevention of AIDS in intravenous drug users, requested the Commission to prepare and submit to the Council a programme in this area;

Whereas the conclusions of the Council and the Ministers for Health of the Member States, meeting within the Council of 16 May 1989, on the improvement of the general system for collecting epidemiological data, including the application of the new definition of AIDS cases, asked the Commission to compare the system for recording notifications of AIDS cases at national and Community level in order to pinpoint where the improvement of coverage can take place, as well as the reliability and the comparability of the data used;

Whereas the conclusions of the Council and the Ministers for Health of the Member States, meeting within the Council of 16 May 1989, regarding future activities on AIDS prevention and control at Community level called upon the Commission to examine the possibilities for harmonization with regard to condoms and HIV self-testing kits;

Whereas the resolution of the Council and Ministers for Health of the Member States, meeting within the Council of 22 December 1989, on the fight against AIDS, requested the Commission to develop exchanges of information and experience defining in priority the details and contents of an action plan integrating appropriate measures to prevent and control AIDS;

Whereas the conclusions of the Council and the Ministers for Health of the Member States, meeting within the Council, of 17 May 1990, on medical and psycho-social care services in relation to the AIDS epidemic, requested the Commission to examine the feasibility of developing a consistent approach to costing the management of care for HIV-seropositive persons;

Whereas the present plan of action for the programme 'Europe against AIDS' contains the aforementioned requests; whereas it also contains other measures intended to contain the AIDS epidemic,

HAVE DECIDED AS FOLLOWS:

Article 1

1. The Commission shall implement the 1991 to 1993 action plan set out in the Annex in close coordination with the competent authorities of Member States.

2. The Commission will cooperate with International Organizations active in this field such as the WHO and the Council of Europe.

3. The Commission will regularly publish technical information on the progress of the action plan.

Article 2

1. The Community funds required for the work to be undertaken under this Decision shall be determined by the budget authority within the context of the appropriations available for each year.

Article 3

1. The Commission will continuously assess the action undertaken and the priorities taking into account emerging urgencies.

2. The Council and the Ministers for Health of the Member States meeting within the Council will carry out an evaluation of the effectiveness of the actions undertaken. To this end the Commission will submit a report on the subject during the second half of 1992.

ANNEX

CHAPTER I

INFORMATION AND HEALTH EDUCATION IN THE PREVENTION OF HIV INFECTION

The importance of prevention cannot be stressed enough as there is no vaccine nor effective treatment available. The Member States have been active for several years in promoting information and health education for the general public in this field. It is of fundamental importance to continue this work in order to ensure the success of prevention efforts.

Different approaches are used in the Member States in preventive strategies and prevention intervention methods are under development and evaluation. This diversity of approach can be used to maximum benefit if there is an interactive knowledge of what is being done. Therefore, exchanges of information are necessary and need to be promoted.

A key role at Community level is to facilitate exchanges of experience, to evaluate results and to promote new approaches, so that the most effective approaches can be promoted taking into account local needs and characteristics.

Health education in schools is an essential part of health promotion, and within the limits of specific national educational policies and structures, appropriate arrangements should be made for coordinating health-promotion measures, so that health education can be seen by children as a practical part of their lives.

Repeated efforts are necessary for prevention messages to be retained by the public and relevant target groups. This will help them develop a real understanding of AIDS problems and their consequences, in order to contribute to a change in their attitudes.

Simple messages can increase the general public's awareness, and can improve the efficiency of an AIDS prevention information campaign, in particular by the use of a European code against AIDS which will take into account the work already carried out in the Council of Europe (1).

Objectives:

— to prevent the spread of the epidemic by providing information on HIV risk factors, and therefore to avoid discrimination and stigmatization of HIV seropositive persons,

— to monitor attitudes towards AIDS in the general population of the Community.

Action 1: Informing the public about AIDS prevention campaigns

Member States have already gained valuable experience in the use of publicity campaigns to inform the public about AIDS. A survey of current AIDS prevention campaigns will be carried out with a view to improving the existing campaigns and to designing more effective ones in the future.

At Community level, a publicity campaign will need to take into account the experience of the Member States in order to ensure maximum impact on the general public, resulting in increased awareness. This campaign will also aim at providing information to prevent discrimination against HIV seropositive persons and AIDS sufferers.

The public and private organizations involved in the fight against AIDS will be closely associated with the preparation and implementation of this action. Broad coverage will be given to the results of the actions.

With the help of appropriate experts, the Commission will establish a European code against AIDS and ensure its transformation into layman's language. Dissemination of the code will be made in all appropriate fora, including schools and the workplace.

Action 2: Prevention of HIV infection and health education in schools

Exchanges of information will be encouraged and supported within the framework of health education in schools. Specific seminars for teachers from the Member States will provide not only an opportunity for exchanging experiences and knowledge but also lay down the foundations for broader cooperation.

Where appropriate, exchanges of teaching materials produced in Member States on health education related to AIDS and HIV infection will be promoted and supported.

Action 3: Eurobarometer surveys on AIDS and its prevention

Repeated monitoring of public opinion and attitudes is necessary in order to assess the effectiveness of prevention efforts.

Regular updating of Eurobarometer surveys will be carried out in close cooperation with European specialists in this field so as to determine to what extent Europeans are informed about AIDS issues and prevention.

(1) In particular recommendation No R(87) 25 of the Committee of Ministers concerning a common European public health policy to fight the Acquired Immunodeficiency Syndrome (AIDS) adopted on 26 November 1987 and recommendation No R(89) 14 of the Committee of Ministers on the ethical issues of HIV infection in the health care and social settings adopted by the Committee of Ministers on 24 October 1989.

CHAPTER 2

PREVENTION AND TREATMENT, SOCIAL CARE AND COUNSELLING

Clinical trials have shown that the available treatments do not cure the disease although they do appear to delay its onset. New approaches are under development and evaluation. Persons with AIDS need specific care, in particular the rapid treatment of multiple infections due to immunodeficiency.

Counselling is an important element in both care and preventive strategies. Intravenous drug users are a high-risk group for which treatment and social care are of particular importance.

Objectives:

— to improve medical and psycho-social support to HIV-positive and AIDS symptomatic drug users,

— to make counselling more accessible to all HIV-positive people,

— to prevent the spread of HIV infection among drug users, their sexual partners and offspring,

— to reduce HIV transmission in blood and blood based products.

Action 4: Exchanges of experience on counselling and treatment services

Accessibility to counselling services, as well as telephone directories and other telephone information systems, are necessary to assist both HIV seropositive persons and AIDS sufferers.

Crisis intervention helplines are increasingly available in Member States. The first European Conference on AIDS hotlines, which took place in Amsterdam (April 1989), has demonstrated their effectiveness not only in providing support in cases of crisis but also to serve as an anonymous personalized information system.

This could lead to the establishment of a Community-wide directory of helplines. This should be done in close coordination with drug helplines, since HIV-seropositive and AIDS symptomatic drug users may have recourse to both systems.

With the growing mobility of people in the European Community, there is a need to promote exchanges of experience between health care professionals on treatment services and medical care, so that they can cope better with an increasing number of patients coming from different cultural backgrounds.

Appropriate means will be established for exchanges of experience, and to develop effective treatment methodologies. That could lead to a European guide of medical care and treatment facilities, which can be used further by Member States and the Commission to promote exchange visits.

Action 5: Development of models for the costing of the management of AIDS

It is foreseen that there could be 150 000 persons with AIDS in the European Community in 1992. The average yearly cost for an AIDS patient has been estimated as being of the order of ECU 20 000 for medication, hospitalization, home care and psycho-social support. Thus ECU 3 billion will be required in 1992 to cover these costs, and this amount could be expected to increase yearly as the number of AIDS victims rises.

The Commission will examine the feasibility of developing models for the costing of the management of AIDS, taking account of the available findings of the WHO report on costs, and the conclusions of the European Health Committee with regard to the impact of AIDS on the organization of health care.

Action 6: Reduction of HIV transmission in blood and blood based products

In the past, a cause of AIDS was the transmission of HIV in blood and blood derived products. Several measures have now significantly reduced the risk of transmission.

Selection of blood and plasma donors and screening of their donation for HIV antibodies is now systematically carried out, in accordance with the recommendations of the Council of Europe. Also, Directive 89/381/EEC relating to medicinal products derived from human blood and plasma lays down requirements for manufacturing and purification processes to ensure, insofar as technology permits, the absence of specific viral contamination.

However, the risk of transmission can be reduced still further. The attainment of European self-sufficiency in blood and blood derived products has become a Community objective, through the promotion of voluntary unpaid blood donations. The Commission will examine carefully the current situation and evaluate how best these objectives can be achieved, bearing in mind its current cooperation with the Council of Europe in this field.

CHAPTER 3

EPIDEMIOLOGICAL ASSESSMENTS

Although statistics are available on the numbers of AIDS cases, there are no reliable statistics for HIV seroprevalence.

Prevention, treatment and risk reduction strategies and the corresponding allocation of resources require knowledge of the patterns and trends of the AIDS epidemic.

Objectives:

— to ensure and improve the availability and comparability of data on AIDS, and HIV seroprevalence,

— to provide through epidemiological studies on AIDS/HIV, appropriate information for preventive policies.

Action 7: Improvements to the system for gathering the data on AIDS

The European Centre for the Epidemiological Monitoring of AIDS (WHO-EC Collaborative Centre in Paris) is playing a major role in gathering and analysing epidemiological data on AIDS.

In order to improve the quality of the data, support will be given to national monitoring systems; to the accessibility of the Paris Centre's data base; and to improving epidemiological information on the disease.

Proposals will be made on the establishment of a Community-wide system, with a view to facilitating exchanges of information.

Action 8: Common methodological approaches to ensure the availability and comparability of epidemiological data on HIV seroprevalence

HIV seroprevalence is becoming a central issue in developing strategies for prevention and care. The present lack of knowledge is not a sufficient basis on which to establish sound health policies.

As a first step, a methodology should be agreed at Community level.

A survey will be made on current approaches determining HIV seroprevalence in the European Community, in order to provide information on the epidemiological situation regarding HIV transmission.

CHAPTER 4

MANPOWER TRAINING AND DEVELOPMENT

The development of the actions contained in this programme in terms of prevention, treatment, risk reduction, socioeconomic integration, as well as epidemiological data collection and evaluation, requires the presence of adequately trained personnel.

Adaptation and improvement of traning for health and social care professionals can be ensured through exchanges of experience.

Objectives:

— to provide health and social care professionals with an adequate knowledge of AIDS prevention and primary care of AIDS patients and HIV seropositive persons,

— to develop an adequate core of specialists in AIDS prevention, treatment and psycho-social care of people with HIV or AIDS.

Action 9: Systems of university training for health care workers; mobility of medical and nursing students

Universities and bodies involved with professional training courses for health and social care should become more involved in the fight against AIDS with adequate information and training on AIDS issues being provided.

To accelerate the education and continuous training of professionals, the development of appropriate teaching materials and supports is necessary.

A survey will be made on the training and instruction given in university education and training, and exchanges of experience will be organized.

A survey on existing teaching materials will be carried out, and if appropriate, the promotion of exchanges of materials, as well as the development of additional training material.

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I

(Information)

COUNCIL

RESOLUTION OF THE COUNCIL AND OF THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL

of 3 December 1990

concerning an action programme on nutrition and health

(90/C 329/01)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES OF THE EUROPEAN ECONOMIC COMMUNITY, MEETING WITHIN THE COUNCIL,

Having regard to the Treaty establishing the European Economic Community,

Considering that proper, balanced eating habits, combined with other factors, efficiently prevent a series of diseases which are currently the main causes of death and morbidity in Europe;

Considering that, although the nutritional situation varies greatly between different Community Member States, between different regions of one and the same State and between different groups of people in the same region, there are still problems linked with both excessive consumption of food and imbalances in the intake of the various nutrients;

Considering the importance of looking at nutritional aspects in relation to various physiological states such as those peculiar to pregnant women, nursing mothers, children, adolescents and the elderly;

Considering that access to sufficient quantities of healthy food is a determining factor for human health;

Considering the existing high level of protection as regards the wholesomeness of food and drink and the general availability of good-quality food on the Community market;

Considering that the Community has dealt on various occasions with nutritional problems and related measures in sectoral contexts, such as the fight against cancer (resolution of 7 July 1986 [1], Decision of 21 June 1988 [2] and Decision of 17 May 1990 [3] or alcohol abuse and the problems of young people (resolution of 29 May 1986 [4] and conclusions of 17 May 1990) or health education (resolution of 23 November 1988 [5]), but has not given overall consideration to aspects of nutritional education and consumer information taken as a whole with the aim of promoting eating habits in keeping with individual needs;

Considering that, on the basis of the above, it is clearly important to find more effective ways of providing all Community citizens with the vital knowledge and education which will enable them, within the framework of their lifestyle, to make the necessary choices for ensuring appropriate nutrition in keeping with individual needs;

Considering that these advances require active support not only from governments and parliaments but also from society as a whole;

Considering that it is important to organize and promote a programme of events and activities aimed primarily at increasing public awareness of the role of a proper diet in maintaining health,

Invite the Commission to submit to the Council a proposal for an action programme, together with the budget proposals necessary under the usual procedures,

(1) OJ No C 184, 23. 7. 1986, p. 19.
(2) OJ No L 160, 28. 6. 1988, p. 52.
(3) OJ No L 137, 30. 5. 1990, p. 31.
(4) OJ No C 184, 23. 7. 1986, p. 3.
(5) OJ No C 3, 5. 1. 1989, p. 1.

which provides in particular that 1994 will be 'European Nutrition Year'. When drafting this programme, the Commission is invited to use as a basis the aims and guidelines set out in the Annex.

Invite the competent authorities in the Member States to take appropriate measures, on the basis of any decisions taken by the Council, to carry out the programme, and to set up the necessary coordination arrangements.

Recommend that Community activities in this sector be conducted while taking into account the activities of the WHO and FAO and, as far as possible, in cooperation with them.

Invite the Commission to call meetings of senior officials appointed by the competent national authorities on a regular basis at least every two years from 1992 onwards to evaluate progress in the programmes on nutritional education and consumer information.

Ask the Commission to keep the Council regularly informed of progress and to submit a final report to the Council on the work done.

ANNEX

OBJECTIVES AND GUIDELINES FOR THE ACTION PROGRAMME ON NUTRITION AND HEALTH

1. OBJECTIVES

The objectives of the action programme are:

(a) to disseminate knowledge about the decisive role for health and well-being of a correct diet in relation to various diseases and risk factors;

(b) to disseminate knowledge about the serious public health problems and social evils associated with alcohol abuse;

(c) to prepare and disseminate information and recommendations promoting eating habits which, while reflecting each community's own traditions and habits, help to promote good health and enable everyone to adopt eating habits suited to his/her personal physiology;

(d) to promote consumer understanding of the type of information given on labels for general and nutritional purposes and of the ways in which such information can be used to protect one's health;

(e) to foster awareness among those concerned of the need to observe the rules of hygiene throughout the various stages of the food cycle, i.e. during agricultural and industrial production, storage, transport, wholesale and retail sale and the preparation of food in the home;

(f) to encourage to a greater extent consideration of nutritional and health aspects in the measures in the various relevant sectors of the Community and its Member States;

(g) to promote studies and investigations, in close coordination with the Community medical research programme, including epidemiological research, into the relationships between nutrition and disease or risk factors and the best ways of protecting health and preventing disease by means of a sensible and balanced diet;

(h) to disseminate knowledge about the important results which European policies in the nutrition sector have obtained to date.

2. MEASURES TO BE TAKEN

From a Community angle, and in order to achieve the objectives set out in Section 1, the Community and the Member States, according to their respective competences will take the following measures, acting in close cooperation:

(a) **European Nutrition Year**

Decision to declare and implement a European Nutrition Year, in 1994.

(b) **General measures to heighten awareness**

Activities focused on a limited number of aspects geared to different sectors of society, particularly to schools and scientific and industrial circles and mass catering as well as to typically national, regional or local aspects. Such activities will include, amongst others, information programmes via television, radio and the press as well as conferences and the distribution of educational and informative material and, possibly, prizes.

(c) **Pilot projects on nutrition**

Ad hoc projects aimed at improving the nutritional standards of select groups of people at risk and the nutritional quality of food and at assessing the levels currently achieved in the Community. Such projects will be directed, *inter alia*, at the methods of disseminating such knowledge.

(d) **Research and studies**

Research and studies on nutrition and health and in particular on:

— factors affecting choice of food by consumers and the effect of foods on metabolic rates,

— the consequences of changes in eating habits,

— the consequences of rapid changes in methods of food manufacture, preservation and distribution,

— the formulation of information for consumers,

— studies on eating habits in the various regions of the Community.

(e) **Work of the Scientific Committee for Food**

Stepping up and diversifying the work of the Scientific Committee for Food in the nutritional field and, if need be, examination of setting up a Scientific Committee for Nutrition, attached to the Commission.

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CONCLUSIONS OF THE COUNCIL AND THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL

of 3 December 1990

on the safety of food and drink and water intended for human consumption

(90/C 329/05)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL,

Whereas, with the single market in prospect, the regulatory innovations so far introduced into Community rules under the Single European Act must be developed further to ensure the reasonable protection of public health in a system based on free movement of foodstuffs;

Whereas, whenever Community harmonization is lacking or inadequate, the diversity of national legislation frequently gives rise to difficulties in trade and, at any rate, to an increase in disputes and may have adverse repercussions on public health protection;

Recognize that the chief task of the Community in this situation is to take coordinated and thorough action to adopt as soon as possible, and at all events by the end of 1992, effective rules, particularly in priority sectors where a high level of health protection has to be attained;

Consider that the implementation of such action must take account of the fact that the protection of public health has long been the basic aim of Community foodstuffs and water regulations and is not merely a question of adopting new rules but also of coordinating, updating and amplifying existing ones and guaranteeing, through effective, uniform application, that they are actually complied with;

Recognize that the Commission must play an important role in the success of such action and that the Commission needs to take the necessary steps to bring unity to the differing approaches within the Commission itself, with precedence being given to the aim of protecting public health;

Emphasize that, in order to ensure more effective health protection, uniform legislative principles and approaches should be adopted for the foodstuffs, agricultural and veterinary sectors as well as for the environment and the safety of water intended for human consumption;

Emphasize the need for the involvement of the Council and of the Ministers for Health, *inter alia* adequate information, enabling a contribution to be made, in particular, by formulating general health objectives and criteria, to decisions in the foodstuffs and water sector on matters involving the protection of public health.

31. 12. 90 Official Journal of the European Communities No C 329/19

CONCLUSIONS OF THE COUNCIL AND OF THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL

of 3 December 1990

concerning cardio-vascular disease in the Community

(90/C 329/04)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE MINISTERS FOR HEALTH OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL,

1. note that cardio-vascular disease is one of the main causes of death in all the Member States of the Community, particularly in the working population;

2. consider that a number of preventive measures have already been put in hand for cancer and that these measures have an effect in preventing cardio-vascular disease;

3. consider that further measures should be identified and implemented;

4. call upon the Commission to investigate the best way of facilitating exchange of information and cooperation on national measures, including in the field of research and means of diagnosis, obtaining to that end the assistance of experts and of representatives appointed by the Member States and to report to the Council on the outcome of that investigation.

In carrying out this work the Commission should, in order to avoid duplication, take account of the work of other bodies in this area, particularly the WHO.

RESOLUTION OF THE COUNCIL AND OF THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL

of 3 December 1990

on Community action to combat the use of drugs, including the abuse of medicinal products, particularly in sport

(90/C 329/02)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES OF THE EUROPEAN ECONOMIC COMMUNITY, MEETING WITHIN THE COUNCIL,

Having regard to the Treaty establishing the European Economic Community,

Whereas the use of drugs, including the abuse of medicinal products, which is damaging to health, is increasingly prevalent in Europe, particularly in sport; whereas sport has a considerable impact on society, in particular on young persons, given the substantial publicity given to it in the media; whereas, as a result, vigorous action against drug use in sport may serve as an example to show that, generally, it can and must be possible to win without recourse to stimulants and medicinal substances which endanger health;

Whereas, in view of the above, one important objective of the fight against the use of drugs in sport should be the protection of the health of those taking part in sporting activities;

Having regard to the Council of Europe Convention, its importance and the advisability of close cooperation between the Member States of the Community and the Council of Europe in this sphere, in a spirit of complementarity,

Whereas the use of drugs in sport contravenes health regulations in a number of ways, in particular to the extent that it implies:

(a) the use of substances authorized by the Community as medicinal products (Directive 65/65/EEC) (1) for purposes other than those for which authorization was given (the diagnosis or treatment of recognized pathological states);

(b) the use of such substances in forms and dosages not covered by the authorization (Directive 65/65/EEC);

(c) failure to comply with rules on distribution (Directive 75/319/EEC — black market and/or sale to non-authorized persons) (2), prescription (sale without a doctor's prescription — Directive 75/319/EEC, as amended by Directive 89/341/EEC) and advertising of such products (Directive 84/450/EEC) (3);

Whereas an educational and preventive approach should prevail and extend to cover all persons taking part in sporting activities, in particular young people and the circles in which they move;

Whereas it would be opportune for a European code of conduct to combat the use of drugs in sport to be publicized at the 1992 Olympic Games in order to take advantage of the impact of that event on public opinion,

Invite the Commission, assisted by a Group of Experts appointed by the Member States:

— to draft and circulate, in close conjunction with the Member States, by the end of 1991, with a view to the Olympic Games in 1992, a code of conduct to combat the use of drugs in sport, based on the guidelines set out in Annex I,

— to propose to the Council measures of Community interest based on the guidelines set out in Annex II, taking into account the measures already initiated by government sporting authorities, the Council of Europe and international sporting organizations.

(1) OJ No 22, 9. 2. 1965, p. 369/65, as last amended by Directive 89/341/EEC (OJ No L 142, 25. 5. 1989, p. 11).

(2) OJ No L 147, 9. 6. 1975, p. 13, as last amended by Directive 89/381/EEC (OJ No L 181, 28. 6. 1989, p. 44).

(3) OJ No L 250, 19. 9. 1984, p. 17.

ANNEX I

DRAFTING, CIRCULATION AND USE OF A CODE OF CONDUCT TO COMBAT THE USE OF DRUGS IN SPORT

The code should constitute an important instrument of information and education against the use of drugs in sport. Denouncing the use of drugs in sport as contravening the rules of health protection and in any case as constituting unsporting behaviour, it should be submitted for joint discussion by medical and sporting circles operating in the Community.

ANNEX II

MEASURES OF COMMUNITY INTEREST

(guidelines)

(a) Stepping-up training information and health education initiatives against the use of drugs in sport.

(b) Study of most common current drug-use practices.

(c) Drug-testing methods and cooperation between laboratories.

(d) Research on effects of drug-taking on health within the Community biomedical research framework programme.

No C 329/6 Official Journal of the European Communities 31. 12. 90

RESOLUTION OF THE COUNCIL AND OF THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES, MEETING WITHIN THE COUNCIL

of 3 December 1990

on improving the prevention and treatment of acute human poisoning

(90/C 329/03)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE REPRESENTATIVES OF THE GOVERNMENTS OF THE MEMBER STATES OF THE EUROPEAN COMMUNITIES, MEETING WITHIN THE COUNCIL,

Having regard to the Treaty establishing the European Economic Community,

Having regard to the draft resolution submitted by the Commission (1),

Having regard to the opinion of the European Parliament (2),

Having regard to the opinion of the Economic and Social Committee (3),

Whereas, for a policy aimed at preventing the risks of acute poisoning in the population and, in particular, among workers, it is desirable to have the maximum amount of comparable data on clinical toxicology at Community level;

Whereas poison centres in the Community, by virtue of their informative therapeutic and analytical functions, are amongst those bodies in the best position to collect clinical toxicology data in their geographical areas of activity and to process this information;

Whereas harmonization of the procedures for collecting clinical toxicology data for all the poison centres in the Community would facilitate the development of a policy for toxic risk prevention;

Whereas, by fostering the integration of clinical and analytical data, the Community wishes to achieve one of the main objectives of its programme of action on toxicology for health protection (4), namely to help ensure the quality and comparability of data and encourage the exchange of experience and information in the field of clinical toxicology;

Whereas harmonized annual reports would be of value in the context of the Ehlass project subject of Council Directive 86/138/EEC of 22 April 1986 concerning a demonstration project with a view to introducing a Community system of information on accidents involving consumer products (5); whereas Annex I (Section 2, third paragraph) of that Decision stipulates that additional information may be obtained from poison centres to supplement the basic information obtained from the casualty departments of hospitals;

Whereas, with a view to the free movement of persons and goods, it is important to improve the availability of antidotes by facilitating exchanges of information on their availability, in particular in areas adjacent to other Member States;

Whereas this resolution would help to develop the use of clinical toxicology data in overall assessments of the impact of chemical products and preparations on the health of the public in general and, more particularly, on the health of workers exposed to dangerous substances liable to cause acute poisoning;

Whereas it is important to ensure access to information on the chemical composition of preparations in order to ensure the correct advice and treatment in connection with poisoning;

Whereas this resolution should contribute to the development of health data with respect to the unlawful use of drugs with reference to the resolution of the Council of the Ministers for Health of the Member States, meeting within the Council of 16 May 1989, concerning a European network of health data on drug abuse (6);

Whereas the information obtained in the event of poisoning by medicinal products may constitute a factor in the assessment of their safety in use; whereas it is desirable for the information collected in this connection by poison centres to be forwarded to the authorities responsible for medicinal products and drug monitoring;

(1) OJ No C 294, 22. 11. 1989, p. 10.

(2) Opinion delivered on 23 November 1990 (not yet published in the Official Journal).

(3) OJ No C 124, 21. 5. 1990, p. 1.

(4) OJ No C 184, 23. 7. 1986, p. 1.

(5) OJ No L 109, 26. 4. 1986, p. 23.

(6) OJ No C 185, 22. 7. 1989, p. 1.

Whereas continued close cooperation with the various international agencies active in this area, in particular the World Health Organization (WHO), the United Nations Environment Programme (UNEP) and the International Labour Organization (ILO) through their joint International Programme on Chemical Safety (IPCS), and where appropriate the implementation of joint measures with those agencies, would be beneficial and is necessary to avoid duplication of effort,

I

EXPRESS THE WILL to take the necessary steps to improve the prevention and treatment of acute human poisoning.

II

INVITE THE MEMBER STATES:

1. to designate a competent authority to take the necessary measures to ensure that the collection of call data and the annual reports on the work of the poison centres or, where appropriate, other competent services operating in the territory of the Member State concerned are based essentially on the indications set out in Annexes I and II;

2. to ensure that antidotes i.e. the substances and preparations used specifically in cases of acute poisoning, are as widely available as possible in their respective territories;

3. to increase the practical scope for using antidotes in their respective territories.

   To that end, the competent authority will have drawn up and distributed to the poison centres and, where appropriate, to other competent services, information, based on the indicative list in Annex III, on the availability of antidotes for treating acute poisoning cases and on the sources of supply. That information should enable the recipients to obtain these antidotes within the requisite period for administering them effectively;

4. to provide better emergency services in areas adjacent to other Member States.

   To that end, the relevant competent authorities, in cooperation with the Commission, will set up between the poison centres or, where appropriate, other competent services a Community system of information and collaboration concerning the availability of antidotes;

5. to arrange for the competent authority to produce a summary of the harmonized annual reports of the poison centres and, where appropriate, of other competent services;

   This summary will deal in particular with records of acute poisoning, with a note on the measures taken or planned to improve the prevention of acute poisoning and will, if possible, also take account of available anonymous data on poisoning resulting from the taking of illegal drugs.

   The summary will be forwarded to the Commission before 15 May of the following year, together with a list of the poison centres or, where appropriate, other competent services operating in the territory of the Member State, showing the areas which they cover, and the list of available antidotes.

   The Commission may, where necessary, arrange for all or part of the harmonized annual reports referred to in Annex II to be forwarded to it.

   To help improve the safety of use of medicinal products, it would be desirable for the annual report on cases of poisoning involving them to be forwarded also to the authorities responsible for the safety of those products. The poison centres or, where appropriate, other competent services would be encouraged to give the drug-monitoring authorities every assistance possible and should in particular respond, on the basis of the legislation in force, to any specific request for informtion from those authorities.

III

INVITE THE COMMISSION TO:

— prepare regular summary reports for the Community indicating, in particular, the measures required at Community level for the prevention of acute poisoning,

— expand on specific topics based on the information received from the Member States on the prevention and treatment of acute poisoning.

IV

AGREE:

— to review the provisions of this resolution within five years of their adoption on the basis of a Commission report. That review will take account of the need to step up prevention by means of the activities provided for in this resolution,

— to invite the Commission to review the technical Annexes to this resolution at least every two years and, if necessary, update them regularly in the light of the experience acquired,

— that in the preparation of the above report and in the updating of the Annexes the Commission will be assisted by a working party of experts appointed by the Member States.

ANNEX I

HARMONIZED CASE DATA RECORD SHEET

(to be completed in so far as the data are available, at the time of consultation or at a later stage, provided this is compatible with national laws and policies) (1)

1. Centre code: .....

2. Call registration number: .....

Further call: .....

Method of call: .....

3. 3.1. Date (yymmdd) (2): .....

3.2. Time (hhmm) (3): .....

4. 4.1. Enquirer: Name: .....

Address: .....

Tel. No: .....

4.2. Type of enquirer:

4.2.1. Not identified

4.2.2. Hospital:

- Accident and emergency (Casualty) ☐
- Internal medicine ☐
- Intensive care, resuscitation ☐
- Paediatrics ☐
- Psychiatry ☐
- Other poison centre ☐

4.2.3. Outside hospital:

- Physicians ☐
- Nurses ☐
- Pharmacists ☐
- Veterinary surgeons ☐
- Occupational health services ☐
- Industry/manufacturers ☐
- General public ☐
- Mass media ☐
- Authorities ☐
- Others ☐

** 5. Type of enquiry:

Call related to a case ☐ Information only ☐

Request for antidotes ☐ Other ☐ Unknown ☐

(1) The headings of particular relevance for the purpose of prevention are marked by a double asterisk.
(2) yymmdd = abbreviation corresponding to year/month/day.
(3) hhmm = abbreviation corresponding to hour/minute.

** 6. Patient 6.1. Multipe cases: Yes ☐ Number: .....

6.2. Human: Name (optional): .....

6.2.1. Age (yymmdd): ..... ; if estimated ☐

Foetus ☐ Unknown Child ☐ Unknown Adult ☐ Unknown ☐

6.2.2. Sex: Male ☐ Female ☐

6.2.3. Weight (kg): .....; if estimated ☐

6.2.4. Pregnant: Duration (weeks): .....

6.2.5. Lactating: yes ☐

6.3. Animal species: .....

** 7. Agents

Information to be repeated where poisoning is by more than one agent

7.1. Name (given by enquirer): .....

Composition of product: .....

.....

Manufacturer (if applicable): .....

Quantity: No: .....; Vol: .....; Wt: ....., if estimated ☐

Unknown ☐

Exposure: Single ☐/Repeated/Chronic ☐

— duration: ..... — frequency: .....

— duration: .....

7.2. Time elapsed since exposure: ..... (yymmdd hhmm)

** 8. Location

8.1. Home and surroundings ☐

8.2. Workplace:

Factory/workshop ☐ Laboratory ☐ Agriculture/horticulture ☐

Other ☐

8.3. Community:

Nursery or primary school ☐ Other school, university, educational establishment ☐

Hospital, clinic, nursing home ☐ Institution: prison, military, etc ☐ Other ☐

8.4. Enclosed public places (e.g.: bars, discotheques, restaurants, shopping centres, department stores, etc.) ☐

8.5. Open places (e.g.: sports grounds, children's playgrounds, etc.) ☐

8.6. Other ☐

8.7. Unknown ☐

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** 9. Circumstances

9.1. Accidental/unintentional
- Household ☐
- Occupational ☐
- Environmental ☐
- Transport accident ☐
- Fire ☐
- Therapeutic error ☐
- Misuse ☐
- Other ☐
- Unknown ☐

9.2. Intentional
- Suicide ☐
- Misuse ☐
- Abuse ☐
- Malicious/criminal ☐
- Other ☐
- Unknown ☐

9.3. Adverse reaction
- Drug ☐
- Food ☐
- Other ☐

9.4. Unknown ☐

** 10. Route of exposure

10.1. Ingestion ☐

10.2. Inhalation ☐

10.3. Cutaneous ☐

10.4. Eye contact ☐

10.5. Bite ☐

10.6. Sting ☐

10.7. Injection:
- Subcutaneous ☐
- Intramuscular ☐
- Intravenous ☐
- Intra-arterial ☐

10.8. Mucosal:
- Buccal ☐
- Nasal ☐
- Rectal ☐
- Vaginal ☐

10.9. Placental ☐

10.10. Other ☐

10.11. Unknown ☐

11. Signs and symptoms

11.1. Signs and symptoms present

11.2. Signs and symptoms not present

11.3. Unknown

Comments in free text: .....

.....

12. Identification and/or quantification of the toxic agent: yes ☐ .....

13. Other investigations requested: yes ☐ .....

14. Treatment:

	Treatment carried out before enquiry	Treatment recommended by first poison centre
14.1. None	☐	☐
Prevention of absorption:		
Gastric emptying: Emesis	☐	☐
Lavage	☐	☐
Activated charcoal	☐	☐
Activated charcoal	☐	☐
Elimination	☐	☐
Antidote therapy	☐	☐
Other	☐	☐

14.2. Place of treatment

Treatment at home or at place of poisoning, not by physician ☐

Treatment outside hospital by a physician ☐

Treatment in hospital ☐

Other ☐

15. Estimated risk:

Non-toxic ☐

Probably non-toxic (low toxicity/minimal exposure) ☐

Poisoning possible ☐ Confirmed poisoning ☐

Symptoms unrelated to exposure ☐

16. Outcome:

Hospitalization ☐ — If yes, number of days:.....

Complete recovery ☐ Sequelae ☐ Death ☐ Unknown ☐

Signature: .....

ANNEX II

LAYOUT OF THE HARMONIZED ANNUAL REPORTS (1)

1. Identification of the body drafting the report

Name; full address (indicating country); telephone, telex and fax numbers (if any); name of person in charge of centre.

2. Year

The year covered by the annual report in question.

3. Administrative information on the centre

Description of staff at centre (medical and administrative personnel); a brief description of the centre's work; the size of the population served.

** **4. Calls to the centre**

The total number of calls, their monthly variation, their distribution according to the person making the enquiry, the way in which the call is made (telephone, letter, etc.), the reasons (actual or presumed poisoning, simple request for information, etc.).

** **5. Poisoning cases**

— the number of cases and the frequency should be indicated for each category or sub-category,

— if the centre has the necessary resources, it would be desirable to break down the data in terms of the classes of aetiological agents listed below.

5.1. *Cases involving human beings*

— males, females (including pregnant women, nursing mothers), unspecified

— age groups (in years): < 1
1 - 4
5 - 9
10 - 14
15 - 19
20 - 49
50 - 69
> 70
unknown

— Aetiological agents:
  — non-pharmaceutical chemical substances (simple or compound, natural or synthetic):
    — industrial
    — pesticides
    — household products
    — cosmetics and personal hygiene products
    — drugs which may lead to dependence
    — others

(1) The headings of particular relevance for the purpose of prevention are marked by a double asterisk.

— pharmaceutical substances (human or veterinary)

— animals as such (whether by their venom or through consumption of poisonous meat — e.g. ichthyosarcotoxism — where chemical products, bacteria or putrefaction are not the cause)

— plants as such (including poisonous mushrooms and plants which may lead to dependence)

— others (including toxins of bacterial origin, e.g. botulism)

— not identified

— Location:

Home and surroundings ☐

Workplace:

Factory/workshop ☐ Laboratory ☐ Agriculture/horticulture ☐ Other ☐

Community:

Nursery or primary school ☐

Other school, university, educational establishment ☐

Hospital, clinic, nursing home ☐

Institution: prison, military, etc. ☐

Other ☐

Enclosed public places (e.g.: bars, discotheques, restaurants, shopping centres, department stores, etc.)

Open places (e.g.: sports grounds, children's playgrounds, etc.)

Other

Unknown

— Circumstances:

(a) Accidental/ unintentional		(b) Intentional		(c) Adverse reaction	
Household	☐	Suicide	☐	Drug	☐
Occupational	☐	Misuse	☐	Food	☐
Environmental	☐	Abuse	☐	Other	☐
Transport accident	☐	Malicious/criminal	☐		
Fire	☐	Other	☐		
Therapeutic error	☐	Unknown	☐		
Misuse	☐				
Other	☐				
Unknown	☐				

(d) Unknown ☐

— Estimated risk:

Non-toxic ☐

Probably non-toxic (low toxicity/minimal exposure) ☐

Poisoning possible ☐ Confirmed poisoning ☐

Symptoms unrelated to exposure ☐

— Treatment:
  — none
  — symptomatic only
  — specific (antidote therapy)
  — elimination of the toxic substance
— Outcome
  — complete recovery
  — hospitalization (number of days)
  — sequelae
  — death
  — unknown

5.2. *Animals*

** 6. **Record of poisoning cases**

Draw up a list of the 15 most frequent causes of poisoning in decreasing order of frequency (indicating the number of calls) with a breakdown by age group, if the centre has the necessary resources.

7. **Record of requests for information**

Draw up a list of the 15 reasons for which most requests for information are received.

8. **Record of toxicological analyses**

Draw up a list of the 15 toxicological analyses which are most frequently requested by the centre.

9. **Comments in free text**

On all treatment given and information provided; on particularly interesting cases which may have been encountered, on other activities (teaching, research, etc.) and on any other aspect not included elsewhere.

10. **Conclusions**

These are to deal mainly with the impact of the centre's activities on prevention.

ANNEX III

INDICATIVE LIST OF ANTIDOTES

A. SPECIFIC ANTIDOTES

Antidote	Main indications	Availability in terms of urgency of use in treatment
Acetylcysteine	Paracetamol	B
	Carbon tetrachloride	B
Amylnitrite	Cyanide	A
Antivenins and antitoxins		A-C
Atropine	Cholinergic syndrome	A
Benzylpenicillin	Amanitotoxins	B
Calcium gluconate	Hydrofluoric acid	A
	Fluorides	A
	Oxalates	A
Calcium disodium edetate ($Ca\ Na_2$ EDTA)	Lead	A
Dantrolene	Malignant hyperthermia	A
	Malignant neuroleptic syndrome	A
Deferoxamine	Iron	B
	Aluminium	B
Diazepam	Seizures	A
	Chloroquine	A
Dicobalt Edetate	Cyanide	A
Digoxin-specific (Fab) antibody fragments	Digoxin	A
	Digitoxin	A
	Digitalis glycosides	A
Dimercaprol (BAL)	Arsenic	B
	Gold, inorganic mercury	B
	Lead encephalopathy	B
4-Dimethylaminophenol (4-DMAP)	Cyanide	A
Diphenhydramine	Drug-induced dystonias	A
Ethanol	Methanol	A
	Ethylene glycol	A
Etybenzatropine	Drug-induced dystonias	A
Flumazenil	Benzodiazepines	B
Folinic acid	Folic acid antagonists	A
Glucagon	Beta-blockers	A
Hydroxocobalamin (Vitamin B12a)	Cyanide	A
Methionine	Paracetamol	B
4-Methylpyrazole	Ethylene glycol	A
	Methanol	A
Methylthioninium chloride (Methylene blue)	Methaemoglobinaemia	A
N-Acetyl penicillamine	Mercury (organic and metallic)	C
Naloxone	Opiates	A
Neostigmine	Neuromuscular block (curare type)	A
	Peripheral anticholinergic poisoning	A
Oximes	Organophosphates	B
Oxygen	Carbon monoxide	A
	Cyanide	A
	Hydrogen sulphide	A

Antidote	Main indications	Availability in terms of urgency of use in treatment
Oxygen hyperbaric	Carbon monoxide	C
	Cyanide	C
	Hydrogen sulphide	C
D-Penicillamine	Copper	C
	Gold, lead, mercury (elemental), zinc	C
Pentetic acid (DTPA) Diethylenetriamine pentaacetic acid	Plutonium, actinides	A
Phentolamine	Alpha-adrenergic poisoning	A
Physostigmine	Central anticholinergic syndrome from	
	— atropine and derivatives	A
	— other drugs	A
Phytomenadione (Vitamin K1)	Coumarin and indanedione anticoagulants	B
Potassium ferric hexacyanoferrate (Prussian Blue)	Thallium	B
Prenalterol	Beta-blockers	A
Protamine sulphate	Heparin	A
Pyridoxine (Vitamin B6)	Isoniazid	A
	Crimidine	B
	Gyromitrin	B
	Hydrazines	B
Silibinin	Amanitotoxins	B
Sodium nitrate	Cyanide	A
Sodium thiosulphate	Cyanide	A
Succimer (DMSA) 2.3-Dimercaptosuccinic acid	Lead	B
	Mercury (inorganic and organic)	B
	Arsenic	B
Tolonium chloride (Toluidine Blue)	Methaemoglobinaemia	A
Trientine (Triethylene tetramine)	Copper	B
Unithiol (DMPS) 2.3 Dimercapto-1-propanesulphonic acid	Mercury (methyl- and inorganic)	B
	Lead	B

B. AGENTS TO PREVENT ABSORPTION OF TOXIC SUBSTANCES IN THE GASTRO-INTESTINAL TRACT

Antidote	Main indications	Availability in terms of urgency of use in treatment
Activated charcoal (1)	For most poisonings	A
Cholestyramine	Digitalis, coumarin, chlordecone	B
Fullers earth	Paraquat, diquat	A
Potassium ferrocyanide	Copper	A
Sodium bicarbonate	Iron	A
	Organophosphates	A
Sodium sulphate	Barium	A
Starch	Iodine	A

(1) Can also be used to enhance elimination of some toxic substances.

C. AGENTS TO PREVENT ABSORPTION AND/OR DAMAGE ON THE SKIN

Antidote	Main indications	Availability in terms of urgency of use in treatment
Calcium gluconate gel	Hydrofluoric acid	A
Macrogol 400 (PEG)	Phenol	A
Copper sulphate, sodium bicarbonate, hydroxy-ethylcellulose	White phosphorus	A

D. EMETICS

Antidote	Main indications	Availability in terms of urgency of use in treatment
Ipecacuanha		A

E. CATHARTICS AND SOLUTIONS USED FOR WHOLE GUT LAVAGE

Antidote	Main indications	Availability in terms of urgency of use in treatment
Magnesium citrate		B
Magnesium sulphate		B
Mannitol		B
Sodium sulphate		B
Sorbitol		B
Polyethylene glycol electrolyte (lavage solution)		B

F. AGENTS TO MODIFY URINARY pH

Antidote	Main indications	Availability in terms of urgency of use in treatment
Ammonium chloride		B
Agrinine hydrochloride		B
Hydrochloric acid (0,1 N)		B
Sodium bicarbonate		A

A: required to be immediately available (within 30 minutes).
B: required to be available within two hours.
C: required to be available within six hours.

9. 1. 91 Official Journal of the European Communities No C 5/3

II

(Preparatory Acts)

COMMISSION

Amendment to the draft Council resolution on improving the prevention and treatment of acute human poisoning (1)

COM(90) 598 final

(Submitted by the Commission pursuant to Article 149 (3) of the EEC Treaty on 14 December 1990)

(91/C 5/03)

(1) OJ No C 294, 22. 11. 1989, p. 10.

ORIGINAL PROPOSAL	AMENDED PROPOSAL
Citations and recitals 1 to 4 unchanged	
Recital 5	Recital 5
Whereas harmonized annual reports will also be of value in the context of the Council Decision of 22 April 1986 (86/138/EEC) (2) concerning a demonstration project with a view to introducing a Community system of information on accidents involving consumer products, which stipulates in Annex I (sub-section 2, paragraph 3) that additional information may be obtained from poison centres to supplement the basic information obtained from the casualty departments of hospitals;	Whereas harmonized annual reports will also be of value in the context of the Council Decision of 22 April 1986 (86/138/EEC) concerning a demonstration project with a view to introducing a Community system of information on accidents involving consumer products (Ehlass project), which, stipulates in Annex I (subsection 2, paragraph 3) that additional information may be obtained from poison centres to supplement the basic information obtained from the casualty departments of hospitals;
Recital 6 unchanged	
Recital 7	Recital 7
Whereas this resolution should help to develop the use of clinical toxicology data in overall assessments of the impact of chemical products and preparations on the health of the public in general and, more particularly, of workers exposed to dangerous substances liable to cause acute poisoning;	Whereas this resolution should help to develop the use of clinical toxicology data in overall assessments of the impact of chemical products and preparations, principally on workers exposed to dangerous substances liable to cause acute poisoning, and more generally on the health of the public in general;

(2) OJ No L 109, 26. 4. 1986, p. 23.

ORIGINAL PROPOSAL	AMENDED PROPOSAL

ANNEX 2

Layout of the harmonized annual reports

Points 1 to 5.1 (indents 1 to 3) unchanged

Indent 4	Indent 4
— Location:	Location:
— home and immediate surroundings	home and surroundings ( )
— workplace:	workplace:
— industry	— factory/workshop ( ) laboratory ( )
— agriculture/horticulture	— agriculture/horticulture ( )
— other	— other ( )
— public establishment (e. g. schools or training centres, government offices, post offices, libraries, public transport — trains, buses, underground railways, etc.)	community: — nursery or primary school ( ) other school, university, educational establishment ( ) — hospital, clinic, nursing home ( ) — institution: prison, military, etc. ( ) other ( )
— enclosed public spaces (e. g. bars, discotheques, restaurants, shopping centres, department stores, etc.)	— enclosed public spaces (e. g. bars, discotheques, restaurants, shopping centres, department stores, etc.) ( )
— open places (e. g. sports grounds, children's playgrounds, etc.)	— open places (e. g. sports grounds, children's playgrounds, etc.) ( )
— other or unknown	— other ( ) — unknown ( )

Indents 5 to 8 unchanged

Points 5.2 and 6 to 10 unchanged

ANNEX 3

unchanged

ORIGINAL PROPOSAL	AMENDED PROPOSAL

ANNEX 1 (1)

Harmonized case data record sheet

Points 1 to 7 unchanged

8. Location:	8. unchanged
8.1. Home and surroundings ( )	
8.2. Workplace:	
— Factory/workshop ( )	
Laboratory ( )	
Agriculture/horticulture ( )	
— Other ( )	
8.3. Community:	
— Nursery or primary school ( )	
Other school, university, educational establishment ( )	
Hospital, clinic, nursing home ( )	
— Institution: prison, military, etc. ( )	
Other ( )	
8.4. Enclosed public spaces ( )	8.4. Enclosed public spaces (e. g. bars, discotheques, restaurants, shopping centres, department stores, etc.) ( )
8.5. Open places ( )	8.5. Open places (e. g. sports grounds, children's playgrounds, etc.) ( )
8.6. Other ( )	unchanged
8.7. Unknown ( )	

Points 9 to 16 unchanged

(1) The nomenclature for poisoning locations to be harmonized in Annexes 1 and 2.

ORIGINAL PROPOSAL	AMENDED PROPOSAL
	Recital 8
	(new)
	Whereas the current fruitful collaboration with the WHO, the poison centres of the Member States, and of non-Community countries must be continued and developed;
Paragraph I unchanged	
Paragraph II unchanged in indents 1 to 4	
Indent 5	Indent 5
— to arrange for the competent authority to produce a summary of the harmonized annual reports of the poison centres and the associated toxicology services. This summary will deal in particular with records of poisoning, with a note on the measures taken or planned by the competent authority to improve the prevention of acute poisoning, and shall be forwarded to the Commission before 31 March of the following year, together with a list of the poison centres operating on their territory showing the areas which they cover, and the list of available antidotes. The Commission may, where necessary, arrange for all or part of the harmonized annual reports to be forwarded to it;	— to arrange for the competent authority to produce a summary of the harmonized annual reports of the poison centres and the associated toxicology services. This summary will deal in particular with records of poisoning, in particular those due to illicit use of drugs, with a note on the measures taken or planned by the competent authority to improve the prevention of acute poisoning, and shall be forwarded to the Commission before 21 March of the following year, together with a list of the poison centres operating on their territory showing the areas which they cover, and the list of available antidotes. The Commission may, where necessary, arrange for all or part of the harmonized annual reports to be forwarded to it;
Paragraph III unchanged	
Paragraph IV	Paragraph IV
AGREES to review the provisions of this resolution within a maximum period of five years following its adoption, on the basis of a report from the Commission.	AGREES to review the provisions of this resolution within a maximum period of three years following its adoption, on the basis of a report from the Commission, taking into account the need for the Annexes to be updated.

COMMUNICATION FROM THE COMMISSION TO THE COUNCIL

of 8 November 1990

regarding

the report on national programmes for drug demand reduction in the European Community

(COM(90) 527 final)

Background

The European Council on 25 and 26 June 1990 in Dublin invited the Commission to present on a regular basis to the Council and the Ministers for Health a report on work done on drug demand reduction in the Member States. At its meeting on 19 and 20 July 1990 in Rome, the Celad expressed an interest in receiving the first of these reports in time for the Rome Summit in December.

On 30 July 1990, the Commission, following discussions with experts from Member States (meeting in Luxembourg on 16 July 1990), requested, through the Permanent Representations, the relevant authorities to forward by mid-September national reports on the programmes for the reduction of drug demand, giving the following information:

(i) The introduction should contain details of the scale of and trends in drug demand, policies for reducing drug demand and whether these are regional or national, and the role of central organizations in financing action;

(ii) The other sections of the report should cover the following points:

legal aspects of drug demand,

information and instruction,

treatment and reduction of risk,

social and vocational rehabilitation,

education,

statistics and epidemiology — population studies,

public opinion surveys,

promotion of research.

For each of these fields it was considered useful to have details of:

national, regional and local structures,

the level and sources of aid,

what action has been taken and the main results to date,

any future measures planned.

The reports transmitted by a number of Member States departed considerably from the above outline. This overview report, which has been prepared in consultation with national experts (meeting in Luxembourg on 2 and 3 October 1990) provides a comprehensive synthesis of the situation in the European Community regarding drug demand reduction in Member States (a summary of the national reports is annexed).

Introduction

The definition of drug policies and the setting up of appropriate actions reflect the socio-cultural and political context at various levels. In this respect in each Member State, national, regional and local levels have their own competence in the field of drug demand reduction. Most of the Member States involve each level with specific responsibilities.

In most Member States policies and general guidelines for drug demand reduction are established at national level, while the implementation of actions in prevention, treatment and rehabilitation is the responsibility of regional or local bodies. There is a trend towards decentralization even in Member States where such responsibilities are not clearly distributed.

National support and coordination are often considered essential for the establishment of general policies. There is a willingness to keep a balance between local innovative activities and the necessity to have a minimum coordination of policies.

The sources of funding and their allocation reflect the distribution of responsibilities between the national, regional and local levels. In some Member States levels of government funding are enhanced by the substantial contribution by the non-government sector. In several of them the levels of funding have shown a substantial increase in recent years, in a number of cases due to the additional threat of AIDS.

The levels and trends of drug use, when looked at in comparative terms, must be considered with caution, since each Member State uses different methodologies and definitions for data collection. In some cases, trends cannot be ascertained within some Member States, since no consistent data collection effort has been implemented over a period of time.

Member States stressed the difficulty of estimating the total number of drug users since many do not seek help nor do they come into contact with the authorities. On the basis of the limited available data on the number of known drug users, many Member States have experienced

an increase in their number in recent years. In some Member States there are reports of a stabilization in the overall number of users, in particular for heroin. This probably reflects the overall changing pattern of supply and demand and the type of drug used. Health-based indicators on drug users applying for treatment and drug-related deaths show an increasing trend of drug-related problems in most Member States. In a number of Member States, there is a clear indication that the average age of the drug-using population is increasing. Heroin and polydrug use remain the main problems; there is evidence in some Member States that the use of cocaine and new drugs is increasing; however, this is not substantiated at present by health data.

Legal aspects

Regarding the legal framework of drug demand reduction in Member States, four aspects are to be pointed out: legal provisions regarding drug possession or use and the consequences for drug users; regulations and practices concerning compulsory detoxification and treatment; voluntary detoxification and treatment and substitution treatments; and special provisions related to the prevention of HIV transmission and AIDS.

There is a constant adaptation of legislation and regulations in response to a complex and changing situation. In most Member States the legal provisions favour the therapeutic approach for drug users. This may be voluntary or compulsory, and it is, when compulsory, an alternative to prison. There is, however, in certain Member States a tendency to increase the penalties for drug possession for personal use.

More recently, the awareness of the role of intravenous drug use as a risk behaviour for HIV infection has emphasized, in the legislation of many Member States, the public health aspects of drug misuse. Two examples can be mentioned in this respect: the substitution treatments on one hand, in particular involving methadone, which are increasingly approved in some Member States for pilot experiments where methadone was not available for normal medical treatments; and on the other hand, the liberalization of the sales of syringes to take into account the new risk of HIV transmission and AIDS. Needle-exchange programmes still remain limited.

Prevention

Member States have made numerous efforts to deal with the drug abuse problem. As a common factor for most Member States the increasing recognition of the need to develop coordinated, continuous and structured preventive actions can be highlighted responding to a rapidly evolving situation. Guidelines mentioned for prevention activities include:

(i) the importance of a broader framework of prevention measures in which various cultural, health and social problems are addressed;

(ii) the need for a comprehensive approach to drug abuse problems, covering a range of different environments simultaneously, taking into account risk factors and including illicit and licit drugs;

(iii) the importance of adapting interventions to local needs and circumstances;

(iv) the integration of drug education in general health education school programmes;

(v) the emphasis on the promotion of a healthy lifestyle and avoiding risk behaviours;

(vi) the need for factual, objective, non-dramatized and non-fear-raising information;

(vii) the importance of the responsibility of parents and leading figures as positive role models;

(viii) the training of educators, youth workers, and health professionals.

There are two approaches concerning the use of mass media in information campaigns. Some countries consider them not a very effective way to carry out prevention interventions while others have recently launched campaigns.

Treatment and rehabilitation

Most Member States have treatment structures with services ranging from hospital and community-based medical facilities, outpatient centres, and therapeutic communities to self-help groups. The coverage, diversification and decentralization of services varies considerably between them; both formally structured institutions with professional staff, and loosely organized voluntary assistance provide these services.

Member States report the need to continue to strive for better, more diversified and an increased number of treatment possibilities. An important factor conditioning treatment policies is the role of intravenous drug use as a risk factor for HIV transmission. This fact has prompted many Member States to have flexible approaches to substitution treatments and syringe availability, as well as to try to reach drug users in their environments, and to make help available to them without the requirement of a drug-free lifestyle as a first goal.

The balance between health and social services in the approaches to the care of drug users is different between the Member States; while in some of them the emphasis is on the social approach, with the collaboration of health care when needed, in others the trend is to include the treatment of substance abuse in the general health-care system with the collaboration of social services. Finally, in some Member States the mental health care system also plays an important role. Most Member States report a need for better adapted services aimed at individuals with specific problems: prisoners, AIDS patients and HIV-positive persons, drug-using pregnant women, children of drug users, etc.

Statistics and epidemiology

As a whole, health-based data collection at national level is recent, scarce and generally not consistent. The data sources at national level most commonly used among Member States are treatment-based reporting systems, drug-related deaths and school surveys. In some instances national general population surveys on drug use and specific population surveys have been carried out using different methodologies. Member States mention the need for more systematized, coordinated, comparable and in-depth data collection. A number of Member States participate in the work of the Pompidou Group on health-based indicators and collection of data in pilot cities.

At a regional/local level the picture is similar. Most countries have carried out isolated regional and local data collection efforts, which although very valuable in their specific contexts, do not permit trend assessments or the establishment of comparisons between regions due to a lack of consistent methodology.

Specific research-oriented studies have been carried out at local and/or regional levels with a psychosocial/sociological/anthropological perspective to provide a more in-depth view of different aspects of substance abuse.

Manpower training

Most Member States report a recent increase in awareness on the urgent need for adequately trained personnel for the prevention and treatment of drug use. Up to the present, the most common approach to manpower training has been sporadic and/or of short duration and sometimes outside normal structures. Interdisciplinary courses for professionals and, in a few cases, continuous training has been provided. Some Member States have produced resource information/training materials for physicians, pharmacists, teachers and parents. Several Member States have structured, regular university and postgraduate studies for training and specialization in substance abuse.

The need to develop permanent programmes is recognized by a number of Member States, and in some instances, the planning is well under way. Examples of such plans are: the integration of substance abuse training in university curricula of teachers, health professionals and psychologists; university and postgraduate training on substance abuse; and continuing education systems for professionals involved in prevention and treatment.

Research

There seems to have been, up to very recently, only minor attention given to research, with a lack of coordination at national level (mostly isolated research initiatives at some universities). This highlights the need for an increase of funding and coordination in substance abuse research. Some Member States have already started responding to this need by creating new research coordinating bodies and/or specific funding for substance abuse research.

Conclusions

Member States are deeply aware of the importance of drug demand reduction programmes and the need to develop them as an essential element in an overall drug policy. The approaches to drug demand reduction are continually and often rapidly evolving in Member States; furthermore a large variety of approaches is being explored. Member States consider it important to introduce and improve evaluation programmes. They emphasize the importance of a broader framework of prevention measures in which various cultural, health and social problems are addressed and for a comprehensive approach to drug abuse problems, covering a range of environments simultaneously, taking into account risk factors and including illicit and licit drugs. Member States stress the need to have available a variety of different treatment methods for drug users. They consider that there is a clear need for developing comparable data collection systems on drug demand reduction. They recognize the need for increased support and coordination of research efforts. Adequate funding and manpower resources are fundamental to ensuring that drug demand reduction (prevention, treatment and rehabilitation) is carried out effectively.

Annex

Summary of the national reports

Introduction

1. Definition of drug policies

1.1. National level

Belgium

Everything to do with drug trafficking is a matter for the national authorities (i.e. the Ministries of the Interior, Justice and Finance and the Department of Health). As regards demand reduction, the Ministry of the Interior is responsible for the crime prevention aspect, mainly taking the form of training the police force with a view to enhancing their capacity to meet the specific demand issue of such 'drugs issue adult target groups' as parents, teachers, educators, etc. The legal and criminal aspects of drug demand reduction come under the Ministry of Justice, while drugs prescription monitoring duties fall to the Health Department's pharmacy inspectorate.

Denmark

The national level establishes statutes and other regulations, all control measures and general coordination.

France

Responsibility for policies regarding prevention, care and rehabilitation and for financing special addict care structures lies entirely with the national authorities. There is a General Delegation for combating drugs and drug abuse which is responsible for the overall coordination of drugs policies.

Greece

There is an interministerial body operating since the beginning of 1988 which determines national policy against the misuse of drugs. The Ministry of Health, Welfare and Social Security is currently expanding a network of institutions for prevention, treatment and rehabilitation and financially supports a non-governmental national programme based on the therapeutic community concept.

Ireland

The Department of Health plays a key role at the national level in a concerted effort with other government departments and agencies to monitor the position and to stimulate corrective action regarding the abuse of drugs covered by the Misuse of Drugs Act. There is a National Coordinating Committee on Drug Abuse which is chaired by the Minister of State at the Department of Health and is representative of all the relevant government departments and agencies (i.e. Justice, Education, Foreign Affairs, Police, Customs, etc.). This Committee is currently drafting a national plan to combat drug abuse.

Italy

The new law on drug dependence which entered into force on 26 June 1990 has redefined the institutional instruments for the formulation of policies and action programmes for the fight against drugs. The President of the Council of Ministers chairs the National Coordinating Committee for the Fight against Drugs, which comprises the competent Ministers (Health, Defence, Internal Affairs, Education, Social Affairs, Justice and External Affairs) and is supported by a Committee of Experts and the Permanent Observatory for the Drugs Phenomenon (responsible for the collection of data needed to prepare action policies). The Permanent Conference on Relations between the State, Regions and Autonomous Provinces is responsible for coordination between the central and regional governments in respect of programme implementation.

Luxembourg

Action to be taken in the fight against drugs is decided at national level by the Ministries of Health, Justice, Education, Family Affairs and Youth. A Coordinating Committee chaired by a senior official of the Ministry of Justice was set up in 1980 to facilitate interministerial cooperation.

Netherlands

Drug policy is defined at national level in close cooperation between the Ministry of Justice and the Ministry of Welfare, Health and Cultural Affairs.

Portugal

There is an interministerial and interinstitutional integrated plan against drugs, called 'Project Life', in effect since March 1987, coordinated in each specific area by the following Ministries: Internal Affairs, Justice, Education, Health, Employment and Social Security, Youth and Adjunct Minister Cabinet. Their aim is to decentralize the response to drugs and reinforce community initiatives. The areas covered are: information, treatment, rehabilitation, social reinsertion and supply reduction.

Spain

There is a national plan on drugs since 1985. It coordinates all governmental and non-governmental organizations, as well as citizens in general on actions against drugs. This plan is implemented through two bodies: an Interministerial Group, which coordinates the Central Administration (Health and Consumer Affairs; Employment and Social Security; Justice; Interior; Education and Science; and Social Affairs), and a Sectorial Conference, with representations from the autonomous communities (regions). They take decisions and actions related both to offer and demand reduction. The NGO National Assembly acts as a consultative body. The fight against drugs demand is seen as a collective, participative and integrative task, based on specific and unspecific prevention, treatment, rehabilitation and training of professionals. The basic objective is to normalize the social perception and response to the problem, therefore providing care through the general health and social resources and minimizing specific resources.

United Kingdom

Responsibility for implementing the Government's strategy rests with a number of Departments. Their activities are coordinated by Ministers. An Advisory Council on the Misuse of Drugs has also been established.

The UK drug demand reduction strategy has two main components. One is a programme of publicity and education aimed at discouraging people, in particular young people, from trying drugs. The other is to bring existing misusers into contact with a range of services intended to facilitate their adoption of less dangerous habits of misuse and, ultimately, to lead to total abstinence from drugs.

1.2. Regional and local levels

Belgium

Drug demand reduction, including prevention and treatment, is essentially a matter for the three regional (i.e. Flemish, French and German-speaking) communities. Some provinces have their own structure for organizing the coordination and development of specific programmes in conjunction with the national authorities and the regional communities.

Denmark

The regional level is responsible for treatment matters, regional coordination and expert counselling; the local level is responsible for prevention and early intervention.

France

The *départements* are responsible for adolescent maladjustment matters, and to this end run and finance clubs and drug advisory units active in this area, which is clearly linked with drug dependency. The prevention of delinquency is a matter for the local mayors under their overall responsibility for the maintenance of public order, and it is in this light and in the context of urban social development policies that local authorities are concerning themselves increasingly with matters relating to drug addiction, particularly in the fields of prevention and rehabilitation (before and after the event). The General Delegation has the task of developing activities involving the various levels of jurisdiction and financing, as well as central government.

Germany

Public health, including the care of drug addicts, is the responsibility of individual *Länder*.

Greece

Several regional and local consulting and therapeutic centres are currently in operation or will operate shortly. The centres are under the auspices of the public or the private sectors, the local authorities or the church.

Ireland

Details of the organizations providing services for drug abusers are set out in the Department of Health's publication *Directory of organizations dealing with substance abuse*. The Health Promotion Unit of the Department of Health seeks to encourage community-based responses to local drug problems. Coordination of regional services is the responsibility of the eight Regional Health Boards.

Italy

The law makes the regions and autonomous provinces responsible for drawing up (on the basis of guidelines issued by the Ministry of Health) and implementing plans of action relating to prevention, health treatment and social rehabilitation of drug addicts. The local and mountain-community authorities take action to prevent social deprivation and facilitate educational, occupational and social reintegration of addicts.

Netherlands

The major 23 municipalities are responsible for the development of ambulatory treatment and prevention policy. The 12 provinces are responsible for hospital-based treatment services (residential addiction clinics).

Portugal

Regional and local initiatives have recently been encouraged in order to develop and coordinate local partners.

Spain

There is a progressive development of autonomous plans on drugs (17 autonomous communities). These plans implement prevention, treatment and rehabilitation in each community, setting out the national plan on drugs.

United Kingdom

Regional Health Authorities (RHA) are responsible, with the help of their Drug Advisory Committee and Regional Drug Problem Team, for developing and coordinating local drug misuse treatment services.

Local services for drug misusers are provided by a diverse range of statutory and voluntary services, general practitioners (GPs) and health authorities themselves. Proper coordination of service delivery should be provided by District Drug Advisory Committees, whose members should include representatives of the health service, social services, the police, the probation service, the local education authority and the voluntary sector (including parents and self-helf groups). Their role is to monitor the prevalence of drug misuse, to assess the effectiveness of local services and make proposals for their improvement, and to coordinate, at working level, the efforts of different agencies involved in preventive measures and in service provision.

2. Level and sources of funding

Belgium

The system of demand reduction — ranging from prevention to care and treatment — is financed in whole or in part by the regional authorities (institutions resulting from public or private, governmental or non-governmen-

tal initiatives). One exception here concerning some primary prevention educational projects consists of very fragmentary sponsoring of such projects by private commercial institutions. The Ministry of the Interior finances its own prevention activities. The current level of prevention financing — especially primary prevention — is on the whole inadequate to meet the needs of the regional communities.

Denmark

Denmark has distinguished the respective parts of fundings from municipalities, counties and national authorities; for instance, treatment expenses are provided both by municipalities (50%) and counties (50%); social assistance support by municipalities (50%) and the State (50%); reception centres and shelters by counties (25%) and the State (75%).

France

Over recent years, central government has substantially increased its financial involvement. Taking a look just at the Ministry of Solidarity, Health and Social Protection, expenditure on addiction prevention and the care of addicts in special centres, hospitals and the social system increased from FF 235 million (ECU 33.6 million) in 1984 to FF 428 million (ECU 61 million) in 1990. In addition, an annual allocation of FF 250 million (ECU 35.7 million) has, for a number of years, been divided by the General Delegation among the various ministries, with some FF 150 million (ECU 21.4 million) allocated for demand reduction work to the Ministries of Education, Solidarity and Health, Justice, Youth and Sport.

Germany

Germany has pointed out that the national authorities have increased their funding by DM 11 million (ECU 5.3 million), from DM 1.8 million (ECU 870 000) to 12.8 million (ECU 6.2 million).

Greece

The Ministry of Health, Welfare and Social Security has allocated DR 582 million (ECU 2.9 million) for the public sector and DR 450 million (ECU 2.2 million) for the non-governmental programme of therapeutic communities for the year 1990. For the year 1991, the respective sums are DR 2 000 million (ECU 10 million) for the public and DR 450 million (ECU 2.2 million) for the non-governmental sectors.

Ireland

Over UKL 1 million (ECU 1.3 million) has been allocated from national lottery funds to a number of statutory and voluntary agencies dealing with intravenous drug abusers, who are at risk of contracting and transmitting HIV. The National Drug Treatment and Advisory Centre is funded by the State at a cost of UKL 1 million per annum (approximately).

Italy

The new drugs law and other recent legislation provide for the funding of the following activities over the period 1990-92:

(i) LIT 360 million (ECU 230 000) per annum for the creation and operation of the Central Service for Alcohol, Narcotic and Psychotropic Substance Dependence attached to the Health Ministry;

(ii) LIT 6.05 billion (ECU 3.9 million) per annum from 1991 for the employment of 200 social assistants within the Ministry of Internal Affairs;

(iii) LIT 4 billion (ECU 2.6 million) per annum for the operation of Ministry of Public Education committees, whose main task is to prevent drug addiction in schools;

(iv) LIT 176 040 billion (ECU 114 million) for 1990, including LIT 30 billion (ECU 20 million) for expanding the State drug addiction services, and LIT 180 billion (ECU 120 million) per annum for 1991 to finance anti-drug projects presented by the ministries, regions and local authorities;

(v) LIT 150 billion (ECU 97 million) per annum to finance help for drug-addicted and AIDS-infected prisoners;

(vi) LIT 10 billion (ECU 6.5 million) for the marketing of non-reusable ('self-blocking') syringes;

(vii) LIT 20 billion (ECU 13 million) for 1990 and LIT 38 billion (ECU 25 million) from 1991 for employment of State services staff to work on the prevention of AIDS among drug addicts.

Netherlands

All aid and treatment facilities — except for the methadone programmes of some municipal health services — are autonomous non-governmental institutions. The medical consultation bureaux for alcohol and drug problems (CAD) with a multidisciplinary orientation have a total budget of HFL 79 million (ECU 34 million) for 1990; the budget for social welfare services directed to drug users is HFL 55 million (ECU 23.6 million) in 1990, the budget of the methadone programmes of municipal health services is approximately HFL 7 million (ECU 3 million). Approximately 95% of the funds is dependent on the Ministry of Welfare, Health and Cultural Affairs that distributes these funds among the major municipalities. Residential treatment facilities are financed by the public health insurance funds (HFL 100 million, i.e. ECU 43 million). Furthermore, the Ministry of Welfare, Health and Cultural Affairs provides HFL 6 million (ECU 2.5 million) for AIDS prevention among drug users and HFL 4 million (ECU 1.7 million) for specialized national residential treatment facilities and experimental projects. The total cost of addiction treatment and prevention is approximately HFL 250 million (ECU 107 million). These costs include the treatments for alcohol dependency.

United Kingdom

The Government has allocated specific funds since 1986/87 to all Regional Health Authorities for the expansion of services for drug misusers; further additional funds have been allocated since 1987/88 to help prevent the spread of HIV among and from injecting drug users; in 1990/91, this funding totalled over UKL 15.5 million (ECU 22.6 million), and this money is distributed on the basis of the

proportion of the population between the ages of 15 and 34 within each region.

3. Levels and trends of drug use

Belgium

Estimates put the number of users and addicts at between 10 000 and 20 000, half of whom are regarded as problem cases. These figures are for the whole of the country. It is not possible to give reliable and significant figures, given that nothing is known of the number of users outside the specialized care and treatment network.

Denmark

It is estimated that the total number of drug abusers is about 10 000, with a substantial increase of drug abusers in methadone substitution treatment in recent years.

France

The number of drug users is put at some 100 000, a figure which has remained stable since 1980.

Germany

The number of regular hard drug users is estimated at 60 000 to 80 000, with a shift towards older age groups.

Greece

The number of regular hard drug users as judged by the commonly used indicators is currently estimated at between 9 000 and 13 000 users.

Ireland

The number of patients who attended the Dublin drug advisory and treatment centre was 1 052 in 1988, decreasing steadily from 1 514 in 1983, as compared with the number of persons charged with drug offences — 1 422 in 1989 and regularly increasing. There is evidence to suggest, however, that polydrug use in particular and new drug use are increasing.

Italy

The information available at present is not sufficient to allow an estimate of the total number of users of illegal substances. Figures are available for the number of persons who turn to the State help services and social rehabilitation structures. The Ministry of Health has estimated the number of drug addicts who at least started treatment under the State health services during the 12 months of 1989 at around 6 000, an increase of almost 18% over the previous year. On 30 June 1990, according to data compiled by the 'Observatory' operated by the Ministry of Internal Affairs, some 38 000 persons were currently being treated on that specific day by the State structures, plus 11 000 in residential therapy communities. The average age of new users is increasing. 30 to 40% of persons receiving treatment were found to be HIV-seropositive. Almost 90% of new subjects starting treatment over the past two years have been addicted to heroin as the primary substance, with 5 to 6% addicted to cannabinoids.

Luxembourg

Department of Toxicological and Pharmaceutical Chemistry statistics show that 1 799 analyses were carried out on samples from drug addicts in 1989. These figures reflect the level of activity of the service rather than trends in drug addiction in Luxembourg. Of the 1 799 analyses requested in 1989, around 700 samples had been collected under the new methadone maintenance treatment programme (two compulsory urine analyses per week for each person participating in the programme).

Netherlands

Reliable estimates for 1989 put the number of heroin addicts in the country as a whole at approximately 20 000, with stabilization of the overall problems but an increase in socio-economically disadvantaged populations. The mean age and the age of first use of heroin users are rising. Multiple drug use among heroin addicts is common. There are no indications that the use of cocaine has increased in recent years and has presented problems comparable to the nature and size of heroin problems. According to some local reports, the pattern of the misuse of other drugs, such as benzodiazepines and MDMA (Extacy), changes rapidly.

Portugal

The estimate of the total number of addicts in Portugal is 40 000 to 50 000, one third of them concentrated in the greater Lisbon area. There are around 3 000 first treatment admissions every year, mostly because of intravenous heroin use. It is estimated that there are 4 000 addicts in treatment and 350 in methadone substitution. Users seeking treatment are getting younger, and there are indications that heroin is increasing on the streets. Cocaine use is low but increasing, frequently combined with heroin. Polydrug use is also increasing.

Spain

In the last three years, there has been an increase in offer indicators, as well as an increase in acute deaths and treatment admissions; this seems to indicate an increase of drug use associated problems. There is also an age increase among addicts in treatment centres, emergency rooms and acute deaths. Problems are concentrated around heroin, although an increase of cocaine consumption is pointed out.

United Kingdom

It is difficult to measure the extent of an illegal activity such as drug-taking. One indicator is the number of addicts formally notified to the Home Office by doctors. This shows an increase in notifications of some 30% a year between 1980 and 1985, a fall between 1985 and 1987, and a renewed rise from 1987. However, this does not represent a complete picture of the scale of drug misuse. It has been estimated that the Addicts' Index underestimates addicts of notifiable drugs by a factor of at least 5, though these proportions, too, may be changing as a result of efforts to attract clients to drug services. There are also perhaps as many misusers of non-notifiable drugs, excluding those who use cannabis. Other indicators of the changing scale of the drug misuse problem are

statistics for the seizure of drugs and for persons involved in drug-related offences. This corroborates the evidence from the Home Office Addicts' Index of a respite in the increase in the number of misusers during the mid-1980s, although changes in statistics for seizures can, of course, be influenced by a range of other factors. The figures for drug-related offences show a similar correlation with the general trend.

Legal aspects

Belgium

The problem of drug abuse is generally covered by laws relating to public order and the protection of young people. However, there are a number of measures in certain districts at the instigation of public prosecutors seeking an alternative to the penal sanctioning of illicit drug-taking and requiring the drug abuser to consult a mental health service run by the aid network or to seek aid under a methadone programme.

Denmark

Treatment programmes for drug abuse are authorized under the Social Assistance Act, and treatment has always been voluntary. As regards the prevention of HIV transmission, specific recommendations have been added as amendments to treatment programmes.

France

The law of 31 December 1970 authorizes compulsory treatment of drug users on the basis of a court decision. It also allows the public prosecutor to suspend legal proceedings if the addict agrees to undergo treatment. 3 800 addicts benefited from this provision in 1988. The 1970 law also encourages spontaneous requests for treatment by making such treatment anonymous and free of charge. In order to prevent the spread of AIDS, legislation was introduced in 1988 to liberalize the sale of syringes. Pilot needle exchange programmes were set up, although without specific legal provisions.

Germany

There is disagreement in the Federal Republic of Germany as to the form drug substitution treatment should take, as reflected in the resolution passed by the special conference of the *Länder* of 30 March 1990. The current situation is that the *Länder* apply different criteria (medical and otherwise). A decision clarifying the legality of substitute drug treatment was taken by the Bundesrat (Second Chamber) on 11 May 1990. The Government endorses the position adopted by the Chamber of Physicians on 9 February 1990, setting out the various circumstances in which L-Polamidon can be dispensed to drug addicts. The Chamber of Physicians' view is that substitute drugs should be made available to addicts only in very specific (medically determined) cases under strict medical supervision and in conjunction with intensive psychosocial care. Drug substitution treatment should take place only in special institutions.

Greece

Arrested drug users are separated into two categories: non-dependent users arrested for personal use are obliged to follow a counselling programme, and they are imprisoned if recidivists in detoxification units; dependent users arrested for personal use follow either a voluntary detoxification programme or a compulsory confinement in a prison detoxification unit for therapy without any penalty: if these dependent users are arrested for drug trafficking, penalties are reduced with the same two above options (voluntary detoxification or compulsory confinement). Extensive modifications of the current law are being advanced for approval by the Greek Parliament. These modifications provide for extended authorities for the interministerial policy-making body and institute measures for the materialization of the public sector programme. They also provide alternate solutions to punishment to encourage convicted drug users to attend treatment and rehabilitation programmes.

Ireland

The previous Regulations (1979), relating in particular to the possession of controlled drugs, have been updated by the new Misuse of Drugs Regulations (1988), and the Minister for Health has established an out-patient drug treatment centre in the city centre of Dublin which has statutory responsibility for organizing and administering out-patient drug treatment services.

Italy

The law confirms the illicitness of the personal use of illegal substances, but punishes only possession. Possession of a quantity of an illegal substance below the average daily dose, fixed by the Health Ministry, is punishable by administrative penalties, with criminal penalties commensurate with the offence of drug-pushing for larger quantities. Both administrative and criminal penalties may be suspended if the subject agrees to undergo treatment. Persons requesting voluntary treatment are guaranteed anonymity. The use of methadone is subject to ministerial regulations and must be available at State help centres. The sale of syringes by pharmacies has been liberalized.

Luxembourg

The law of 19 February 1973 on the sale of medicinal substances and the fight against drug addiction offers addicts the option of withdrawal treatment in a specialized establishment.

Netherlands

There is a clear-cut distinction between drug users and traffickers, in order to avoid classifying the possession of drugs by users as a serious crime, and to allow easy access to prevention and voluntary interventions. As a consequence of prosecution policy, no special action is taken by the police to detect offences involving possession of drugs for personal use except in practice in the course of finding evidence against drug dealers, or in cases of public order disturbances. The selling or possessing of up to 30 grams of hemp products is illegal, but has lowest priority in prosecution policy, except in cases where minors are involved or (illegal) advertising takes place. There are no legal restrictions on the distribution of methadone in addiction treatment or the sale and free distribution of

syringes in AIDS prevention. All medical treatment of addicts takes place within the framework of the ordinary legislation concerning medical practice. For drug addicts who commit drug-related crimes the Penal Code provides for different measures to divert the suspects or convicts from the criminal justice system to the treatment system.

Portugal

Both traffic and use are punished with prison and/or fines. In the case of addicts, prison can be commuted to treatment. The sale of syringes is free, but there are no exchange programmes or free availability. Methadone is not commercially available.

Spain

The use of drugs has never been penalized in Spain. Possession for personal use is not penalized, but there is an open clause which allows to consider as an offence the invitation to use or the donation for use. A regulation on public use is under study, which foresees administrative sanctions (not penal). In 1990, a new law made substitutive treatments more flexible and less restrictive, due to the risk of HIV transmission. The sale of syringes has always been free in Spain. As to what concerns the workplace, there is a lack of legislation to allow drugs intake detection among employees.

United Kingdom

The principal legislation concerned with the control of drugs in the UK is the Misuse of Drugs Act 1971 and the various regulations made under it. The Act defines illegal drugs, placing them in three categories according to their degree of harmfulness. It is designed to be flexible, allowing new drugs to be added to the lists of illegal substances by secondary legislation. The Act prohibits the import and export, production and supply and possession of controlled drugs and sets out a range of penalties relating to its infringement. The Act also established the Advisory Council on the Misuse of Drugs.

Other relevant legislation includes the Medicines Act 1968, which provides for the control of medicinal products and certain other substances and articles, for example syringes and sterile water for injecting, through a system of product licences and clinical trial certificates, licences for manufacturers, and, where appropriate, restrictions on methods of sale. The Customs and Excise Management Act 1979 and the Drug Trafficking Offences Act 1986 broadened the range of drug-related offences and set out penalties.

Prevention

Belgium

The French and German-speaking regional communities place the emphasis on coordinated and global approaches with fieldworkers, organized by the Coordinating Committee on Alcohol and Other Drugs in the French-speaking community and the Working Party for the Prevention of Drug Addiction and Coping with Life in the German-speaking community. These approaches are centred on such centre-of-interest groupings as the family, the school, the working environment, the local communities, etc. They cover training for people with a 'relay' function and the organization of ongoing activity programmes addressed to young people and adults. In the Flemish-speaking community, information and education responsibilities lie with the Association for Alcohol and other Drug-related Problems, whose prevention staff work to strengthen the existing cooperation within and between such groupings as education, young people, adult education, health care and law enforcement agencies.

Denmark

Denmark bases its prevention interventions on two main paths: general social preventive measures to provide good conditions of life, and specific information given through two-way communication activities rather than mass media. Their emphasis is on harm-reduction rather than abstinence.

The implementation is based on national delineation of basic principles together with the publication of resource materials and a local planning and implementation of specific prevention interventions.

France

In 1990, France set up a major prevention programme based on three lines of attack: mass communication largely based on the media; the school and the family as role-leaders for young people; local initiatives bringing together a wide variety of people and organizations in towns and neighbourhoods.

Germany

Germany puts an emphasis on the concept of vulnerability and the need for protecting those at risk, as well as of including secondary prevention. Its aim is to develop targeted information campaigns to make people aware of the danger and legal implications of drug abuse, pointing towards total abstinence. Its plan of action encompasses a broad-based range of interventions aimed at reaching multiple target groups: publicity campaigns using the mass media for the general public work with media representatives, community figures and staff in schools; youth in their natural environments and institutional group situations (military and civilian national servicemen); young adults and parents.

Greece

There are no systematic primary prevention programmes, but several actions oriented towards secondary prevention: a network of consulting and drop-in centres, and groups of immediate intervention with high-risk populations. A national programme based on the 'health careers' concept is under approval for immediate implementation.

Ireland

Ireland has actions mostly oriented towards the information and training of professionals: teachers, workers in local communities, doctors, pharmacists, and specialists in drug abuse.

Italy

A publicity campaign to prevent drug abuse, aimed primarily at young people aged between 12 and 16, is currently being carried out through the mass media, parallel to the AIDS campaign. The Ministry of Health has promoted the expansion of educational initiatives which have proved effective (school team approach) and is to support initiatives of other agencies (the Unicri's 'Stop droga' programme), which will be coordinated with the measures implemented by the Ministry of Public Education. The Ministry of Defence has introduced an information programme for military service conscripts.

Luxembourg

Efforts are concentrated on supplying information to the population, parents, teachers and youth. The police participates in these information activities. Another focus is the promotion of alternative activities.

Netherlands

Drug prevention is part of general health education in schools as well as prevention programmes in the field of youth, mental health and social welfare. Specific drug information campaigns are found to be effective only with specific at-risk groups; therefore, mass media campaigns are not found to be appropriate. On the basis of local risk assessments (in a community, a school, a youth service, etc.) emphasis is given to substance abuse in general, specific licit or illicit substances, primary or secondary prevention. On a national level special funds are made available for prevention-workers and the development of technical support. However, priority is given to alcohol, smoking, and AIDS prevention among drug users.

Portugal

Portugal uses in its prevention efforts an array of initiatives, through a variety of channels: information and awareness campaigns to motivate social groups to become involved in prevention; production and distribution of informative materials for specific target groups, mass media campaigns and collaboration with the media; a telephone help line; information and education programmes for specific groups (school environment, parent-to-parent, youth-to-youth, professionals); and leisure-time activities with the collaboration of NGOs.

Spain

In recent years, there has been a progressive increase of resources allocated to prevention by the autonomous communities in relation to the total budget allocated to drug abuse control (from 14% in 1986 to 28.6% in 1989). The three main areas of intervention for prevention are: schools, communities and the workplace. A school prevention programme was launched by the Education Ministry in 1987-88. It created the post of provincial coordinator and entails teacher training, creation of resource materials, the incorporation of school health education in curricula and training for parent associations. Pilot projects are planned to evaluate the integrated curriculum. According to the priorities set up in community prevention, special support is given to programmes dealing with: high-risk youth, the improvement of the social image of drug abusers, the support of community social and health services, a technical information network, ongoing prevention programmes 'IDEA-prevención', and the training of local professionals. These community programmes are based on the knowledge of the current situation regarding drug abuse in each municipality in which they are to be implemented, and are drawn up with the coordinated participation of representatives from the various levels of power and the community sectors concerned. Pilot programmes at the workplace are starting to develop in Spain, some of them with the support of the main trade unions.

United Kingdom

The twin-pronged strategy of seeking to discourage people from using drugs in the first place and bringing those who use drugs into touch with a range of services reflects the Government's overriding priority of eliminating completely the misuse of drugs. But it also recognizes the important role of risk minimization among people who continue to misuse drugs. This emphasis is in large measure the product of recognition of drug misusers' role as a channel by which the HIV virus can spread into the general population.

In 1985, the Government launched a major health education and information campaign to discourage drug misuse. The campaign was developed in the wider context of Government action, begun in 1983, to improve treatment facilities, encourage professional interest and improve training. It was also a preliminary step in the fuller development of other preventive measures, which are now under way, such as advice and counselling services for parents and young people and educational material for use in schools. An extension of the Government's strategy on prevention was the introduction of needle exchange schemes in 1987.

Treatment and rehabilitation

Belgium

In the French-speaking community, there is a special network of out-patient, reception and residential facilities in addition to the conventional hospital and psychiatric services. The German-speaking community uses addiction-treatment professionals operating within the mental health care system. There is a scheme (in the French-speaking community) in day centres for rehabilitation and for helping people to readjust to working life, while the Flemish-speaking community also has a substantial network of addict-aid associations.

Over recent years, there has been a definite trend towards making evaluation of the types of treatment available and their results more uniform. This applies also to the other regional communities, who are trying to move in the same direction. The various self-help groups also have a specific role to play in the rehabilitation system throughout the country.

Denmark

Denmark reports an important revision of aims and methods in the last five years. The importance of offering different treatment options, including low-threshold ones in order to meet the needs of individual abusers, is

stressed. There is an emphasis on out-patient treatment, rather than in-patient; an increasing use of reception and shelter centres and a decreasing use of psychiatric hospitals. The majority of professional staff are social pedagogues and social workers. Prescription of methadone should be only a part of the treatment, accompanying continued control and assistance in the different areas; the improvement of methadone prescription practices by general practitioners is stressed. There are insufficient programmes, and their geographical distribution is irregular, not always covering the needs of the different types of abusers. There are special services for pregnant women and abusers with children. Special HIV/AIDS prevention interventions have been developed: information, easy access to needles and syringes and distribution of condoms. A clinic for HIV patients and drug abusers has been set up, and the collaboration between treatment centres and hospitals promoted.

France

A system specifically designed for drug addicts was set up in the 1970s, characterized by a wide range of schemes: reception centres (including out-patient, psychotherapy, and reintegration services), special hospital units, aftercare centres and foster families. The aim here is to provide an optimum response to the wide range of individual needs, leaving plenty of leeway for multiple therapeutic models. The role of general health services is growing in importance, and general practitioners have received training in drug abuse since 1988. In the main prisons, specific services have been set up to prepare prisoners for release, putting them in touch with sources of aid. Steps have been taken to limit the risk of transmission of infectious diseases, particularly HIV, with the deregulation of syringe sales and a syringe exchange programme. These are seen as an important source of prevention work thanks to the information on HIV transmission and contact with addicts who are not registered with a care centre. Improved job access is also a part of the overall reintegration programme for young people.

Germany

Germany has set up some prerequisites for treatment: accessibility, availability and diversification to cater for specific needs, long-term addicts being one main target group. They stress the need to supplement treatment with a fully integrated range of follow-up services and, within treatment, to provide for many stages (although it may entail a risk to prolong addiction). There is controversy about drug substitution, without uniformity between *Länder*. The Federal position is to administer it in special cases, under medical and psychosocial supervision. There is a comprehensive system which, nevertheless, needs to be extended in quantitative and qualitative terms, especially to rural areas; outreach work; confidence-building facilities (to reach more addicts); provision of special accommodation; women and addicts with children; easy-access hospital detoxification; and, in some *Länder*, drug substitution.

Greece

There is a network of services operating within the National Health System (public sector) and a variety of services operating within the private sector which include a national programme based on the therapeutic community concept. Both sectors are being substantially financed by the Ministry of Health, Welfare and Social Security and are currently expanding their services. The services available are several counselling and evaluation centres, a physical detoxification centre, a drug therapy unit within a hospital psychiatric section, therapeutic communities, day hospital, a hot-line for emergencies and mobile units for action in the community. The therapeutic communities include a rehabilitation and social reintegration programme as well as a programme for vocational training.

Ireland

Ireland has an out-patient treatment centre which coordinates comprehensive services: out-patient treatment; toxicology laboratory service; referral for in-patient treatment; counselling services; ante-natal and post-natal advice and methadone maintenance. There is also a drop-in centre for IVDU, offering counselling, medical services, needle exchange services, methadone maintenance, welfare advice and link with housing. Statutory and voluntary agencies are funded to facilitate the expansion of special services and AIDS preventionprogrammes, in particular outreach research and services, and a community-based information programme.

Italy

In the various regions of Italy, there are 517 State help centres for drug addicts, which operate as part of the State Health Service. Addicts may also be admitted into hospitals providing detoxification treatment. There are around 11 000 drug addicts in the 433 residential therapy communities, almost all of which are run by voluntary non-governmental organizations, although financed by the State or regions. The interdisciplinary teams of the State help services practise programmes of treatment with substitute products, psychotherapy and social rehabilitation programmes. They also cooperate with the AIDS unit to care for HIV-seropositive subjects.

Luxembourg

There is a system of decentralized reception and information centres, including psychology guidance departments in schools and street workers' networks. The therapeutic facilities include out-patient treatment centres, specialized psychiatric services, in-patient detoxification, therapeutic community and a post-treatment centre. The AIDS and drugs programme aims at reaching as many addicts as possible, and includes a network of street workers (including visits to hospitals and prisons), a pilot project on methadone substitution, a pilot project in the prison, and the preparation of a system for syringe exchange and free distribution of condoms.

Netherlands

The Netherlands has the following principles for the treatment and rehabilitation of addicts: a multifunctional network of medical and social services built up at local or regional level; easily accessible aid; the maximum use of unspecific services and the promotion of social rehabilitation of present and former drug abusers. The regional

networks include non-residential services (field work, social counselling, therapy, methadone supply and rehabilitation); semi-residential services (day/night centres, day-care treatment, employment and recreation); and residential services (crises and detoxification drug dependence units and therapeutic communities).

In this network there are forms of assistance not primarily intended to end addiction, but geared to 'harm reduction': field work, initial reception, supply of substitute drugs, material support and opportunities for social rehabilitation. The AIDS prevention measures provide information on safe sex and safe drug use, offer new-for-old syringes exchange programmes and distribute condoms. These networks are based on various types of centres: medical consultation bureaux for alcohol and drug problems; municipal methadone programmes; social welfare services and residential facilities. The consultation bureaux also have a probation task in relation to the criminal justice system.

Portugal

There are insufficient treatment (out-patient, methadone substitution, therapeutic community) facilities, and the existing ones are concentrated on the coast. More cooperation with social services is needed. The government coordinates eight out-patient centres and two therapeutic communities. Methadone is administered in only one centre in Oporto. One centre attached to 'Project Life' (Taipas) is a specialized unit with an array of services (out-patient, in-patient detoxification, emergency service and day-care centre). NGOs have an important role in the implementation of treatment and rehabilitation. There are plans to create penitentiary units. There is an agreement with a maternity clinic for the care of pregnant addicts, although insufficient. Care of addicts with AIDS is assumed from drug abuse treatment centres.

Spain

In 1989, there were in Spain more than 300 out-patient treatment centres, 120 therapeutic communities and more than 200 hospital beds for detoxification. Most out-patient services and half of the therapeutic communities are funded with public resources. The general services of health, in special primary care, have progressively more active participation in drug users' attention. Although there has been an important increase of resources in recent years, there are still waiting lists. There is a special programme for care of drug abusers in prison. Special risk-reduction activities have been developed to combat HIV transmission (including education programmes for high-risk groups and methadone maintenance). The priorities are the following: increased coverage; diversification of treatment services; improvement of care programmes for drug abusers having legal problems; and programme evaluation. Rehabilitation efforts are concentrated around the promotion of the reinsertion in the socio-laboral environment. The participation of general social services in this process is potentiated. Occupational promotion is sought through training and support for youth cooperatives' initiatives, and general promotion of employment alternatives.

United Kingdom

Government guidelines state that all DHAs should have access to the following services:

(i) advice and counselling;

(ii) in-patient and out-patient facilities for detoxification;

(iii) short-term residential rehabilitation facilities, including re-entry houses;

(iv) hostel or other housing provision.

In addition to developing, coordinating and monitoring the provision of drug treatment services locally, RHAs provide at least one specialist drug service; an expert regional drug problem team (RDPT) made up of professional medical, nursing and social care staff.

They are based at a Drug Dependency Unit, with full in-patient and laboratory facilities.

The RDPT also gives expert advice, support and training for district services.

In Scotland and Wales, detailed arrangements differ to take account of the different organizational and administrative structure of the National Health Service and local government; but overall policy relating to the provision of drug misuse services is the same as in England. Primary responsibility for the planning and provision of services lies with Health Boards and local authorities in consultation with the voluntary sector. Inter-agency Drug Liaison Committees have been established in all mainland Health Board areas to coordinate local action. In addition to their allocations, some UKL 2.2 million per annum is currently being made available to Health Boards in Scotland, specifically for the support and development of drug misuse services. A wide range of services for drug misusers has developed from a low base over the last six years, but some gaps remain, particularly in relation to residential crisis intervention and rehabilitation facilities.

Statistics and epidemiology

Belgium

A variety of regional studies, mostly among schoolchildren and other target populations, have been conducted over the past 10 years. With such a variety of survey methods, it is impossible to make any comparison at present between times and regions. No estimate has been made of the total number of addicts or drug users. A one-day prevalence survey was carried out in 1986, 1987 and 1988 in all treatment institutions in all three regional communities. An inter-community coordinating committee has been set up, along with a permanent observation unit on drug and alcohol-related problems.

A summary report for the three communities is now being drawn up, including national data from the various departments concerned. The German-speaking community has set up a 'permanent measuring instrument', while the Flemish-speaking community has an epidemiology working party. The three units are organized differ-

ently in the three regional communities, but work together with the Hygiene and the Epidemiology Institute nationally.

Denmark

Denmark has annual reports from the counties based on drug abusers in treatment, as well as estimates of the prevalence of drug abuse and the characteristics of drug abusers in contact with service providers. The National Board of Health collects information on methadone prescriptions and the Institute of Psychiatry on drug-related admissions to hospitals. School surveys have been conducted in local areas, but there are no long-term observations. A project under way is a national substance abuse profile, which will provide more complete nation-wide information.

France

France conducts an annual national statistical survey (by the Ministry of Solidarity and Health) at special consultation and treatment centres, and an epidemiological survey on drug addiction in prisons (conducted by Inserm – the national institute of health and medical research). At regional level, there is a monitoring network which collects and analyses indicators on drug abuse. Demographic studies are mostly related to licit drugs, but since 1978, other surveys have been carried out (by the Inserm) in schools on illicit drugs. Several sociological and anthropological, as well as evaluation, studies have been carried out. A permanent drug and drug addiction observatory is now being set up by the General Delegation and all the ministries concerned.

Germany

Under the Establishment-based information system (EBIS), information is collected on addicts in some 300 out-patient centres. A survey is conducted every three years by the Centre for Youth Education on susceptibility to drugs among young people. Other studies have been conducted, e.g. extensive interviewing and HIV testing of drug addicts. The Ministry of Youth, the Family, Women and Health has for many years now conducted representative surveys on the nature and extent of drug use in particular age-groups. The survey currently in progress uses a sample of 19 000 people aged between 12 and 39, and for the first time includes what used to be the territory of the GDR. In-depth analysis of the survey results should reveal what factors operate on individuals in triggering and stabilizing drug abuse.

Greece

The Department of Psychiatry of Athens University, in connection with the Department of Youth, has conducted several nation-wide and local studies: a retrospective study of recorded drug addicts (1973-83); a nation-wide general population survey (1984); a nation-wide high-school student survey (1984); other high-school surveys in Athens and in other major cities; and psychosocial studies on drug addicts.

Ireland

Ireland collects treatment-based data.

Italy

Help centres and doctors send information on subjects receiving treatment to the Regional Epidemiological Observatories. The data are processed on a central basis by the Ministry of Health and cover the following aspects:

(i) Number of subjects taken into care during the year;

(ii) Substances to which they are addicted;

(iii) Type of treatment (in 1989, 33 000 subjects were treated with substitute drugs, around half of them with methadone; a total of 55% of subjects received substitute drug treatment, whilst 45% received only psychosocial treatment);

(iv) Age and sex of persons receiving treatment.

These data are published (also in English) in the Ministry of Health's *Bollettino per le Farmacodipendenze*.

The Permanent Observatory for the Drug Phenomenon, which is an instrument of the National Coordinating Committee for the Fight against Drugs and operates under the Ministry of Internal Affairs, carries out regular systematic surveys covering the whole country, in collaboration with State and local authorities. These surveys involve the collection of epidemiological data on social and health aspects and the prevention and suppression of illicit drug traffic.

The main data published by the Observatory are as follows:

(i) the number, distribution and characteristics of drug addicts who have turned to the State health structures and residential therapy communities (situation on four specific days of the year);

(ii) the number, distribution and characteristics of the State services and social rehabilitation structures.

Luxembourg

Luxembourg has statistics from the toxicological and pharmaceutical chemical division on forensic toxicology.

Netherlands

The Netherlands has a reporting system based on drug treatment services, which, at this point, includes the Ambulatory Consultation Bureau for Alcohol and Drugs and the residential addiction clinics; and in 1991, it will be expanded to municipal methadone programmes and local rehabilitation services. The Central Bureau of Statistics reports on drug deaths and AIDS data are also collected. A study on 'Acute death after misuse' was conducted in Amsterdam (1990). Surveys have been carried out both at national (National school survey 1988) and regional/local level (Household survey City of Amsterdam 1989-90), and several sociological (qualitative/descriptive) studies have been conducted. After positive experiences with anthropological techniques in several local studies on drug abuse, a continuous nation-wide drug abuse monitoring programme is now under consideration. The Netherlands participates in the epide-

miology programmes of the Pompidou Group, directed to school surveys and city-based studies.

Portugal

The development of a systematic drug abuse data collection network is under way. This network is to be integrated in the European network called for in Resolution 89/C 185/01 of the Council of Health (EEC).

Spain

Spain has an ongoing reporting system based on three indicators: out-patient treatment admissions, acute deaths, and non-fatal emergency room episodes (State information system on drug addiction: SEIT). This system provides information on opiate and cocaine use at national and regional levels.

A retrospective study on drug-related deaths was conducted in six Spanish cities (1983-89). Several surveys, mostly regional, have been conducted between 1984 and 1989, but, since there was no standardized multiwave survey, trend assessment is not possible. Indirect indicators regarding drugs on offer are also available.

United Kingdom

Wales and all Regional Health Authorities in England have been asked to set up a database which collects anonymous data about clients attending both voluntary and statutory services and will enable regions to monitor trends in drug misuse and the use of drug misuse services in their own region, and to plan future services.

A similar database has been established in Scotland. This information will be submitted to the Department of Health at six-monthly intervals and used to monitor and evaluate the expenditure by health authorities and boards of earmarked moneys, and to develop future policies. The database will also provide information required by the Home Office for the Addicts' Index.

Manpower training

Belgium

There is no specific curriculum at university level on drug abuse. A number of universities have developed training modules for health, social work and education professionals to provide knowledge on treatment and prevention. One of them now offers a full second-level course, while even more recently, a new, more intensive programme (160 hours) has been organized by the provincial authorities, aimed at graduates in paramedical and social studies.

Denmark

Manpower training had a low priority at national level until recently. In July 1990, a model training programme was established. This programme is addressed at post-graduate training of staff dealing with substance abusers, with the long-term aim to reform local treatment in general.

France

France has continuous national drug misuse training for general practitioners, organized by the Ministry of Solidarity, Health and Social Protection; practical organization is up to the regional authorities. There is also a national training scheme for professionals in after-care centres on problems related to HIV and a programme for pharmacists similar to the one for physicians. An information brochure for pharmacists has been published, to be followed shortly by another for local politicians.

Germany

Germany reports a need for general improvement in manpower training. This improvement means the extension of the range of multidisciplinary further training courses available (for judges, public prosecutors, and social services connected to the courts and the police).

Greece

A few sporadic actions have been carried out up to now. Meetings and short training programmes for health workers have been conducted with the aim of forming small expert groups in the different regions.

Ireland

There is a programme for interdisciplinary training for people working in local communities which seeks to encourage community-based responses.

One college offers a diploma course on addiction studies which provides specialized training for workers in direct contact with drug abusers and their families. Information resources, such as a document for doctors and pharmacists with recommendations on the prescribing and dispensing of controlled drugs, and an information booklet on substance abuse, have been produced.

Italy

At the moment, there are no post-university training courses for doctors and psychologists working with drug addicts. Occasional initiatives by individual universities are limited to short, non-permanent courses. Staff training is currently entrusted to the regional authorities. Non-government agencies provide for a national staff training plan specific to the needs of health service personnel and therapy community staff, together with permanent training structures. Special training programmes are also planned for staff involved in prevention. These will form part of a series of training actions promoted by the Ministry of Health through its recent financing of around 50 courses at national level to be organized according to guidelines drawn up by the Ministry itself for the following programmes: attitude training, training for staff involved in preventing the spread of AIDS among drug addicts, training for drugs workers and counsellors, etc.

Netherlands

Several projects have been funded in order to stimulate manpower training in universities and professional education, post-graduate training and in-service training. These projects were meant for addiction treatment personnel

and for personnel in general health care and social work facilities. The Netherlands Institute on Alcohol and Drugs provides many training programmes, which cover the whole range of treatment and prevention modalities.

Portugal

At this point, generalists start getting some specific information on drug abuse. It is considered to be of great importance and need to integrate training on drug abuse within medicine, psychology and nursing schools.

Spain

In 1987, the national plan funded postgraduate university studies on drug abuse in five Spanish universities. Nowadays, three Spanish universities offer a Masters in Drug Abuse. Other higher-education institutions have included drug abuse education for their students. Schools of Public Health in the autonomous communities offer specialized training. Training packs are being produced to support courses for health professionals, teachers and parents. The Ministry of Education promotes training of teachers and parents.

United Kingdom

The Advisory Council on the Misuse of Drugs (ACMD) made a number of recommendations regarding the training of professional staff who (may) work with drug misusers, but also of health-care staff, teachers, youth workers, health service managers and residential care staff. The Government has itself initiated a range of activities and supported others to help meet the financing needs identified in the ACMD's report. Teachers play a crucial role in making young people aware of the risks involved in drug-taking. The Government also provides funds for a number of training activities. For example, it has provided pump-priming money for training courses run by the English National Board for Nurses, and by the National Association for the Care and Resettlement of Offenders.

Research

Belgium

A number of universities have ongoing research covering different aspects of drug abuse (prevention, treatment and training) looked at from different angles: psychiatry, social psychology, medical sociology, hygiene and pedagogics, legal aspects, etc. Generally speaking, these projects tend to be isolated, apart from two coordinated projects involving a number of universities in the two main regional communities, centring on use habits and activities undertaken in the two communities. The intercommunity coordinating committee and its *ad hoc* working party on epidemiology want to start work in 1991 on epidemiological research using a standard method throughout Belgium.

Denmark

A review on research from 1986 reported the existence of few integrated environments for substance abuse research, mostly by medical doctors, few by social scientists, and virtually none by humanists. There is a need for increased priority to be given to substance abuse research, especially aspects of prevention and control policy. In 1988, and for a trial period of five years, an organization and funding project to promote substance abuse research was initiated. It intends to promote educational possibilities for young researchers and the establishment of integrated environments for substance abuse research.

France

Research into drug addiction has always had an important place in France. The main areas covered are basic neuroscientific research, epidemiological, ethnographic and psychosocial research and, to a lesser degree, historical and legal research.

Germany

There are problems in research, since substance abuse professionals do not have, in general, adequate research training, and researchers in universities, on the other hand, have not given enough attention to the subject. The areas needing improvement are: basic biological research, medicament development, interlinking available data systems, family background and drug use, and different prevention aspects.

There is a need for coordination between the federal government and other bodies, as well as more commitment from research institutions and their collaboration with treatment centres. At a national level, an analysis of research requirements and potentials is under way.

Greece

Several epidemiological research studies have been carried out primarily by the University of Athens. In addition, Greece is participating in the development of methodology for reporting and survey systems in connection with the Pompidou Group (ECU 2.2 million).

Ireland

Ireland is participating in the setting up of a drug reporting system under the aegis of the Pompidou Group.

Italy

A considerable amount of drug dependence research is financed by the various Ministries (Health, Internal Affairs, Universities, etc.) and the regional authorities. The new drugs law includes provisions on coordination between the research promoted by the mentioned industries. Increased funding is needed if more in-depth research and monitoring of the phenomenon are to be made possible.

Netherlands

The Netherlands has different lines of research: epidemiological studies (including methodology development for surveys and reporting systems in connection with the Pompidou Group), treatment evaluation studies, qualitative and descriptive sociological studies. There is promotion of research through funds from the Ministry of Welfare, Health and Cultural Affairs, the Ministry of

Justice and the Ministry of Education and Science; also, non-governmental funds are involved.

Portugal

Research carried out up to the present is very insufficient and with no specific support, although there is scientific potential to develop it. Some epidemiology studies in the school environment have been carried out in connection with the Pompidou Group.

Spain

There has been an important increase in funding for research in fields associated with drug use. A specific line of funding for drug abuse research within the main Spanish research agency in the area of health is to be created. There have been some epidemiological and sociological studies and other research initiatives funded by the national and autonomic plans on drugs. There is a need to define priority areas for research in the field of drugs. An information and documentation centre was created in 1987 by the national plan on drugs. Its documentation (over 7 000 titles) constitutes a database named Eleusis that is fully computerized.

United Kingdom

The Department of Health and the Scottish Office have funded or commissioned a number of research projects and other studies relevant to the prevention of misuse, and the treatment and rehabilitation of misusers. Research is carried out by a variety of people or bodies — independent researchers, university departments, and specialist units.

No C 329/20 Official Journal of the European Communities 31. 12. 90

CONCLUSIONS OF THE COUNCIL AND THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL

of 3 December 1990

on reducing the demand for narcotic and psychotropic substances

(90/C 329/06)

THE COUNCIL OF THE EUROPEAN COMMUNITIES AND THE MINISTERS FOR HEALTH, MEETING WITHIN THE COUNCIL,

Having regard to the interim report and the guidelines for a European plan to combat drugs approved by the European Council in Dublin on 25 and 26 June 1990,

Having noted the task which the European Committee for the fight against drugs (Celad) assigned to the *ad hoc* Working Party on Drug Abuse, namely to examine the aspects relating to drug demand reduction contained in the preliminary draft European plan to combat drugs, drawn up by the current Presidency of Celad, and to prepare a document on the subject;

In the light of the thorough work carried out by the *ad hoc* Working Party on Drug Abuse in preparing that document;

Having noted that at its meeting of 19 and 20 November 1990 Celad used the findings of that work in its European plan to combat drugs, to be submitted by Celad to the Rome European Council on 13 and 14 December 1990;

Having examined, furthermore, the report drawn up by the Commission in conjunction with the Member States on demand reduction policies in the Member States, requested of the Commission by the European Council in Dublin on 25 and 26 June 1990;

Express their appreciation of the work carried out by the *ad hoc* Working Party and the Commission;

Suggest that the European Council, at its meeting of 13 and 14 December 1990, approves the paragraph on demand reduction in the draft European plan to combat drugs proposed by Celad, in view of the important health-related objectives which it contains and which the Council supports;

Take note of the conclusions of the report on demand reduction policies, which the Commission forwarded to the Council;

Identify, amongst social and health measures, the following as the most urgent of the measures defined by Celad in the European plan to combat drugs and as being in keeping with the needs emphasized by the Commission in its report on demand reduction policies in the Member States:

1. The intensification of prevention measures in each Member State, aimed at the general population and high-risk groups.

2. The intensification of measures in the Member States, to extend the range of effective methods for treating drug addiction by:

   (a) developing services providing the main therapeutic options, where appropriate in an integrated fashion, with special emphasis on those groups among which the continued use of drugs entails serious subsequent risks to their health;

   (b) analysing, updating and applying the various methods of treatment assessment.

3. The intensification of intervention in the Member States of proven efficacy in obtaining and maintaining the social and occupational integration of addicts.

4. The intensification in the Member States of those activities and in-service training of qualified staff in the prevention, treatment and social integration sectors,

INVITE THE COMMISSION:

(a) to promote the Community-wide exchange of information, concerning in particular information and educational material on prevention, approaches to treatment and measures taken on social and occupational integration;

(b) to promote the exchange of information on the methods used to evaluate the efficacy of the different measures taken and, in close cooperation with the Member States, to explore the possibility of improving methods of evaluation, enabling the Member States to use compatible and comparable evaluation methods;

(c) to draw up regular reports, in collaboration with the Member States, on demand reduction policies;

(d) to carry out a feasibility study on the organization within the Community of regular training and update courses for qualified staff on themes which, because of their novelty and/or special nature, have not yet been sufficiently developed and studied;

Invite finally the *ad hoc* Working Party on Drug Abuse to act on any requests from Celad to examine the social and health aspects of studies concerning a Drugs Monitoring Centre and to report to the Council.

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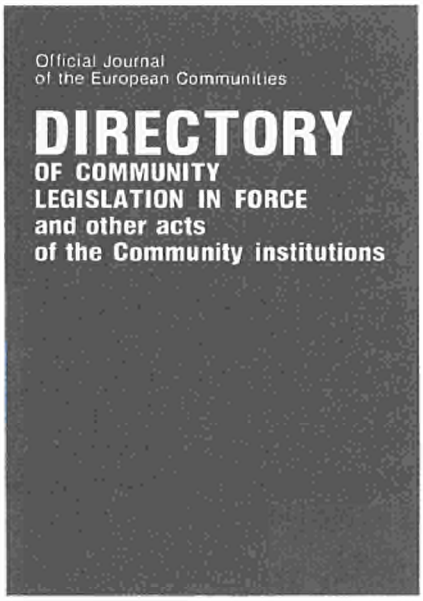

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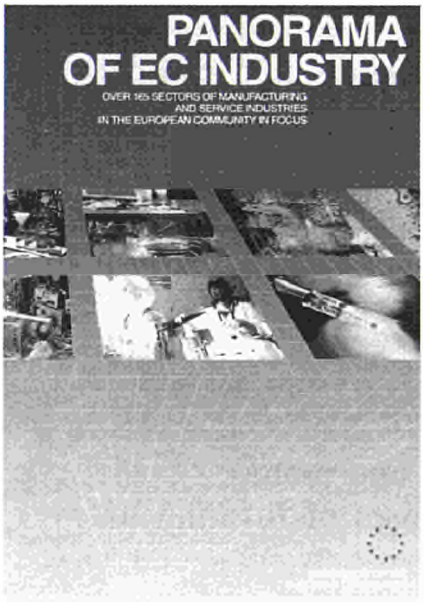

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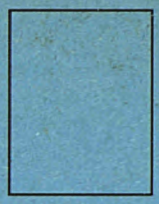

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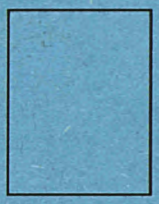

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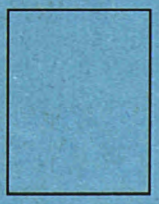

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